

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE WEKIWA SPRINGS

**203 S WEKIWA SPRINGS ROAD
APOPKA, FL 32703**

(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 The re-licensure survey with Limit Nursing Services, generator and control monitoring were conducted at Brookdale Wekiwa Springs Assisted Living Facility on Deficiencies were identified at the time of survey.	A 000		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff	A 056		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2020
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703		
(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 056	Continued From page 1 who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxed, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2020
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703		
(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 056	Continued From page 2 the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to make every reasonable effort to ensure a prescription was filled in a timely manner for 2 of 5 sampled residents (#3 and #4) who received assistance with medications. Findings: Resident #3's 1823, dated _____, indicated the resident required assistance with self-administered medications. Review of the resident's _____ and _____ Medication Observation Records (MORs) revealed an entry for _____ 20 milligrams (mg,) 1 tablet by _____ every twelve hours for _____. The code 09 was charted for the doses on through _____ through _____ and _____ through _____. The key on the MOR indicated that 09 meant "other/see nurse's notes" however, there was no documentation on either the MOR or in the nurse's notes to indicate why 09 was charted. Review of the _____ count	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE WEKIWA SPRINGS

**203 S WEKIWA SPRINGS ROAD
APOPKA, FL 32703**

(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 056	Continued From page 3 sheets also revealed there was no documentation to indicate the medication was signed as given on those dates. At 4:35 p.m. on _____ the DON confirmed the findings and said code 09 meant the resident ran out of the medication. Resident #4's 1823, dated _____, indicated the resident required assistance with self-administered medications. Review of the resident's _____ MOR revealed an entry for 40 mg by _____ daily for _____. Code 09 was charted for the doses on _____ through _____. A facility note, dated _____, indicated the was called in to a pharmacy on that day. A facility note, dated _____, indicated the pharmacy was called to find out the status of a prescription faxed on _____ and the pharmacy staff said it was filled on _____ and it was awaiting pick up by the family. The notes nor the MOR contained additional documentation to indicate the facility made any efforts prior to the resident running out of the _____ on _____ and none to indicate the facility contacted the resident's family to discuss the filled prescription. At 4:59 p.m. on _____, the DON confirmed the findings and said she believed the staff did contact the family but had not documented their efforts.	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11695474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2020
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS		STREET ADDRESS, CITY, STATE, ZIP CODE 203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703		
(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 056	Continued From page 4 Class III	A 056		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011() FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents.	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE WEKIWA SPRINGS

**203 S WEKIWA SPRINGS ROAD
APOPKA, FL 32703**

(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 081	Continued From page 5 (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to blood borne pathogens, may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE WEKIWA SPRINGS

**203 S WEKIWA SPRINGS ROAD
APOPKA, FL 32703**

(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 081	Continued From page 6 receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to have evidence that 2 of 5	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2020
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703		
(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 081	Continued From page 7 sampld staff (B and C) received the required in-service training. Findings: 1. On _____ at 11:45 AM, staff B, a caregiver, said she was hired by the facility on _____. She said she previously had worked at another facility owned by the same company. Personnel record review for staff B, a caregiver hired _____ revealed the following training certificates were signed by the facility's business office manager as the instructor and that the training location was Brookdale Wekiwa Springs and was 9 months prior to her hire date as follows: _____ control on _____ -1 hour Major adverse incidents and emergency procedures _____ -1 hour Resident Behaviors, Needs and assisting with ADL's- _____ -3 hours _____, Neglect and _____, resident rights- _____ -1 hour Elopement- _____ 2019-1 hour Safe Food Handling _____ -1 hour was signed by the dining services manager as the instructor and the location was Brookdale Wekiwa Springs. On _____ at 4 PM, the business office manager said staff B, worked for one of the company's other facility. She said when staff B began employment with Brookdale Wekiwa Springs, she used the transcript of the other facility where staff B use to work and took the dates of it and made the certificates that were dated in _____. She said she did not provide the training and the training was not taken at Brookdale Wekiwa Springs as she noted on the	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE WEKIWA SPRINGS

