Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969459	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER'S CREEK	1701 BALL PARK RD KISSIMMEE, FL 34741

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Complaint Investigations #2021014419 and #2021015290 were conducted on , , , and , Hunter's Creek had deficiencies at the time of survey.	A 000		
A 030 SS=G	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents	A 030		

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A 030	Continued From page 1 and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where	A 030		

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A 030	Continued From page 2 residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as	A 030		

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A 030	Continued From page 3 provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with	A 030		

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A 030	Continued From page 4	A 030		

relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility

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A 030	Continued From page 5 must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interviews, review of facility policy, and record reviews, the facility failed to ensure 1 of 3 sampled residents lived in a safe and decent living environment, free from and neglect (#1). Findings: A Health Assessment Report 1823 dated for resident #1 listed diagnoses of ,	A 030		

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A 030	Continued From page 6 jaundice, and . Per report, she needed supervision with all activities of daily living (ADLs). On at 1:49 PM, an order was received for an of the right to be done immediately. The right X -ray report, dated , indicated the reason for the was . The report result was mild diffuse changes, and further studies would be needed if persisted. A Healthcare provider note dated indicated the resident was seen for evaluation of activities of daily living (ADLs). A Healthcare provider note dated indicated diagnoses of with behavioral disturbances, , and and , and the resident was seen for medication refill and . A Healthcare provider note dated indicated the resident was non-complaint with medications, and a refill for was ordered. is an medication. Investigation by facility of events reflected that on at approximately 9:30 AM, two staff reported that staff C had been physically to resident #1 when the resident became aggressive toward the staff. The resident had X-ray of completed. The were negative for . The facility reported the incident to Adult Protective Services (APS). Per report, once APS came, the staff recanted their stories and APS did not look at the resident. APS did not recommend to the administrator to terminate the staff. On , staff C was given a written warning, told not to approach resident #1, and if a resident resisted care, to call for assistance or re-approach the resident later. On , a notice received from APS to the	A 030		

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A 030	Continued From page 7 resident and the facility indicated the case was closed with injury verified but no additional services were recommended. APS notice of conclusion dated indicated maltreatment - physical injury was verified, and the alleged , was staff C. Review of the facility staff schedule of to revealed staff A was still employed and worked the Memory Care Unit (MCU) since her return on . On at 2 PM, the Executive Director said the decision to allow staff C to return to the MCU was done by the Director of Nursing and the Corporate Director. She said she was not in the facility when the incident took place. She felt confident that no further incidents would happen. On at 3:0 PM, staff C said last , she went to help resident #1. There were three caregivers. Staff C said the resident had a history of aggression, so they cared for her with witnesses. She said the resident tried to hit her in the , and stated, "I did not fight her. I did not kick her. I put my out to so she would not hit me." She said the co-workers present did not help and "They complained about me." She was sent home for 3 days, then came to the MCU. She said, "I don't touch [resident #1 name]. I don't help her." She said the staff had a training on after that incident in . The facility's Prohibition policy and procedure indicated that an investigation of alleged neglect/ / , will be done and read that "during the investigation the resident would be protected from the suspect; the employee would be suspended until the Executive Director and appropriate authorities	A 030		

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A 030	Continued From page 8 have reviewed results. In the event the result of the investigation validated the incident, the Executive Director shall proceed with appropriate corrective action." The facility did not protect resident #1 from and allowed staff C to continue to work in the MCU, where the resident resided. Class II	A 030		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c),	A 032		

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A 032	Continued From page 9 F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to make a minimum daily effort to determine that at risk residents	A 032		

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A 032	Continued From page 10 have identification on their persons that included their name, the facility's name, address, and telephone number for 11 of 16 residents at risk for elopement, and did not ensure staff were generally aware of the location of residents assessed at risk for elopement at all times for 1 of 2 sampled residents (#2). Findings: On at 9:15AM, the administrator stated all residents in memory care were assessed to be at risk for elopement. A tour of the memory care unit (MCU) on at 9:30 AM with a resident care aide found 11 of the 16 residents not wearing ID at the time of the visit, including resident #2, who had eloped from the facility on . On at 10 AM, the MCU resident aide stated the nurse checks for identification (ID) on the residents. She was not sure where that was documented. Review of the medication observation records (MOR) for the 11 residents observed without ID on was done. The MORs reflected a once daily check for each resident at varying times. Of the 11 residents not wearing ID at 9:30 AM on , the nurse documented in the MOR that 8 of them were wearing their ID at 8 AM or 9 AM that morning. On at 12:30 PM, the nursing director stated she understood the nurses were doing a visual check that the residents were present, but were not actually checking for the presence of the ID .	A 032		

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A 032	Continued From page 11 Resident #2's record revealed an admission date of . The most recent health assessment (AHCA form 1823) was dated and included diagnoses of history of , impulsive behaviors, and . The resident was noted to be at risk for elopement and required assistance with activities of daily living. Review of facility notes from through revealed on at 7:50 AM, resident #2 could not be located. Staff found the window in the resident's room open, and the screen removed. A search was conducted inside and outside of the building. Police were notified at 7:55 AM. At 8:20 AM, the apartment across the street notified the facility that resident #2 was with them. Staff were sent to retrieve the resident and return the resident to the facility without injury. The facility sent the resident to the hospital emergency room (ER) for evaluation later in the day. Following the elopement, resident #2 was reassessed for elopement risk and a private sitter was hired for 72-hour monitoring. Photographic evidence was obtained. On at 1:40 PM, the nursing director stated new window locks were added to all memory care windows to prevent them from opening enough for a resident to go out. Class III	A 032		