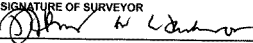


STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11968782	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT Y2 Y3
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 A0078	Correction	ID Prefix A0093	Correction	ID Prefix	Correction
Reg. # 58A-5.019(2) FAC	Completed	Reg. # 58A-5.020(2) FAC	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
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
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR 	DATE 12/1/10
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 8/23/2016		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 10/06/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968782	(X3) DATE SURVEY COMPLETED R 09/28/2016
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 to CCR#2016008429 was conducted at Crossroads Caring Home Assisted Living Facility (license number 12630) on . At the time of survey two of the deficiencies were corrected and 2 was not corrected.

0092 Food Service - General Responsibilities

Based on observation and interview, upon the revisit, the facility failed to ensure that the administrator was responsible for total food services, specifically that the food items in the pantry and kitchen were appropriate for resident use and not past their use by date.

The Findings:

On an observation was conducted of the facility's food pantry at 6:49AM (Central Time) with employee B who used key to unlock door. Upon entrance three cans of diced tomatoes were expired on , 2016; Jellied Cranberry Sauce expired , 2016; 2 boxes of Little Bites muffins expired , 2016, expired coleslaw mix in refrigerator , and 4th. Eggs not on bottom shelf of refrigerator, there were three freezers with a black substance noted in all three; the freezer against back wall contained one open bag of pizza lying at bottom without dates, original packaging and closure. Bags of bread housed on bottom rack of pantry to the right of door found to be wet from unknown source and expired in both and . Refrigerator in kitchen found to have cooked hamburger meat in a sour cream container without date.

0152 Physical Plant - Safe Living Environ/Other

Based on observation, resident interview and staff interview upon the revisit, the facility failed to maintain a safe living environment, provide a clean, comfortable bed and maintain all existing architectural and structural systems in good working order in 4 of 4 buildings and the office building.

The Findings:

On at approximately 5:30AM an observation was conducted of the office and found to certain areas to sink in when walking. The laundry was housed in the office revealed unlevelled flooring and no functioning light. Several residents were observed to come in the office and one female resident was observed to take clothes in the laundry wash.

On an observation was conducted of the men's dorm #1 at 07:35a.m, the observation revealed

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**SUMMARY STATEMENT OF DEFICIENCIES
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a smoke detector hanging from the ceiling and missing the battery and beeping. The lights in the foyer were not working with exit sign not illuminated. A total of four mattresses were observed in the dorm and three had visible concaves in the mattress.

An observation was made of the men's dorm #2 at 07:45 AM, an interview was conducted with two residents sitting on the porch resident #10 who reported " I have piss in my bed " and has requested twice for a new mattress but has not received one. Resident #11 exited the dorm and stated " my bed dips and is hard ". An observation was made of two chairs sitting on porch one of which was found to be cracked and unsafe. Resident #12 stated " it has been broken for a while ".

An observation was conducted of women's dorm #22 at 07:55 AM, which revealed broken tiles in both dorm . . . Of the six chairs on porch two were damaged.

An observation was conducted of the table outside of kitchen building where residents sit to smoke and socialize had multiple broken chairs that residents were observed sitting.

On : at approximately 12:00PM, an interview was conducted with employee B who confirmed the findings and stated that the administrator will need to have staff go around and conduct a tour of all four houses to correct all findings.



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

1, 2016

Administrator
Crossroads Caring Home
2563 River Rd
Caryville, FL 32427

RE: CCR #2016011154, 2016010615, 2016010195

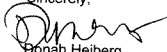
Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 1, 2016 by representatives of this office. 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. 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 1, 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.

Sincerely,


Donah Heiberg
Field Office Manager

DH/dh
Enclosure

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
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