**203 S WEKIWA SPRINGS ROAD
APOPKA, FL 32703**

(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 081	Continued From page 8 certificates. She said she had no other documentation to provide to confirm that the staff had received the above training to include the facility's specific training. 2. At 1:18 p.m. on _____, certified nursing assistant (CNA) C said she transferred to this facility from a sister facility. Review of her personnel record revealed a hire dated of _____. The record contained certificates of training, signed by the business office manager, dated prior to her transfer and given at the sister facility on the topics of resident elopement, facility emergency procedures and reporting major adverse incidents. The record did not contain documented evidence to indicate she received training specific to this facility, as required. At 4 p.m. on _____, the business office manager confirmed the findings, said she used the transcript of the other facility to create the certificates, she did not provide the trainings and she was unable to provide additional documentation. Class III	A 081		
A 082 SS=D	59A-36.011(4) FAC Training - / . . . (4) _____ _____. Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on _____, including the topics prescribed in the section 381.0035, F.S. New facility staff must	A 082		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE WEKIWA SPRINGS

**203 S WEKIWA SPRINGS ROAD
APOPKA, FL 32703**

(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 082	Continued From page 9 obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview the facility failed to ensure 2 of 5 sampled employees (B and C) completed a one-time education course on _____ and _____ within 30 days of employment. Findings: 1. Review of CNA C's personnel record revealed a hire date of _____. The record did not contain documented evidence to indicate she completed a one-time education course on _____ and _____, as required. At 4 p.m. on _____, the business office manager confirmed the findings and was unable to provide additional documentation. 2. On _____ at 11:45 AM, staff B, a caregiver, said she was hired by the facility on _____. She said she previously had worked at another facility owned by the same company. Personnel record review for staff B, a caregiver hired _____ revealed the _____ training certificate was dated _____ (signed 9 months before hire) and was signed by the facility's business office manager as the instructor and that the training location was Brookdale Wekiwa Springs. On _____ at 4 PM, the business office manager said staff B, worked for one of the	A 082		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2020
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703		
(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 082	Continued From page 10 company's other facility. She said when staff B began employment with Brookdale Wekiwa Springs, she used the transcript of the other facility where staff B use to work and took the dates of it and made the certificate. She said she did not provide the training and the training was not taken at Brookdale Wekiwa Springs as she noted on the certificates. She said she had no other documentation to provide to confirm that the staff had received the above training. Class III	A 082			
A 090 SS=D	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding _____ within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview the facility failed to have evidence that 2 of 5 sampled staff (B and C) had at least one hour of training in the facility's policies and procedures regarding _____ (_____s)	A 090			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE WEKIWA SPRINGS

**203 S WEKIWA SPRINGS ROAD
APOPKA, FL 32703**

(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 090	Continued From page 11 that included information in Rule 59 A-5.0186, F.A.C. within 30 days after employment. Findings: 1. On _____ at 11:45 AM, staff B, a caregiver, said she was hired by the facility on _____. She said she previously had worked at another facility owned by the same company. Personnel record review for staff B, a caregiver hired _____ revealed the _____ training certificate was dated _____ (signed 9 months before hire) and was signed by the facility's business office manager as the instructor and that the training location was Brookdale Wekiva Springs. On _____ at 4 PM, the business office manager (BOM) said staff B, worked for one of the company's other facility. She said when staff B began employment with Brookdale Wekiva Springs, she used the transcript of the other facility where staff b use to work and took the dates of it and made the certificate. She said she did not provide the training and the training was not taken at Brookdale Wekiva Springs as she noted on the certificates. She said she had no other documentation to provide to confirm that the staff had received the above training. 2. Review of CNA C's personnel record revealed a hire date of _____. The record did not contain documented evidence to indicate she received at least one hour of training in the facility's policies and procedures regarding _____.	A 090		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE WEKIWA SPRINGS

