RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Willow Brook
1580 South Marion Avenue
Lake City, FL 32025

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative(s) of this office.

Enclosed is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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(s). Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Charles Bourg for

Kriste J. Mennella
Field Office Manager

KJM/amw
Enclosure

XG90

Alachua Field Office
14101 N.W Hwy 441, Suite 800
Alachua, FL 32615-5669
Phone:(386) 462-6201; Fax:(386) 418-5300
AHCA.MyFlorida.com

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965555	06/29/2016
NAME OF PROVIDER OR SUPPLIER **WILLOW BROOK**	STREET ADDRESS, CITY, STATE, ZIP CODE **1580 SOUTH MARION AVENUE** **LAKE CITY, FL 32025**	

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

0000 Initial Comments

On [redacted], 2016 through [redacted], 2016, a Biennial Licensure with Extended Congregate Care (ECC) Survey was conducted at Willow Brook (facility license number 9909). Deficient practice was identified. The facility was not in compliance at this time.

0008 Admissions - Health Assessment

Based on record review and interview, the facility failed to obtain omitted information for 1 of 2 residents' (Resident #10) Resident Health Assessment (AHCA Form 1823).

Findings:

On [redacted], a record review was conducted on Resident #10's Resident Health Assessment (AHCA Form 1823), dated [redacted]. It was observed that page 1. was missing height, weight and name. Page 2. was missing comments for Activities of Daily Living. Page 4. was missing whether the resident needed help with the medication or not.

On [redacted] at approximately 11:00 AM, the Administrator stated she did not know that required information was omitted from Resident #10's 1823.

Class III

0010 Admissions - Continued Residency

Based on record review and interview, the facility failed to have an interdisciplinary care plan, signed by facility staff, for 1 of 14 sampled residents (Resident #1); and, the facility failed to update the Resident Health Assessment (AHCA Form 1823) for 1 of 14 sampled residents (Resident #1), for a change in condition.

Findings:

1.) On [redacted], a record review was conducted of Resident #1's Interdisciplinary (IDT) care plan, dated [redacted], which revealed that no facility staff signatures were present on the care plan.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965555	06/29/2016
NAME OF PROVIDER OR SUPPLIER **WILLOW BROOK**	STREET ADDRESS, CITY, STATE, ZIP CODE **1580 SOUTH MARION AVENUE** **LAKE CITY, FL 32025**	

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

During an interview on at 3:30 PM with the Administrator, she stated that the facility staff has never met with the hospice staff to discuss Resident #1's plan of care. The Administrator confirmed the IDT care plan did not contain any signatures from the facility staff. The Administrator also confirmed that none of the typed names on the IDT form contained signatures.

2.) On , a review of Resident #1's Resident Health Assessment (AHCA Form 1823), dated / / , showed no documentation that the resident is currently receiving hospice care, and further, it showed the resident documented as being independent with and toileting, while requiring supervision or assistance with ambulation and dressing.

During an interview on at 3:30 PM with the Administrator, she stated that she was not aware that Resident #1's primary care physician had to complete a new 1823 for a significant change in the resident's condition to include that the resident now requires hospice care. The Administrator confirmed that the Resident Health Assessment, dated / / , is the current Resident Health Assessment for Resident #1.

Class III

0025 Resident Care - Supervision

Based on observation, record review, and interview, the facility failed to ensure the physician was notified of a significant weight loss for 1 of 14 sampled residents (Resident #1).

Findings:

An observation of Resident #1 on at 10:30 AM revealed the resident was lying in bed. The resident was very thin in appearance.

On , a review of Resident #1's weight record showed that the resident was weighed daily since his return to the facility on . On / , the resident's weight was 145 pounds; and, on , the resident's weight was 108 pounds. Review of Resident #1's nursing progress notes did not show documentation that the resident's physician was notified of a significant weight loss. Review of Resident #1's Interdisciplinary (IDT) care plan did not show that any interventions were in

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965555	06/29/2016
NAME OF PROVIDER OR SUPPLIER **WILLOW BROOK**	STREET ADDRESS, CITY, STATE, ZIP CODE **1580 SOUTH MARION AVENUE** **LAKE CITY, FL 32025**	

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

place to address the resident's significant weight loss.

