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 _____	10/30/2023

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 A complaint investigation #2023012198 was conducted on [redacted] at [redacted] Hunter's Creek Assisted Living Facility. A deficiency was identified at the time of the survey.	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: Based on observation, record reviews, and interviews the facility failed to provide adequate supervision and provide care and services appropriate to meet the needs of residents by failing to prevent an elopement for 1 of 4 residents sampled (#1). Findings: On . . . . . A review of an Adverse Incident report revealed resident #1 eloped from the facility's secured memory care unit on . . . . . He was last seen on at 12:30pm. There was camera footage of resident #1 exiting the memory care unit at 1pm. He then exited through a	A 025		

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A 025	Continued From page 2 door to the facility parking lot. He was noticed by staff to be missing at 2:34pm. He was found walking outside on the sidewalk at 2:37pm. A review of a facility note written . . . . . Resident #1 was not in his room. Staff checked other areas in the memory care unit then initiated an elopement drill. Staff found a resident outside the building walking on the sidewalk. The time of incident was documented as 1:51pm A review of resident #1 record revealed he was admitted on . . . . . He did reside in the Secured Memory Care Unit. His record contained a Resident Health Assessment form (1823) dated . His diagnoses included , and . He required safety precautions and assistance with his activities of daily living. On at 10:50am resident #1 was observed in his room sitting on the bed. He had an identification bracelet on his right . He said he was feeling fine and was in no , . . . He was unable to recall the elopement event. At 11am an interview and tour of the elopement route was conducted with the administrator. She used a key fab to unlock 2 doors to enter the memory care unit's main entrance. We walked across the common area into the dining room. She used her key fab to unlock an exit door used by resident #1 to exit the memory care unit. The exit door led to another closed door that was not locked. (About 5 . . from the first door.) The second door led to a staff/service area with the laundry, kitchen, break area, and an exit door to the outside. The door to the outside was not locked and led to the . of the facility. The	A 025		

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A 025	Continued From page 3 door locked from the outside. Outside there were no sidewalks. There was a curb, and parked cars. The administrator said she verified resident #1 left through the MC exit door and then through the exit to the outside at 1pm on . . . . . She said she reviewed the camera footage. She was unable to say exactly how he was able to exit the secured memory care unit or where he went after exiting the building. There were no cameras on the outside of the facility. At 1:45pm the surveyor requested, from the administrator, to see the camera footage for elopement of resident #1. She said the footage could only be seen for 1 day. She said she believed the resident was able to exit after a staff member. She was unable to confirm the time between the staff exiting and the resident eloping through what she said was an improperly closed door. On at 2pm the administrator confirmed resident #1 eloped from the secured memory care unit and his whereabouts were unknown for more than one and a half hours. Class II	A 025		