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
	AL11968599	A. BUILDING: _____ B. WING _____	11/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS RESIDENCE	700 E WELCH RD APOPKA, FL 32712

(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 re-licensure survey with Extended Congregate Care (ECC) was conducted at Wellsprings Residence on . The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=B	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) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 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 electronic record review and interview, the facility did not maintain a written record of a significant change (hospice enrollment) for 1 of 5 sampled residents (#7). Findings: On . . . . . at 9:15 AM, the administrator identified resident #7 as receiving hospice services. Review of the facility's record and hospice record revealed the resident was enrolled in hospice services on	A 025		

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A 025	Continued From page 2 Review of the facility's electronic notes for resident #7, revealed there was no documentation found that noted when the resident was enrolled in hospice services as required. On at 2 PM, the administrator said she did not agree with the requirement to document the hospice enrollment in the facility notes, because she had obtained a resident health assessment (1823) for the hospice enrollment, the resident did not have a decline in his health, and it was the family's suggestion for the resident to receive hospice services. Class	A 025		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care	A 054		

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A 054	Continued From page 3 provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the medication observation record (MOR) for 1 of 5 sampled residents was properly updated (#6). Findings: Review of resident #6's record revealed a facility admission date of [illegible]. Review of an 1823 health assessment form, dated [illegible], revealed the resident's diagnoses included [illegible] D deficiency, [illegible] and [illegible], and [illegible]. The 1823 indicated the resident required assistance with self-administration of medications. There was no documentation in the record that indicated the resident had a [illegible]. Review of the resident's [illegible] MOR revealed an entry for [illegible] 2% cream, apply to base of [illegible] daily. Both unlicensed caregivers B and C signed that they applied the cream, which was a task they were not permitted to do as it involved applying a treatment to a [illegible].	A 054		

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A 054	Continued From page 4 On at 1:54 p.m. caregiver C said she did not apply the cream; she signed the MOR in error and said the resident did not have a . On at 2:01 p.m. caregiver B said she never applied the cream and that she only applied cream to the resident's for redness. She said she signed the MOR in error and the resident did not have a . Class III	A 054		
AE206 SS=D	59A-36.021(6) FAC ECC - Service Plans (6) SERVICE PLANS. (a) Before receiving services, the extended congregate care administrator or manager must develop a preliminary service plan that includes an assessment of whether the resident meets the facility's residency criteria, an appraisal of the resident's unique physical, , , and social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs. (b) Within 14 days of receiving services, the extended congregate care administrator or manager must coordinate the development of a written service plan that takes into account the resident's health assessment obtained pursuant to subsection (6); the resident's unique physical, , , and social needs and preferences; and how the facility will meet the resident's needs including the following if required: 1. Health monitoring, 2. Assistance with personal care services, 3. Nursing services, 4. Supervision, 5. Special diets,	AE206		

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AE206	Continued From page 5 6. Ancillary services, 7. The provision of other services such as transportation and supportive services; and, 8. The manner of service provision, and identification of service providers, including family and friends, in keeping with resident preferences. (c) Pursuant to the definitions of "shared responsibility" and "managed risk" as provided in section 429.02, F.S., the service plan must be developed and agreed upon by the resident or the resident's representative or designee, surrogate, guardian, or attorney-in-fact, and must reflect the responsibility and right of the resident to consider options and assume risks when making choices pertaining to the resident's service needs and preferences. (d) The service plan must be reviewed and updated quarterly to reflect any changes in the manner of service provision, accommodate any changes in the resident's physical or mental status, or pursuant to recommendations for modifications in the resident's care as documented in the nursing assessment. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to develop a preliminary service plan that included an assessment of whether the resident met the facility's residency criteria, an appraisal of the resident's unique physical, [illegible], and social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs for 2 of 5 sampled residents who received an Extended Congregate Care (ECC) service (#3 & #5.) Findings: 1. Review of resident #5's record revealed a	AE206		

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AE206	Continued From page 6 facility admission date of . The resident's diagnoses included wedge , of first primary and type 2 with . Observations made on at 10:40 a.m. revealed resident #5 sat in a wheelchair in the hallway. She wore an on her left , which was an ECC service. She said she wore it because her was positioned inward and said the facility staff put it on and removed it every day. On at 11:30 a.m. caregiver A said she put the on resident #5's left that morning after she helped the resident out of bed. Continued review of the resident's record revealed it did not contain an ECC service plan. On at 2:55 p.m. the administrator said resident #5's family brought the from home, and they wanted the resident to wear it. The administrator said the resident wore the since she was admitted to the facility and said a service plan was not developed. 2. Observations of resident #3 on at 9:30 AM, revealed she was sitting in her wheelchair with a brace on her lower left , the brace had Velcro straps. On at 10 AM, resident #3 said she did not know why she had to wear the brace. She said the staff at the facility would place the brace on her lower and remove it for her. She said	AE206		

