| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11966273 | 10/09/2017 |
| NAME OF PROVIDER OR SUPPLIER<br>**CEDAR CREEK LIFE CENTER** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**4279 JUDITH AVE**<br>**MERRITT ISLAND, FL 32953** | |

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

**0000 - Initial Comments**

Complaint investigations #2017008361 and #2017008356 was conducted on , 2017. Cedar Creek Life Center, license #10541, had deficiencies related to #32017008361 at the time of the visit.

**0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC**

Based on observations, record reviews, and interviews, the facility failed to notify a health care provider when 3 of 8 sampled residents (#1, #4, and #5) experienced a change in condition.

Findings:

1. Observations made of resident #4 on at 9:15 am revealed that he had a crescent shaped that measured approximately 3 centimeters in length on his left hand, between his thumb and forefinger. The was covered with a scab and the surrounding skin was red. When questioned about the cause of the , resident #4 did not respond.

Record review for resident #4 revealed a health assessment form 1823 that was dated on . The form indicated that he had a diagnosis of .

The record for resident #4 did not contain any documentation regarding the presence of the to his left hand and no documentation to indicate a health care provider was notified of the .

On at 5 pm, the director of nursing confirmed the findings.

2. Record review for resident #1 revealed she was admitted to the facility on with a diagnosis of type 2, memory loss, , , , , Sleep , , and Valve .

Review of the nurse's notes for resident #1 revealed the following:

On at 12:15 am, resident #1 was observed sitting in a chair in the hallway with only a shirt on. When she was advised to return to her put on clothes, she lifted up her shirt, refused, and stated that her father was there and she did not have to. Transportation was called to have her transferred to the Hospital for an evaluation.

On at 2:15 am, she went out of the building, walked around in the parking lot, and still was not fully dressed. She refused to go inside the facility. The staff continued to monitor her and persuade her

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SUMMARY STATEMENT OF DEFICIENCIES
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to put on clothes.

On at 2:30 am, transportation arrived to the facility. Resident #1 became physically aggressive with the attendant and tried to leave the facility again. She was placed on a stretcher and transported to the Hospital.

On at 10 am, she was admitted to the Hospital for .

On , her family informed the facility that she .

The record for resident #1 did not contain documentation to indicate a health care provider was notified when she had a change in her condition on .

On at 5 pm, the director of nursing confirmed the findings.

3. During an interview with resident #5 on at 4:30 pm, she said she asked on more than one occasion for the nurse to call her health care provider because she had symptoms of a ( ) but that she had not received a follow up to her requests.

During an interview with staff D, a nurse, on at 4:58 pm, she said she faxed the health care provider on and regarding the resident's concern. She said the health care provider for resident #5 was notorious for not responding. When questioned about making a phone call to the office to follow up on the faxes, staff D said she did not call the office because when the facility nurses called the office of the health care provider, they just got a voice mail. She said the nurses just continued to fax the health care provider until they received a response.

During an interview with the director of nursing on at 5:15 pm, she confirmed the findings and said the nurse should have also called the health care provider to notify him or her of the resident's health concern.

Class III

**0028 - Resident Care - Activities of Daily Living - 58A-5.0182(4) FAC**

Based on observations, record reviews, and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs) for 1 of 6 sampled residents (#4.)

Findings:

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

Observations made of resident #4 on [redacted] at 9:15 am revealed his nails were long with dirt underneath his nails. When questioned further, he did not verbally respond.

Record review for resident #4 revealed that he had a diagnosis of [redacted] and he required assistance with [redacted].

Observations made on [redacted] at 2 pm revealed his nails remained long and dirty. The administrator was notified and said he would address it with the staff.

Observations made on [redacted] at 4:10 pm revealed his nails remained long and dirty. When questioned, the administrator said the resident normally had his nails done by the hairdresser because the resident did not allow the facility staff to assist him. The administrator said the hairdresser was at the facility every Monday and Tuesday and the resident was on the schedule to have his nails done on [redacted].

During an interview with the hairdresser on [redacted] at 4:15 pm, she said the last time she assisted resident #1 with his nails was 5-6 weeks ago. She said she only cared for his nails when his wife requested it. She confirmed that he had an appointment with her on [redacted] but said it was only for his hair.

During an interview with the administrator and director of nursing on [redacted] at 5:10 pm, the administrator said the staff had not attempted to assist resident #1 with nail care on [redacted]. The director of nursing said she thought assisted living facilities were not allowed to provide nail care to the residents. The director of nursing said she did not know that nail care was a part of [redacted].

Class III

**0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC**

Based on observations and interviews, the facility failed to honor resident rights and failed to maintain a clean and decent living environment for 2 of 6 residents (#3 and #4).

Findings:

1. During an interview with resident #3 on [redacted] at 10:27 am, he said his carpet was stained and that he previously reported it to administration.

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SUMMARY STATEMENT OF DEFICIENCIES
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Observations made of his carpet revealed there were black stains on the carpet located in the kitchen and living .

2. Observations made on at 9:15 am revealed the kitchen area carpet in the resident #4 contained black stains.

On at 4:30 pm, the administrator confirmed the carpets were stained.

Class III