RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

[redacted], 2016

Administrator
Brookdale Tuskawilla
1016 Willa Springs Drive
Winter Springs, FL 32708

RE: Revisit to #2016005443

Dear Administrator:

This letter reports the findings of a complaint investigation revisit survey conducted on [redacted] 29, 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 [redacted], 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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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964388	R
NAME OF PROVIDER OR SUPPLIER **BROOKDALE TUSKAWILLA**	STREET ADDRESS, CITY, STATE, ZIP CODE **1016 WILLA SPRINGS DRIVE** **WINTER SPRINGS, FL 32708**	

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

0000 Initial Comments

A revisit to a complaint investigation (CCR 2016005443) was conducted at Brookdale Tuskawilla license #8985 on / . Brookdale Tuskawilla had deficiencies at the time of the visit.

0010 Admissions - Continued Residency

Revisit conducted. Deficiency A- 0010 remained uncorrected.
Based on record review and interview, the facility failed to ensure that 1 of 6 residents (#1) had a face-to-face medical examination by a health care provider recorded on a health assessment form (1823) after the resident experienced a significant change.

Findings:
Record review for resident #1 revealed an 1823 health assessment form dated / .
Continued review revealed she was admitted to hospice services, a significant change, on with no evidence to confirm that an updated 1823 health assessment form had been obtained from her health care provider upon her admission to hospice.
During an interview with the wellness director on at 1:45 PM, she said her physician came to the facility briefly on but he had not faxed the 1823 assessment form.
Class III

0054 Medication - Records

Revisit conducted. Deficiency A- 0054 remained uncorrected.

Based on record review and interview the facility did not keep an up to date Medication Observation Record (MOR) for 2 of 6 sampled residents (#2 & #3).

Findings:

The 2016 MOR for resident #3 listed 200 mg daily and 50 micrograms (mcg) nasal spray twice daily. On , the 8:00 PM dose of had been signed and indicated 'not completed,' 'within normal range' and on , the 9:00 PM dose of had been signed and indicated 'not completed,' 'within normal range.'
During an interview with the wellness director on / at 3:15 PM, she said he received the medication and "I just think she clicked the wrong thing, we've been having a problem with sigma care."
The 2016 MOR for resident #2 listed 2.5 milligrams (mg) daily. On , the 8:00 AM dose had been signed and indicated 'not completed', "held per physician order."

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964388	R
NAME OF PROVIDER OR SUPPLIER **BROOKDALE TUSKAWILLA**	STREET ADDRESS, CITY, STATE, ZIP CODE **1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708**	

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

Review of her record revealed no evidence of a health care provider order to hold the medication. During an interview with the wellness director on / at 3:30 PM, she said she believed the medication had been given to the resident but the staff member chose the wrong option on the electronic MOR.

Class III

0056 Medication - Labeling and Orders

/ Revisit conducted. Deficiency A- 0056 remained uncorrected.

Based on record review and interview, the facility did not make every reasonable effort to ensure prescriptions were filled or refilled in a timely manner for 1 of 6 sampled residents who received assistance with their medications (#3).

Findings:

Record review for resident #3 revealed he required assistance with self-administration of his medications. His 2016 Medication Observation Record (MOR) listed Multi- once daily and indicated "not completed," "awaiting prescription refill" on , / , , , , , , , , .

During an interview with the wellness director on at 2:05 PM, she said "they are waiting on a refill."

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11964388 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE TUSKAWILLA	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

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 A0053 Reg. # 58A-5.0185(4) FAC LSC	Correction Completed	ID Prefix A0079 Reg. # 58A-5.019(3) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** [signature]	**DATE** 10/11/16	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 8/3/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			