**AGENCY FOR HEALTH CARE ADMINISTRATION**

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11965474 | R |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BROOKDALE WEKIWA SPRINGS** | **203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703** |

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

**0000 Initial Comments**

Revisit was conducted on 02/03/2016. Brookdale Wekewa Springs had deficiencies at the time of the visit.

**0008 Admissions - Health Assessment**

DEFICIENCY REMAINED UNCORRECTED
Based on record review and interview, the facility failed to obtain a corrected health assessment (AHCA Form 1823) for Resident #1.

Finding:

Resident#1's record review revealed the facility had not yet obtained an updated AHCA 1823 with all required information. The facility had provided the most current AHCA Form 1823 dated which indicated that the resident needed total assistance with all activities of daily living (ADL). Further review showed the assessment had not indicated whether or not the resident needed help with medications.

The acting executive director stated at 12:35 p.m. on the AHCA 1823, dated was completed after the resident returned from a hospital. Currently, the resident did not need "total" assistance with all ADL anymore. She confirmed that the facility needed to update a health assessment for Resident#1.

Class III

**0165 Risk Mgmt & QA: Adverse Incident Report**

DEFICIENCY REMAINED UNCORRECTED.
Based on record review and interview, the facility had not submitted an adverse incident report when a resident (#1) had a of undermined origin.

Findings:

Facility record review conducted on revealed the facility had not yet submitted an adverse incident report regarding Resident #1's lower leg of undetermined origin that happened in 2015.

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11965474 | R |
| NAME OF PROVIDER OR SUPPLIER<br>**BROOKDALE WEKIWA SPRINGS** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**203 S WEKIWA SPRINGS ROAD**<br>**APOPKA, FL 32703** | |

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

Interview on at 12:35 p.m. the current executive director confirmed the facility had not submitted an adverse incident report regarding Resident#1's .

Class III

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| AL11965474 Y1 | A. Building<br>B. Wing Y2 | Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE WEKIWA SPRINGS | 203 S WEKIWA SPRINGS ROAD<br>APOPKA, FL 32703 |

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix A0025 | Correction | ID Prefix A0078 | Correction | ID Prefix AN277 | Correction |
| Reg. # 429.26(7) FS; 58A-5.0182(1) FAC | Completed | Reg. # 58A-5.019(2) FAC | Completed | Reg. # 58A-5.031(2) FAC | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix AN278 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # 58A-5.031(3) FAC | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE 8/28/16 | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| REVIEWED BY CMS RO ☐ | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |

| FOLLOWUP TO SURVEY COMPLETED ON | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? |
|---|---|
| 8/31/2015 | ☐ YES ☐ NO |

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

', 2016

Administrator
Brookdale Wekiwa Springs
203 S Wekiwa Springs Road
Apopka, FL 32703

RE: Revisit to #2015005613

Dear Administrator:

This letter reports the findings of a complaint revisit survey conducted on 3, 2016by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

BBT7

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