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 _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE LIVING AT 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
CZ814 SS=D	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	CZ814		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic ⌄ , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review, and interviews, the facility failed to provide an up-to-date Background Screening Clearinghouse for 1 of 6 sampled employees (E). Findings: On while conducting records review it was observed that employee E had an initial hire date of . On at 3:00pm, asked to speak with the business office manager. This writer asked her to verify the date of hire for employee E, as well as bring to her attention that the employee (E) was not on the BGS. On at 4:32pm the administrator stated that she the BGS roster was not working. This writer stated that the facility had ample time to place employee E on the roster and per the	CZ814		

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CZ814	Continued From page 2 regulation she should have been placed on it 5 days after being hired. Class III	CZ814		
A 000	Initial Comments A complaint survey (2024016665) and generator monitoring were conducted at Providence Living at Hunters Creek on . The facility deficiencies at the time of the survey.	A 000		
A 025 SS=D	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 or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . 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 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.	A 025		

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A 025	Continued From page 3 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 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 record reviews and interviews, the facility failed to ensure appropriate supervision and the general whereabouts for 1 of 1 sampled resident (1) eloped from the facility on . Findings:	A 025		

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A 025	Continued From page 4 A review of resident #1's record revealed a facility admission date of . The resident's health assessment (1823) revealed a medical history of, , , , , 's, and Sleep , . The resident needed assistance with self- administration of medications. The resident was not an elopement risk. On at 11:45am the administrator confirmed the incident did indeed occur. The administrator stated that once she found out she immediately contacted resident #1's wife and called law enforcement. It was then that she and the Director of Nursing (DON) were notified by law enforcement that they had been called about an elderly man at the gas station at 9:24pm who seemed to be disoriented and was not able to tell them where he lived. It was then that the law enforcement proceeded to take resident #1 to the hospital for further evaluation. The administrator stated that resident #1 ambulates with a 4-wheel walker, and he had never displayed any exit seeking tendencies. On at 12:15pm the DON was asked what time does the front desk personnel leaves for the day. The DON said the front desk staff leaves at 7pm. The DON was then asked what happens with the front door when the staff leaves for the day. The DON stated that residents and their family have key FOBs to get into the building during after-hours. The DON was asked how often the caregivers/ unlicensed staff checks the residents. She stated that caregivers are to check the residents every three hours and for the residents that require toileting, and diaper changes they are checked every two hours. The DON stated that the resident #1 was last seen by staff at approximately 8:30pm. The DON then	A 025		

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A 025	Continued From page 5 stated that the camera shows that at 8:48pm resident #1 was seen exiting the building without staff or family members. This writer asked the DON what time was she notified of resident #1's elopement, she stated it was at 12:50am. The DON stated the facility notified the police at 1:20am. It was then that the police confirmed that they did find resident #1 at the gas station across the street from the facility at 9:24pm, which they then took him to the hospital for further evaluation. On at 1:42pm spoke with Caregiver A, who stated that she heard of the incident with resident #1 eloping from the facility. Caregiver A was asked what the procedure is for checking on residents, she stated that for the residents that need to be changed and toileted they are checked every two hours, and the other residents are checked every three hours. Caregiver A stated that since the elopement the administrator and the DON remind staff to make frequent checks on the residents. Caregiver A stated that when a resident elopes, they must notify the shift supervisor who then will call the administrator and the DON. On at 1:46pm caregiver B stated that she was not on shift when resident #1 eloped, but the facility protocol is to notify the shift supervisor and continue to look for the resident and maintain a headcount for all the other residents. The caregivers are to check on residents that need to be toileted every two hours and three hours for the other residents. The facility does elopement drills every month. Since she has been working at the facility, that was the only elopement, and it was scary because of how busy the roads are. The facility is a safe place for the residents that live here and everyone loves it here.	A 025		

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A 025	Continued From page 6 On at 3:15pm caregiver C Stated that she did hear of the elopement that happened to resident #1. She stated that he was never an exit seeking person and no one would have ever seen it coming. It is just a scary time when the incident occurred. When asked how often are checks performed on each resident caregiver, C stated that if the resident's need to be taken to have their diaper changed it is every two hours, and the other residents are every three hours. When asked how often elopement drills are conducted, she stated it is conducted every month, and all shifts must participate. When asked what the protocol for a missing resident caregiver C stated that they announce it over the walkie and begin searching for the resident but if they are unsuccessful, they will then tell the shift supervisor who then reports it to the administrator and the DON. On at 3:35pm caregiver D stated that resident #1 was a great guy and he did not have any exit seeking behaviors prior to that single incident. His family is very active in his life, so it was a huge when it all occurred. When asked what the facility protocol is for a resident elopement, she stated that all staff begin searching for the resident and if they are not able to find the resident, they will tell the shift supervisor, and she will then call the administrator and the DON who will then notify family and the police. When asked how often residents are checked she stated all that needs to be taken to the bathroom must be checked every two hours and the residents who require less are checked every three hours. Class III	A 025		