STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965661	**11/06/2017**
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 Limited Nursing Service (LNS) monitoring visit was conducted on , 2017. Spring Hills Lake Mary, license #10007, had deficiencies at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observations, record reviews, and interviews, the facility failed to follow an order from a health care provider for 1 of 4 sampled residents (#1).

Findings:

During the entrance conference on at 2 pm, the resident care director identified resident #1 and said he received a Limited Nursing Service (LNS) for compression stockings to be put on every morning and removed every evening.

Observations made of resident #1 on at 3 pm revealed he was not wearing his compression stockings. When questioned, resident #1 said the staff came into his one hour prior and he told them it was too late to put the stockings on. Observations made also revealed his legs were edematous.

During an interview with staff E, a nurse, on at 3:45 pm, she said at approximately 7:30 am that morning, resident #1 had his stockings on. However, she forgot the had to put lotion on his legs so the stockings were removed. She said he did not have the stockings put back on because he was out of the building for the day with his family or with activities.

On at 3:55 pm resident #1 said he did not leave the facility on that day with either his family or with activities. Review of the facility sign out book revealed he did not sign out.

Record review for resident #1 revealed he had a diagnosis of , he was prescribed 2 milligrams every morning as a , and he was alert and oriented.

A health care provider order dated on indicated that resident #1 was to have compression stockings applied every morning and removed every evening for .

Class III

0086 - Training - ADRD - 58A-5.0191(9) FAC

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

Based on personnel record reviews and interview, the facility failed to ensure 1 of 4 direct care staff (B) received 4 hours of and Related (ADRD) continuing education annually.

Findings:

Personnel record review for staff B, a caregiver, revealed a hire date of .

Staff B received level 2 training on and one hour of ADRD continuing education on .

The record did not contain documented evidence to indicate staff B received an additional three hours of continuing education, as required.

On at 5:30 pm, the business office manager confirmed the findings.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on personnel record reviews and interviews, the facility failed to ensure that certificates of completion were issued to 3 of 4 sampled staff (B, C, and D) who received training.

Findings:

Personnel record reviews for staff B, C, and D revealed they all signed a document that outlined the facility's resident elopement policies and procedures.

On at 5:30 pm, the business office manager said the facility trained the staff on the facility's resident elopement policies and procedures by having them sign the policy.

The records for staff B, C, and D did not contain a certificate of completion for the training, as required.

Class

N278 - LNS - Records - 58A-5.031(3) FAC

Based on record reviews and interview, the facility failed to ensure nursing progress notes were maintained and nursing assessments were conducted at least monthly for a resident (#1) who received Limited Nursing Services (LNS).

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

Findings:

During the entrance conference on at 2 pm, the resident care director identified resident #1 and said he received LNS for compression stockings to be put on every morning and removed every evening and at bedtime.

Review of a document that was dated 2017 revealed an entry to apply compression stockings in the morning and remove in the evening. There were no staff initials on and to indicate the compression stockings were applied in the morning.

In addition, on at 5 pm, the resident care director provided a document and said it contained documentation of the LNS monthly assessments for resident #1. Review of the documentation revealed that on and resident #1 was not in his . The resident care director said the monthly assessments were not completed in and because a nurse only came to the facility once a month and the resident was unavailable on the day the nurse arrived. When questioned as to why an assessment was not conducted on a day when resident #1 was available, the resident care director was unable to provide an answer.

Class III