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 _____	09/09/2025

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 000	Initial Comments A complaint survey (#2025012348) and a generator monitoirng were conducted on at Cedar Creek Assisted Living, Merritt Island. A deficiency was found at the time of the visit.	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. 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	A 025		

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A 025	Continued From page 1 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 reviews, interviews and observations, the facility failed to ensure daily observation of the activities of the residents while on the premises, and awareness of the general safety, and physical and emotional well-being of the residents, and to maintain a general awareness of the residents' whereabouts to prevent elopement and for 1 of 2 sampled residents (#1). Findings: A review of resident#1's was admitted to the facility on . The most recent health	A 025		

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A 025	Continued From page 2 assessment was dated Resident #1 was admitted to hospice services on . The resident had a medical history of dyslipidemias, , , , , and mild , , , . Resident#1 required assistance with activities of daily living which included bathing. The resident was assessed to need supervision with toileting and assistance with medications. The resident was assessed to be at risk for but not at risk for elopement. In a review of the facility notes for resident#1, it revealed the following: unwitnessed resident was observed on the floor with a cushion on her bottom and a on the right . Resident stated she was trying to sit on her chair when the chair moved, and she lost her balance unwitnessed resident observed at 1:30pm during rounds on her floor. The was unwitnessed. Resident stated that her bed moved as she was trying to sit down. Resident had a level 2 , . Resident was until she got off the floor 8:50pm unwitnessed resident called for help. She was observed on the ground in her bedroom. Resident stated she was in , . No injuries visible. staff notified by dispatch that a resident was observed on the ground outside the facility. Resident was taken to hospital for evaluation. According to the discharge paperwork she had no injuries but was treated for a . discussed with family members and	A 025		

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A 025	Continued From page 3 physician of recent ␣ and increasing the medication dosage. Facility plan was did not have signatures or dates. In an observation on of resident#1, she was lying in her bed, limited ␣ abilities to understand or speak, wearing an identification bracelet. She stated she did not remember the incident. The facility's elopement policy states: The ability of a resident who is not capable of protecting themselves from harm to successfully leave the facility unsupervised and unnoticed and who may enter harm's way. ␣ refers to a ␣ , , resident's ability to move about inside the facility aimlessly and without an appreciation of personal safety needs and who may enter a dangerous situation. Reviewed resident#1's hospital record dated Cape Canaveral Hospital emergency department. reports low , , unspecified , laterality, unspecified whether present due to . In an interview on at 11am with the director of nursing she stated they added staff to the overnight schedule to have 3 staff instead of 2 staff. She stated the exit door now has a loud chime on it so the staff will hear if anyone leaves. She stated resident#1 was a and especially after she had a , . She confirmed that the individual plan for resident#1 states she is a and risk, but no interventions were put into place until after the incident. She stated the resident was supposed to have a 24-hour sitter before the incident but that was never put in place. She stated the rounds are now are every 15 minutes but was not sure what	A 025		

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A 025	Continued From page 4	A 025		

they were before the incident. She stated this facility is not equipped for an elopement risk resident and cannot provide supervision all the time. She stated there is no receptionist at the front desk after 5pm so residents can leave the facility, but the door is locked to come in. She stated the residents are aware of signing out before leaving but resident #1 did not. She stated resident #1 likes to the halls but never suspected she would leave the facility. She stated if the fire department did not bring her , the staff would have never known she was gone.

In an interview on at 10:15am with staff A, stated she normally works the 1st floor on the overnight shift where resident#1 resides. She stated at the time of the incident she was on break on the 2nd floor. She stated the protocol was to check on the residents every 2 hours or so. She stated she did not know the resident was missing until she was brought to the facility. She stated she did not know where the second staff person on duty was at the time. She stated the staff levels were poor at the time of the incident, especially when there is a lot to do.

In an interview on at 1pm with the administrator, she confirmed the above statements and stated she does not consider the incident to be an elopement based on the facility's elopement policy. She stated the resident never left the grounds, and the incident was caused by a ( ). She stated the resident is fine now since the incident. She stated they have installed chimes on the front door so if anyone leaves the chimes go off. She stated the door is locked at night, but someone can leave through the doors from inside the facility. She stated she has increased the overnight shift staff schedule since the incident. She stated there are

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A 025	Continued From page 5 2 shifts 7am-7pm and 7pm-7am. She stated there were 2 staff members on duty that night (A&B). She stated after the incident she added a third person for the 2nd shift. She stated there are no other residents that have an elopement status. Photographic evidence obtained Class III	A 025		