STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966273	04/16/2018
NAME OF PROVIDER OR SUPPLIER **CEDAR CREEK**	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

Change of Ownership survey with Limited Nursing Services was conducted on . Cedar Creek Life Center, License #10541, had deficient practice at the time of the visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observations, record reviews and interviews, the facility failed to ensure that a face-to-face medical examination by a health care provider was recorded on a health assessment form 1823 after developing a , for 1 of 4 sampled residents (#6), and retained continued residency of 3 of 4 sampled residents who could not ambulate and required total care with activities of daily livings (ADLs) (#14, 15 & 16).

Findings:

1. Resident #6's record revealed an admission date of and a health assessment form 1823 dated . A facility progress note, dated on , indicated that a caregiver reported that resident #6 had three open areas on her .

A hospice note, dated on , indicated the resident had a to 3 , on her area.

Resident #6's record did not contain a new health assessment form 1823 to indicate a health care provider conducted a medical examination when the resident developed the , , which was a significant change.

On at 4:15 p.m., the nursing director confirmed the findings.

2. On at 1:25 PM, resident #14 required 4 people to assist with a transfer from the wheelchair to toilet in then back to the wheelchair. Resident #14 was not able to hold himself up. Caregivers B, F, H and I were all needed to transfer the resident. Resident #14 did not use his feet to help turn or pivot. A caregiver had to push his wheelchair for him at all times, because he could not push his own wheelchair. He was not . He did not say anything during the transfer. Resident #14 could not sit up on his own on the toilet without at least 2 or more caregivers holding him up. Three of the caregivers held him up while the fourth caregiver hurried up putting on his adult briefs. All four caregivers lifted the resident back onto the wheelchair and wheeled him back to his living . Resident #14 was not able to assist or help himself with the transfer.

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3. On at 12:45 PM, resident #15 required a 2-person assist. Caregivers B and caregiver I lifted and transferred the resident from the wheelchair to the toilet. Both caregivers held him up to stand against the while changing his adult brief. Once resident #15 was on the toilet seat, he sat up with one caregiver holding him up while the other caregiver quickly changed his adult brief. Resident #15 did not hold on to the grab bar and turn and pivot his legs and feet during the transfer. Resident #15 was able to ask for help but could not do it on his own. Resident #15 could not wheel himself to and from. Caregivers wheel him all the time.

4. On at 1:05 PM, resident #16 required 5-person assist to transfer her from the bed to a walker then to a recliner chair to sit. Caregivers stated that they were going to fix her sheets and staff B drained her , bag. Resident #16 has a wheelchair and a hanging bar over her bed to help herself pull up but do not use it. Resident #16 stated that she always needed staff to help her to the , for showers, and put the foot on. Resident #16 could not pivot and turn her legs and feet, to assist staff with transferring. She was very alert and oriented, and able to make her needs known. Every meal was brought to her .

At 1:10 PM, caregiver B called on the facility radio for help from the nurse to come to resident #16's put the on per resident request. At 1:15 PM, the nurse came to the put the on resident #16's foot. Then caregivers B, I and the nurse tried to lift and transfer resident #16 back to her bed. They were unsuccessful in lifting her and resident #16 slowly slid down to the floor with the caregivers helping her down. At 1:20 PM, the three of them were not able to lift her up from the floor safely, and the nurse called for additional help. Two more caregivers, F and H, arrived and all five staff lifted resident #16 back up and onto her bed. Resident #16 apologized to the staff stating that she has , and not able to feel her feet.

On at 3:50 PM, the administrator and director of nursing confirmed the findings.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation and interview, the facility failed to honor resident rights and treat with respect and dignity in regards to the use of individual personal property issued from resident #7 to another resident #17 without permission.

Findings:

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On at 2:30 PM, caregiver H and caregiver I stated that resident #17 usually always run out of his adult diaper briefs and it result in having to borrow from resident #7. Both these resident has the same hospice providers. The caregivers stated that they would replace them when resident #17 get his order.

In resident #7's at 3:30 PM, an individual box of adult briefs sent from the hospice agency had her name and address on the box shipment.

On at 3:30 PM, resident #7 stated that she was aware and seen staff taking her adult briefs out of her . She also stated that staff never ask her for permission to take them and was not sure if the staff replaced them. Resident #7 stated that this bothered her and did not feel it was right.

On at 3:50 PM, the administrator and director of nursing confirmed the finding.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on review of a medication container, record review and interview, the facility failed to ensure a medication container was properly labeled for a resident who received assistance with self-administered medications (#5).

Findings:

Observations made during a medication pass for resident #5 on at 11:10 AM revealed caregiver F gave the resident one tablet from a bottle that was labeled as l-cap tablets. The manufacturer's directions for use was to take one tablet twice daily. However, review of resident #5's , 2018 Medication Observation Record (MOR) revealed the directions for use of the l-cap was to take one tablet by mouth daily. The container of l-cap tablets did not contain an alert label to direct staff to examine the revised directions for use on the MOR. On at 11:30 AM, caregiver F confirmed the findings.

Resident #5's record contained a health assessment form 1823, dated on , that indicated the resident required assistance with self-administered medications. The record contained an active medication list, dated , that indicated there was an electronic prescription dated for l-caps oral tablet, take 1 tab by mouth daily.

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Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observations, staff schedule record review, time sheet review and interviews, the facility did not have enough staff to meet the needs of the residents and did not maintain a staff schedule that accurately reflected its 24-hour staffing pattern for a given time period.

