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 _____	R 02/21/2022

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 revisit to a Relicensure survey with Extended Congregate Care (ECC) was conducted on . Wellsprings Residence had an uncorrected deficiency at the time of the visit.	{A 000}		
{A 025} SS=G	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}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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: UNCORRECTED DEFICIENCY Based on observations, record reviews, and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision to 1 of 4 sampled residents who experienced a that resulted in a (#2), and by failing to conduct an investigation when 1 of 4 sampled residents sustained a injury (#5). Findings: 1. Resident #2's 1823 health assessment form,	{A 025}		

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{A 025}	Continued From page 2 dated .. ...., revealed the resident's diagnoses included , , , , and . The assessment form indicated the resident had , cognition and judgement, was a risk, and required supervision with ambulation, toileting, and transferring. On ....., a health care practioner ordered , , , to evaluate and treat for gait and balance . On ..... , a health care practitioner ordered a walker as needed for ambulation. On at 3:48 p.m., resident #2's family member said that on ....., she was in the resident's room when the resident said she had to use the restroom. The family member left the room to find staff but initially had trouble locating someone, so she went ... to the resident's room to check on her. The family member left the room, then found a staff member in the room where medications were kept. The staff member who responded put her arm out for the resident to stand. The family member told the staff member three times that the resident was going to need more help than that but the staff member continued to walk with the resident to the bathroom. While the staff member and the resident were in the bathroom, the resident forward into the shower, striking her . Staff D responded to the room and sat the resident up and against the wall. Staff D said the resident's ... injury was just a .... and she would be fine. The family member said she wanted the resident sent to the hospital. Staff D picked the resident up, placed her in a wheelchair, then said paramedics were not allowed to come in the , so he wheeled the resident to the front	{A 025}		

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{A 025}	Continued From page 3	{A 025}		

lobby. The assistant administrator handed a phone, which had the administrator on time, to staff D. Emergency medical services was called and the resident was transported to the hospital. Within that same week, the family member spoke with the administrator, who apologized for what happened, said she accepted all responsibility and said the state was already notified. The family member asked the administrator why staff D moved the resident after the because the family member understood that the person should not be moved. The administrator said it was okay because staff D was a medic in the military. The family member later informed the administrator that the family member would not be bringing the resident to the facility.

The facility report, dated ....., revealed documentation that indicated the following: On ..... at approximately 12:40 p.m., resident #2 was inside her private suite with her daughter present. The resident was instructed by staff to alert staff if she needed assistance and not to get up from the wheelchair on her own. At approximately 12:45 p.m., the resident got up from her wheelchair and walked to the bathroom, refusing to alert the staff. The resident forward while ambulating to the bathroom inside her private suite due to possible syncopal episode. The resident's daughter was present and witnessed the . In less than a minute post- , staff D provided assistance and a post- assessment was conducted. An injury was noted above and below the resident's left .. She remained awake and oriented to person, time and place but exhibited ..... prior to the incident. At approximately 12:47 p.m., a secondary post- assessment was conducted by the administrator and paramedics were called,

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{A 025}	Continued From page 4	{A 025}		

two minutes after the first assessment. At approximately 1:20 p.m., fire rescue arrived, and the resident was taken to the hospital.

On ..... at 12:10 p.m., staff A said that on , resident #2's daughter came out of the resident's room and said the resident was not listening, kept getting up, and wanted to use the restroom. Staff A entered the resident's room and attempted to assist the resident, who was sitting in a wheelchair, to the restroom but the resident was being combative. Staff A then turned to the resident's daughter and told her to keep a close , on the resident. While staff A was talking to the daughter, the resident walked to the restroom by herself. Staff A said she did not see the resident walk to the restroom and when she turned and saw the resident, she was standing in front of the toilet and was pulling her pants down. Before staff A could reach the resident, she . Staff A saw .... dripping down the resident's , so she went to get a pillow and to get staff G. Both staff G and staff D responded to the resident's room and staff D told staff A that he and staff G would handle it from there.

On ..... at 1:32 p.m., staff F said resident #2 was a risk, so staff F always walked with the resident.

On ..... at 2:45 p.m., staff E said resident #2 used a walker and was unsteady, so she had to be supervised. To prevent resident #2 from falling, staff E said she made sure walkways were clear and there was no water on the floor. She also ensured the lighting was adequate and if resident #2 did not feel well, staff E instructed the resident to not stand on her own, and the resident was usually compliant.

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{A 025}	Continued From page 5 On [redacted] at 3:03 p.m., the administrator said she could not discuss resident #2's [redacted] from memory. When asked why the [redacted] was not documented in the resident's record, the administrator said because she documented all of the details on the report that she submitted to the regulating agency. On [redacted] at 3:07 p.m., staff D said resident #2 [redacted] and he responded to her room to help get her off the floor. He said resident #2 was sitting on the floor and was against the wall. She had [redacted] and a small amount of [redacted] on her cheek. He stated that the resident said, "I just need to get up", then tried to get herself up but staff D told her not to. The resident complained of [redacted] in her [redacted]. The resident's daughter asked staff D if he was able to get the resident up. The resident was against the shower wall and the toilet. Staff D stood the resident up and walked her to her wheelchair. Staff D applied gauze to the resident's cheek. Staff D said there a staff member was not in the room when the resident [redacted]. The daughter wanted the resident to be sent to the hospital. Staff D took the resident to the lobby and 911 was called. Staff D said emergency medical service personnel were not allowed to go to the resident's room because those people did not usually have proof of Covid-19 testing, so it was better to not let them walk through the facility. Staff D said prior to the resident's recent hospital stay, she used a walker and when she returned, she used a wheelchair. Staff D said he did not believe that staff A was in the resident's room when the resident [redacted]. An attempt was made on [redacted] at 5:05 p.m. to interview the assistant administrator about resident #2's [redacted] but she immediately said she was not allowed to answer any questions.	{A 025}		

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{A 025}	Continued From page 6 Review of a the hospital surgery history and physical, dated , revealed documentation that the result of a computerized ( ) of the (relating to the jaw and) was acute left cerebellar parenchymal 5 by 2.5 centimeters, and a left and periorbital soft tissue . 2. Resident #5's 1823, dated , revealed diagnoses including . The resident was identified as a risk, required a walker for an unsteady gait, and supervision for activities of daily living (ADLs). On at 9:05 a.m., observation found resident #5 walking with the aid of a walker through the lobby area. and a , purple in color, was seen under his left . When asked what happened to his , the resident's response was nonsensical. On at 12:06 p.m., staff E said she did not know how resident #5 sustained the to his . She saw it when she worked on . Prior to that, she worked on and could not remember if the was present at that time. On at 12:08 p.m., both the administrator and the assistant administrator said they did not know resident #5 had a . On at 12:10 p.m., staff A said when she worked on , she saw that resident #5's left was and puffy. She was unaware of how the resident sustained the and said she did not inform anyone of what she saw.	{A 025}		

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{A 025}	Continued From page 7 On [redacted] at 1:32 p.m., staff F said she did not know how resident #5 sustained the [redacted] under his left [redacted] and said she first saw it during her shift on the previous night. She said resident #5 told her that he [redacted]. Staff F did not report the [redacted] to anyone because she saw a yellow discoloration and thought that meant it had already been reported. On [redacted] at 3:32 p.m., staff B said she saw the [redacted] on the morning of [redacted] and said she did not report what she saw to anyone. Class II	{A 025}		