| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11966273 | 12/27/2018 |
| NAME OF PROVIDER OR SUPPLIER<br>**CEDAR CREEK** | 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**

A Limited Nursing Service (LNS) monitoring visit was conducted on . Cedar Creek, license #10541, had deficiencies 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 ensure an concentrator was in working order for 1 of 3 residents (#1) who received a Limited Nursing Service (LNS) for .

Findings:

On at 1:30 p.m. the resident care director identified resident #1 as receiving a LNS for .

Observations made on at 2:15 p.m. revealed resident #1 was laying in her bed. She wore an . She removed the from her and asked whether the was on. Observations made of the concentrator that was located in a separate room revealed it was turned on however, it was not working. There was no noise coming from the concentrator and the liter flow ball indicator was resting on zero. Resident #1 said she did not know anything about the concentrator.

On at 2:19 p.m. nurse E confirmed the findings and said when she last checked the concentrator at 8 a.m. it was working properly.

On at 2:25 p.m. the resident care director also confirmed the concentrator was on but not working.

Resident #1's record contained an order from a health care provider, dated , for at 2 liters via continuously at bedtime and during the day as needed. Her diagnoses was Valve .

Photographic evidence obtained.

Class III

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

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

Based on record reviews and interview, the facility failed to contact a health care provider to request revised instructions for 1 of 3 sampled residents (#1) who had an order for "as needed."

Findings:

On at 1:30 p.m. the resident care director identified resident #1 as receiving a Limited Nursing Service (LNS) for .

Resident #1's record contained an order from a health care provider, dated , for at 2 liters via continuously at bedtime and during the day as needed. Her diagnoses was Valve . The order did not contain the circumstances under which it would be appropriate for the resident to request the and there was no documentation in the record to indicate the facility contacted a health care provider to request revised instructions.

On at 3:57 p.m. the resident care director confirmed the findings and said resident #1 actually wore her continuously but the health care provider had not yet been contacted to request revised instructions for the use of the .

Photographic evidence obtained.

Class III

**0078 - Staffing Standards - Staff - 58A-5.019(2) FAC**

Based on personnel record reviews and interview, the facility failed to ensure 1 of 4 sampled staff (A) submitted a written statement from a health care provider documenting freedom from communicable within 6 months prior to employment or 30 days after hire and failed to ensure the personnel record for 3 of 4 sampled staff (B, C and D) contained documented evidence of a negative ( ) exam on an annual basis.

Findings:

1. Resident assistant A was hired on . The record contained a written statement, dated , documenting freedom from communicable , including however, the signature of the examiner was illegible and the form did not contain printed information to assist in identifying the examiner.

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| NAME OF PROVIDER OR SUPPLIER<br>**CEDAR CREEK** | 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)

2. Resident assistant B was hired on . The record contained a written statement, dated , documenting freedom from communicable , including however, the signature of the examiner was illegible and the form did not contain printed information to assist in identifying the examiner.

3. Resident assistant C was hired on . The record contained a written statement, dated , documenting freedom from communicable , including however, the signature of the examiner was illegible and the form did not contain printed information to assist in identifying the examiner.

4. Registered Nurse D was independently with the facility to conduct monthly Limited Nursing Service assessments since . The record contained a written statement, dated , documenting freedom from communicable , including however, the signature of the examiner was illegible and the form did not contain printed information to assist in identifying the examiner.

On at 3:45 p.m. the administrator confirmed the findings.

Photographic evidence obtained.

Class III

**0081 - Training - Staff In-Service - 58A-5.0191( ) FAC**

Based on personnel record reviews and interview, the facility failed to ensure that 1 of 4 sampled staff (D) received the required in-service trainings within 30 days of hire.

Findings:

Registered Nurse D was independently with the facility to conduct monthly Limited Nursing Service assessments since .

Nurse D's personnel record did not contain documented evidence to indicate she received training on the topics of reporting major and adverse incidents, resident rights in an assisted living facility and recognizing and reporting resident , neglect, and , as required.

The record did not contain documentation to indicate she was core trained to exempt her from resident

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

rights and .

On at 4 p.m. the administrator confirmed the finding and was unable to provide additional documentation.

Class III

**Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)**

Based on personnel record reviews and interview, the facility failed to ensure 2 of 4 personnel records ( A and B) contained an Attestation of Compliance with Background Screening Requirements.

Findings:

Resident assistant A was hired on .

Resident assistant B was hired on .

Neither personnel record contained an Attestation of Compliance with Background Screening Requirements, as required.

On at 4 p.m. the administrator confirmed the findings.

Unclassified