STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942983	**07/11/2016**
NAME OF PROVIDER OR SUPPLIER **AIDEN SPRINGS**	STREET ADDRESS, CITY, STATE, ZIP CODE **5520 HOWELL BRANCH ROAD WINTER PARK, FL 32792**	

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

0000 Initial Comments

Complaint investigation #2016005187 was conducted on / . Aiden Springs (License #8419) had deficiencies at the time of the visit.

0008 Admissions - Health Assessment

Based on record review and interview, the facility failed to ensure a resident health assessment (AHCA 1823) had all required and accurate information for 1 of 4 sampled residents (#3).

Findings:
An interview conducted on / at 10:00 AM. with the administrator revealed the resident was admitted on from a skilled nursing home with and the resident was receiving services from a home health agency. The administrative staff who worked part time at the facility also stated at 4:00 PM that Resident #3 had wounds on the leg, lower abdomen and .

A review of the Home Health Certification and Plan of Care revealed the SOC (Start of Care) date . The resident's principal diagnosis was of sacral region, . Other pertinent diagnoses were of other site, . A review of home health agency service dated revealed the resident had on on right lower abdomen and left lower leg.

A review of the resident#3's chart revealed a health assessment, AHCA Form 1823, dated . The health assessment indicated the resident did not have any , 3 or 4 pressure sores.

The same AHCA 1823 also did not address ADL Level (activities of daily living) under ambulation. It did not address whether or not the resident was independent or needed supervision or assistance with ambulation.

On / at 5:45 PM. the administrator confirmed that the AHCA 1823 did not address the ADL level.
On / at 4:45 PM. the administrator was informed about the resident's status according to the HHA assessments. He stated he was not aware that the resident had wounds at admission. He stated the resident had been discharged on / to a more appropriate facility.

Class III

0010 Admissions - Continued Residency

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Based on record review and interview, the facility failed to ensure an appropriateness of admission and continued residency for 1 of 4 sampled residents (#4).

Findings:

On / at 10:15 AM an interview was conducted with the administrator regarding clinical status of all residents. He stated that resident #4 was admitted on from a skilled nursing home with cellulitus and was receiving home health services at the facility.

A review of the resident's chart revealed a health assessment, AHCA Form 1823, dated . It revealed the resident's diagnoses included but were not limited to acute , and pelvic , unspecified pain, and type 2. The health assessment indicated the resident did not have any , 3 or 4 pressure sores.

On / the administrator could not provide any information regarding home health services. He stated that he would have to contact the home health agency (HHA) to obtain detailed information.

On the HHA information was provided by the administrator via E-mail.

A review of the Home Health Certification and Plan of Care revealed the SOC (Start of Care) date . The resident's principal diagnosis was of sacral region, . Other pertinent diagnoses were of other site, ; Type 2 without complication; essential (primary) ; and muscle .
A review of HHA service dated revealed the dimensions of the resident's wounds as follow:
: Length (L) 3.3 cm (Centimeter); Width (W) 1.6 cm; Depth (D) approximate 1.4 cm.
Right lower abdomen: L 2.3 cm, W1.4 cm, D approximate 0.1 cm.
Left lower leg: L. 2 cm, W 1.8 cm, D. approximate 0.1 cm.

A review of the service date of / revealed the following dimensions:
: L 4 cm, W 3 cm, D. 3.3 cm.
Right lower abdomen: L .5 cm, W. 1 cm, D. 0 cm.
Left Leg: L. 4 cm, W. 3.3 cm, D. approximate 0.2 cm.

It was evident that the resident's wounds had not improved.

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SUMMARY STATEMENT OF DEFICIENCIES
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On / at 2:45 p.m. the administrator was informed about the resident's status according to the HHA assessments. He stated he was not aware that the resident had , wounds at admission. He stated that the resident had been discharged on / to a hospital for a . From the hospital, she was sent back to the skilled nursing facility.
Class III

0078 Staffing Standards - Staff

Based on record review and interview, the facility failed to ensure 2 of 4 sampled staff had statements of freedom from communicable including ( ) from their health care provider, within 30 days of employment (Staff A and D).

Findings:

A review of Staff A's and Staff D's personnel files revealed neither of them had provided a statement from a health care provider indicating they did not have any signs or symptoms of communicable including .

Staff A was hired on , Staff D . Both were direct care staff.

On / at 5:00 PM. the administrator confirmed the findings.

Class III

Z814 Background Screening Clearinghouse

Based on facility record review and interview, the facility failed to register and maintain its employment status off all employees within the AHCA background screening (BGS) clearinghouse.

Findings:

A review of the facility staffing schedule of / revealed 9 caregivers, 1 dietary staff.

A review of the facility BGS website conducted on / revealed 14 employees plus the administrator. On / at 10:45 AM. the administrator stated that 4 employees whose names were

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still on the BGS roster no longer worked at the facility. He said that he was not aware that he had to update the roster.

Unclassified.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Aiden Springs
5520 Howell Branch Road
Winter Park, FL 32792

RE: CCR #2016005187

Dear Administrator:

This letter reports the findings of a state licensure complaint investigation survey that was conducted on , 2016 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 , 20, 2016.** 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
XG90

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