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
	AL11968681	A. BUILDING: _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCANY VILLA	8562 WINDER WAY MELBOURNE, FL 32940

(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 complaint investigation (202001420) was conducted at Tuscany Villa Assisted Living Facility on . The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26(&9) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility. (9) A , ill resident who no longer meets	A 010		

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
	AL11968681	A. BUILDING: _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCANY VILLA	8562 WINDER WAY MELBOURNE, FL 32940

(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 010	Continued From page 1 the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-[illegible] medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care	A 010		

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
	AL11968681	A. BUILDING: _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCANY VILLA	8562 WINDER WAY MELBOURNE, FL 32940

(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 010	Continued From page 2 provider, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C.	A 010		

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
	AL11968681	A. BUILDING: _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCANY VILLA	8562 WINDER WAY MELBOURNE, FL 32940

(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 010	Continued From page 3 This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the administrator failed to determine the appropriateness of admission for 2 of 4 sampled residents (#3 and #4) and accepted the residents who required total care with all activities of Daily living, (ADL's) and could not ambulate which exceeded the continued residency criteria. Findings: 1. Record review for resident #3 revealed he was admitted to the facility on from a nursing home, review of an Medical Certification for Medicaid Long-Term care services and patient transfer form (3008 used for nursing home admission) that was dated , the health care provider noted the resident was non-ambulatory and required 2 persons to transfer. There was no Resident Health Assessment form 1823 available for review. A telephone interview was conducted on at 12 PM with the emergency contact of resident#3. She said the resident resided in a nursing home and because the Assisted Living Facility(ALF) cost was less than what they were paying, she and resident #3 decided to move there because the administrator told them the facility was capable of providing the care that he needed. She said resident #3 was non-ambulatory, could not do anything for himself, he required total care. She said he could feed himself. She said the resident stayed in bed for 3 days because there was no one at the facility that could lift him. She said on the day that he was admitted, the administrator's husband called her within an hour to say that she had to come get the resident because he needed more	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968681	A. BUILDING: _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCANY VILLA	8562 WINDER WAY MELBOURNE, FL 32940

(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 010	Continued From page 4 care than what the ALF could provide. She had another nursing home come to the home to assess him and he was admitted because he needed a higher level of care. On documentation was received via email for the nursing home's admissions director where resident #3 currently resides that noted: On , The emergency contact informed her that the resident was transfered to the ALF, and on the same day the owner informed her they would be unable to care for him and she would need to place him elsewhere. She gave her the phone number of the ALF so she could arrange a visit to evaluate the patient. The admission's director visited resident #3 and discussed his transfer to the Nursing Home. She noted After reviewing his History and Physical and evaluating the resident at the facility, he was deemed appropriate for a Skilled Nursing Facility (SNF) placement and agreed to admit the resident. 2. Observations on at 9:30 AM, revealed the hospice staff used a wheel chair to bring resident #4 to the common area. Resident #4 was alert but could not communicate. Record review for resident #4, revealed she was admitted , the resident health assessment form 1823 dated . . . . . noted the type of assistance she required with ambulation left blank, the health care provider document "use wheelchair." The type of assistance she required with bathing and toileting were left blank, the health care provider noted she required total care with . . . . . ,, grooming and transferring all which exceeded the	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968681	A. BUILDING: _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCANY VILLA	8562 WINDER WAY MELBOURNE, FL 32940

(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 010	Continued From page 5 admission criteria for an Assisted Living Facility. Interview with the staff A, a caregiver at 9:45 AM who said resident #4 required total care with bathing, grooming and [redacted], and could not ambulate and she could feed herself. She said the resident received hospice services. On [redacted] at 11 AM, the owner said he was not aware both residents required total help at admission. He said resident#4 was admitted with hospice services and he thought that was appropriate. Class III	A 010		
A 168 SS=B	429.24(3)(a) FS; 429.27(7), FS Resident Refund Policy 429.24 (3)(a) . . . The refund policy shall provide that the resident or responsible party is entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the termination date after all charges, including the cost of damages to the residential unit resulting from circumstances other than normal use, have been paid to the licensee. For the purpose of this paragraph, the termination date shall be the date the unit is vacated by the resident and cleared of all personal belongings. If the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident or his or her estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed 20 percent of the regular rate for the unit, provided that 14 days' advance written notification is given. If the resident's possessions are not claimed within 45 days after	A 168		

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
	AL11968681	A. BUILDING: _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCANY VILLA	8562 WINDER WAY MELBOURNE, FL 32940

(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 168	Continued From page 6 notification, the facility may dispose of them. The contract shall also specify any other conditions under which claims will be made against the refund due the resident. Except in the case of . . . . or a discharge due to medical reasons, the refunds shall be computed in accordance with the notice of relocation requirements specified in the contract. However, a resident may not be required to provide the licensee with more than 30 days' notice of termination. If after a contract is terminated, the facility intends to make a claim against a refund due the resident, the facility shall notify the resident or responsible party in writing of the claim and shall provide said party with a reasonable time period of no less than 14 calendar days to respond. The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or . . . . of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18. 429.27, FS Property and personal affairs of residents. - (7) In the event of the of a resident, a licensee shall return all refunds, funds, and property held in trust to the resident's personal representative, if one has been appointed at the time the facility disburses such funds, and, if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the facility to the resident. If the resident has no spouse or adult next of kin or such person cannot be located, funds due the resident shall	A 168		

