STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966273	R 08/18/2015
NAME OF PROVIDER OR SUPPLIER **CEDAR CREEK LIFE CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **4279 JUDITH AVE** **MERRITT ISLAND, FL 32953**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

Conducted revisit to Complaint Inspection #2015003141 on / /. Cedar Creek Assisted Living Facility had deficiencies that remained uncorrected at the time of the visit.

0025 Resident Care - Supervision

THE FOLLOWING DEFICIENCY REMAINED UNCORRECTED

Based on record review and interviews the facility failed to:
1. Provide adequate supervision to meet the needs through proactive measures to minimize the potential for risk of harm for 1 of 13 sampled residents (#2), who was , had previously eloped from the facility, walked up a two lane road with multiple water ditches and a pond on the sides of the road, in her robe and pajamas, was found on by a passerby and taken to a nearby convenience store.
2. Document the healthcare provider and responsible party were notified of the elopement for 1 of 13 sampled residents (#2).

Findings:

1. Review of an Adverse Incident report dated / / revealed, "resident #2 and another resident decided they were hungry and thought they remembered that there was a restaurant right down the street, so they set out to find the restaurant. Another resident's family member was just arriving to visit and saw both ladies leaving the property. When she entered the building, she immediately reported it to the receptionist at the front desk. An alert code was send out to our staff who followed our elopement procedures and began the search. After a 10 minute unsuccessful search we notified the police department to report the elopement. Around the same time the police department received a call from the near-by neighbor who reported two ladies sitting in lawn chairs on their property. Police were in the area and responded to the call immediately and when we saw their patrol car we turned into the drive that they had taken and found our two ladies sitting in the shade."

Review of the adverse incident report dated / at 12 PM revealed resident #2 had been agitated for the past several days in the afternoons. She was walking down the entrance to the facility's property with the staff running after her. The resident started running and was swinging a stick and stated to leave her alone. 911 was called and when they arrived she dropped the stick, got into the deputy's car and was returned safely to the facility. The facility did not have a secure area and had a private sitter with the resident during waking hours, until another placement could be made.

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Review of the adverse incident report dated / / at 7:45 PM revealed resident #2's private duty sitter put the resident to bed at approximately 7:30 PM and waited for her to asleep. The sitter then left for the night as the resident usually slept through the night, once in bed. Resident #2 woke up and went downstairs in her pajamas and robe and left the facility. When the nurse went to check on her in her , she found her missing. They immediately started searching for her and the Director of Nurses (DON) was notified by cell phone at approximately 8:10 PM regarding the resident not being in her . The DON called the Executive Director (ED) and both left home to return to the facility to help search for resident #2. The DON received a call again that the resident had been found safe. Someone saw her walking down the road and picked her up and went to the Circle K convenience store to call the police to notify them they had found this lady. This was around 8 PM. Both the DON and the ED arrived at the convenience store at the same time and spoke with the man who had found her. The DON placed resident #2 in the car and returned her to the facility. There was no documentation to review that indicated the healthcare provider and family member were notified of the elopement on / .

Review of the Assisted Living Facility Health Assessment Form (1823) date / / indicated a diagnosis of .

The facility did not have a proactive plan in place to provide 24 hour supervision to resident #2 who was and had previously eloped from the facility.

In an interview with the DON on / / at approximately 3:30 PM, she stated the resident had a 12 hour sitter who left after the resident was put to bed. The resident did not have a sitter on the night shift. She also stated the facility did not document they had contacted the healthcare provider and family member and they had been notified.

Class II

0078 Staffing Standards - Staff

THE FOLLOWING DEFICIENCY REMAINED UNCORRECTED

Based on personnel record review and interview the facility failed to ensure that 2 staff in a sample of 4 staff (A and C) who were newly hired, had a statement from a health care provider that was based on an examination that was conducted within the last six months, that they did not have any signs or symptoms of a communicable including ( ).

Findings:

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Personnel record review for Staff A revealed she was hired on / . Review of her Freedom from statement revealed it was dated (more than 6 months before hire). There was no documentation found to confirm she was free from Communicable .

Personnel record review for Staff C revealed he was hired / . There was no documentation found to confirm he was free from Communicable .

During an interview with the Administrative Assistant on / she confirmed the findings and stated the staff was scheduled to have the Communicable statement completed on Thursday.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Cedar Creek Life Center
4279 Judith Ave
Merritt Island, FL 32953
Attention: Judy Martin

Dear Martin:

This letter reports the findings of a revisit inspection survey conducted on , by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) **by** .

The inspection resulted in findings of non-compliance in the following areas:

A - 0025 - Resident Care - Supervision Class II

Your Assisted Living facility failed to provide adequate supervision to meet the needs through proactive measures to minimize the potential for risk of harm for 1 of 13 sampled residents, who was , had previously eloped from the facility, walked up a two lane road with multiple water ditches and a pond on the sides of the road, in her robe and pajamas, was found on by a passerby and taken to a nearby convenience store. Also, failed to document the healthcare provider and responsible party were notified of the elopement for 1 of 13 sampled residents.

Your facility must comply with the following:

1) Your facility must in-service your staff on your elopement policy and procedures. The in the in-service must include risk factors that may lead to a resident being considered an elopement risk, including but limited to and exit seeking. The staff should be trained to be observant and report any significant changes in a resident's behavior to the nurse or administrator immediately. A resident exhibiting agitation should be monitored, this may be considered a change in behavior. The staff also should be trained to monitor closely a residents that are at risk for elopement and has an elopement in the past. The in-service training must be documented and a sign in sheet should be included. The documentation of the training must be available for Agency review. This must be completed **by** .

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

Cedar Creek Life Center
[illegible], 2015

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact . Lorraine Henry, at (407) 420-2534.

Sincerely,

Theresa DeCanio
Field Office Manager

D7JR

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

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[illegible], 2015

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

RE: Revisit to #2015003141

Dear Administrator:

This letter reports the findings of a complaint investigation revisit survey conducted on 18, 2015by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2015.**

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. Should you have any questions please call this office at (407) 420-2502.

Sincerely,

for Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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