Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966273	A. BUILDING: _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK	4279 JUDITH AVE MERRITT ISLAND, FL 32953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	CZ821		

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CZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	CZ821		

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CZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit a preliminary report within 1 business day and a full report within 15 calendar days to the Agency for Healthcare Administration (AHCA) after law enforcement responded to the facility for the unexpected of 2 of 2 sampled residents (#16 and 32) and after a resident experienced a that resulted in injuries and transfer to a hospital for 1 of 15 sampled residents (#19.) Findings: 1. Review of resident #16's record revealed the health and wellness director documented on at 11:33 am the resident , , on the previous night. On at 8:38 am, the health and wellness director said the resident's was unexpected. That caregiver A went in to give the resident her evening medication and found the resident. On at 9:24 am, the health and wellness director provided additional documentation that she wrote which indicated on (incorrect	CZ821		

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CZ821	Continued From page 4	CZ821		

date) caregiver A went to give the resident her bedtime medications and observed the resident had . Caregiver A called the health and wellness director and looked for the resident's (.) The health and wellness director instructed caregiver A to call the police as it was an unexpected passing. The police and fire department responded. The resident was declared .

On at 11:35 am, the administrator said preliminary and full reports were not submitted to AHCA because the police did not give her paperwork to indicate an investigation was conducted.

On at 2:33 pm, caregiver A said that on at approximately 9 pm she walked into the resident's room and found only the bathroom light was on. She turned the other lights on and found the resident sitting on her walker. Her , were open, and she was stiff. She had a shirt on, and her pants were partly down as if she just came from the bathroom. The caregiver called the health and wellness director who instructed her to call 911 and have police respond because the resident had a and was found . The caregiver said police and emergency medical services arrived and pronounced the resident . The police entered the resident's room. They asked for the caregiver's name, title and for identification. The police instructed the caregiver not to go to the resident's room. They requested the residents' demographics and medication list.

2. Review of resident #32's record revealed the health and wellness documented that on at 3:05 pm (incorrect time) caregiver I walked into the resident's room and observed her laying on

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CZ821	Continued From page 5 her bed with her , rolled and unresponsive. The caregiver called 911. The fire department arrived and called time of . On at 9 am, caregiver I said that on between 3 am and 4 am she was conducting routine rounds when she entered the resident's room and found her unresponsive in bed. She called 911. She did not perform , because the resident had a . On at 9:46 am, caregiver I said police responded to the resident's and wrote a report. On at 9:49 am, the administrator said preliminary and full reports were not submitted to AHCA because of police being called for the resident's . 3. Review of resident #19's record revealed the health and wellness director documented a "late entry" note on at 10:27 am that the resident was observed out front near the portico supine on the black top. The resident said he turned around with his walker and . He complained of right . His family was present at the time of the . 911 was called and he was transported to a hospital. The note did not indicate the actual date and time the occurred. On at 12:23 pm, the health and wellness director said documentation of the was in her other book and she would get it. She never provided additional documentation. On at 9 am, the administrator said a	CZ821		

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CZ821	Continued From page 6 preliminary report was not submitted to AHCA because the facility could not have prevented the . Unclassified	CZ821		
A 000	Initial Comments A complaint investigation (2025003248) and generator monitoring were conducted at Cedar Creek on , , and . The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards.	A 025		

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A 025	Continued From page 7 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to document a significant change in the record of 4 of 15 sampled residents (#15, 16, 19, 29.) Findings:	A 025		

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A 025	Continued From page 8 1. Review of resident #15's record revealed the health and wellness director documented on at 4:02 pm that she spoke with the resident's physician regarding the resident had in his right after a . There was not a documented in the record. On at 12:21 pm, the health and wellness director said the was not documented. She said the occurred when the resident tried to get out of bed and landed with his underneath him. 2. Review of resident #16's record revealed a facility note that indicated the resident in the dining room. She was unable to move her right . 911 was called and she was transported to a hospital. Her family member reported she sustained a right , . On the health and wellness director documented the resident had a follow up with an orthopedic the next day. There was no note to indicate when the resident returned from the hospital. On at 12:20 pm, the health and wellness director said a note was not written. 3. Review of resident #19's record revealed the health and wellness director documented a "late entry" note on at 10:27 am that the resident was observed out front near the portico supine on the black top. The resident said he turned around with his walker and . He complained of right , , . His family was present at the time of the . 911 was called and he was transported to the hospital.	A 025		

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A 025	Continued From page 9 The note did not indicate the actual date and time the occurred. On at 12:23 pm, the health and wellness director said documentation of the was in her other book and she would get it. She never provided additional documentation. 4. Review of resident #29's record revealed the health and wellness director documented on at 11:52 am the resident's family reported the resident , , while at the hospital. There was no note of when he was sent to the hospital. On at 11:55 am, the health and wellness director said there was no note, and she could not remember why the resident was sent to the hospital. Class III	A 025		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be	A 054		

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A 054	Continued From page 10 immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the medication observation record (MOR) for 1 of 15 sampled residents was updated to reflect why a medication was not given (#16.) Findings: Review of resident #16's 1823 revealed the resident required assistance with self-administration of medications. Review of the residents' MOR revealed "9," which meant "other/see progress notes," was documented for the 8 pm medications on . Neither the MOR nor the progress notes had documentation to explain why the medications were not given.	A 054		

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A 054	Continued From page 11 On at 4:20 pm, the findings were discussed with the administrator and the health and wellness director. No additional documentation was provided. Class III	A 054		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to	A 055		

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A 055	Continued From page 12 other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise	A 055		

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A 055	Continued From page 13 prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a medication cart was locked and medications were secured. Findings: On at 5:40 am, a medication cart in a hallway outside of resident rooms was unlocked. The drawers were opened which revealed medications. Two medication packages were on top of the cart. Unlicensed caregiver B rounded the corner. He said the cart was unlocked because "I guess I didn't hit it hard enough (the lock)." Regarding the medications on top of the cart he said "that was my bad. The pharmacy just came, and I need to take them to the second floor." The facility's medication storage policy, revised on , indicated all medications, including over the counter, are kept in locked storage at all	A 055		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966273	A. BUILDING: _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK	4279 JUDITH AVE MERRITT ISLAND, FL 32953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 055	Continued From page 14 times. Class III	A 055		