

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105987	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/20/2024
NAME OF PROVIDER OR SUPPLIER  Hunters Creek Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  14155 Town Loop Blvd Orlando, FL 32837	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46665</p> <p>Based on interview, and record review, the facility failed to protect the resident's right to be free from neglect by not ensuring staff implemented measures to mitigate the risk and prevent elopement for 1 of 3 residents reviewed for elopement, of a total sample of 13 residents, (#1).</p> <p>These failures contributed to the elopement of resident #1 and placed him at risk for serious injury, harm, and/or death. While resident #1 was out of the facility unsupervised, there was likelihood he could have died , been accosted by unknown persons, become lost, or hit by a vehicle.</p> <p>On [DATE], resident #1, a [AGE] year-old male was admitted to the facility from the hospital. While he was at the hospital, doctors determined he was at risk of harm and falls without 24-hour supervision and care and services to monitor him and implement measures to ensure freedom from harm and prevent known risks of endangerment.</p> <p>On [DATE] at 6:28 PM, the facility failed to provide appropriate care and services to prevent a physically and severely cognitively impaired resident, assessed to be an elopement risk, from exiting the facility unsupervised. The resident was allowed to exit the building unsupervised, and he walked approximately 0.2 miles across a high traffic 4-lane road with a curbed median into an apartment complex. The route along the way had wet, uneven terrain/pavement and curbs. The facility was unaware of the resident's elopement until a Certified Nursing Assistant (CNA) realized the resident was missing and determined a receptionist had unlocked the lobby door and allowed him to exit the building. Police found the resident in a nearby apartment complex parking lot with apparent minor injuries. The facility failed to implement preventive interventions per standards of care to mitigate the resident's risk of elopement.</p> <p>The facility's failure to identify the need for adequate supervision and ensure a secure environment placed all residents who wandered at risk. This failure resulted in Immediate Jeopardy starting on [DATE]. The Immediate Jeopardy was determined to be removed on [DATE] after verification of the immediate actions implemented by the facility. The facility corrected the noncompliance at F600 on [DATE]. The noncompliance at F600 was determined to be past noncompliance.</p> <p>Findings:</p> <p>Cross reference F689</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the medical record revealed resident #1, a [AGE] year old male was admitted to the facility from an acute care hospital on [DATE] with diagnoses of: encephalopathy (brain dysfunction), acute systolic congestive heart failure (inefficient blood pumping), pneumonia, acute respiratory failure with hypoxia (low blood oxygen), right bundle branch (heart vessel) block, type 2 diabetes mellitus, coronary artery (heart vessel) disease, dementia, abnormalities of gait (walking pattern) and mobility, lack of coordination, muscle weakness, cognitive communication deficit, and disorientation.</p> <p>The Admission Data Set form dated [DATE] documented resident #1 was alert and confused, had a language barrier (Spanish), and required a walker to walk safely. The form indicated the resident was at risk for elopement, and received high-risk antipsychotic (psychosis prevention), anticoagulant (blood thinner), diuretic (fluid removal), and antiplatelet (blood clot prevention) medications. The Care Needs section read, total care.</p> <p>The Minimum Data Set (MDS) 5-day Assessment with Assessment Reference Date [DATE] revealed during the look-back periods, resident #1 scored 5 out of 15 on the Brief Interview for Mental Status (BIMS) that indicated he was severely cognitively impaired. The Mood assessment noted for ,d+[DATE] days, the resident had little interest or pleasure in doing things, felt down, depressed, or hopeless. Nearly every day, he had trouble sleeping and concentrating on things like reading or watching television. The Behavior Assessment noted the resident wandered for 1 to 3 days. Functional Abilities and Goals indicated the resident used a walker and needed help with functional cognition, eating, self-care, mobility, and to complete Activities of Daily Living (ADL).</p> <p>The Florida Agency for Health Care Administration ,d+[DATE] Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form dated [DATE] revealed resident #1 was alert and disoriented, but able to follow simple instructions. His decision-making capacity required a surrogate, he had risk alerts for falls, and his physical function for transferring and ambulation (walking) required an assistive device (walker) with 1 assistant.</p> <p>The hospital Speech-Language Pathology (SLP) report dated [DATE] indicated resident #1 required , d+[DATE] supervision due to cognitive/memory deficits, the supervision required was described as, Direct 1:1 supervision.</p> <p>The hospital Occupational Therapy (OT) report dated [DATE] indicated resident #1 was oriented only to person, had decreased /impaired insight for safety judgement and decreased/impaired safety awareness.</p> <p>The hospital physician's History and Physical report dated [DATE] read, . he has declined cognitively, and it appears that his gross and fine motor skills are also impaired .