STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968599	11/26/2018
NAME OF PROVIDER OR SUPPLIER **WELLSPRINGS RESIDENCE**	STREET ADDRESS, CITY, STATE, ZIP CODE **700 E WELCH RD** **APOPKA, FL 32712**	

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

0000 - Initial Comments

A Complaint investigation #2018011372 was conducted on . Wellsprings Residence Assisted Living Facility, license #12479 had deficiencies at the time of the visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observations, record review and interview the administrator failed to monitor the continued appropriateness of placement 1 of 3 (#3) sampled residents and retained the resident who required total care with ambulation and transfers which exceed the admission and continued residency criteria for an Assisted Living Facility.

Findings:

On 10:50 AM observations of the supply room revealed there was a Hoyer , located inside.

The administrator stated at the time, the Hoyer , belonged to a resident who use to reside at the facility, and used it during his , . She stated the facility was just storing it for the family. The administrator was asked the name of the resident who use to reside in the facility and she gave the name of resident #3. The agency staff reviewed the census that included the name of the current residents and notice resident #3 was listed as a current resident. The agency staff informed the administrator that resident #3 was listed as a current resident.
The administrator then stated the Hoyer , was not being used by the facility for resident #3, the family did not have anywhere to store it and they were storing it for the family.

During interviews with facility caregivers on , it was revealed that the caregivers were using the Hoyer- , because the resident could not assist at all with transfers and could not ambulate. The staff stated that was the only way they could transfer him. They were all told to use the Hoyer , . The staff stated there was a sliding board, however they were not using it.

Record review for resident #3 revealed he was admitted to the facility on , the resident health assessment form 1823 dated the health care provider noted , , right sided /immobility. The health care provider noted he required assistance with bathing, , transfers, supervision with eating, grooming, toileting, the space for the type of assistance with ambulation was left blank, the health care provider noted wheelchair dependent. The resident's was recorded as 5 10 and inches, his was recorded , on the 1823.

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There was an order dated [redacted] that noted please supply a Hoyer stand lift for [redacted].

A history and physical report from an emergency room visit dated [redacted] noted the resident had right side , total and was unable to walk.

Review of the facility's electronic note revealed a staff noted the following;

at 12:09 PM-Resident was put in the chair with using x 2. Gait belt was in place and was used to assist with resident to pull in power chair.
at 1:41 PM-resident was transferred from bed to power chair using the , and gait belt was used to adjust resident in the power chair x 2 assist.

Observation at 2 PM on revealed the resident was sitting in his motorized wheelchair. The resident had a large body frame. Staff C was present in the room. The administrator alone, placed her arms around resident #3, told him that she would be transferring him, she counted, she struggled to lift the resident alone because he was much larger than the administrator, while struggling, she placed him on the edge of the bed, he moaned, staff C had to hurry to assist him in the bed so that he would not slide to the floor. They placed the resident in a laying position on the bed. The resident did not assist with the transfer, his did not move at all when transferred. The administrator then placed a sliding board on the bed that went to the wheel chair, she moved the resident over to one side in the bed, placed the sliding board under the resident's lower body, assisted him to sit up on it. The administrator lifted the resident down the sliding board into the wheel chair, the administrator and staff C attempted to use the gait belt to bring him upright in the wheelchair because he was sitting close to the edge. When they attempted to use the gait belt to position him in the wheelchair, the belt slipped, it did not work and the resident laughed. They attempted again and positioned him in the chair the correct way. The resident did not help at all with that transfer, nor did he use the sliding board himself to move from the bed to the wheelchair.

On at 3 PM the administrator was informed that the staff stated they used the Hoyer stand-up lift to transfer the resident to the bed from his wheel chair because he could not walk or pivot to assist them. The administrator said the staff were not to be using the Hoyer stand-up lift to transfer him. She was not aware they were using the Hoyer , . The administrator was informed at the time, the resident could not assist with the transfers/pivot, and he could not use the sliding board. The administrator was asked again at the time why did she originally state that the hoer , belonged to a resident that use to reside at the facility, she stated at the time she was not feeling well and made a mistake when she answered the question.

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Resident #3 was not able to transfer or ambulate with the use of the sliding board or staff assistance, this exceeded the residency criteria for assisted living facilities.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility failed to obtain a health care providers order for 1 of 3 sampled residents (#1) before allowing the resident to self-administer .

Findings:

On , staff C was observed assisting resident #1 with the self-administration of her medications. Staff C asked the resident at the time if she had taken her for the morning and resident #1 stated she had. Staff C stated resident #1 administered her own .

Record review for resident #1 revealed a resident health assessment form (1823) dated , the health care provided noted she required assistance with her medications.

Further record review of resident #1 revealed there was no order found that the resident could self-administer any medications.

On at 11:30 AM, the administrator was informed of the findings. The administrator contacted the health care provider and provided an order dated (day of survey) that noted "Patient may administer her own . Currently taking 22 units once daily."

The administrator said on at 3 PM, she could not locate an order prior to .

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on review of the facility emergency environmental control documentation, the facility had no evidence to confirm that written policies were developed to ensure that the assisted living facility could effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source, that also included procedures to ensure residents would not experience complications from fluctuations in air temperatures inside the

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facility.

Findings:

Review of the facility's emergency environmental control plan documentation revealed there were no written policies and procedures that included:

How the facility would immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source.
The care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including:
1. The use of cooling devices and equipment;
2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration;
3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury ; and,
4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy.

On at 3:15 PM, the administrator confirmed the findings.
Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on personnel record review, the agency's background screening website and interview, the facility did not initiate all criminal history checks through the clearinghouse before employment.

Findings:

Personnel record review for staff B hired revealed an eligible background screening result dated .

Review of the agency's background screening website on at 9 AM, revealed staff B was not listed on the facility's roster.

Further review of the agency's background screening website at the time revealed staff b did have background screening results that were dated .

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On [redacted] at 3 PM, the administrator reviewed the roster and confirmed the findings.

Unclassified