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 _____	11/13/2024

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 complaint investigation (#2024014047) and a generator monitoring was conducted at Wellsprings Residence on 11/13/24. The facility had a deficiency at the time of the survey.	A 000		
A 025 SS=D	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 record reviews and interviews, the facility failed to accurately administer medications as prescribed by a health care provider for 2 of 3 sampled residents (#1 & #5.) Findings: 1. Review of resident #1's health assessment form (1823) revealed the resident needed assistance with self-administration of medications. On a health care provider ordered , 5 milligrams (mg) daily, hold for , , ( ) less than 110.	A 025		

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A 025	Continued From page 2 A review of the residents' and Medication Observation Records (MORs) revealed unlicensed caregiver A documented the resident was given the , on at 9:30 am despite the resident's being 104. In addition, the caregiver documented the resident was given 25 units of on at 1 pm despite the order to give 10 units. On at 1:12 pm, co-owner D said the unlicensed caregivers were instructed to call her with resident and vital sign results then she tells them whether or not to give the medication. When asked why the caregivers, who were all trained on providing assistance with medications, were not permitted to give the medications without first speaking with her, she replied because she wanted to make sure it's done right. She said not everyone spoke good English. When asked about the instance when resident #1 was given 25 units of instead of the ordered 10 units, the co-owner said she obtained a telephone order from a health care provider to do so. She said she had to look for the order and notes she wrote to provide them for review. On at 2:44 pm, the findings were discussed with unlicensed caregiver A, who said facility co-owner D dialed the resident's , then the caregiver took the pen to the resident, who then self-administered it. When asked specifically about giving the resident 25 units of on , the caregiver again said co-owner D dialed the pen then told the caregiver to chart 25 units on the MOR. The caregiver said this was the process every time. When asked specifically about the , the caregiver responded, "I don't know." She then repeated the	A 025		

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A 025	Continued From page 3 co-owner prepared the medication; the caregiver handed the cup of pills to the resident then the co-owner told her what to chart on the MOR. 2. Review of resident #5's 1823 revealed the resident needed assistance with self-administration of medications. A review of the residents' MOR revealed an order for 10 milligrams given as needed for , at or below . The resident was given an as needed dose on , and despite no documentation of , to justify giving it. On at 1:30 pm, the finding was discussed with co-owner D, who did not provide an explanation or , readings for those doses. On at 3:40 pm, co-owner D said the unlicensed caregivers check the resident's vital signs, and saturation then relays the results to her, and she tells them what to chart. She said the caregivers did not give medications; they only observed the residents taking their medications. She said the problem may lie with the electronic medication charting system the facility used. When asked if there was a process in place to check for accuracy of the caregiver's charting, the co-owner said she was supposed to check it weekly but does it monthly. On at 3:50 pm, unlicensed caregiver B and C confirmed their initials on the MORs. They both said co-owner D prepares the resident's medications, they take the cup to the resident then the co-owner tells them what to chart.	A 025		

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A 025	Continued From page 4 Class III	A 025		