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AE206	Continued From page 7 she could probably do it herself, but she never did. On at 11 AM staff A, a caregiver said she would place the brace on resident #3 because she could not do it herself. The application and removal of a brace is an extended congregate care (ECC) service. Record review of resident #3 revealed she was admitted to hospice services on , there was no documentation to confirm that before receiving the ECC service (application and removal of a brace), a preliminary service plan that included an assessment of whether the resident meets the facility's residency criteria, an appraisal of the resident's unique physical, , and social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs. The administrator said on at 5 PM, resident #3's family requested that she wear the brace about 2 weeks ago. She said it was the family's choice for the resident to have the brace and the facility did not develop a preliminary service plan. Class III	AE206		
AE207 SS=D	59A-36.021(7) FAC ECC - Services (7) EXTENDED CONGREGATE CARE SERVICES. All services must be provided in the least restrictive environment, and in a manner that respects the resident's independence, privacy, and dignity. (a) A facility providing extended congregate care	AE207		

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AE207	Continued From page 8 services may provide supportive services including social service needs, counseling, emotional support, networking, assistance with securing social and leisure services, shopping service, escort service, companionship, family support, information and referral, assistance in developing and implementing self-directed activities, and volunteer services. Family or friends must be encouraged to provide supportive services for residents. The facility must provide training for family or friends to enable them to provide supportive services in accordance with the resident's service plan. (b) A facility providing extended congregate care services must make available the following additional services if required by the resident's service plan: 1. Total help with bathing, [illegible], grooming and toileting, 2. Nursing assessments conducted more frequently than monthly, 3. Measurement and recording of basic vital functions and [illegible], 4. Dietary management including provision of special diets, monitoring nutrition, and observing the resident's food and fluid intake and output, 5. Assistance with self-administered medications, or the administration of medications and treatments pursuant to a health care practitioner's order. If the individual needs assistance with self-administration the facility must inform the resident of the qualifications of staff who will be providing this assistance, and if unlicensed persons will be providing such assistance, obtain the resident's or the resident's surrogate, guardian, or attorney-in-fact's informed written consent to provide such assistance as required in section 429.256, F.S., 6. Supervision of residents with [illegible] and	AE207		

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AE207	Continued From page 9 7. Health education and counseling and the implementation of health-promoting programs and preventive regimes, 8. Provision or arrangement for rehabilitative services; and, 9. Provision of escort services to health-related (c) Nursing staff providing extended congregate care services may provide any nursing service permitted within the scope of their license consistent with the residency requirements of this rule and the facility's written policies and procedures, provided the nursing services are: 1. Authorized by a health care practitioner's order and pursuant to a plan of care, 2. Medically necessary and appropriate for treatment of the resident's condition, 3. In accordance with the prevailing standard of practice in the nursing community, 4. A service that can be safely, effectively, and efficiently provided in the facility, 5. Recorded in nursing progress notes; and, 6. In accordance with the resident's service plan. (d) At least monthly, or more frequently if required by the resident's service plan, a nursing assessment of the resident must be conducted. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to obtain a health care provider's order and failed to maintain nursing progress notes that described the type, amount, duration, scope, and outcome of services that were rendered and the general status of the resident's health when the service was provided for 2 of 5 sampled residents who received an ECC service (#3 & #5.)	AE207		

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AE207	Continued From page 10 Findings: 1. Review of resident #5's record revealed a facility admission date of . . . . The resident's diagnoses included wedge , of first , primary , type 2 with . Observations made on . . . . . at 10:40 a.m. revealed resident #5 sat in a wheelchair in the hallway. She wore an . . . . . on her left , which was an ECC service. She said she wore it because her . . . was positioned inward and said the facility staff put it on and removed it every day. On . . . . at 11:30 a.m. caregiver A said she put the on resident #5's left that morning after she helped the resident get out of bed. Continued review of the resident's record revealed it did not contain a health care provider's order to put the . . . . on and off did not contain any nursing progress notes for the ECC service. On at 2:55 p.m. the administrator said resident #5's family brought the . . . . . from home, and they wanted the resident to wear it. The administrator said the resident wore the . . . . since she was admitted to the facility and said a health care provider's order was not obtained nor were nursing progress notes maintained. 2. Observations of resident #3 on . . . . at 9:30 AM, revealed she was sitting in her wheelchair with brace on her lower left , the brace had Velcro straps.	AE207		

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AE207	Continued From page 11 On at 10 AM, resident #3 said she did not know why she had to wear the brace. She said the staff at the facility would place the brace on her lower , and remove it for her. She said she could probably do it herself, but she never did. On at 11 AM staff a, a caregiver said she would place the brace on for resident #3 because she could not do it herself. The application and removal of a brace is an extended congregate care (ECC) service because resident #3 was not applying and removing the brace herself. Record review of resident #3 revealed she was admitted to hospice services on , there was no health care providers order for the application and removal of the brace as required. Further review of the resident #3's record and electronic notes revealed there were no written progress notes for resident #3, from the facility's staff that described the type, amount, duration, scope, and outcome of services (application and removal of the brace) that were rendered and the general status of the resident's health when the service was provided. The administrator said on at 5 PM, resident #3's family requested that she wear the brace about 2 weeks ago. She said it was the family's choice for the resident to have the brace and the facility did not have a health care provider's order and did not maintain written progress notes. Class III	AE207		

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