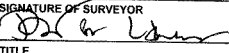


STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11968782	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 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 A0081	Correction	ID Prefix A0161	Correction	ID Prefix A0162	Correction
Reg. # 58A-5.0191(2) FAC	Completed	Reg. # 429.275(2) FS; 58A-5.024(2) FAC	Completed	Reg. # 58A-5.024(3) FAC	Completed
LSC		LSC		LSC	
ID Prefix AZ814	Correction	ID Prefix AZ815	Correction	ID Prefix	Correction
Reg. # 435.12(2)(b-d), FS	Completed	Reg. # 408.809, 435.02(2), 435.06	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 12.11.16
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
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**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 survey was conducted at Crossroads Caring Home Assisted Living Facility (license number 12630) on . At the time of survey all deficiencies were corrected except AZ816.

Z816 Background Screening-Compliance Attestation

Based on record review and staff interview upon the revisit the facility failed to ensure that 5 of 5 employee's record (A, B, C, D and E) contained a signed and dated Affidavit of Compliance with Background Screening Requirements (AHCA form 3100-0008) or a similar document attesting under penalty of perjury that they are in compliance with Chapter 435, F. S.

The Findings:

A record review was conducted of all five employee's personnel files upon revisit and none of the employee's files contained a signed Affidavit of Compliance with background screening requirements.

On at approximately 10:00 AM, an interview was conducted with the employee D who verified that none of the employee's files had a signed Affidavit of Compliance with background screening requirements.



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Crossroads Caring Home
2563 River Rd
Caryville, FL 32427

RE: CCR #2016011154, 2016010615, 2016010195

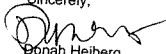
Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 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 , 2016.** Staff from this office will conduct a review of the provided corrective 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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