STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965525	04/20/2018
NAME OF PROVIDER OR SUPPLIER **HAVENCREST II ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **4244 NW 51ST STREET** **COCONUT CREEK, FL 33073**	

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

0000 - Initial Comments

An unannounced Abbreviated Relicensure survey was conducted on at Havencrest II ALF Inc, License #9878. The facility had deficiencies at the time of the visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, interview and record review, the facility failed to appropriately determine continued residency after a signficant health change (including enrollement into hospice) by having the licensed Physician or licensed Practitioner conduct a face to face assessment to determine appropriateness and that the facility could met the resident's needs, for 1 of 4 residents in the facility (Specifically, Resident # 1).

The findings included:

On at 02:00 PM, an interview was conducted with Resident # 1. She was observed dressed appropriately for the weather. She was neat, clean and well-. She was observed sitting in her wheelchair sideways, relieving pressure from her right thigh and . She later explained that she had a that had persisted for several months. She further stated that it was painful to her. She went on to state that the Nurses come all of the time, but the is not healing. She stated she was and did not feel like doing very much.

A review of the resident's record was conducted to review the notes on Hospice and care. The record revealed the female was admitted into the facility around , based on her demographic form. A review of the Florida Health Assessment Form (AHCA 1823 form) dated indicates she suffers from and . She has Nursing/treatment/ service requirements of Physical and Nursing Services. The form states she needs assistance with the following Activities of Daily Living (ADL's): ambulation, bathing and dressing; requires supervision with eating and self care . She is independent with toileting and transferring.

A review of the Hospice Physician certification for services revealed the Resident was certified to begin Hospice services effective . Further review of Resident #1's file revealed that there were no additional 1823 forms completed by the Physician to capture the Hospice service or new Hospice certifying diagnosis.

On at 03:00 PM, an interview was conducted with the Administrator of the facility. She

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965525	**04/20/2018**
NAME OF PROVIDER OR SUPPLIER **HAVENCREST II ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **4244 NW 51ST STREET** **COCONUT CREEK, FL 33073**	

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

stated it is very difficult to get the doctors to complete the forms She confirmed the Hospice services should have been added on the form.

Class III