STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964388	**11/08/2017**
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

Complaint Investigation #2017009219 was conducted on . Brookdale Tuskawilla, License #8985, had deficiencies at the time of the visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the facility failed to obtain an complete and accurate resident health assessment (AHCA form 1823) every 3 years for 1 of 4 sampled residents (#1), and at admission for 1 of 4 sampled residents (#2).

Findings:
1. Resident #1's record revealed an Resident Health Assessment (1823) that was dated . The next 1823 was due .

The 1823, dated , did not have the type of assistance the resident required with dressing, , eating, toileting. They were all left blank. The 1823 form did not indicate if the resident had a communicable that could be transmitted to other residents or staff, and whether she required 24 hours nursing or care. Those sections were also left blank

An updated 1823, completed on , did not have the type of assistance the resident required with dressing, , eating, toileting. They were all left blank. The 1823 did not indicate if the resident had a communicable that could be transmitted to other residents or staff and whether she required 24 hours nursing or care. Those sections were also left blank. The section for the health care provider to document the type of assistance she required with her medications were all left blank.

2. Resident #2's record revealed an admission 1823 that noted she required total care with ambulation, bathing, dressing, , toileting, transferring. All exceeded admission criteria for an Assisted Living Facility.
The 1823, dated and completed after a hospital visit, noted she required total care with ambulation, toileting and transferring.

On at 1 PM, the wellness director said resident #2 was not total care. She confirmed resident #1's 1823 was not completed every 3 years, and was missing information on both assessments.

Class III

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0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, medication observation record review (MOR), resident record review and interview, the facility did not provide care and services appropriate to meet the needs to ensure the safety through proactive measures to minimize the potential for and injuries for 1 of 4 sampled residents (#2) who was a risk, demonstrated behavioral issues, and did not provide as ordered by the health care provider for 1 of 4 sampled residents (#1).

Findings:
1. Resident #1's record revealed an order for dated that noted flexpen 100u/ml (unit. per milliliter) per sliding scale three times daily and coverage follows: 0-200-0 units; 201-250=2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units. Greater than 400 call doctor-need order.

On , there was an order change for the and coverage to be done twice daily.

Review of the MOR revealed at 7:30 AM and 4 PM on the MOR was blank. There was no way to determine whether or not the resident's sugar (BS) results were taken and if she required .

The MOR on noted the BS result was document as 219 at 4 PM. Two (2) units of were required and the nurse marked "0" was given.

The MOR revealed on at 8 AM, an "X" in the BS result space and the amount given space.

On at 11 AM, the wellness director confirmed the findings. She said the facility changed to a new electronic MOR system and in the nurse was not able to document the BS results timely, however it was taken.

2. Observations on at 10:15 with the wellness director revealed resident #2's door was closed. Upon entering the , the resident was found on the floor on her knees facing her wheel chair. She began to say "help me". The wellness director proceeded to help the resident to her bed.

On at 10:15 AM, the wellness director said the resident would sometimes throw herself on the floor or slide out of her wheelchair. She said the were more of a behavior issue.

Resident #2's record revealed she was admitted into the facility on . A resident health

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assessment form (1823), dated , noted diagnosis that included or behavior status was noted as: , and Special Precaution: Risk. The 1823 indicated the resident required assistance with ambulation, dressing, , eating, toileting and transferring. An updated 1823, dated , noted the resident required total care with ambulation, bathing, dressing, , toileting, transferring, and was a risk.
Another 1823, completed on after a hospital visit, noted she was total assistance with ambulation, toileting and transferring.

