

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AL11968825</b>	(X3) DATE SURVEY COMPLETED  <b>R</b>  <b>09/12/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>CRISTAL PALACE RESORT PB LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1881 PALM BAY RD NE</b> <b>PALM BAY, FL 32905</b>	

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

**0000 - Initial Comments**

Revisit to Complaint Investigation #2017006089 was conducted from 9/10 to 9/12/18. Cristal Palace Resort PB LLC., License #12660, had 3 uncorrected deficiencies found at the time of the visit.

**0004 - Licensure - Requirements - 58A-5.016 FAC**

UNCORRECTED

Based on observations and interviews, the facility did not obtain approval from the Agency prior to converting the third floor of the facility to a locked secured memory care unit, and a resident . . . . . a medication . . . . .

Findings:

1. Review of the facility's resident census on . . . . . at 10 AM noted resident #34 was the only resident who lived on the third floor.

Observations of the 3rd floor on . . . . . at 11 AM noted a key . . . . . next to the elevator. There was a paper sign taped by the up and down buttons that indicated "elevator code 1000 and . . . . .".

On . . . . . at 11 AM, resident #34 said she was moving to the second floor. She said, "There was a man who lived here too but he moved out." She added that she did her activities in the . . . . . she sat. Observations noted some chairs, a table, puzzles boxes, and activity books. The . . . . . previously a resident . . . . .

Resident #4's record revealed an admission date of . . . . ., and a health assessment report 1823, dated . . . . . that indicated diagnoses of . . . . . deficiency, . . . . ., and . . . . . behavior. The report also indicated the resident needed 24-hour nursing or . . . . . care and a "possible referral to psych on . . . . .".

Facility note dated . . . . . at 3:02 PM indicated resident #4 was a new admission to memory unit . . . . . Per note, the resident was an elopement risk. The facility admission and discharge log indicated resident #4 was discharged on . . . . . to another assisted living facility.

On . . . . . at 4 PM, the administrator said the memory care unit opened in . . . . . or . . . . ., 2018. He was told by the consultant that the facility won the hearing against the Agency, which meant all previous

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deficiencies were corrected and they were able to start fresh, from scratch again. He did not have any documentation regarding communication between the owner and the Agency and the memory care unit. Since resident #34 moved to the second floor, he felt that issue was corrected.

On \_\_\_\_\_ at 10 AM on the third floor, resident #34 ambulated with a walker near the elevator. She said she wanted to be with people and was going downstairs. The elevator door was open, so she got in and went down. After the resident left, the elevator button was pressed but it did not light up. The elevator would stop at the 2nd floor but not come to the 3rd floor. The elevator stopped on the 3rd floor only after the elevator "code 1000" was pressed. There was a sign by the elevator that read, "code 1000 . . ." When the elevator door opened, resident #34 was inside and said I don't want to be alone, "I am looking for people."

On \_\_\_\_\_ at 12:30 PM, the administrator was made aware of the observations made earlier that day on the third floor and resident #34.

2. Observations made on \_\_\_\_\_ at 12:05 p.m. revealed resident \_\_\_\_\_ was converted to a facility medication \_\_\_\_\_. Caregiver A was present in the medication \_\_\_\_\_ the time of the observations and she confirmed the finding.

At 3:30 p.m., the administrator confirmed the facility changed resident \_\_\_\_\_ into a medication \_\_\_\_\_. \_\_\_\_\_ said the Agency was not notified of the change in use of space, as required.

Class III

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

UNCORRECTED

Based on record reviews and interviews, the facility admitted 1 of 19 sampled residents who exceeded the Assisted Living Facility (ALF) residency criteria (#4), and retained 1 of 19 sampled residents who exceeded ALF continued residency criteria (#15).

Findings:

1. Resident #4's record revealed an admission date of \_\_\_\_\_, and a health assessment report 1823, dated \_\_\_\_\_, that indicated diagnoses of \_\_\_\_\_ deficiency, \_\_\_\_\_, and \_\_\_\_\_ behavior. The report also indicated the resident needed 24-hour nursing or \_\_\_\_\_ care and a "possible referral to psych on \_\_\_\_\_."

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Facility note dated ..... at 3:02 PM indicated resident #4 was a new admission to memory unit ..... Per the note, the resident was an elopement risk. A note dated ..... reflected the resident was out of control in the dining ..... lunchtime. A note dated ..... at 10 PM indicated he was very aggressive, punching walls, shoving people, yelling at other residents, and trying to hit staff after he was redirected from the elevator. A ..... note at 1:57 PM reflected he was aggravating others.

On ..... at 4:30 PM, the administrator said the resident was discharged.

2. Resident #15's record revealed a facility admission date of ..... An admission 1823 health assessment form, dated ....., indicated she did not have a communicable ..... which could be transmitted to other residents or staff. A more recent 1823 health assessment form, dated ....., indicated resident #15 had a diagnosis of ..... and she had a communicable ..... which could be transmitted to other residents or staff, which exceeded the continued residency criteria in an Assisted Living Facility. The record did not contain documentation to indicate the facility contacted the health care provider for clarification or to indicate the facility issued a 45-day notice of discharge.

On ..... at 1:45 p.m., the director of nursing (DON) confirmed the findings.

Class III

**0151 - Physical Plant - Existing Facilities - 58A-5.023(2) FAC**

Based on observations and interviews, the facility did not ensure that prior to modifications or alterations to the third floor by converting into a secured memory care unit, the building was in compliance with the rule or building code.

Findings:

Review of the facility's resident census on ..... at 10 AM noted resident #34 was the only resident who lived on the third floor. At 11 AM on the third floor, resident #34 said, "There was a man who lived here too but he moved out." She said she did her activities in the ..... she sat on the third floor. Observation noted some chairs, a table, puzzles boxes and activity books. The ..... previously a resident .....

Resident #4's record revealed an admission date of ....., and a health assessment report 1823, dated ....., that indicated diagnoses of ....., ..... deficiency, ....., and .....

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behavior. The report also indicated the resident needed 24-hour nursing or care and "possible referral to psych on .....". A facility note of ..... at 3:02 PM indicated resident #4 was new admission to the memory unit . Per note, the resident was an elopement risk. The facility admission and discharge log indicated resident #4 was discharged on to another assisted living facility.

On at 4 PM, the administrator said the memory care unit opened in , or , 2018. He was told by the consultant that the facility won the hearing against the Agency , which meant all previous deficiencies were corrected and they were able to start fresh, from scratch again. He did not have any documentation regarding communication between the owner and the Agency and the memory care unit. He did not have permits or any other paperwork.

Class III