STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965480	05/05/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Spring Hills Hunter's Creek	3800 Town Center Blvd. Orlando, FL 32837	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - N278 - 58a-5.031(3) Fac - Lns - Records S-S= D

Specific Tag Findings:

0000-Initial Comments
Complaint inspection CCR#2014001158 was conducted on [redacted] through [redacted] Spring Hills Hunter's Creek had deficiencies found at the time of the visit.

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC
Based on observation, record review and interview the facility failed to ensure that a resident (#14) identified at risk of elopement had identification on her person that included her name, the facility name, address and telephone number for one of 35 sampled residents.

Findings:

Resident Record Review on [redacted] for resident #14 revealed the resident was admitted to the facility on [redacted] An updated Facility Health Assessment Form (AHCA 1823 Form) dated [redacted] revealed diagnosis of [redacted] and [redacted] The physician indicated the resident requires assistance with self-administration of medications, a regular diet and assistance with ambulation and is independent in all other activities of daily living. There is a photo of the resident in the record.

Further review of the record on [redacted] #14 revealed a Nurse Notes dated [redacted] "receptionist bought to the Nurses attention that resident was outside and was walking towards gas station, writer went outside and brought resident back into the building. Resident stated that the receptionist tried to chase her and she was mad at her. Later the resident was found back outside, writer walked around building with resident because resident would not go in the front entrance because she would not enter near receptionist. Wander guard was applied to residents wrist per Director of Resident Care (DRC) (Director of Nursing). DRC requested a [redacted] analysis due to increased aggressive behavior, new orders for [redacted] analysis."

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Review of Nursing Evaluation for resident #14 dated revealed that the resident was readmitted to the facility from Central Florida Behavioral Hospital after being on Resident #14 has a diagnosis of and Section for Elopement Risk Evaluation: Indicated the resident has a history of elopement, resident has poor decision making skills ambulates independently with a walker, expresses a desire to go home, has been hospitalized for mental illness and has had a combative episode. Interventions: listed are; Personal safety alarm/device /ID bracelet- N/A patient refused exit and stairwell alarms Secured Unit- N/A, picture on file increased involvement in activities and Staff are aware of resident risk

Interview with administrator on at 4:10 PM who stated that since the initial incident on resident #14 has consistently refused to wear a wander guard or any type of identification. She had a wander guard on earlier today because she sounded the alarm when she went near the front door. The family has been notified and has been asked to bring clothes in that are labeled with the facility name, address and phone number. The resident is watched closely by staff that is aware of her history. They even tried putting the bracelet on her ankle and identification in her shoe. She finds it and throws it away.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on personnel record review and interview the facility failed to ensure all staff were assigned duties consistent with his/her level of education, training, preparation, and experience and allowed unlicensed staff to assist residents 4 in a sample of 35, with the application and removal of leg braces (#28), application and removal and calibration of (#32) and to administer medications with parameters that required them to exercise judgment as to whether or not give a medication (#27 & #35).

Findings:

1. In an interview on at approximately 9:30 AM, during the facility entrance interview, the Director of Nursing stated there were no residents that needed Limited Nursing Services (LNS).

Observations on at approximately 11 AM noted resident #28 sat in the common area.

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She was in a wheelchair and had braces on both her legs. The administrator stated that the caregivers put on and remove the braces on about 3 times a night when she goes to [redacted] in the morning and night.

In an interview with the Director of Nursing (DON) on [redacted] at approximately 1:30 PM, he stated that he and the administrator realized resident # 28 needed to be on LNS. The DON stated that the caregivers put on and removed the brace on 3 times a night when she went to the [redacted] He stated there were nurses around the clock and they could apply and remove it as well. He stated he just wrote a note for [redacted]

Observations on [redacted] at approximately 2 PM noted resident #28 was able to stand with minimal assistance. She stated she was in a car accident and injured her right foot. The braces helped her walk. She was getting physical [redacted] as well. She stated at night she needed help with the application and removal of the braces as she was unable to do it herself. She added that she was up about 3 times each night.

Resident record review on [redacted] revealed a note that indicated the resident was admitted on [redacted] had degenerative [redacted] and orders for lower leg brace for support of ankles, [redacted] involved with physical /occupational and speech [redacted] T/ST) as per 1823. "Staff assisting resident with removal and applying of braces daily and as needed". Skin to lower extremities intact, resident denies pain from braces, will continue to monitor routinely. The health assessment dated [redacted] indicated motor vehicle accident with [redacted] neck [redacted] right ankle bi-malleolar [redacted] degenerative [redacted] and left and right lower extremities braces.

2. Observations on during a medication pass on [redacted] at approximately 11:30 AM noted resident #32 had [redacted] on. After the nurse gave the resident her medications, she asked if her [redacted] was OK or did it need to be checked. The resident replied that she was OK. Resident #32 stated during an interview the nurses and certified nursing assistants (CNAs) helped her with her [redacted] as she was unable to do it by herself.

