

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966273	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	Initial Comments A Complaint Investigation #2025008013 and a generator monitoring was conducted at Cedar Creek Assisted Living, LLC. with Limited Nursing Services (LNS) on _____ & _____. The facility had deficiencies at the time of the survey visit.	A 000			
A 167 SS=D	59A-36.018 FAC; 429.24 FS Resident Contracts 59A-36.018 Resident Contracts. (1) Pursuant to section 429.24, F.S., the facility must offer a contract for execution by the resident or the resident's legal representative before or at the time of admission. The contract must contain the following provisions: (a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services that the resident elects to receive; (b) The daily, weekly, or monthly rate; (c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule that must be attached to the contract; (d) A provision stating that at least 30 days written notice will be given before any rate increase; (e) Any rights, duties, or _____ of residents, other than those specified in section 429.28, F.S.; (f) The purpose of any advance payments or deposit payments, and the refund policy for such advance or deposit payments; (g) A refund policy that must conform to section 429.24(3), F.S.; (h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care	A 167			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966273	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 167	Continued From page 1 facility, or _____ facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf. (i) A provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility; (j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those that the facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, must be notified in writing that the resident must make arrangements for transfer to a care setting that is able to provide services needed by the resident. In the event the resident has no one to represent him or her, the facility must refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions outlined in section 429.26(8), F.S., will take effect; (k) A provision that residents must be assessed upon admission pursuant to subsection 59A-36.006(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4), of that rule; (l) The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to rule	A 167			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966273	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 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 167	Continued From page 2 59A-36.008, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule; and, (m) The facility's policies and procedures related to a properly executed DH Form 1896, (2) The resident, or the resident's representative, must be provided with a copy of the executed contract. (3) The facility may not levy an additional charge for any supplies, services, or accommodations that the facility has agreed by contract to provide as part of the standard daily, weekly, or monthly rate. The resident or resident's representative must be furnished in advance with an itemized written statement setting forth additional charges for any services, supplies, or accommodations available to residents not covered under the contract. An addendum must be added to the resident contract to reflect the additional services, supplies, or accommodations not provided under the original agreement. Such addendum must be dated and signed by the facility and the resident or resident's legal representative and a copy given to the resident or resident's representative. 429.24 FS (1) The presence of each resident in a facility shall be covered by a contract, executed at the time of admission or prior thereto, between the licensee and the resident or his or her designee or legal representative. Each party to the contract shall be provided with a duplicate original thereof, and the licensee shall keep on file in the facility all such contracts. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration. (2) Each contract must contain express	A 167			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966273	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 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 167	Continued From page 3 provisions specifically setting forth the services and accommodations to be provided by the facility; the rates or charges; provision for at least 30 days' written notice of a rate increase; the rights, duties, and _____ of the residents, other than those specified in s. 429.28; and other matters that the parties deem appropriate. A new service or accommodation added to, or implemented in, a resident's contract for which the resident was not previously charged does not require a 30-day written notice of a rate increase. Whenever money is deposited or advanced by a resident in a contract as security for performance of the contract agreement or as advance rent for other than the next immediate rental period: (a) Such funds shall be deposited in a banking institution in this state that is located, if possible, in the same community in which the facility is located; shall be kept separate from the funds and property of the facility; may not be represented as part of the assets of the facility on financial statements; and shall be used, or otherwise expended, only for the account of the resident. (b) The licensee shall, within 30 days of receipt of advance rent or a security deposit, notify the resident or residents in writing of the manner in which the licensee is holding the advance rent or security deposit and state the name and address of the depository where the moneys are being held. The licensee shall notify residents of the facility's policy on advance deposits. (3)(a) The contract shall include a refund policy to be implemented at the time of a resident's transfer, discharge, or _____ (b) If a licensee agrees to reserve a bed for a resident who is admitted to a medical facility, including, but not limited to, a nursing home,	A 167		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966273	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 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 167	Continued From page 4 health care facility, or _____ facility, the resident or his or her responsible party shall notify the licensee of any change in status that would prevent the resident from returning to the facility. Until such notice is received, the agreed-upon daily rate may be charged by the licensee. (c) The purpose of any advance payment and a refund policy for such payment, including any advance payment for housing, meals, or personal services, shall be covered in the contract. (4) The contract shall state whether or not the facility is affiliated with any religious organization and, if so, which organization and its general responsibility to the facility. (5) Neither the contract nor any provision thereof relieves any licensee of any requirement or _____ imposed upon it by this part or rules adopted under this part. (6) In lieu of the provisions of this section, facilities certified under chapter 651 shall comply with the requirements of s. 651.055. (7) Notwithstanding the provisions of this section, facilities which consist of 60 or more apartments may require refund policies and termination notices in accordance with the provisions of part II of chapter 83, provided that the lease is terminated automatically without financial penalty in the event of a resident's _____ or relocation due to _____ hospitalization or to medical reasons which necessitate services or care beyond which the facility is licensed to provide. The date of termination in such instances shall be the date the unit is fully vacated. A lease may be substituted for the contract if it meets the disclosure requirements of this section. For the	A 167			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966273	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 167	Continued From page 5 purpose of this section, the term "apartment" means a room or set of rooms with a kitchen or kitchenette and lavatory located within one or more buildings containing other similar or like residential units. