STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966273	10/09/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Cedar Creek Life Center	4279 Judith Ave Merritt Island, FL 32953	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= D

Specific Tag Findings:

0000-Initial Comments
Complaint invesigation #2014007515 was conducted on [redacted] to [redacted] in conjuction with Change of Ownership (CHOW) with Extended Congregate Care (ECC) and Limited Nursing Services (LNS) licensure survey. Cedar Creek Life Center had deficiencies found at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review and interview the facility failed to ensure the physician was notified of a significant change for 1 of 18 sampled residents (#1).

Findings:

Resident record review for #1 revealed an Assisted Living Facility Health Assessment form (1823) updated on [redacted] that indicated [redacted] and [redacted] and stated the resident's diet was regular and she received a [redacted] tube feeding.

Review of facility notes revealed on [redacted] at 5 AM the resident's feeding tube was pulled out and she was sent to the hospital. There was no documentation to review that indicated the physician was notified.

In an interview with the director of nursing on [redacted] at approximately 2 PM who was not aware there was no documentation the physician was notified.

Class III
0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review and interview the facility failed to ensure residents were treated with dignity and respect and did not respond to grievances and document their resolutions.

Findings:

1. In an interview on [redacted] at 10:30 AM with resident #3, she stated she needed assistance

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with showering. The shower staff gave her a shower 3 times a week. The shower staff was out a few weeks ago and she only got two showers that week. She stated she informed the facility of her concern.

Resident record review revealed #3 had an 1823 dated that indicated diagnoses of pain, and The resident was independent with eating, needed supervision with ambulation and and needed assistance with bathing, dressing, transferring and toileting.

2. Review of the Resident Council Meeting minutes for:

2014 revealed, "The bus needs to be fixed. Need more lights on the outside. Resident's want information about the Fire Drills.
Bus: Suggested from Residents and Family when bus is out of order rent a bus. Residents feel it is a must to get out. Also they feel if the bus cannot be fixed with the A/C (air conditioner) trade it in and get another.

2014 revealed, resident #3 stated staff had not been able to get all of her showers for the week.

2014 revealed, "Residents said there are not enough CNAs (Certified Nursing Assistants) on the floor. A huge complaint is that beds are not being made every day. Also the trash is not being taken out every day. That is concerning to a very large amount of residents. needs the refrigerator defrosted. Bus: The residents thought this would be a good time to start working on a plan for new ideas for fixing the bus and it issues. They were saying how they feel the facility should get rid of the old bus and start to lease a new bus in better condition. Also residents feel because of the A/C is not working well there should be 2 fans added in the bus, in the front of the bus and in the back of the bus."

Review of the Facility Outing sign out sheet revealed on seven residents went shopping on the bus. On six residents went to the grocery store and bank on the bus. On at 11:30 AM, six residents went out to lunch on the bus.

The facility did not ensure the residents were treated with dignity and respect, respond to their concerns and provide needed repairs to the bus that transported the residents, during the summer in a bus with an A/C that did not keep the bus cool and comfortable for the residents.

Review of the grievance log revealed there was no documentation that indicated the facility had responded to grievances and provided a resolution.

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In an interview with the administrator on [redacted] at approximately 12 PM who stated the grievances and resolutions were not documented.
Class III

0079-Staffing Standards - Levels 58A-5.019(3) FAC
Based on record review and interviews the facility failed to ensure they had enough staff available to provide resident care (showers); and a 2 person assist for 2 of 19 sampled residents (#2 and 6) and did not have an accurate schedule for a given week.

Findings:

During the facility entrance on [redacted] at approximately 9AM, 4 residents including # 2 and were identified as needing 2 staff to assist with mobility/transfers. During the facility tour on [redacted] at approximately 9:30 AM multiple residents were observed ambulating by wheelchairs and or scooters.

Observations at approximately 2:30 PM on [redacted] noted resident #2 was in bed. Three (3) staff entered the [redacted] One gathered the equipment- scooter /briefs/wipes/clothes. Two staff turned the resident to change the brief. The staff dressed the resident, she put on her pants and socks without the resident's assistance. The resident was unable to assist because of the hand deformities. The resident turned over with assistance. One staff stated to let the resident do as much as she could for herself. The resident attempted to sit up but was unable. The staff assisted her to sit up on the bed. Two (2) staff lifted the resident and sat her on the scooter. The resident did not pivot.