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Order Summary dated [DATE] and Medication Administration Reports for [DATE] noted physician's orders that included an alerting bracelet to left ankle, check function and placement of alerting bracelet every night shift, psychiatric consultation, and Physical Therapy (PT)/OT/Speech Therapy (ST), evaluate and treat. Medication ordered on [DATE] included: Seroquel (antipsychotic) 25 Milligrams (MG) once daily and 50 MG at bedtime for psychosis, Lasix (diuretic) 40 MG once daily for congestive heart failure, Humalog (insulin) before meals and at bedtime as per sliding scale parameters, Glargine (insulin) 10 units at bedtime, Hydroxyzine HCl (antihistamine) 25 MG once daily for anxiety, Losartan Potassium 25 MG once daily for high blood pressure, Metformin (blood sugar lowering) 1000 MG once daily for diabetes mellitus, Terazosin HCl 2 MG at bedtime for high blood pressure, Apixaban (blood thinner) 5 MG twice daily for atrial fibrillation (heart arrhythmia) started [DATE], Glimepiride (blood sugar lowering) 2 MG every 12 hours for diabetes mellitus, and Midodrine HCl 10 MG three times daily for low blood pressure.</p> <p>The facility SLP Evaluation and Plan of Treatment notes dated [DATE] indicated the resident had, severe-profound cognitive-linguistic impairment characterized by deficits in orientation, memory, attention, naming, and problem solving .</p> <p>The facility PT Evaluation &amp; Plan of Treatment Assessment Summary completed on [DATE] noted diagnoses of encephalopathy and lack of coordination, and showed the resident was referred for skilled PT following a recent hospitalization due to progressive weakness that led to non-ambulation. The assessment documented the resident had a fall risk and confusion with impulsivity, he required supervision/touching assistance for transfers and walking, the need for physical assistance to function safely in his home for transfers and ambulation, presented with impulsivity and poor to non-existent safety awareness resulting in increased risk for falling.</p> <p>The facility OT Evaluation &amp; Plan of Treatment completed [DATE] revealed resident #1 was referred to OT due to issues with balance, a decrease in strength and falls/fall risk. The evaluation indicated his decision-making ability for routine activities was severely impaired . Another OT Treatment Encounter completed [DATE] revealed the resident was observed with behavioral impulses and difficulty with safety awareness.</p> <p>An Elopement Risk Screen and Care Plan dated [DATE], before the elopement, noted resident #1's risk score placed him as an elopement risk. The Care Plan's focus indicated the resident was at risk for elopement with a goal that read, Attempts to maintain safety will be provided through review date. The interventions included: alerting bracelet, check function every day and placement every shift, involve resident in appropriate activities, offer pleasant diversions; structured activities, food, television, books, offer reassurance and support as needed, and picture of resident kept in Elopement Binder(s). Other Care Plans included risk for falls, impaired cognitive function/impaired thought process, ADLs with staff assistance, and risk for impaired gas exchange/ineffective airway clearance.</p> <p>The Social Services Admission Evaluation dated [DATE] indicated the resident's cognitive patterns showed the resident had short-term and long-term memory recall problems, severely impaired abilities to make decisions regarding tasks of daily life, no acute changes in mental status from baseline. The evaluation showed the family expected the resident to remain in the facility as discharge to the community was not feasible.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A Nursing Progress Admission Note dated [DATE] written by Licensed Practical Nurse (LPN) L read, Resident arrived on unit [DATE] at [4:45 PM] via stretcher accompanied by 2 transport personnel and numerous family members from [hospital name]. Resident is alert, confused most of the time No c/o [complaints of] pain or discomfort this shift. VSS [vital signs stable]. Resident is a fall risk but refused to use a walker or have staff assistance as he walked down the hall looking for an exit. [alerting bracelet] placed on left ankle. Bed in lowest position.</p> <p>In an interview on [DATE] at 1:03 PM, PT J recalled resident #1 received skilled therapy during his stay. PT J explained the resident needed supervision because he had confusion, and stated, we worked on gait training, balance, and lower extremity stabilization; balance and stabilization to prevent falls.</p> <p>On [DATE] at 3:15 PM, LPN L said when resident #1 was admitted to the facility on [DATE] during the 3:00 to 11:00 PM shift, he was on her assignment. The LPN recalled she completed the resident's elopement risk assessment within a few hours after he arrived, and found he was at risk. She explained, she notified the Captiva Unit Manager (UM) about the resident's behaviors and her concerns. She said an alerting bracelet was implemented before the end of her shift. LPN L said approximately 2 days later, during her 3:00 PM to 11:00 PM shift, she noticed the resident was wandering again. She stated, When the family left, he started trying to find a way out; he was determined he didn't want to stay here; he said he wanted to go out to the parking lot to go to his car; he was convinced his car was in the parking lot.</p> <p>In an interview on [DATE] at 2:54 PM, CNA B explained she knew resident #1 well and he was part of her assignment during her 3:00 PM to 11:00 PM shifts. She said CNAs used the information entered by the nurses in the Kardex to guide the care they provided to the residents. She said the resident spoke Spanish, was often focused on his family coming to visit, and he frequently asked for his wife. The CNA recalled on [DATE] during her shift, resident #1 walked around a lot, and she tried to redirect him. She stated, he was mentioning my wife is coming and he was coming out {of his room} again; he was wandering; he tried to go out to the back yard, and I stopped him.</p> <p>Review of resident #1's Visual Bedside Kardex for CNAs dated [DATE] listed under Safety interventions such as an alerting bracelet is placed, bed in lowest position, check alerting bracelet function every day, check alerting bracelet placement every shift, non-skid footwear, offer pleasant diversions, structured activities, food, television, and books.