

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11968782	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
NAME OF FACILITY CROSSROADS CARING HOME LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2563 RIVER RD CARYVILLE, FL 32427	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0084	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 58A-5.0191(5) FAC	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
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LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KC	DATE 8-31-16	SIGNATURE OF SURVEYOR Kristi Longino Roxey Keel	DATE 8-31-16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 6/7/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
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**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 08/31/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968782	(X3) DATE SURVEY COMPLETED R 08/23/2016
NAME OF PROVIDER OR SUPPLIER CROSSROADS CARING HOME LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2563 RIVER RD CARYVILLE, FL 32427	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced revisit survey was conducted at Crossroads Caring Home Assisted Living Facility (license # 12630) located in Caryville, FL on [redacted]. A complaint survey and a biennial survey were conducted in conjunction. Deficient practice was identified at the time of the survey.

0080 Training - Core & Competency Test

Based on record review and staff interview the facility failed to ensure the facility manager completed the assisted living facility core training requirements, including completing and passing the core training competency test within 3 months of the date of becoming the manager. (employee D)

The findings include:

Review of employee D's file revealed a letter of confirmation signed by the Administrator and employee D and dated [redacted] indicating employee D was in charge of the facility operations in the absence of the Administrator. The surveyors arrived on [redacted] for the survey and were informed by employee D the Administrator was out of town and would not return to the facility until [redacted]. Employee D's date of hire was [redacted]. A certificate of completion indicated 26 hours of core training was obtained on [redacted]. The record revealed no evidence employee D had passed the core competency exam.

An interview was conducted with employee D on [redacted] at approximately 2:23 PM. Employee D stated she had not completed the core competency test because she had a medical emergency last month.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Crossroads Caring Home LLC
2563 River Rd
Caryville, FL 32427

RE: CCR #2016008429

Dear Administrator:

This letter reports the findings of a state licensure biennial survey with limited mental health services that was conducted on , 2016 by representatives of this office in conjunction with a complaint survey and a survey revisit for a complaint survey originally conducted on 7, 2016.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit as well as uncorrected deficiencies and/or new deficiencies identified during the revisit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call me at 850-412-4540.

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone: 850-412-4540; Fax: (850) 922-9162
AHCA.MyFlorida.com



Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Sincerely,

A handwritten signature in cursive script, appearing to read "Kristi Anderson".

For

Donah Heiberg, M.S.W.
Field Office Manager

DH/kc
Enclosure

XG90