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to obtain a new executed contract agreement and/or an updated addendum to the contractual agreement with new provisions for 1 of 5 sampled residents (#5) as required. Findings: A review of resident #5's contract agreement signed & dated _____ listing room/board rate amount \$1200 monthly. There was no new or updated contract agreement and/or any updated addendum with new provisions after a significant change (wife _____, _____ in _____). In further review, the facility could only provide the rate increase letter dated _____ effective _____ in the amount \$3622.50. On _____ at 2:25 PM, an interview with the Administrator confirmed the findings and further stated that a new contract agreement was not found in the record. (Photographic Evidence Obtained) Class III A 170: 429.24(3)a Resident Refund Policy SS=D The facility shall provide a refund to the	A 167			
		A 170			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966273	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 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 170	Continued From page 6 resident or responsible party within 45 days after the transfer, discharge, or of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to provide a refund to 1 of 3 sampled residents (#5) after financial assistance from Medicaid was applied as required. Findings: A review of resident #5's contract agreement signed and dated for \$1200/month. A review of the facility's rate increase letter to resident #5 dated , effective in the amount of \$3622.50. A review of the Medicaid Long Term Care (LTC) approval letter dated for resident #5 to apply Medicaid monthly rate of \$1800 subtracted from the total \$3622.50. All Medicaid payments are prorated and paid on the 1st of each month. A review of the facility's invoice for resident #5's payment was dated documented line item below: On the ending balance was zero. On , an invoice printed by the facility	A 170			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966273	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 170	Continued From page 7 amount \$3622.50 and automatic bank payment applied \$3622.50 (entire amount), no Medicaid monthly rate prorated was deducted. The ending balance was zero on . On , an invoice printed by the facility amounted to \$3622.50 and automatic bank payment applied \$3622.50 (entire amount), no Medicaid monthly rate prorated was deducted. The ending balance was zero on . On , an invoice printed by the facility amount \$3622.50 and automatic bank payment applied \$3622.50 (entire amount) on , no Medicaid monthly rate prorated was deducted. The ending balance was zero on . Below documented was when the billing error began: a. On (two months later) the facility deducted the owed/prorated Medicaid monthly rate \$1800.00 amount for , & . **Note**The ending balance was -\$3600.00 (refund for Medicaid , &) applied to the invoice dated . b. On , the facility generated again incorrectly (billing error) amount \$3622.50 (bounced check) on account, the payment of \$3622.50 had already been paid on . c. On , the facility used the Medicaid owed/prorated -\$3600.00 (credit) amount (billing error) to the invoice, making the balance of \$22.50 and then added a bounced check fee amount of \$50.00, making the ending balance of	A 170			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966273	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 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 170	Continued From page 8 \$72.50. Again, payment was already paid. d. On , the facility deducted the Medicaid owed/prorated/prorated/prorated monthly rate amount \$1800.00 with an ending balance with-\$1727.50 (credit). e. On , an invoice printed by the facility amounted to \$3622.50 and the facility applied the billing error -\$1727.50 (credit), making ending balance of 1895.00. Resident #5 had not paid \$1822.50 for , yet. f. On , the facility deducted the Medicaid monthly rate \$1800.00 amount for , to \$1895.00 billing error, making ending balance \$95.00. The facility could not provide evidence that a bounced check amount \$3622.50 (billing error) dated when payment was already paid. The facility should not have charged a bounced check fee of \$50.00. There was no documented evidence that the facility did not apply timely (2 months later) the Medicaid owed/prorated monthly amount of \$1800 for , and , creating error in accounting applying payments inappropriately. On at 9:19 AM, a telephone interview with the Administrator requesting more documentation of the invoices dated from , any additional supporting	A 170		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966273	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 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 170	Continued From page 9 documents. It was further explained that a refund was most likely due. On at 9:26 AM, a telephone interview with resident #5's family member said that she had been calling, emailing, and texting the management regarding to the balance of the \$95.00 billing error on the account and did not get any updated communication regarding this. In further conversation, the family said they would provide Resident #5 bank statements and the letter from bank that the overdraft was applied due to the billing error of the facility's accounting office in . A review of resident #5's bank statements for . and showing that the entire room/board rate amount \$3622.50 was paid the entire amount. A review of a bank letter apologizing to the facility for the error amount \$3622.50 over drafted and resident #5 did have sufficient funds in the account. As a courtesy to waive any service charges or fees from the invoice (\$95.00). This bank letter was signed by a person providing a direct contact telephone number. The facility failed to review timely resident #5's account in after & Medicaid LTC owed/prorated monthly payment of \$1800.00 were applied to the two months to catch the billing error. On at 1:25 PM, an email message from the Administrator providing all the documentation the facility had for this billing inquiry, and it was further explained that a refund of 95.00 on resident #5's account was due.	A 170			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966273	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 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 170	Continued From page 10 On at 10:57 AM, an attempted telephone exit conference with the Administrator, unable to contact. Left a voicemail message. (Photographic Evidence Obtained) Class III	A 170			