</p> <p>On [DATE] at 10:21 AM, in a telephone interview, LPN A explained she had resident #1 on her assignment for the first time during the 3:00 to 11:00 PM shift on [DATE], the day he exited the facility. She recalled, Registered Nurse (RN) G gave her report from the 7:00 AM to 3:00 PM outgoing shift and the RN told her resident #1 had dementia, was only alert to himself, and he wandered. She said the last time she saw resident #1 was around 6:00 PM the same day.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 10:45 AM, RN G explained she knew resident #1 well and took care of him during the 7:00 AM to 3:00 PM shifts his entire stay. She stated the resident spoke Spanish, and she was able to communicate with him well because she also spoke Spanish. The RN recalled the day following the resident's admission, she had been concerned about the resident's behavior and wandering. She said she told the Captiva UM the resident may need the secured unit or to be closer to the nurse's station however, the Captiva UM told her no beds were available there at that time. She explained, every day when she gave report to the 3:00 PM to 11:00 PM oncoming nurse, it was mentioned resident #1 was exit-seeking. The RN said during her shifts, she asked CNAs to keep closer checks on the resident but stated, no extra checks were officially put on him.</p> <p>On [DATE] at 3:27 PM, LPN O explained nurses and CNAs were expected to be aware of any residents who wandered, had increased anxiety, paced, or tried to find exits, especially if the behavior escalated. She said any concerns or changes were reported to the Unit Manager or Director of Nursing (DON). The LPN stated, We can put them on 1-to-1 observation, call the doctor, and they may consider them for the locked unit. It could be making more rounds on the patient to protect them. Logs are in the forms book.</p> <p>Review of the Psychotropic Medication Progress Note written by the Captiva UM dated [DATE] read, . Behaviors exhibited warranting the use of medications to include: Anxious, insomnia, not sleeping, pacing . Remove from situation/ensure resident safety. Interventions effective.</p> <p>On [DATE] at 10:40 AM, the Captiva UM explained CNAs and nurses were expected to recognize residents with increased agitation and wandering. She said CNAs notified nurses and nurses notified supervisors and the doctor. She stated some residents needed to go on the locked unit and if so, she brought the concern to the IDT to decide if that was needed.</p> <p>On [DATE] at 2:55 PM, in an interview with the Captiva UM and the Director of Clinical Services, the Captiva UM said she knew resident #1 well, had worked the day he was admitted and the days that followed. She recalled LPN L called her the night the resident was admitted and told her about his behaviors and elopement risk and the LPN told her, We've got an issue. The Unit Manager explained she told the LPN, We need to get this accomplished, and referred to implementing an alerting bracelet. She said nurses placed the bracelet on the resident that night. She recalled, resident #1 wandered in hallways, the living room, and the dining room and stated, We were concerned because of his dementia with the elopement evaluation; I had no bed on the locked unit; he was supposed to walk with a walker with therapy and therapy said without the walker he was unsafe, and he was to be with somebody to walk. She confirmed the resident was not placed on 1-to-1 supervision, She explained there was no documentation of additional supervision because the facility only utilized a handwritten log/form for 1-to-1 documentation, but not for other supervision types. She described other increased supervision interventions as, CNAs and nurses would be rounding more frequently; more frequently meant every ,d+[DATE] minutes. She said none of the nurses ever told her the resident had increased wandering or exit-seeking behaviors.</p> <p>In an interview on [DATE] at 10:50 AM, RN G, who spoke fluent Spanish recalled during the 7:00 AM to 3:00 PM shift on [DATE], the day the resident eloped, he was anxious, looking for his keys, and he told her he wanted to go home. She explained she was concerned about him wandering and he went to the locked unit door, so she asked CNAs to pay more attention to that. The RN stated, He was seeking the exits.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 12:40 PM, in a telephone interview, receptionist D said she had worked the 4:30 PM to 8:00 PM shift for approximately 5 months. She recalled on [DATE] at approximately 6:30 PM, resident #1 approached the locked lobby door. She said she thought the resident was a visitor and was going out to his car for a few minutes, so she didn't ask him to sign out or return a badge. She said the resident was wearing shorts and she remembered looking at the door camera but didn't recall seeing an alerting bracelet. She said the resident went through the parking lot and stood for a few minutes near the therapy exit doors at the side of the building. She recalled, after about 10 to 15 minutes, while she was busy on the phone and assisting others, she heard an overhead announcement that described the resident and his clothing. She said she checked the computer for resident #1's photo and realized it was the person she had recently let out of the building, so she called the nurse's station to let them know what had happened. She explained, she wasn't aware there was an elopement binder that contained the at-risk for elopement residents' information that was kept at the reception desk because no one had told her about it. She said she later reviewed the video footage that showed resident #1 was in the facility parking lot and near the side of the building for about 5 minutes before he walked towards the street. She said she should have asked the resident to sign out which may have stopped her from unlocking the door so quickly.</p> <p>Review of the weather history for the area on the afternoon/ evening of [DATE] revealed the presence of strong thunderstorms, and passing clouds with a high temperature of 79 degrees Fahrenheit, (retrieved from www.timeanddate.com on [DATE]).