STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968599	**02/16/2018**
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 #2017014036 was conducted on and . Wellsprings Residence, license #12479, had deficiencies at the time of the investigation.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record reviews and interview, the facility failed to ensure a health assessment form 1823 was complete for 1 of 4 sampled residents (#1).

Findings:

During an interview with resident #1 on at 10:30 am, he said the facility staff assisted him with taking his medications.

Review of the record for resident #1 revealed a health assessment form 1823 that was dated on . The section on the form that pertained to whether resident #1 required assistance with his medications was not answered, as required.

On at 2:45 pm, the administrator said the facility assisted resident #1 with his medications and she confirmed the finding.

Class III

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

Based on record reviews and interview, the facility failed to maintain a written record for a resident (#1) who was sent to the hospital.

Findings:

Review of the 2017 and , 2018 Medication Observation Records (MORs) for resident #1 revealed documentation that indicated on and he was out of the facility.

When questioned on at 1:30 pm regarding where the resident was on those dates, the administrator said the resident went to the hospital several times since he was admitted to the facility.

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A Hospice admission note, dated on , indicated the resident was sent to the hospital three times for ( ) exacerbation since his admission to the facility.

Review of the record for resident #1 revealed no documentation to indicate he was sent to the hospital, as required.

The administrator provided a document that indicated a communication note was sent to a health care provider on at 12:52 pm and again on at 9:17 am via an internet portal regarding the resident being sent to the hospital. In addition when he returned to the facility. However, the documents were not part of the resident's record.

On at 2:51 pm, the administrator said resident #1 was sent to the hospital two or three times and she confirmed his record did not contain documentation to reflect those occurrences.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observations, record review, and interview, the facility failed to ensure the unlicensed staff who assisted a resident (#5) with medications followed the correct procedure and failed to notify a health care provider when a resident (#1) refused to take medications.

Findings:

1. Observations made during a medication pass for resident #5 on at 9:35 am revealed staff C, an unlicensed caregiver, donned gloves. She unlocked the medication cart, removed medication packages from the cart, and then she locked the cart. She took the medication packages to the resident, read the prescription labels to the resident, and then she returned to the medication cart with the packages. While standing at the cart, she popped out the pills into a medicine cup, and then she took the cup to the resident. The resident took the medications without assistance. The caregiver signed the Medication Observation Record (MOR.)

The caregiver did not prepare the medications in the presence of the resident, as required.

On at 9:45 am, staff C confirmed the findings.

2. Review of a health assessment form 1823, dated on , for resident #1 revealed he required

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assistance with self-administration of his medications.

Review of the resident's , 2018 MOR revealed documentation that indicated he refused medications on through , , , , and through .

Review of the resident's record revealed no documentation to indicate the facility notified a health care provider of his refusals.

On at 2:54 pm, the administrator confirmed the findings.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record reviews and interviews, the facility failed to ensure the Medication Observation Record (MOR) was updated for 2 of 2 sampled residents (#1 and #4) who required assistance with self-administered medications.

Findings:

1. Review of the record for resident #1 revealed a health assessment form 1823 that was dated on . The form indicated he required assistance with self-administration of his medications. His diagnoses included ( ), Carotid , (HLD), , ( ), , ( ), ( ) and .

Review of the resident's 2017 MOR revealed the following:

An entry for 40 milligrams (mg) by mouth at bedtime for was not signed as given on , , , and .

An entry for 12.5 mg by mouth twice daily for , and chest pain was not signed as given for the 7 pm dose on and .

An entry for , 50 mg by mouth daily for fluid retention was not signed as given on , , and .

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Review of the resident's , 2018 MOR revealed the following:

An entry for 12.5 mg by mouth twice daily for , and chest pain was not signed as given for the 9 am dose on .

An entry for MONO ER 30 mg by mouth daily for chest pain was not signed as given on .

2. Review of the record for resident #4 revealed a health assessment form 1823 that was dated on . The form indicated that the resident required assistance with self-administered medications. Her diagnoses included (OP), (A-fib), , ( ), Chronic Pain, , and .

Review of the resident's 2017 MOR revealed the following:

An entry for , ER 15 mg by mouth every 8 hours was not signed as given for the 7 am dose on , , the 12 pm dose on , through , , , , , , , and the 7 pm dose on , , .

Review of the resident's 2017 MOR revealed the following:

An entry for , ER 15 mg by mouth every 8 hours was not signed as given for the 7 am dose on , , , the 12 pm dose on , , and the 7 pm dose on , .

On at 4 pm, the administrator confirmed the findings.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on record reviews and interview, the facility failed to provide notification and failed to return all medications to the resident or the resident's family for a resident (#4) whose stay in the facility had ended.

Findings:

A letter, dated , from the resident to the facility indicated the resident was terminating her

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residency at the facility effective immediately.

A facility drug disposition form, dated on , indicated that 214 tablets and 159 tablets were returned to the pharmacy because the resident was discharged from the facility.

When questioned further on at 4:50 pm, the administrator confirmed the medications were sent to the pharmacy and she was unable to provide documentation to indicate the resident or her family were provided notification to retrieve the medications.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record reviews and interview, the facility failed to provide a preliminary adverse incident report to the Agency within 1 business day and a full report to the Agency within 15 days of an event that was reported to law enforcement.

Findings:

Review of a facility incident report, dated on , indicated the Orange County Sheriff's office was notified when resident #4 did not swallow her pills and she hid the pills.

Review of an Orange County Sheriff's Office Incident Report revealed two deputies responded to the facility, in reference to a suspicious incident, on .

During a phone interview with the administrator on at 9:50 am, she said an adverse incident report was not submitted to the Agency, as required.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record reviews and interviews, the facility failed to submit its emergency management plan for review and approval to the local emergency management agency within 30 days after obtaining a license.

Findings:

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Review of the website FloridaHealthfinder.gov revealed the facility was issued its license on .

On at 9:15 am, a request was made to review the facility's approval letter from the County for its emergency management plan.

On at 12:45 pm, the administrator provided an approval letter that was not addressed to the facility and was not signed by a representative from the County. In addition, she was unable to provide documentation to indicate the facility submitted its plan.

During a phone interview with a representative from the Orange County office of Emergency Management on at 8:53 am, the representative said the facility submitted its plan for approval in 2017. An email was sent to the facility on with instructions to revise the plan and a response from the facility was not received.

Class III