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 _____	03/17/2023

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 Complaint Investigations #2022011895 and #2022017841 were conducted on [redacted] and [redacted]. Wellsprings Residence LLC had deficiencies at the time of the survey.	A 000		
A 025 SS=G	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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. 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 [redacted] 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		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 _____	03/17/2023

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 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 observations, record reviews and interviews, the facility failed to provide adequate supervision to 2 of 2 sampled residents who were at risk for elopement and eloped from the facility (#9 & #14). Findings: 1. Review of resident #9's record revealed a facility admission date of . . . . . A . . . . . health assessment form (1823) indicated her diagnoses included . . . . . She was independent with ambulation and was not identified as an elopement risk.	A 025		

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 _____	03/17/2023

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 025	Continued From page 2 Facility notes read: On at 8:53 PM - "The resident moved into the facility. Safety measures in place to observe for possible elopement due to ." On at 9:53 PM - "The resident gets easily and tends to around the facility and into other resident's rooms. Safety checks done." On at 10:48 PM - "The resident was really and and asking questions." On at 6:57 AM - "The resident was throughout the night and was redirected to bed. Safety checks completed during the shift." On at 10:22 AM - "The resident had periods of increased agitation, , and . calming techniques employed by caregiver staff." On at 2:02 PM - "The resident was often as to where she was and often outside of the facility. She was to be monitored frequently and closely to avoid off. She was still adjusting and often had periods of ." On at 9:53 PM - "The resident was everywhere and went outside. Staff looked for her and brought her inside. She was really ." On at 3:07 PM - "The resident often off and needed to be monitored	A 025		

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 _____	03/17/2023

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 025	Continued From page 3 closely." On ..... at 9:59 PM - "The resident was ..... and being aggressive while being redirected .... to the dining room." On ..... at 6:59 AM - "The resident was ..... throughout the night and was redirected to bed. Safety checks completed during shift." On ..... at 7 AM - "The resident was ..... throughout the night and was redirected to bed. Safety checks completed during shift." On ..... at 4:01 PM - "The resident eloped immediately after the holiday luncheon (the facility's incident report indicated the elopement occurred at 2:18 PM). Her family and the police department were notified. She was wearing a lifesaver tracker and located within a few minutes of reporting elopement. No injuries noted. She was pleasant and ..... with a history of elopement at home. One-to-one close monitoring immediately re-implemented." The police report indicated the resident was found on ..... at 3:41 PM approximately one mile away from the facility. On ..... at 11 AM, the resident's daughter said the resident was at the facility for one week when on Thanksgiving Day she received a call that her mom had eloped from the facility. A woman called 911 to say a woman was at her door. It was in a neighborhood approximately 2 blocks from the facility. She purchased an Apple air tag (GPS device) for her mom after the elopement. Her mom had a history of ..... prior to moving	A 025		

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 _____	03/17/2023

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 025	Continued From page 4 into the facility. She discussed this with the administrator prior to her mom's admission to the facility. In [redacted], she was in Hawaii when she received a call from the facility that her mom could not be found. It was dark outside at the time. She checked the location of the Apple air tag, and it showed her mom was still in the facility and was found hiding under furniture. She then purchased a Samsung device that is the size of a quarter that her mom has in both a necklace and a bracelet. She said the facility staff always make sure her mom has them both on. She was satisfied with the facility's response during both incidents. She said the facility's doors were not alarmed when her mom eloped, but now they were due to her suggestion. On [redacted] at 3:40 PM, caregiver B said resident #9 eloped "maybe [redacted]. We were busy. All I remember was I seen her in the hallway before lunch". To prevent the resident from eloping, she said "she gets really aggressive and [redacted]. I'll do my arms like this (while holding both of her arms up). I hug her and this calms her down." She said the resident aimlessly [redacted] around the facility. "I have to walk with her." She said when the resident was first admitted to the facility, she frequently looked for a way out of the facility, but this behavior had since decreased. She said she was trained in the facility's elopement policy. On [redacted] at 4:35 PM, the administrator said the facility's cameras did not record. When asked about resident #9's elopement she said she'd have to read the incident report to recall what happened. She was asked if she wanted the opportunity to review the report to refresh her memory and she declined to do so. She said there were two hallway doors and a service door	A 025		

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 _____	03/17/2023

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 025	Continued From page 5 that were all alarmed. She said the front door was locked every day from 5 PM-9 AM. She said resident #9 wears a bracelet that is tracked by the sheriff's office and one that her daughter tracks. She said an alarm device is activated when resident #9 is put to bed so staff will know if she gets up. She said staff kept resident #9 with them and alternated staff if they had to provide care to another resident. She said the door alarms were tested every day and resident #9's GPS device was tested by asking her daughter to see where the resident was at the time of testing, neither of which was documented by the facility. 2. Review of resident #14's record revealed a facility admission date of . A 1823 indicated the resident's diagnoses included . It indicated he was not at risk for elopement. Facility notes reflected the following: On at 9:49 PM, he was around after dinner. He was redirected to the dining room, and he was aggressive. On at 9:23 PM, he outside and had to be redirected inside. On at 9:36 PM, he was . On at 9:29 PM, he was and aggressive. On at 2:52 PM, he eloped from the facility and was found. No apparent injuries were noted. He was transported to a hospital by fire rescue due to having a while trying to urinate in bushes. He was returned to the facility by his family following the emergency room visit.	A 025		