</p> <p>On [DATE] at 3:00 PM, the Captiva UM recalled she found the resident's alerting bracelet in the trash can in his room after he eloped. She explained the band looked like it had been cut off and staff found a butter knife on the floor near the dresser.</p> <p>The (Agency name) Calls For Service Summary report noted on [DATE] at 7:13 PM, revealed law enforcement was notified by facility staff that resident #1 was missing from the facility. At 7:18 PM, the agency changed the incident classification from Missing Person to Missing Endangered. At 7:39 PM, the report noted the resident was located by law enforcement and described resident #1 had tripped and fell and had blood on his face. The report indicated he was transported to a nearby hospital by emergency medical services personnel.</p> <p>The hospital emergency room physician's notes for [DATE] described resident #1's condition when he was found. The note detailed the resident had a laceration on his lip and an abrasion to his right knee.</p> <p>In an interview on [DATE] at 12:14 PM, the DON explained resident #1 was assessed to be an elopement risk the day he was admitted . She said behaviors were discussed every morning in clinical meetings and the Unit Managers were expected to implement any additional interventions when needed. She said the staff she interviewed after the incident told her resident #1 wandered. The DON stated, He looked for family that evening, he was looking for them. The night he got out they didn't come.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 1:46 PM, a telephone interview with Spanish translation was conducted with resident #1's wife. She said on [DATE], the day after the resident was admitted to the facility, the Captiva UM met with her and discussed use of the alerting bracelet as he was noted to be wandering and looking for their car. She said the family visited every day, and she wasn't aware he had become more anxious after that. She said had she known, the family would have visited more often to make him more comfortable. Resident #1's wife said her cell phone history showed on [DATE] at 7:54 PM, she received a call from the facility about the incident, and she immediately went to the hospital. She recalled, when she saw her husband, he was soiled, wet, disoriented, and anxious, with injuries to his face and knees. She said she knew he must have been very worried when he wasn't aware of what happened; and he was out there for so long. She said the resident told her some men brought him to that place and she stated, It gave me pity to see him in those conditions. She recalled she was very distressed and concerned to learn her husband had been missing, alone and unsupervised outside and stated, It was raining; he could have died ; he crossed the road.</p> <p>On [DATE] at 2:11 PM, in a telephone interview, the Medical Director recalled on [DATE] the facility notified him by telephone resident #1 had exited the facility unsupervised after the receptionist unlocked the front door. He conveyed, residents assessed to be at risk of elopement were at a higher risk of endangerment outside the facility while alone and unsupervised.</p> <p>In interviews on [DATE] at 1:00 PM, and on [DATE] at 12:13 PM, the Nursing Home Administrator, DON, Regional Clinical Director, Director of Clinical Services, and [NAME] President of Operations, the DON stated, We discuss behaviors every morning in clinical meetings and [the Captiva UM] will maybe bring attention that something else needs to be implemented. The Director of Clinical Services stated, The Receptionist didn't follow the policy to let the resident out. The [NAME] President of Operations explained the facility conducted an investigation after the incident and determined resident #1 would have been prevented from exiting if the receptionist hadn't unlocked the door for him. He acknowledged, He could have got further and been seriously hurt; the [alerting bracelet] doesn't supersede supervision.</p> <p>Review of the facility's standards and guidelines dated [DATE] titled Abuse &amp; Neglect Prohibition SHCO20003.03 revealed neglect meant a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The document indicated facility supervisors would immediately correct and intervene in reported or identified situations involving neglect.</p> <p>Review of the facility's corrective actions were verified by the survey team and included the following:</p> <ul style="list-style-type: none"> <li>*On [DATE], the receptionist on duty was suspended.</li> <li>*On [DATE] an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held.</li> <li>*On [DATE], an audit was conducted to ensure all current residents were present, alerting bracelets and physician's orders were in place, and elopement risk evaluations were validated.</li> <li>*On [DATE], door system alarm checks for proper functioning were completed.</li> <li>*On [DATE], the Nursing Home Administrator educated the receptionist who was on duty [DATE].</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665</b></p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision and a secure environment to prevent elopement for 1 of 3 residents reviewed for elopement, of a total sample of 13 residents, (#1).</p> <p>These failures contributed to the elopement of resident #1 and placed him at risk for serious life-threatening injury or even death. While resident #1 was out of the facility unsupervised, there was high likelihood he could have sustained serious life-threatening injuries, become lost, been accosted by a stranger, or hit by a motor vehicle and died .</p> <p>On [DATE] at 6:28 PM, resident #1 exited the facility's front entrance when the receptionist unlocked the door for him to leave the facility. He walked approximately 0.2 miles across a highly trafficked 4-lane road with a curbed median and into an apartment complex. The route along the way was noted to have wet, uneven terrain/pavement and curbs. The facility was unaware of the resident's elopement until a Certified Nursing Assistant (CNA) realized the resident was missing and it was determined the receptionist had unlocked the lobby door and allowed him to exit the building. Police later found the resident in a nearby apartment complex parking lot with apparent minor injuries. The resident's whereabouts were unknown to the facility until after law enforcement located him, more than an hour after he left.