Findings:

1. During interviews on with staff/caregivers and residents, it was revealed that on days there was not enough staff/caregivers at the facility to meet the needs of the residents. On the weekend, there was only 2 staff/caregivers per shift and residents were not able to get showers as needed. The residents who required total care with ambulation and transferring and activities of daily living (ADLs) would require the assistance of all of the staff on duty while other residents had to wait for help. There were also days when staff/caregivers would call in and the staff were not replaced. Through the interviews it was revealed that the nurses were on duty, however they would not assist with any transfers or ADLs.

Review of the staff schedule for through and through revealed on weekends, there was two caregivers present per shift and a nurse on duty.

On , review of the schedule revealed there were 3 staff listed on the 7 AM-3 PM shift, staff H and I, there was a circle around the time for staff B.

Review of the time sheets revealed on there was only one caregiver who worked from 7 AM until a staff/caregiver arrived at 11 AM.

On at 2:30 PM, staff H was asked if she recalled working alone on from 7 AM-11 AM. She confirmed that she was the only caregiver on that day and time. She said there was a nurse present.

On at 4:45 PM, the director of nursing reviewed the time sheets and staff schedule and said that the circle around staff B's time meant she called in that she would not be at work. She confirmed that staff I did not worked on , and the schedule was not accurate. She said after reviewing the timesheets, there was only one caregiver present for the day and the next staff that was called did not

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arrive until 11 AM.

There were residents who required total care with ADLs and ambulation who required 2-3 staff to assist them as follows:

2. On at 1:25 PM, resident #14 required 4 people to assist with a transfer from the wheelchair to toilet in then back to the wheelchair. Resident #14 was not able to hold himself up. Caregivers B, F, H and I were all needed to transfer the resident. Resident #14 did not use his feet to help turn or pivot. A caregiver had to push his wheelchair for him at all times, because he could not push his own wheelchair. He was not . He did not say anything during the transfer. Resident #14 could not sit up on his own on the toilet without at least 2 or more caregivers holding him up. Three of the caregivers held him up while the fourth caregiver hurried up putting on his adult briefs. All four caregivers lifted the resident back onto the wheelchair and wheeled him back to his living . Resident #14 was not able to assist or help himself with the transfer.

3. On at 12:45 PM, resident #15 required a 2-person assist. Caregivers B and caregiver I lifted and transferred the resident from the wheelchair to the toilet. Both caregivers held him up to stand against the while changing his adult brief. Once resident #15 was on the toilet seat, he sat up with one caregiver holding him up while the other caregiver quickly changed his adult brief. Resident #15 did not hold on to the grab bar and turn and pivot his legs and feet during the transfer. Resident #15 was able to ask for help but could not do it on his own. Resident #15 could not wheel himself to and from. Caregivers wheel him all the time.

4. On at 1:05 PM, resident #16 required 5-person assist to transfer her from the bed to a walker then to a recliner chair to sit. Caregivers stated that they were going to fix her sheets and staff B drained her bag. Resident #16 has a wheelchair and a hanging bar over her bed to help herself pull up but do not use it. Resident #16 stated that she always needed staff to help her to the , for showers, and put the foot on. Resident #16 could not pivot and turn her legs and feet, to assist staff with transferring. She was very alert and oriented, and able to make her needs known. Every meal was brought to her .

At 1:10 PM, caregiver B called on the facility radio for help from the nurse to come to resident #16's put the on per resident request. At 1:15 PM, the nurse came to the put the on resident #16's foot. Then caregivers B, I and the nurse tried to lift and transfer resident #16 back to her bed. They were unsuccessful in lifting her and resident #16 slowly slid down to the floor with the caregivers helping her down. At 1:20 PM, the three of them were not able to lift her up from the floor safely, and the nurse called for additional help. Two more caregivers, F and H, arrived and all five staff

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lifted resident #16 back up and onto her bed. Resident #16 apologized to the staff stating that she has and not able to feel her feet.

On at 3:50 PM, an interview with both administrator and director of nursing confirmed the findings.

5. On at 3:30 PM, resident #4 said the facility was short staffed on the weekends and there were times when she did not receive her showers on the weekend due to the shortage.

Class III

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

Based on observations and interview, the facility failed to ensure the carpet was clean and a window was in good working order in two resident .

Findings:

Observations made on at 2 PM revealed a window in did not stay up when opened. A plastic cup was in place to hold the window open. The carpet in was stained.

On at 5 PM, the administrator confirmed the findings.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observations, record reviews and interviews, the facility did not obtain a health care provider's order for nursing services care and application and removal of a leg brace for 2 of 4 sampled residents (#6 & 16).

Findings:

1. Resident #16's record revealed nurses' progress notes that documented the following:
at 10:30 AM - sitting in bed requesting left ankle be put on. on and secure-completed by licensed practical nurse (LPN).
at 2:30 PM - Applied left ankle brace per resident request-completed by LPN. There was no health care provider's order available for review for the nurse to apply and remove the leg brace.

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at 1:10 PM - caregiver B called on radio for help from the LPN to come to resident #16 . . put the . . . /brace on per resident request. At 1:15 PM, LPN arrived and placed the . . . /brace on resident #16's foot.
. . . at 3 PM - the director of nursing said she could not locate the health care provider's order for the application and removal of the leg brace.

2. Resident #6's record revealed an order from a health care provider that indicated an indwelling . . . , ... was to be inserted to prevent further breakdown to a . . . . , ... and to assist with . . . healing. However, the order was incomplete and did not contain instructions regarding care. On . . . . at 3:55 PM, the director of nursing confirmed the findings.

Class III