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 _____	03/17/2023

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 025	Continued From page 6 A facility report indicated the resident eloped on . . . . . at 10:15 AM and found at 11:30 AM. He ambulated without an assistive device and used the facility's service entrance door to exit the facility. The police report from the incident indicated that on . . . . . at approximately 10:39 AM, an officer responded to the facility and met with the resident's daughter, who said she arrived at the facility and was unable to locate the resident. A facility nurse reported last seeing the resident north of the property at approximately 10:15 AM. At approximately 11:59 AM, fire rescue found the resident approximately 1 mile away from the facility. On . . . . . at 3:40 PM, caregiver B said resident #14 eloped "plenty of times". She said he went out facility doors and was brought . . . in. She said that sometime in , , she saw him sitting in a chair outside the front door as she entered to begin her shift at 3 PM. At some point, she realized he was missing so she told the administrator. She said the resident loved walking and went outside to the front of the facility whenever he wanted. She said the administrator did not discuss elopement prevention with her after resident #14's elopement. She said to prevent further resident elopements, "We monitor them all the time". On at 4:35 PM, the administrator said she could not recall the events surrounding resident #14's elopement and declined to review the report. She said resident #14 wore a GPS bracelet. She said resident #14 was getting to where he could not walk as well, so he walked only on occasion.	A 025		

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 _____	03/17/2023

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 025	Continued From page 7 On at 10:34 AM via telephone, the resident's daughter said that when she went to visit with her father on she could not find him in the facility. She alerted the staff then she searched for him for 15-20 minutes but was unable to find him, so she called the police. She said the resident previously lived with her and during that time he often and left her home. She said the facility's administrator was informed of this when she moved the resident in. She said the resident did not have a tracking device prior to eloping from the facility and that one was purchased for him afterwards. The facility's resident elopement policy indicated a resident was considered at-risk if they lack the ability to make relevant decisions about safety. It defined a resident as one who has shown a propensity to stray beyond the view or control of employees, thereby requiring a high degree of monitoring and protection to ensure the resident's safety. It defined a missing resident as one who disappears from the resident care areas. Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or	A 032		

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 _____	03/17/2023

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 032	Continued From page 8 a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement	A 032		

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 _____	03/17/2023

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 032	Continued From page 9 response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure its resident elopement policy indicated the facility would make, at a minimum, a daily effort to determine that at risk residents have identification (ID) on their persons that includes their name and the facility's name, address, and telephone number. Findings: Review of the facility's resident elopement policy revealed it did not indicate the facility would make, at a minimum, a daily effort to determine that at risk residents have ID on their persons that includes their name and the facility's name, address, and telephone number. On . . . . . at 4:35 PM, the administrator said regarding the findings "Even though the policy doesn't say it, we do it. They're monitored at all times." Class III	A 032		

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 _____	03/17/2023

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 055	Continued From page 10	A 055		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other	A 055		

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 _____	03/17/2023

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 055	Continued From page 11 locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days	A 055		

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 _____	03/17/2023

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 055	Continued From page 12 of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, resident record review and interview, the facility failed to keep medications for 1 of 4 sampled residents (#10) in a locked cabinet, locked cart or any other locked storage receptacle, room or area at all times required. Findings: On [redacted] at 9:44 AM in resident #10's room, a small dixie cup of medications was sitting on top of his walker seat. The medications were not secured and not locked up in a central location. Photographic evidence was obtained. Resident #10's record revealed an admission date [redacted]. The last 1823 Health Assessment, dated [redacted], listed a medical history of [redacted], and [redacted] dependency. He had mild [redacted] and needed assistance with bathing, [redacted], ambulation, grooming, toileting, transferring and eating. He needed assistance with self-administration of medications. On [redacted] at 9:45 AM, resident #10 said that the staff always bring his medicines to his room in a cup every day.	A 055		

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 _____	03/17/2023

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 055	Continued From page 13 Observation on at 12:20 PM, resident #10 came to the dining room for lunch and still had the small dixie cup with medications on the seat of his walker. After lunch, caregiver D reminded the resident to take his medications which were in the small dixie cup. On . . . . . at 4 PM, the Administrator confirmed the finding. It was explained that when a resident required assistance with self-administration of medications, the staff assisting must watch the resident take the medication in front of them to ensure that medications were taken. Class III	A 055		