</p> <p>The facility's failure to identify and provide adequate supervision and ensure a secure environment contributed to resident #1's elopement and placed all residents who wandered at risk. This failure resulted in Immediate Jeopardy starting on [DATE]. The Immediate Jeopardy was determined to be removed on [DATE] after verification of the immediate actions implemented by the facility. The facility corrected the noncompliance at F600 on [DATE]. The noncompliance at F600 was determined to be past noncompliance.</p> <p>Findings:</p> <p>Cross reference F600</p> <p>Review of the medical record revealed resident #1, a [AGE] year old male was admitted to the facility from an acute care hospital on [DATE] with diagnoses of: encephalopathy (brain dysfunction), acute systolic congestive heart failure (inefficient blood pumping), pneumonia, acute respiratory failure with hypoxia (low blood oxygen), right bundle branch (heart vessel) block, type 2 diabetes mellitus, coronary artery (heart vessel) disease, dementia, abnormalities of gait (walking pattern) and mobility, lack of coordination, muscle weakness, cognitive communication deficit, and disorientation.</p> <p>The Admission Data Set form dated [DATE] documented resident #1 was alert and confused, had a language barrier (Spanish), and required a walker to walk safely. The form indicated the resident was at risk for elopement, and received high-risk antipsychotic (psychosis prevention), anticoagulant (blood thinner), diuretic (fluid removal), and antiplatelet (blood clot prevention) medications. The Care Needs section read, total care.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Minimum Data Set (MDS) 5-day Assessment with Assessment Reference Date [DATE] revealed during the look-back periods, resident #1 scored 5 out of 15 on the Brief Interview for Mental Status (BIMS) that indicated he was severely cognitively impaired. The Mood assessment noted for ,d+[DATE] days, the resident had little interest or pleasure in doing things, felt down, depressed, or hopeless. Nearly every day, he had trouble sleeping and concentrating on things like reading or watching television. The Behavior Assessment noted the resident wandered for 1 to 3 days. Functional Abilities and Goals indicated the resident used a walker and needed help with functional cognition, eating, self-care, mobility, and to complete Activities of Daily Living (ADL).</p> <p>The hospital Speech-Language Pathology (SLP) report dated [DATE] indicated resident #1 required , d+[DATE] supervision due to cognitive/memory deficits, the supervision required was described as, Direct 1:1 supervision.</p> <p>The Florida Agency for Health Care Administration ,d+[DATE] Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form dated [DATE] revealed resident #1 was alert and disoriented, but able to follow simple instructions. His decision-making capacity required a surrogate, he had risk alerts for falls, and his physical function for transferring and ambulation (walking) required an assistive device (walker) with 1 assistant.</p> <p>A Nursing Progress Admission Note dated [DATE] written by Licensed Practical Nurse (LPN) L read, Resident arrived on unit [DATE] at [4:45 PM] via stretcher accompanied by 2 transport personnel and numerous family members from [hospital name]. Resident is alert, confused most of the time No c/o [complaints of] pain or discomfort this shift. VSS [vital signs stable]. Resident is a fall risk but refused to use a walker or have staff assistance as he walked down the hall looking for an exit. [alerting bracelet] placed on left ankle. Bed in lowest position.</p> <p>On [DATE] at 1:46 PM, a telephone interview with Spanish translation was conducted with resident #1's wife. The resident's wife said no one from the facility mentioned placing him on the locked unit before he had left the facility however, they told her after he eloped that he needed to be placed there if he came back from the hospital. She said the family visited every day, and she had not been aware he had become more anxious before he left. She said had she known of his behaviors, the family would have visited more often to make him more comfortable. She said her cell phone history showed on [DATE] at 7:54 PM, she received a call from the facility. She recalled someone informed her about the incident, and she immediately went to the hospital. She said she later viewed the video footage, and saw her husband tried to go out the locked front door, then the Receptionist unlocked it and let him out without checking him. She said she asked the facility why the Receptionist let him out so easily and they told her she no longer worked there. She recalled when she saw her husband at the hospital, he was soiled, wet, disoriented, and anxious with injuries to his face and knees. She said she knew he must have been very worried outside when he wasn't aware of what happened, and he was out there for so long. She stated, it gave me pity to see him in those conditions. She recalled she was very distressed and concerned to learn her husband had been missing, alone, and unsupervised outside and stated, it was raining; he could have died ; he crossed the road.</p> <p>Review of the weather history at the facility's zip code showed on [DATE] from 12:00 PM to 6:00 PM there were strong thunderstorms, and from 6:00 PM to 12:00 AM there were passing clouds with a high temperature of 79 degrees Fahrenheit, (retrieved from timeanddate.com on [DATE]).