STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965013	12/26/2017
NAME OF PROVIDER OR SUPPLIER **HUNTER'S CROSSING PLACE-MEMORY CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **4607 NW 53RD AVENUE GAINESVILLE, FL 32606**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced complaint survey (CCR#2017010383) was conducted on at Hunter's Crossing Alf-Memory Care (license number 9442). Deficient practice was noted at the time of the survey.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on interview and record review, the facility failed to notify residents family, guardian, and health care provider (hospice) when the resident moves out of the facility for 1 of 3 residents reviewed.

Findings:

On at 11:27 am an interview was conducted with the Executive Director of Hunter's Crossing ALF-Memory Care. The Executive Director confirmed the facility evacuated the residents of the facility to a facility in Atlanta, GA on , , 2017. The Executive Director states that each family was provided notification of the evacuation via telephone or email. The Executive Director confirmed she did make contact with several care givers but was unsuccessful in reaching all care givers.

ED confirmed she left messages regarding the evacuation for the care givers but did not speak to them. She confirmed the comprehensive emergency management plan states the facility must notify the families within 24 to 48 hours in the event of an impending evacuation (moving residents).

On at 12:39 pm an interview was conducted with the interim Resident Care Manager. In the interview she confirmed she made attempts to contact each of the residents care giver. She confirmed she did not speak with all the family members but rather left messages instead. The Interim Resident Care Manager also confirmed the entire evacuation situation was extremely chaotic.

A record review was conducted of the comprehensive emergency management plan which outlines the facility responsibilities on pages 9 and 10 section labeled Hurricanes- subsection titled If Impending Evacuation: number 10-Contact families to notify of potential need to evacuate and inquire if the family wishes to take the resident with them or if the resident should evacuate with the house.

Number 15 -Notify residents' family or responsible party of where residents will be sheltered.

Page 16 number 6 titled Notifying Families- Families will be telephoned with as much notice as possible (preferably 24-48 hours) of the impending need to evacuate.

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Page 17 number 2 titled Transportation Arrangements- in the event of evacuation, families will be contacted 48-hours in advance.

Record review of the Executive Director's work cell phone log provided by Verizon Wireless reveals only one attempt made to contact the complainant on at 8:13 pm.

Record review of resident roster provided by Interim Resident Care Manager for the time period of , 2017 displays hand written notes which identifies each resident. The hand written notation identifies which responsible party received a message, if actual verbal communication was made, message mailbox full, or phone off. The notation made for the complainant stated a message was left.

Record review of resident #1's chart was conducted on . Resident #1 record reveals that hospice services were terminated on , , 2017 and reinstated in 2017.

On at 12:53 pm and interview was conducted with a Hospice Case Manager. In the interview she confirmed that the complainant's family member hospice services were terminated on , 7, 2017. She informed the survey team the facility failed to notify Hospice in a timely manner. She states that regulations prohibit Hospice from providing services across state lines without the proper travel plan. The lack of notification by the facility resulted in the termination of services for all Hospice recipients who evacuated during that time period.

On at 12:39 pm in an interview with the interim Resident Care Manager. She confirmed that all hospice residents that evacuated, services were discontinued during the evacuation period.

Class III