**203 S WEKIWA SPRINGS ROAD
APOPKA, FL 32703**

(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 090	Continued From page 12 At 4 p.m. on, the BOM confirmed the findings and was unable to provide additional documentation. Class III	A 090		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE WEKIWA SPRINGS

**203 S WEKIWA SPRINGS ROAD
APOPKA, FL 32703**

(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 The re-licensure survey with Limit Nursing Services, generator and control monitoring were conducted at Brookdale Wekiwa Springs Assisted Living Facility on Deficiencies were identified at the time of survey.	A 000		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff	A 056		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2020
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703		
(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 056	Continued From page 1 who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxed, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2020
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703		
(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 056	Continued From page 2 the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to make every reasonable effort to ensure a prescription was filled in a timely manner for 2 of 5 sampled residents (#3 and #4) who received assistance with medications. Findings: Resident #3's 1823, dated , indicated the resident required assistance with self-administered medications. Review of the resident's , and . . . Medication Observation Records (MORs) revealed an entry for , 20 milligrams (mg,) 1 tablet by . . . every twelve hours for , . The code 09 was charted for the doses on through . . . through . . . through . . . and . . . through . . . The key on the MOR indicated that 09 meant "other/see nurse's notes" however, there was no documentation on either the MOR or in the nurse's notes to indicate why 09 was charted. Review of the . . . count	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE WEKIWA SPRINGS

**203 S WEKIWA SPRINGS ROAD
APOPKA, FL 32703**

(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 056	Continued From page 3 sheets also revealed there was no documentation to indicate the medication was signed as given on those dates. At 4:35 p.m. on _____ the DON confirmed the findings and said code 09 meant the resident ran out of the medication. Resident #4's 1823, dated _____, indicated the resident required assistance with self-administered medications. Review of the resident's _____ MOR revealed an entry for 40 mg by _____ daily for _____. Code 09 was charted for the doses on _____ through _____. A facility note, dated _____, indicated the was called in to a pharmacy on that day. A facility note, dated _____, indicated the pharmacy was called to find out the status of a prescription faxed on _____ and the pharmacy staff said it was filled on _____ and it was awaiting pick up by the family. The notes nor the MOR contained additional documentation to indicate the facility made any efforts prior to the resident running out of the _____ on _____ and none to indicate the facility contacted the resident's family to discuss the filled prescription. At 4:59 p.m. on _____, the DON confirmed the findings and said she believed the staff did contact the family but had not documented their efforts.	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11695474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2020
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703		
(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 056	Continued From page 4 Class III	A 056			
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011() FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents.	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2020
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703		
(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 081	Continued From page 5 (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to blood borne pathogens, may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE WEKIWA SPRINGS

**203 S WEKIWA SPRINGS ROAD
APOPKA, FL 32703**

(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 081	Continued From page 6 receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to have evidence that 2 of 5	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2020
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703		
(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 081	Continued From page 7 sampld staff (B and C) received the required in-service training. Findings: 1. On _____ at 11:45 AM, staff B, a caregiver, said she was hired by the facility on _____. She said she previously had worked at another facility owned by the same company. Personnel record review for staff B, a caregiver hired _____ revealed the following training certificates were signed by the facility's business office manager as the instructor and that the training location was Brookdale Wekiwa Springs and was 9 months prior to her hire date as follows: _____ control on _____ -1 hour Major adverse incidents and emergency procedures _____ -1 hour Resident Behaviors, Needs and assisting with ADL's- _____ -3 hours _____, Neglect and _____, resident rights- _____ -1 hour Elopement- _____ 2019-1 hour Safe Food Handling _____ -1 hour was signed by the dining services manager as the instructor and the location was Brookdale Wekiwa Springs. On _____ at 4 PM, the business office manager said staff B, worked for one of the company's other facility. She said when staff B began employment with Brookdale Wekiwa Springs, she used the transcript of the other facility where staff B use to work and took the dates of it and made the certificates that were dated in _____. She said she did not provide the training and the training was not taken at Brookdale Wekiwa Springs as she noted on the	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2020
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703		
(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 081	Continued From page 8 certificates. She said she had no other documentation to provide to confirm that the staff had received the above training to include the facility's specific training. 2. At 1:18 p.m. on _____, certified nursing assistant (CNA) C said she transferred to this facility from a sister facility. Review of her personnel record revealed a hire dated of _____. The record contained certificates of training, signed by the business office manager, dated prior to her transfer and given at the sister facility on the topics of resident elopement, facility emergency procedures and reporting major adverse incidents. The record did not contain documented evidence to indicate she received training specific to this facility, as required. At 4 p.m. on _____, the business office manager confirmed the findings, said she used the transcript of the other facility to create the certificates, she did not provide the trainings and she was unable to provide additional documentation. Class III	A 081			
A 082 SS=D	59A-36.011(4) FAC Training - / . . . (4) _____ _____. Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on _____, including the topics prescribed in the section 381.0035, F.S. New facility staff must	A 082			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE WEKIWA SPRINGS