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 12:15 PM, the Nursing Home Administrator (NHA), Director of Nursing (DON), Regional Clinical Director, Director of Clinical Services, and [NAME] President of Operations acknowledged resident #1 eloped from the facility on [DATE] at 6:28 PM. The NHA stated the resident was last seen on the unit by nursing staff at 6:18 PM. The DON explained shortly after his admission, resident #1 was assessed by the admitting LPN to be a high elopement risk and an alerting bracelet was placed on his left ankle. She said the bracelet didn't alarm at the exit door when the resident left because he had removed it. The Regional Clinical Director said the receptionist didn't follow procedures and allowed the resident to exit the facility unsupervised. The NHA said the facility's investigation of the incident revealed the resident removed the alerting bracelet in his room with a butter knife which prevented the exit alarm from sounding, and the receptionist didn't verify who he was before she unlocked the door and allowed him to exit alone. In a joint review of the video footage captured on [DATE], from 2:00 PM to 6:30 PM, resident #1 was observed wandering the Captiva Unit hallways, common areas, dining room, the Captiva nurses station, employee hallway locked door, and his room. Twice, he was seen on the video as he attempted to open locked doors. The alerting bracelet was visible on the resident's left ankle until 6:16 PM, when the footage showed he walked out of his room, and down the hallway, attempted to open the locked secured unit door, went past the Captiva nurses station, and down the hallway to the front lobby reception area where he attempted to open the exit door at 6:28 PM. Within seconds, the receptionist unlocked the door, and the resident was seen walking out the door alone. The resident was viewed as he remained outside, wandered in the parking lot, stood near the building's therapy exit door, and wandered out of the parking lot towards the road at approximately 6:30 PM.</p> <p>The Social Services Admission Evaluation dated [DATE] indicated the resident's cognitive patterns showed the resident had short-term and long-term memory recall problems, severely impaired abilities to make decisions regarding tasks of daily life, no acute changes in mental status from baseline, the family expected the resident to remain in the facility as discharge to the community was not feasible, and the BIMS showed the resident scored 5 out of 15 that indicated he had severe cognitive impairment.</p> <p>In an interview on [DATE] at 1:03 PM, Physical Therapist (PT) J recalled resident #1 and explained the resident received skilled therapy during his stay and he needed supervision because he had confusion. The PT stated, we worked on gait training, balance, and lower extremity stabilization; balance and stabilization to prevent falls.</p> <p>In an interview on [DATE] at 3:15 PM, LPN L said when resident #1 was admitted to the facility on [DATE] during the 3:00 to 11:00 PM shift, he was included in her assignment. The LPN recalled she completed the resident's elopement risk assessment within a few hours after he arrived, and found he was at risk. She explained, she notified the Captiva Unit Manager about the resident's behavior and her concerns. She said an alerting bracelet was implemented before the end of her shift. She said during her 3:00 PM to 11:00 PM shift approximately 2 days later, she noticed the resident was wandering again. She stated, when the family left, he started trying to find a way out; he was determined he didn't want to stay here; he said he wanted to go out to the parking lot to go to his car; he was convinced his car was in the parking lot.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Order Summary dated [DATE] and Medication Administration Reports for [DATE] noted physician's orders that included an alerting bracelet to left ankle, check function and placement of alerting bracelet every night shift, psychiatric consultation, and PT/Occupational Therapy (OT)/Speech Therapy (ST), evaluate and treat. Medication ordered on [DATE] included: Seroquel (antipsychotic) 25 Milligrams (MG) once daily and 50 MG at bedtime for psychosis, Lasix (diuretic) 40 MG once daily for congestive heart failure, Humalog (insulin) before meals and at bedtime as per sliding scale parameters, Glargine (insulin) 10 units at bedtime, Hydroxyzine HCl (antihistamine) 25 MG once daily for anxiety, Losartan Potassium 25 MG once daily for high blood pressure, Metformin (blood sugar lowering) 1000 MG once daily for diabetes mellitus, Terazosin HCl 2 MG at bedtime for high blood pressure, Apixaban (blood thinner) 5 MG twice daily for atrial fibrillation (heart arrhythmia) started [DATE], Glimepiride (blood sugar lowering) 2 MG every 12 hours for diabetes mellitus, and Midodrine HCl 10 MG three times daily for low blood pressure.</p> <p>An Elopement Risk Screen and Care Plan dated [DATE], before the elopement, noted resident #1's Risk Score placed him as an elopement risk. The Care Plan's focus indicated the resident was at risk for elopement with a goal that read, Attempts to maintain safety will be provided through review date. The interventions included: alerting bracelet, check function every day and placement every shift, involve resident in appropriate activities, offer pleasant diversions; structured activities, food, television, books, offer reassurance and support as needed, and picture of resident kept in Elopement Binder(s).</p> <p>Other Care Plans included risk for falls, impaired cognitive function/impaired thought process, ADLs with staff assistance, and risk for impaired gas exchange/ineffective airway clearance.</p> <p>Review of resident #1's Visual Bedside Kardex for CNAs dated [DATE] listed under Safety interventions such as an alerting bracelet is placed, bed in lowest position, check alerting bracelet function every day, check alerting bracelet placement every shift, non-skid footwear, offer pleasant diversions, structured activities, food, television, and books.