During an interview on at 3:30 PM with the Administrator, she stated the physicians come to the facility once a month to see the residents and review the resident's records for their weights. The Administrator confirmed there was no documentation in Resident #1's chart to show that the facility's nursing staff had notified the resident's physician of a significant weight loss. She confirmed there is also no documentation on the resident's care plan of any interventions in place to address the resident's significant weight loss.

During an interview on at 4:05 PM with the Licensed Practical Nurse (LPN), she stated she had never reported to Resident #1's primary care physician that the resident had a significant weight loss in the two and a half months that she has been working at the facility. The LPN stated hospice usually takes care of the residents weights and vital signs.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on interview and record review, the facility failed to ensure that 1 of 3 staff (Staff C) completed the required 2 hour annual assistance with self-administration of medication updated training.

Findings:

On at approximately 2:19 PM an interview was conducted with Staff C. She was asked if she assists residents with self-administration of medication and she stated, "Yes."

On a record review was conducted on Staff C's medication training. It was observed that Staff C took her initial 4 hours of assistance with self-administration of medication training on . There was no documentation that Staff C had taken the required 2 hours of updated training for assistance with self-Administration of medications.

On at approximately 9:38 AM, the Administrator stated she could not find any documentation

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965555	06/29/2016
NAME OF PROVIDER OR SUPPLIER **WILLOW BROOK**	STREET ADDRESS, CITY, STATE, ZIP CODE **1580 SOUTH MARION AVENUE** **LAKE CITY, FL 32025**	

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

that Staff C has taken the required 2 hours of annual updated assistance with self-administration of medication training.

Class III

E207 ECC - Services

Based on record review and interview, the facility failed to ensure physician's orders were obtained to start a resident on needed Extended Congregate Care (ECC) services for 1 of 14 sampled residents (Resident #1).

Findings:

On , a review of Resident #1's clinical record revealed the resident was not receiving ECC services. The resident is no longer able to perform her Activities of Daily Living (ADLs) care independently or with minimum assistance.

During an interview on at 2:13 PM with Resident #1's day shift Certified Nursing Assistant (CNA), she stated the resident requires a lot of assistance some days with her care; such as providing total care for bathing, , toileting, eating. Some days she can assist the facility staff with her Activities of Daily Living (ADLs) such as bathing, , and feeding herself. The resident can stand and pivot and get into her wheelchair with staff assistance of two (2). The resident is not capable of getting out of the bed without staff assistance. The resident is not capable of walking. About 6 weeks ago, the resident was walking with a walker but now she uses the wheelchair. The resident is not capable of toileting herself, she requires staff assistance. The facility does not have an evening or night shift Licensed Practical Nurse (LPN). The LPN goes home at 3:00 PM. If the resident has to have her put on or taken off, the CNA's does it. If the resident's bag comes off, the CNA applies a new one.

During an interview on at 3:20 PM with the evening shift CNA, she stated, when asked about the use by Resident #1, that she or the CNA that is assigned to that hallway applies the resident's . The resident is not able to put her on or remove it by herself. The

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965555	**06/29/2016**
NAME OF PROVIDER OR SUPPLIER **WILLOW BROOK**	STREET ADDRESS, CITY, STATE, ZIP CODE **1580 SOUTH MARION AVENUE LAKE CITY, FL 32025**	

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

CNA stated that she usually changes the resident's wafer on her bag and provides the resident's care, including emptying the bag. The resident is not able to do her own care. The resident used to be very independent until about 6 months ago. In the last four to six weeks, the resident's health has rapidly declined and she is no longer able to assist in the basic ADL care, like going to the , dressing or feeding herself. The resident is a 2 person assist with ADLs.

During an interview on at 3:30 PM with the Administrator, regarding Resident #1, she stated the resident's care is being provided by the CNA's after the LPN goes home. The resident is not currently receiving ECC services.

Class III