**203 S WEKIWA SPRINGS ROAD
APOPKA, FL 32703**

(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 082	Continued From page 9 obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview the facility failed to ensure 2 of 5 sampled employees (B and C) completed a one-time education course on _____ and _____ within 30 days of employment. Findings: 1. Review of CNA C's personnel record revealed a hire date of _____. The record did not contain documented evidence to indicate she completed a one-time education course on _____ and _____, as required. At 4 p.m. on _____, the business office manager confirmed the findings and was unable to provide additional documentation. 2. On _____ at 11:45 AM, staff B, a caregiver, said she was hired by the facility on _____. She said she previously had worked at another facility owned by the same company. Personnel record review for staff B, a caregiver hired _____ revealed the _____ training certificate was dated _____ (signed 9 months before hire) and was signed by the facility's business office manager as the instructor and that the training location was Brookdale Wekiwa Springs. On _____ at 4 PM, the business office manager said staff B, worked for one of the	A 082		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/15/2020
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703		
(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 082	Continued From page 10 company's other facility. She said when staff B began employment with Brookdale Wekiwa Springs, she used the transcript of the other facility where staff B use to work and took the dates of it and made the certificate. She said she did not provide the training and the training was not taken at Brookdale Wekiwa Springs as she noted on the certificates. She said she had no other documentation to provide to confirm that the staff had received the above training. Class III	A 082			
A 090 SS=D	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding _____ within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview the facility failed to have evidence that 2 of 5 sampled staff (B and C) had at least one hour of training in the facility's policies and procedures regarding _____ (_____s)	A 090			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE WEKIWA SPRINGS

**203 S WEKIWA SPRINGS ROAD
APOPKA, FL 32703**

(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 090	Continued From page 11 that included information in Rule 59 A-5.0186, F.A.C. within 30 days after employment. Findings: 1. On _____ at 11:45 AM, staff B, a caregiver, said she was hired by the facility on _____. She said she previously had worked at another facility owned by the same company. Personnel record review for staff B, a caregiver hired _____ revealed the _____ training certificate was dated _____ (signed 9 months before hire) and was signed by the facility's business office manager as the instructor and that the training location was Brookdale Wekiva Springs. On _____ at 4 PM, the business office manager (BOM) said staff B, worked for one of the company's other facility. She said when staff B began employment with Brookdale Wekiva Springs, she used the transcript of the other facility where staff b use to work and took the dates of it and made the certificate. She said she did not provide the training and the training was not taken at Brookdale Wekiva Springs as she noted on the certificates. She said she had no other documentation to provide to confirm that the staff had received the above training. 2. Review of CNA C's personnel record revealed a hire date of _____. The record did not contain documented evidence to indicate she received at least one hour of training in the facility's policies and procedures regarding _____.	A 090		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE WEKIWA SPRINGS

**203 S WEKIWA SPRINGS ROAD
APOPKA, FL 32703**

(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 090	Continued From page 12 At 4 p.m. on, the BOM confirmed the findings and was unable to provide additional documentation. Class III	A 090		