Observations at approximately 3:00 PM on [redacted] noted resident #2 was in her [redacted] sat in a wheelchair. Two staff came to assist the resident to transfer from the wheelchair to chair at the surveyor's request. Observations noted the resident did not pivot; the staff lifted the resident and sat her in the chair.

Resident record review on [redacted] at approximately 9 AM for resident #2 revealed a health assessment report dated [redacted] that did not indicate if her needs could be met in an assisted living facility. She had diagnoses of [redacted] fatigue, muscle [redacted] and [redacted] The assessment indicated she was non-ambulatory and "required assist to transfer from bed to wheelchair/ bedridden/ can sit in

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wheelchair".

Resident record review on at approximately 9 AM for resident #6 revealed a health assessment report dated that listed diagnoses of type II, high and and had "wheelchair status". The assessment did not indicate if her needs could be met in an assisted living facility.

Review of the staff schedule revealed it was not accurate. Some examples are as follows:
On for the 7 AM-7 PM Shift revealed there were 2 caregivers scheduled to work (staff F and Staff G). Review of Staff F and Staff G time sheets revealed that Staff F worked 6:56-11:11 AM and staff G worked 10:31 AM-1:00 PM.
Staff F was listed as working on and Review of her times sheet revealed she did not work those days because she was out on medical leave.

On staff I who worked 7:01 AM to 7:06 PM providing care and she was not listed on the schedule.
On Staff H worked 3:33 AM-7:29 AM and she was not listed on the schedule
On Staff K worked 10:58 PM-7:09 AM and she was not listed on the schedule
On Staff J worked 7:23 AM-1:06 PM and she was not listed on the schedule
For Staff B the following was revealed:
She was listed on the schedule on from 7 AM-3 PM and her time sheet noted that she worked 7:24 AM-3:38 PM
She was listed on the schedule on from 7 AM-3 PM and her time sheet noted that she worked 7:27 AM-3:23 PM
She was listed on the schedule on from 7 AM-3 PM and her time sheet noted that she worked 7:27 AM-3:23 PM
She was listed on the schedule on from 7 AM-3 PM and her time sheet noted that she worked 8:43 AM-2:58 PM
During an interview with Staff B on at approximately 2 PM, she stated she was out on leave due to a work related injury for about two week in she was not sure of the exact date. She explained that her responsibility was to provide showers to the residents and sometimes when she finished she would also assist the caregivers if they needed help with a resident. She stated if she was absent from work the caregivers scheduled would have to also provide showers to the residents.
According to the time sheets Staff B was out from through She was listed on the schedule as working daily from 7 AM-3 PM.

On Staff H worked 3:33 AM-7:29 AM and she was not listed on the schedule
On Staff K worked 10:58 PM-7:09 AM and she was not listed on the schedule

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On [redacted] Staff J worked 7:23 AM-1:06 PM and she was not listed on the schedule

Review of the time sheets for [redacted] revealed the following:
Staff C worked 6:48 PM-7:10 PM
Staff K worked 7 PM-7:10 AM
Staff G worked 6:47 AM-6:48 PM
Staff I worked 6:58 AM-6:18 PM
There was Nurse worked 7 AM-7 PM and another nurse worked 7:03 PM-3:51 PM and 6:45 PM-7:28 AM
A note was received via fax from the facility on [redacted] that Resident Care Director worked the cart (medications) 3 PM-7:30 PM on [redacted] there was no time sheet to confirm this because the note indicated she was a salaried employee and did not have a time sheet.
From 6:18-6:48 PM there was only 1 caregiver working
From 6:48 PM-7 PM there was only 1 caregiver working

Observations [redacted] at approximately 3 PM revealed Staff J was going [redacted] the trash out of the resident's [redacted] She was asked at the time where was the other caregiver were. She stated the other care giver was on a 30 minute break and she was the only caregiver that was working the floor.

In an interview on [redacted] at 10:30 AM with resident #3 she stated she needed assistance with showering. The shower staff gave her a shower 3 times a week. The shower staff was out a few weeks ago and she only got two showers that week.

Record review for resident #3 revealed an 1823 dated [redacted] that indicated diagnoses of [redacted] pain, [redacted] and [redacted]. The resident was independent with eating, needed supervision with ambulation and [redacted] and needed assistance with bathing, dressing, transferring and toileting.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

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

RE: CCR #2014007515

Dear Administrator:

This letter reports the findings of a state licensure complaint investigation survey that was conducted on , 2014 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) 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 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

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