</p> <p>On [DATE] at 10:45 AM, Registered Nurse (RN) G, who spoke fluent Spanish recalled during the 7:00 AM to 3:00 PM shift on [DATE], the day the resident exited the facility, he was anxious and looking for his keys. She recalled he told her he wanted to go home. She explained she was concerned about him wandering and he went to the locked unit door, so she asked CNAs to pay more attention to that. The RN stated, he was seeking the exits.</p> <p>On [DATE] at 10:21 AM, in a telephone interview, LPN A explained she had resident #1 on her assignment for the first time during the 3:00 to 11:00 PM shift on [DATE], the day he exited the facility. She recalled, RN G gave her report from the 7:00 AM to 3:00 PM outgoing shift and the RN told her resident #1 had dementia, was only alert to himself, and he wandered. She said the last time she saw resident #1 was around 6:00 PM the same day.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 2:54 PM, CNA B explained she knew resident #1 well and he was part of her assignment during her 3:00 PM to 11:00 PM shifts. She said CNAs used the Kardex for information entered by the nurses for what care residents needed. She said the resident spoke Spanish, was often focused on his family coming to visit, and he frequently asked for his wife. The CNA recalled on [DATE] during her shift, resident #1 walked around a lot, and she tried to redirect him. She recalled on [DATE], close to 6:00 PM, she assisted the resident in his room with his supper tray and she left to assist other residents. She said she last saw the resident in his room when she passed by about ,d+[DATE] minutes later. She explained, during her shift he seemed anxious, and stated, he was mentioning my wife is coming, and he was coming out [of his room] again; he was wandering; he tried to go out to the back yard, and I stopped him.</p> <p>In an interview on [DATE] at 12:14 PM, the DON explained resident #1 was determined to be an elopement risk the day he was admitted . She said the staff she interviewed after the incident told her resident #1 wandered. The DON stated, he looked for family that evening, he was looking for them. The night he got out they didn't come.</p> <p>On [DATE] at 12:40 PM, in a telephone interview, receptionist D said she had worked the 4:30 PM to 8:00 PM shift for approximately 5 months. She recalled on [DATE] at approximately 6:30 PM, resident #1 approached the locked lobby door. She said she thought the resident was a visitor and was going out to his car for a few minutes, so she didn't ask him to sign out or return a badge. She said the resident was wearing shorts and she remembered looking at the door camera but didn't recall seeing an alerting bracelet. She said the resident went through the parking lot and stood for a few minutes near the therapy exit doors at the side of the building. She recalled, after about 10 to 15 minutes, while she was busy on the phone and assisting others, she heard an overhead announcement that described the resident and his clothing. She said she checked the computer for resident #1's photo and realized it was the person she had recently let out of the building, so she called the nurse's station to let them know what had happened. She explained, she wasn't aware there was an elopement binder that contained the at-risk for elopement residents' information that was kept at the reception desk because no one had told her about it. She said she later reviewed the video footage that showed resident #1 was in the facility parking lot and near the side of the building for about 5 minutes before he walked towards the street. She said she should have asked the resident to sign out which may have stopped her from unlocking the door so quickly.</p> <p>On [DATE] at 2:43 PM, receptionist N said she had trained receptionist D. She explained, the training included the sign in/out process, and they were expected to verify every person who exited the facility before the door was unlocked, even if there were people outside waiting to get in. She said the elopement book was used as a resource to identify current at-risk residents with a photo and their information. She said the book was updated every day with any new admissions and receptionists were supposed to check it at the beginning of their shift so they could look out for anyone who tried to exit unattended. She said after the incident, the facility implemented changes to the visitor badges, so they were brightly color coded to stand out more. Referring to the sign out process she stated, it's important because the patient can get hurt, lost, hit by a car, or end up in the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 10:42 AM, with the Business Office Manager, she said she was the supervisor for all receptionists, and she also provided their training. She explained, the elopement book included a photo and resident information, and all Receptionists were trained to use it, so they were more aware of who the at-risk residents were, and for quick access when there was an alert. She said off going and on coming receptionists reported to each other about daily updates. The Business Office Manager stated, what she didn't do is ask him to sign out; she thought he was a visitor, and he didn't have a bracelet to alert the door.</p> <p>On [DATE] at 3:00 PM, the Captiva Unit Manager recalled she found the resident's alerting bracelet in the trash can in his room after he eloped. She explained the band looked like it had been cut off and the ends of separation were jagged. She said staff found a butter knife on the floor near the dresser.</p> <p>The (Agency name) Calls For Service Summary report noted on [DATE] at 7:13 PM, revealed law enforcement was notified by facility staff that resident #1 was missing from the facility. At 7:18 PM, the agency changed the incident classification from Missing Person to Missing Endangered. At 7:39 PM, the report noted the resident was located by law enforcement and described resident #1 had tripped and fell and had blood on his face. The report indicated he was transported to a nearby hospital by emergency medical services personnel.</p> <p>The hospital emergency room physician's notes for [DATE] described resident #1's condition when he was found. The note detailed the resident had a laceration on his lip and an abrasion to his right knee.