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
	AL11965480	A. BUILDING: _____ B. WING _____	R 03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS HUNTER'S CREEK	3800 TOWN CENTER BLVD. ORLANDO, FL 32837

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{A 000}	Initial Comments A revisit to Complaint Investigation #2021016737 was conducted on [redacted] and [redacted]. Spring Hills Hunter's Creek had an uncorrected deficiency at the time of the visit.	{A 000}		
{A 025} SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	{A 025}		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 025}	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on observations, record reviews, and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision to 1 of 4 sampled residents who eloped from the facility (#3). Findings: Resident #3's record revealed a facility admission date of . The resident's diagnoses included and	{A 025}		

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{A 025}	Continued From page 2	{A 025}		

Documentation in the resident's record indicated the following:
On . . . . . at 7:30 a.m., the resident stated, "I want to leave, I don't trust you people here." She was seen pushing the front doors several times. She exited the facility and was brought by a caregiver. She had no injuries and was agitated.

On . . . . at 6:16 p.m., the resident was transferred from assisted living to the secured memory care unit. She was . . . . . and nervous.

On . . . . . at 7:38 p.m., the resident was upset and looking for her sister.

On . . at 6:03 p.m., the resident was very . . . . . and nervous. She was looking for an exit and staff had to redirect her on multiple occasions.

On . . at 3:06 p.m., the resident was very and looking for an exit.

On at 2:46 p.m., the resident was very . . . . . , aggressive at times, and looking for an exit.

On at 8:19 p.m., "staff observed the resident in the common area at the beginning of the second shift. Around 14:15 [2:15 p.m.] the . . . door alarm in Spring Cottage went off and the housekeeping supervisor went to check and noticed the . . . . door was open. Staff quickly examined the outside property and observed two other staff walking the resident . . . to the community from the Goodwill store. They were alerted by one of the Goodwill store employees, who stated that they believed that one of our

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{A 025}	Continued From page 3 residents was at the Goodwill store. Staff to provide routine checks to ensure safety." On at 1:29 p.m. and on at 4:35 p.m., the resident was very . . . , crying, and wanted to go home. She became agitated and attempted to hit staff. Interviews conducted with facility staff revealed the following: On at 1:27 p.m., caregiver F said that on . . . . she last saw resident #3 at 2 p.m. and said the resident often said she had to go home. On at 1:31 p.m., nurse B said the resident often around and said she was going to look for her husband. On at 1:44 p.m., housekeeper G said that on . . . . , she was in the lobby when someone entered the facility and said there was a resident at the Goodwill store. Housekeeper G assumed it was a resident from the memory care unit, so she immediately responded to the unit and upon entering, she heard a door alarm. She went to the door, opened it, then looked outside. She saw two other facility staff assisting resident #3 to the facility. On . . . . . at 3:21 p.m., the activities director said that on she learned there may have been a resident at the Goodwill store. She went to the store and saw resident #3 outside in the store's "item drop-off" area. She assisted the resident to the facility. On at 3:25 p.m., caregiver H said that on . . . . she was in a training class from 12 p.m. to 4 p.m. She said the resident often exhibited	{A 025}		

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{A 025}	Continued From page 4 exit-seeking behavior. On . . . . . at 3:28 p.m., activities staff D said that on between approximately 2 p.m. to 2:45 p.m., she was the only staff in the memory care unit. At approximately 2:30 p.m., housekeeper G entered the unit and asked staff D, "don't you hear that alarm?" Staff D said she did not hear the alarm. She last saw the resident at approximately 1:50 p.m., at which time, the resident was upset and tried to hit staff D with a walker. Staff D said caregiver I arrived in the unit immediately before housekeeper G arrived. On . . . . . at 3:40 p.m., caregiver I said she arrived in the unit immediately prior to the resident being returned to the facility and prior to housekeeper G responding. Caregiver I said she did not hear a door alarm. On . . . . . at 9:33 a.m., the Resident Care Director (RCD) said that on she was in a training class between 2 p.m. to 4 p.m. At approximately 2:30 p.m., she learned the resident eloped and was being returned to the facility. She checked the resident for injuries and found there were none. She said when the resident . . . . . and exhibited exit-seeking behavior, staff intervened by walking with her, by initiating aroma , , , and by giving her medications. She said that on most evenings, the resident became . . , would say she had to go see her parents, and that she had a car to drive herself. On . . . . . at 10:48 a.m., nurse E said that on she was in the training class from 2 p.m. to 4 p.m. She instructed caregiver I to go to memory care to help activities staff D. On at 10:59 a.m., the assistant	{A 025}		

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{A 025}	Continued From page 5 administrator said that on . . . . at approximately 2:30 p.m., she learned of the resident's elopement. Following the elopement, she instructed staff to frequently check on the resident, keep the resident engaged, and check the doors often. On at 11:31 a.m., the maintenance director identified the door the resident used to leave the facility. It was located in the southwest corner of memory care unit. Two alarm boxes were positioned towards the top of the door. The maintenance director pushed on the door's bar, at which time, one of the boxes emitted an audible alarm. Following a fifteen second delay, the door opened, and the other box emitted a louder alarm. After passing through that door, there was a second door that led to the outside. When the second door was opened, a low audible alarm emitted from a box. The maintenance director said the staff all carried a pager that received an alert anytime an attempt was made to exit through the first door. The surveyor looked outside the second door and saw the Goodwill store was located approximately fifty . . . away from the facility. Grass, a sidewalk, and an asphalt driveway was between it and the store. On . . . . . at 11:40 a.m., nurse B was asked about the pagers, and said they were not used. On at 12 p.m., the assistant administrator said the pager alert system was installed in early , . She had a pager and pushed on the door to demonstrate how it worked. An alert was sent to the pager however, the alert indicated the alarm came from "spa bathroom". The assistant administrator said the location was wrong in the system.	{A 025}		

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{A 025}	Continued From page 6 Class II	{A 025}		