AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965661	07/28/2015
NAME OF PROVIDER OR SUPPLIER **SPRING HILLS LAKE MARY**	STREET ADDRESS, CITY, STATE, ZIP CODE **3655 W. LAKE MARY BLVD.** **LAKE MARY, FL 32746**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

A complaint investigation CCR 2015004262, (done in conjunction with CCR 2015004439) was conducted on at Spring Hills of Lake Mary. Spring Hill of Lake Mary had deficiencies found at the time of the investigation.

0008 Admissions - Health Assessment

Based on record review and interview the facility failed to ensure that 1 of 5 sampled resident records (#1) reviewed had a completed health assessment that addressed all the required criteria.

Findings:

Resident record review for resident #1 revealed an Assisted Living Facility Health Assessment form (1823) dated . Continued review revealed the resident was total care for ambulation, dressing and transferring.

Observation on at approximately 2:45 PM revealed the resident needed assistant with ambulation, dressing and transferring.

In an interview with the Resident Care Director on at approximately 2:45 PM who stated the 1823 was not correct, the resident did not need total care with activities of daily living.

Class III

0010 Admissions - Continued Residency

Based on record review and interview the facility failed to ensure an Assisted Living Facility Health Assessment Form (1823) was completed after a resident had a significant change for 1 of 5 sampled residents (#5).

Findings:

Resident record review for #5 revealed an 1823 dated / / that indicated diagnoses of and . The resident was independent with ambulation, eating, toileting and transferring and needed supervision with bathing, dressing and .

Review of the HHC notes revealed they started providing care to resident #5 on / for

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965661	07/28/2015
NAME OF PROVIDER OR SUPPLIER **SPRING HILLS LAKE MARY**	STREET ADDRESS, CITY, STATE, ZIP CODE **3655 W. LAKE MARY BLVD.** **LAKE MARY, FL 32746**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

treatment of on the

There was no documentation to review that indicated a new 1823 was completed when the resident developed a

In an interview with the Resident Care Director on at approximately 5 PM who stated a new 1823 was not completed when the resident had a change in condition.

Class III

0025 Resident Care - Supervision

Based on observation, record review and interview the facility failed to have a proactive plan in place to prevent from developing in a resident who was resistant to care for 1 of 5 sampled residents (#5).

Findings:

In an interview with the Resident Care Director on at approximately 9:45 AM, it was stated that resident #5 had a and lived in the Memory Care Unit (MCU). Tour of the facility on / at approximately 9:45 AM revealed resident #5 was in the MCU and was reclined in a chair in the common area. Observation on / at approximately 11:15 AM and 3:45 PM and revealed resident #5 was sitting in the recliner in a reclined position.

Resident record review for resident #5 revealed an Assisted Living Facility Health Assessment Form (1823) dated / that indicated diagnoses of and . The resident was independent with ambulation, eating, toileting and transferring and needed supervision with bathing, dressing and

Review of facility notes revealed: On / / resident was observed with redness and to area. Resident had complained of irritation and this nurse cleansed off area with soap and water and reapplied (skin protectant) ointment to .
On / bandage to resident . No complaints of pain/discomfort voiced by resident.
On / dressing to resident ointment applied to resident around .
Review of Home Health Care (HHC) Oasis revealed:
Start of Care / , diagnosis stage description, partial thickness loss of dermis presenting as a shallow open with red pink bed, without . Resident was

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965661	07/28/2015
NAME OF PROVIDER OR SUPPLIER **SPRING HILLS LAKE MARY**	STREET ADDRESS, CITY, STATE, ZIP CODE **3655 W. LAKE MARY BLVD.** **LAKE MARY, FL 32746**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

of bowel and , had decision making and memory loss to the extent that supervision was required. Symptoms were poorly controlled and he needed frequent adjustment in treatment. The onset of was / / . The resident had an exacerbation of , symptoms controlled with difficulty, affecting daily functioning, and needed ongoing monitoring. The resident was in fragile health and had ongoing high risk of serious complications and . He had functional limitations in ambulation, , and intermittent pain in the wounds, 2 on a scale of 10. The Braden Scale for development of score was very high = 20. The was non healing, and the resident had good nutritional status.

On the left was 1.8 centimeters (cm) x 1 cm and the right was 2.5 cm x 2 cm. The was excoriated but now had developed open wounds. The staff was applying ointment to 3 times daily. The was open and red with small amount of drainage noted. Instructed to shift weight while in recliner throughout the day.

In an interview on at 4 PM with the Resident Care Director who stated the resident got the from shearing and sitting on his bottom. He's stubborn and he gets up when he wants to. We get him up as often as he will cooperate. He has his own recliner, he does not have a chair cushion or a pressure relief mattress on his bed and he ambulates ad lib.

In an interview with the HHC nurse on at approximately 4:10 PM who stated the resident did not have a specialized mattress or a pressure relief chair cushion. He came to the facility twice a week to do care. The resident was always sitting in his recliner when he came to visit.

In an interview with Staff A, caregiver on at approximately 4:15 PM who stated we always remind the resident to move, he is resistant to care and will not always cooperate.

In an interview with the Wellness Nurse on at approximately 4:30 PM who stated the resident is , he is in his recliner or in bed in his . He does not walk a lot, he will when he is agitated. We keep him clean and dry. He is resistant to care, ambulation and showers. It took three people to encourage him to get his dressing changed.

Observation of the on / at approximately 5:10 PM revealed the periwound was reddened, the left was 1.0 cm x 0.4 cm and the right was 1.3 cm x 1.0 cm x 0.1 cm, with a small amount of bloody drainage. The was cleansed with normal , skin prep applied to skin and a dressing was applied.

Phone interview with resident #5's physician on / at 5 PM who stated the behavior of residents cannot be controlled. Different modalities can be tried such as moving and repositioning. are not preventable in residents when residents are resistant to care. The resident would need one on one care.

The facility did not provide the care and services needed and have proactive, preventative measures in place to prevent the development of in a resident who had and was resistant with care.

Class II

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Spring Hills Lake Mary
3655 W. Lake Mary Blvd.
Lake Mary, FL 32746
Attention: Nick Lynn

Dear Mr. Lynn:

This letter reports the findings of a complaint CCR#2015004262 inspection survey conducted on , by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) **by** .

The inspection resulted in findings of non-compliance in the following areas:

1) A - 0025 - Resident Care - Supervision Class II

Your facility failed to have a proactive plan in plan in place to prevent from developing in a resident who was resistant to care.

Directed Corrective Actions:

1. Your facility is directed to create and implement a policy and procedures identifying providing are to residents at risk for the development of pressure sores due to their physical and/ or status. This policy must include measures the development of an individualized plan of care to meet the resident's needs. The policy must include meetings for parties involved in the plan of care to ensure the facility can meet the residents needs and the resident is appropriate to remain in the facility. This must be completed by .

2. The facility must conduct an in-service so that all staff aware of the new policy and procedure and are aware what is the expectation of them regarding residents that are at risk for pressure areas due to their status. The documentation of the in-service training, including certificates and sign in sheets must be available Agency review upon request by .

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Spring Hills Lake Mary
[illegible], 2015

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact . Lorraine Henry, Orlando Office, at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be

D7JR

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone (407) 420-2502; Fax (407) 245-0998

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Spring Hills Lake Mary
3655 W. Lake Mary Blvd.
Lake Mary, FL 32746

RE: CCR #2015004262 w/LNS

Dear Administrator:

This letter reports the findings of a state licensure complaint investigation survey that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.