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 _____	03/27/2025

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

(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 #2025003219 and a generator monitoring was conducted at Spring Hills Hunter's Creek Assisted Living Facility and Memory Care with Limited Nursing Services (LNS) on . The facility had deficiencies at the time of the survey 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 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. 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 025		

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A 025	Continued From page 1 (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 facility's documentation, resident record review and interview, the facility failed to provide appropriate supervision for 1 of 3 sampled residents (#1) to prevent elopement from the secured Memory Care unit. Findings: An incident report dated at 7 PM documented that Resident #1 eloped from the Memory Care unit's exit door and was found by the Emergency Medical Transport (EMT)/First responders lying on the ground (on the facility's	A 025		

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A 025	Continued From page 2 premises) near the of the assisted living facility. The resident with injury of a hematoma on his forehead and to his right . The resident was transported to the hospital for observation and treatment. Review of resident #1's record revealed an admission date of . The last 1823 Health Assessment dated listed his medical history of , Prostatic Hyperplasia, ( ), type 2, , ( ), recurrent , , , , Iron Deficiency , ( ), right , , Hyponatremia, and ingestion of detergent or soap. He needs assistance with all activities of daily living in ambulation, , bathing, eating, grooming, toileting and transferring. He has an unstable gait and need assistance with self-administration of medications. He started , , ( ) and , , ( ) on , same day of the elopement from a previous . A facility note dated at 8:34 PM (late entry) documented that the nurse went to resident #1's room and observed him lying on the floor in front of his bathroom on his left side. The resident had a on his right and difficulty bending his right . Resident #1 told the nurse he hit his . The resident was transported to the hospital via ambulance. The resident's physician and family were notified. A facility note dated at 11:09 PM documented Resident #1 returned from the hospital. The resident was alert and oriented and there was no , distress. The resident's skin was intact. The resident had a new	A 025		

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A 025	Continued From page 3	A 025		

medication change order that Ozempic was discontinued. All his tests and , were negative. His body was healing well, and he denied any , or discomfort. The daughter was notified of his return to the facility.

A facility note dated at 9:23 PM documented Resident #1 had uncontrollable coughing and spitting red with , and . A bar of soap was observed by the resident's bed with bite marks and of the soap bar was missing. Resident #1 was transferred to the hospital for observation and treatment. The resident's physician and daughter were notified.

A facility note dated at 9:36 PM documented that the daughter called the facility to inform them that resident #1 was at the hospital for possible soap consumption. His and were , and they are going to admit him.

A facility note dated at 11:39 AM documented Resident #1 returned from the hospital. Also, he has , , , ( ), and , , ( ) scheduled for initial evaluations.

A facility note dated at 7:30 PM (late entry) documented resident #1 was found on the facility grounds outside the community. The resident was transported to the emergency room for observation. The Emergency Medical Transport (EMT) stopped at the community after finding resident #1 to notify the facility, resident #1 was found outside on the assisted living facility grounds and would be taken to the hospital. EMT stated that they found him lying on the ground with a hematoma on his forehead, to right . A for the , , ,

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A 025	Continued From page 4 , and arm will be completed. The Director of Resident Care, Administrator, physician and daughter were notified about the elopement and . A facility note dated at 10:30 PM, a telephone call from the hospital for a follow up, spoke to a nurse in charge at the hospital and the nurse stated that all of resident #1's test were negative, and he would be admitted to the hospital for the with diagnosis of , , . A facility note dated at 9:55 PM, documented resident #1 returned to the assisted living facility via ambulance. He was alert/oriented to self. No , , distress. He had a small and to the right side of his forehead. His , area was discolored. He denied any , and discomfort. There was to the upper arm first aid was applied. A facility note dated at 2:15 PM, an email to the Administrator by the daughter informing her that notice of discharge was submitted. Resident #1's daughter stated the resident was moving out of state to Virginia and his last day at the facility would be . A facility note dated at 3:07 PM documented Resident #1 attempted twice within one hour to exit the facility through the same door he did on but was not successful. The alarms went off and staff redirected him from the door. The daughter called and spoke with the resident to calm him down. She told the resident that she would be at the facility in a few hours to pick him up. An attempted interview on at 1:50 PM with Resident #1 but he was not , . He	A 025		

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A 025	Continued From page 5 did not like me and the nurse being in his room. He asked, "what were we doing in his room"? I quickly answered him that I wanted to see his great room. He paused and said okay. An attempted telephone interview on at 2:30 PM with Resident #1's daughter, no answer. Left a detailed voicemail message to return telephone call. On at 2:48 PM, an interview with the Maintenance Director confirmed that the one exit door alarm was not working on and that was how Resident #1 eloped. Another attempted telephone interview on at 4:10 PM with Resident #1's daughter, no answer and went directly to voicemail. On at 4:45 PM, an interview with the Administrator and Director of Resident Care (DRC) confirmed the findings. (Photographic Evidence Obtained) Class II	A 025		