Resident record review on [redacted] revealed a health assessment dated [redacted] that listed diagnoses of [redacted] high [redacted] and Trans-is[redacted] An order dated [redacted] indicated [redacted] 2 L as needed via nasal cannula; another order dated [redacted] indicated titration conserver device. On [redacted] a doctor prescribed [redacted] flow rate

2 liters PM, continuous. Facility notes dated ... at 10:23 Called Lincare and ordered 6 ... tanks size D. Facility 2/3 at 11:22 Called Lincare and ordered 6 ... tanks size E.

3. Resident record review for resident # 27 revealed a health assessment report dated ... that indicated diagnoses of ... body ... and high ... assistance was needed with self-administration of medications. Continued review revealed a physician's order dated ... that indicated ... 25 milligrams take a half-tablet twice a day; hold for ... less than 115 or ... rate less than 60. The ... 2014 medication observation record (MOR) listed the ... 25 milligrams take a half-tablet twice a day .hold for ... (first number) less than 115 or ... rate less than 60 and was held on ... 8 AM- ... 8 PM- ... and on ... 8 PM ... was ... The back page of the MOR indicated the staff was not a nurse, made a judgment decision to hold the medication.

4. On ... at approximately 10:10 AM, during the medication pass. The unlicensed staff (B) was observed taking resident #35's ... After she took his ... she informed him of the results and provided all of his medications to him. During an interview with staff B she stated that she had to take the resident's ... before giving him his ... medication.

Record review for resident #35 revealed a Physicians Order Sheet for ... that noted ... 25 milligrams (for ... take 1/2 (12.5 mg) by mouth twice daily the parameters were also noted- hold for ... (SBP) less than 100 or ... Rate less than 55. Review of the MOR for ... revealed it noted ... 25 milligrams (for ... take 1/2 (12.5 mg) by mouth twice daily the parameters were also noted- hold for ... (SBP) less than 100 or ... Rate less than 55 the ... results were documented at 8 AM and 8 PM daily. The ... only noted ... 25 milligrams take 1/2 (12.5 mg) by mouth twice daily and did not note the parameters; however the ... results were documented on the MOR. Further review of the MOR revealed that the unlicensed staff had taken the ...'s, documented the results and initialed the MOR as giving the medication to the resident.

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During an interview with a licensed practical nurse, she reviewed the MORs and identified the staff that took the [redacted] and gave the medications. On some of the days she identified nurses as giving the medication and there were days that the unlicensed staff took the [redacted] and gave the medication also.

The unlicensed staff was administering medications with parameters which required a nursing judgment to determine when to hold and give medications.

Class III

N278-LNS - Records 58A-5.031(3) FAC
Based on observations, interviews and record reviews the facility failed to ensure that nursing progress notes and nursing assessments were maintained for 2 of 2 residents, in a sample of 35, who received limited nursing services (#28 & #32).

Findings:

1. In an interview on [redacted] at approximately 9:30 AM, during the facility entrance interview, the Director of Nursing stated there were no residents that needed Limited Nursing Services (LNS).

Observations on [redacted] at approximately 11 AM noted resident #28 sat in the common area. She was in a wheelchair and had braces on both her legs. The administrator stated that the caregivers put and removed the braces on about 3 times a night when she went to [redacted] in the morning and night.

In an interview with the Director of Nursing (DON) on [redacted] at approximately 1:30 PM, he stated that he and the administrator realized resident # 28 needed to be on LNS. The DON stated that the caregivers put and removed the brace on 3 times a night when she went to [redacted]. He stated there were nurses around the clock and they could apply and remove it as well. He stated he just wrote a note for [redacted].

Observations on [redacted] at approximately 2 PM noted resident #28 was able to stand with minimal assistance. She stated she was in a car accident and injured her right foot. The braces helped her walk. She was getting physical [redacted] as well. She stated at night she

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needed help with the application ad removal of the braces as she was unable to do it herself. She added that she was up about 3 times each night.

Resident record review on revealed a note that indicated the resident was admitted on had degenerative and orders for lower leg brace for support of ankles, involved with physical /occupational and speech T/ST) as per 1823. "Staff assisting resident with removal and applying of braces daily and as needed". Skin to lower extremities intact, resident denies pain from braces, will continue to monitor routinely. The health assessment dated indicated motor vehicle accident with neck right ankle bi-malleolar degenerative and and left and right lower extremities braces.

2. Observations on during a medication pass on at approximately 11:30 AM noted resident #32 had on. After the nurse gave the resident her medications, she asked if her was OK or did it need to be checked. The resident replied that she was OK. Resident #32 stated during an interview the nurses and certified nursing assistants (CNAs) helped her with her as she was unable to do it by herself.

During an interview with the Director of Nursing on at approximately 3 PM revealed there were no nursing notes or nursing assessments available.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2014

Administrator
Spring Hills Hunter's Creek
3800 Town Center Blvd.
Orlando, FL 32837

Dear Administrator:

Re: CCR #2014001158

This letter reports the findings of a state licensure survey that was conducted on . 2014 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2014,** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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