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
	AL11968681	A. BUILDING: _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCANY VILLA	8562 WINDER WAY MELBOURNE, FL 32940

(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 168	Continued From page 7 be placed in an interest-bearing account, and all property held in trust by the facility shall be safeguarded until such time as the funds and property are disbursed pursuant to the Florida Probate Code. Such funds shall be kept separate from the funds and property of the facility and other residents of the facility. If the funds of the resident are not disbursed pursuant to the Florida Probate Code within 2 years after the resident's , the funds shall be deposited in the Health Care Trust Fund administered by the agency. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide a refund to 1 of 3 sampled resident's (#3) within 45 days after discharge. Findings: Observations on at 9:30 AM, revealed there was one staff working at the facility and the current census was 5. Interview with staff at the time revealed she was working alone and would work alone daily. Record review for resident #3 revealed he was admitted to the facility on from a nursing home, review of an Medical Certification for Medicaid Long-Term care services and patient transfer form (3008 used for a skilled nursing facility admission) that was dated , the health care provider noted the resident was non-ambulatory and required 2 persons to transfer. On at 10 AM the owner said Resident #3 did reside in a nursing and was admitted from	A 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968681	A. BUILDING: _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCANY VILLA	8562 WINDER WAY MELBOURNE, FL 32940

(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 168	Continued From page 8 there to the facility on . . . . . and left on . . . . . , he said after he was admitted it was found that the resident needed more care and the facility was in the process of trying to get hospice services and other assistance, so that he could remain at the facility. He said his friend became upset and told them that they were going to have him removed. He said they did not give a notice and just removed the resident. He provided a text that noted on . . . . . at 7:05 PM that was sent, that he had sat down with the administrator and she was doing everything in her power to have resident #3 to stay in their home and that she had an assessment in the morning with hospice/home care. We will do everything we can to make this work. A telephone interview was conducted on . . . . . at 12 PM with the emergency contact of resident#3. She said the resident resided in a nursing home and because the Assisted Living Facility(ALF) cost was less than what they were paying, she and resident #3 decided to move there because the administrator told them the facility was capable of providing the care that he needed. She said resident #3 was non-ambulatory, could not do anything for himself, he required total care. She said he could feed himself. She said the resident stayed in bed for 3 days because there was no one at the facility that could lift him. She said on the day that he was admitted, the administrator's husband called her within an hour to say that she had to come get the resident because he needed more care than what the ALF could provide. She had another nursing home come to the home to assess him and he was admitted because he needed a higher level of care. She said she had requested a refund and the facility told her she	A 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968681	A. BUILDING: _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCANY VILLA	8562 WINDER WAY MELBOURNE, FL 32940

(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 168	Continued From page 9 would not receive one because she did not give a notice. She said the owner later told her he could try to get hospice and home health services in order keep him there. She informed that owner that the resident would not be eligible for hospice service, because he did not have a illness and she depended on the facility to provide all the care that he required. Review of the resident's contract dated noted under Section 4: Term, Transfer and Termination B. Reason for Termination. The community may immediately terminate this Residency agreement for the following reasons: i. Medical. Due to changes in your physical or mental condition, supplies services, or procedures are required which extend beyond the certification, licensure, design or staffing of the community. 6. Refunds. The following policy shall apply: (a) You shall receive a refund of any payments to which you are entitled within thirty (30) days of termination of this residency agreement. On at 12:30 PM the owner was informed that the facility accepted resident #3 who was not appropriate for ALF and after accepting the resident, it was found that he needed a higher level of care because in the text he acknowledge that the facility was trying to get hospice and home health. Additionally, the resident was assessed and admitted to a skilled nursing facility, because he required a higher level of care, this does not require the resident to provide a 30-day notice. He was informed that the proper assessment was not done, the 3008 that was completed for the nursing home admission in noted he was not ambulatory, and the facility would only have 1 staff working and the	A 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968681	A. BUILDING: _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCANY VILLA	8562 WINDER WAY MELBOURNE, FL 32940

(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 168	Continued From page 10 resident required a 2 person assist with transfers. The owner confirmed the findings and said the facility would provide a refund. An interview at 12:45 PM with the caregiver B, who worked at the facility during the time resident #3 resided there said resident #3 refused to get out of bed while at the facility. The owner said at the time that he and his wife offered to come to the facility to assist with getting the resident in and out of bed and he refused. On documentation was received via email for the nursing home's admissions director where resident #3 currently resides that noted: On , The emergency contact informed her that the resident was transferred to the ALF, and on the same day the owner informed her they would be unable to care for him and she would need to place him elsewhere. She gave her the phone number of the ALF so she could arrange a visit to evaluate the patient. The admission's director visited resident #3 and discussed his transfer to the skilled nursing facility. She noted after reviewing his History and Physical and evaluating the resident at the facility, he was deemed appropriate for a Skilled Nursing Facility (SNF) placement and accepted to admit. On at 1 PM, the owner confirmed the findings. Class	A 168		