

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
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK LIFE CENTER		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 inspection CCR#2012006044 was conducted on _____ in conjunction with CCR#2012005319 and CCR#2012003087. Three of four of the allegations were confirmed. The facility had deficiencies related to the investigation, refer to Aspen event EO8111 (CCR#2012003087).	A 000		
A 152	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; and 2. Must be maintained free of hazards; and 3. Must ensure that all existing architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents shall be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident _____ sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress a comfortable height to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes; 3. A dresser, chest or other furniture designed for storage of personal effects; 4. A table, bedside lamp or floor lamp, and waste basket; and 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate	A 152		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

5059

6PP411

If continuation sheet 1 of 3

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A 152	Continued From page 1 keys to resident . . . to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility shall be free of tears, stains and not be This Statute or Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that all existing electrical and structural systems and appurtenances were maintained in good working order. Findings: During the tour of the facility on at approximately 11 AM, observations revealed that the air conditioning system located in the kitchen was not working. There were a few fans blowing, however it was very hot in the kitchen. The staff that was observed preparing the food was sweating. Through the dietary staff interviews it was revealed that the air conditioner had not worked since they used to keep the door open until the health department came in to tell them they could not keep the exit door open because flies and pests would come into the kitchen. The dietary staff stated they were very hot and sometimes the temperature reached 90 plus degrees in the kitchen. The staff stated that they had to turn on and off the ice machine so that the temperature would not be too hot and they did not fry anything because using the fryer	A 152			

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A 152	Continued From page 2 made it extremely hot in the kitchen. They were concerned that if the temperature would rise the kitchen would have to be shut down. Observations on at approximately 2:30 PM the temperature in their kitchen was 92 degrees. Class III	A 152		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Cedar Creek Life Center
4279 Judith Ave
Merritt Island, FL 32953

Dear Administrator:

Re: CCR #2012006044

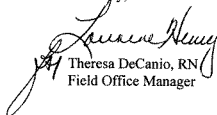
This letter reports the findings of a state licensure survey that was conducted on , 2012 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , 2012, to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at

Sincerely,


Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
<http://ahca.myflorida.com>



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