STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964388	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE TUSKAWILLA	**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 the re-licensure survey with Limited Nursing Services (LNS) was completed on / in conjunction with complaint investigation #2016003805. Brookdale Tuskawilla, license # 8985, had a deficiency at the time of the visit.

0025 Resident Care - Supervision

revisit conducted deficiency A-025 remained uncorrected.
Based on observations, record review and interview the facility failed to ensure it provided care and services appropriate to the needs of 1 of 6 sampled residents (5) and did not give the resident his medications as ordered by the healthcare provider.

Findings:
Resident record review for resident #5 revealed a health assessment report dated that listed diagnoses of , , and . She needed assistance with self-administration of medications. A healthcare provider order dated / / indicated XL 24-hour extended release give 300 milligrams daily. The 2016 Medication Observation Record (MOR) listed XL 24-hour extended release give 300 milligrams daily @ 9PM. The MOR indicated a start date of . The medication was marked as given on / and / . On , , , and not completed. On and the MOR documented the medication was not given because it was awaiting a prescription refill. The MOR indicated that 8 pills had been taken /given to the resident. Observations on the medication container on at 2 PM noted a bubble pack with a prescription label dated that indicated XL 24-hour extended release give 300 milligrams daily and 30 pills were dispensed and 7 pills were used and 23 were available. Had the medication been given according to the healthcare provider's order there should have been 12 pills used and 18 available.
In an interview on at 3 PM with the health and wellness director, a Licensed Practical Nurse who said the staff had been in-serviced about medication practices and most likely overlooked the medication.
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 A0078	Correction	ID Prefix A0081	Correction	ID Prefix A0082	Correction
Reg. # 58A-5.019(2) FAC	Completed	Reg. # 58A-5.0191(2) FAC	Completed	Reg. # 58A-5.0191(3) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0091	Correction	ID Prefix A0152	Correction	ID Prefix A0162	Correction
Reg. # 58A-5.0191(12) FAC	Completed	Reg. # 58A-5.023(3) FAC	Completed	Reg. # 58A-5.024(3) FAC	Completed
LSC		LSC		LSC	
ID Prefix AN277	Correction	ID Prefix AZ814	Correction	ID Prefix	Correction
Reg. # 58A-5.031(2) FAC	Completed	Reg. # 435.12(2)(b-d), FS	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 10/14/16	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? ☐ YES ☐ NO
8/3/2016	

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

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

RE: Revisit to Re-licensure survey with LNS

Dear Administrator:

This letter reports the findings of a revisit survey conducted on 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 , 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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