STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105987	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunters Creek Nursing and Rehab Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to accurately obtain and document fluid intake for a resident on a fluid restriction for 1 of 2 residents reviewed for hydration status, out of a total sample of 11 residents, (#2).Findings: Review of the medical record revealed resident #2 was admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses including type 2 diabetes, chronic obstructive pulmonary disease, chronic kidney disease, stage 4, and heart failure. Review of resident #2's medical record revealed a care plan for nutrition and hydration initiated on 7/23/22 and revised on 4/21/26. The care plan showed resident #2 was at risk for decreased nutritional status and dehydration related to diabetes, chronic kidney disease, edema, hyponatremia (low sodium) and hypoosmolality (low levels of electrolytes and other fluids in the blood). The goals included remaining free from signs and symptoms of dehydration. The interventions indicated resident #2 was on a fluid restriction of 1900 milliliters (ml). Review of resident #2's physician orders revealed an order dated 4/28/26 for a fluid restriction of 1900 ml with a break down as follows: nursing - day shift 290 ml, evening shift 290 ml, night shift 120 ml; dietary - breakfast 720 ml, lunch 240 ml, and dinner 240 ml. The order instructed nurses to document ml provided by the nursing staff every shift. Review of the resident #2's Medication Administration Record (MAR) for April 2026 revealed the nurse documented n on 4/23, 4/25, 4/26 and yes on 4/27 (4 out of 6 entries during the day shift), instead of the measurement of ml of fluid. The MAR for May 2026 showed the nurse documented n on 5/13, 5/14, 5/18, and 5/19, (4 out of 21 entries during the day shift in May), instead of documenting the ml of fluid as ordered by the physician. On 5/21/26 at 3:30 PM, Licensed Practical Nurse (LPN) A stated resident #2 was on a fluid restriction due to low sodium. He indicated resident #2 could have 240 ml of fluids between the medication pass and water during his 8-hour shift. He explained he communicated with the Certified Nursing Assistant (CNA) to obtain and document the resident's fluid intake. When asked about the n documented in April and May, LPN A could not explain why he documented it. He stated n was not accurate. He then stated he did not communicate or coordinate with the CNAs regarding resident #2's fluid intake or restrictions. On 5/22/26 at 3:43 PM, during a telephone interview, the Captiva Unit Manager (UM) stated nurses were expected to document fluid intake accurately in the medical record. She indicated she did not know resident #2's MAR included n or yes instead of the actual ml measurements and acknowledged that documentation was inaccurate. She stated she was not sure how to verify the documentation as she was still learning her role as UM. On 5/22/26 at approximately 4:45 PM, while interviewing the Administrator, the Regional Clinical Services Director indicated they expected the medical records to be accurate. She reviewed resident #2's MAR for April and May and confirmed the documentation for fluid intake, including n and yes, was not accurate. Review of the facility's policy titled Intake and Output revised August 2023 revealed a purpose for, The nursing personnel per physician's order will keep an accurate record of a resident's fluid balance. The procedure for recording Intake included determining the quantity of liquid consumed and documenting the total intake at the end of each shift.

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