</p> <p>On [DATE] at 2:11 PM, in a telephone interview, the Medical Director recalled on [DATE] the facility notified him by telephone resident #1 had exited the facility unsupervised after the receptionist unlocked the front door. He conveyed, residents assessed to be at risk of elopement were at a higher risk of endangerment outside the facility while alone and unsupervised.</p> <p>On [DATE] at 12:13 PM, in an interview with the Nursing Home Administrator (NHA), DON, Regional Clinical Director, Director of Clinical Services, and [NAME] President of Operations, the DON stated, we discuss behaviors every morning in clinical meetings and [the Captiva UM] will maybe bring attention that something else needs to be implemented. The Director of Clinical Services explained receptionists were expected to review the elopement book at the top of their shift and stated, the receptionist didn't follow the policy to let the resident out.</p> <p>On [DATE] at 1:00 PM, the [NAME] President of Operations explained the facility's investigation found resident #1 would have been prevented from exiting the facility if the receptionist hadn't unlocked the door for him. He acknowledged, he could have got further and been seriously hurt; the wander guard doesn't supersede supervision.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility's standards and guidelines dated [DATE] and titled Resident Elopement SHCO20004.05 read, . The center strives to provide a safe environment and implements preventive measures to minimize elopement. A resident who leaves a safe area may have the potential to experience heat or cold exposure, dehydration and/or other medical complications or environmental hazards such as bodies of water or busy roadways. The guideline defined unsafe wandering as random or repetitive locomotion which may be goal-directed (e.g., the person appears to be searching for something or someone), non-goal-directed or aimless. The document described non-goal-directed wandering required a response from staff to address both safety issues and an evaluation to identify root causes as much as possible. The guideline gave examples if a resident moved about the center aimlessly it may indicate the resident was frustrated, anxious, bored, hungry, or depressed. The document explained an elopement occurred when a resident left the premises or a safe area without authorization and/or any necessary supervision. The guidance detailed when an employee observed an attempted exit by a resident, the staff should obtain assistance from other staff members in the immediate vicinity, if necessary; and instruct another staff member to inform the charge nurse or Director of Nursing services of the attempted exit.</p> <p>Review of the facility's undated standards and guidelines titled Receptionist Competency for Visitors and Vendors revealed visitors, vendors, and residents exiting the facility must return the badge and sign out with the time. The guideline directed that at no time shall a visitor or vendor be allowed to exit without turning in their badge and signing the time out.</p> <p>Review of the facility's corrective actions were verified by the survey team and included the following:</p> <p>*On [DATE], the receptionist on duty was suspended.</p> <p>*On [DATE] an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held.</p> <p>*On [DATE], an audit was conducted to ensure all current residents were present, alerting bracelets and physician's orders were in place, and elopement risk evaluations were validated.</p> <p>*From [DATE] to [DATE], majority of staff were re-educated regarding at-risk resident elopement risk identification and implementation of preventive measures, identification of exit-seeking residents and process to minimize risk, protection of residents from harm, signs and symptoms of elopement risk including wandering, expectations for a missing alerting bracelet, sign in/out process, and elopement books.</p> <p>*On [DATE], the NHA educated the Receptionist who was on duty [DATE].</p> <p>*On [DATE], door system alarm checks for proper functioning were completed.</p> <p>*On [DATE], audits were conducted to ensure BIMS, evaluations, care plans, and Leave of Absence and alerting bracelet orders were correct and present for all new admissions.</p> <p>*On [DATE], elopement book audits were conducted to ensure accuracy.</p> <p>*From [DATE] to [DATE], a total of nine staff assigned receptionist duties were re-educated by the Business Office Manager regarding the front door process and received competency checks.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*On [DATE], the front door process, Receptionist Competency for Visitors and Vendors was laminated and placed at the front reception desk.</p> <p>*On [DATE], an Ad Hoc meeting was conducted to ensure all interventions were in place and a root cause analysis was completed.</p> <p>*Ongoing audits were to be continued for new admissions to ensure accuracy of the BIMS, Leave of Absence, bracelets, alerting batch orders, and care plans.</p> <p>Review of the in-service attendance sheets noted staff participated in education on the topics listed above. From [DATE] to [DATE], interviews were conducted with 30 staff members who represented all shifts. The facility's staff included 52 CNAs and 40 licensed nurses. Interviewed staff included: 10 CNAs, 4 LPNs, 4 RNs, 1 Housekeeper, 3 Receptionists, 1 Social Services Assistant, 1 Maintenance Assistant, 1 Business Office Manager, 1 Business Office Assistant, 1 Medical Records Coordinator, 1 Admissions Director, 1 Clinical Resource Coordinator, and 1 Physical Therapy Assistant. Eight of nine staff who were assigned Receptionist duties were interviewed. All staff interviewed verbalized their understanding of the education provided.</p> <p>The resident sample was expanded to include 2 additional residents at risk for elopement. Observations, interviews, and record reviews revealed no concerns related to elopement for residents #3 and #4.</p>