Record review revealed the resident had 10 since admission to the facility:
at 11 AM - rolled out of bed
at 12 PM - found on floor sent to emergency . At 2 PM resident returned
at 7:30 AM - resident out of wheel chair unwitnessed; resident lying face down in front of her wheelchair. 911 called and transported to hospital. Discharge paper showed head injury and ( )
at 1:45 PM - resident observed on floor stated, "I wanted to stand up and no one would help me so I threw myself on the floor." Resident was assessed. Resident was encouraged not to throw self on the floor. Resident will continue to be monitored
at 9:43 (AM/PM not noted) resident on floor in front of wheelchair - unwitnessed no injuries staff will monitor.
at AM - resident on floor in front of her wheelchair unwitnessed no injury
no time - resident out of wheelchair. It was unwitnessed she was on left side
no time - resident slid herself to the floor. No pain
at 8:445 AM - unwitnessed . Lying on kitchen floor on left side. said I heard patient hit the floor but I did not see her. Resident said "I threw myself on the floor. I hit my head and hip and they both hurt please help me." 911 was called.
no time - resident from wheelchair and hit head. Sent to hospital.

Record review did not reveal any facility documentation to confirm there were proactive measure to minimize the that resulted in injuries. The resident was a risk who was at times throwing herself out of her wheelchair.

On at 1:25 PM, staff A caregiver in the memory care unit said the resident would throw herself on the floor. She said it was probably attention seeking behavior. The resident who was in her the time said she was scared of the wheelchair and did not like to use it because she was scared.

Staff A was asked about the preventions in place to minimize the and behaviors. Staff A said they were to try to get to the resident quicker to prevent the and keep her outside where they could

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watch her. Staff A said you could sit and watch resident #2 slide down the wheelchair.

Staff B caregiver who worked in the memory care unit said on 11/ at 1:30 PM that physical , , ordered the high back chair as a prevention. She said the resident could slide down better with that type of chair. She said resident #2 would throw herself out of the chair for attention.

On at 1:45 PM, the wellness director said the resident would throw herself out of the wheel chair and they thought it was behavior more than her falling. The wellness director and the administrator were informed on at 2 PM, the resident had 10 incident not including the incident observed during the tour on , some resulting in hospital visits with a head injury. There were no proactive measures to prevent these noted, no documentation of what the facility was doing in conjunction with her health care provider regarding the behaviors, and no instructions provided to the caregivers on how to manage the resident's behaviors and to provide safety to the resident to avoid further injury.

On at 2 PM, the administrator and wellness director confirmed the findings.

Class II

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on electronic medication observation record (MOR) review and interview, the facility failed to maintain accurate MORs for 2 of 4 sampled residents (#1 & 2).

Findings:
Review of Resident #1's and Resident #2's MORs revealed blank spaces, and no notations documenting the reasons for the omissions as follows.

1. Resident #1:
table 10 milligrams (mg.) 1 in the evening, tablet 20 mg. 1 in the evening, 20 mg. 1 in the evening, and 10 mg. 1 at bed time were all left at 8 PM on and .

ProAir HFA Aerosol Solution 108 (90 base) 1 puff inhale 4 times a day was blank at 12 PM on , , and , and at 8 PM on and .

50 mg. 4 times a day was blank at 12 PM on , and , and at 8 PM on and .

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2. Resident #2:
, 15 mg. was blank at 9 PM on , , and .
, 5 mg. in the evening was blank at 8 PM on and .
, 0.25 mg. three times a day, 25-100 mg. give 0.5 three times a day were blank at 1 PM on .
, Aerosol Solution 20-100 microgram (mcg.) 1 inhalation four times a day was blank at 1 PM on and at 8 PM on and .

On at 1 PM, the wellness director confirmed the findings. She said the residents received their medication and the staff did not correctly input it in the electronic MOR system.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observations and interviews, the facility failed to provide and maintain a home-like and decent environment in which to provide a safe living environment for the residents of facility for 3 of 10 (24, 27 & 29).

Findings:
Observations during the tour of the memory care unit on at 10:10 AM revealed
1. A brown feces-like material smeared on the toilets seats in 24 and 27.

2. A large amount of brown feces-like material on the toilet seat and the inside of the toilet in .

The wellness director confirmed the findings at the time, and said resident #2 required assistance with toileting and the staff should have cleaned up behind her. She said the residents in and were capable of toileting without assistance, but staff should have checked on them after they used the make sure they were clean
On at 1:25 PM, observations of # revealed the toilet was in the same condition.

On at 1:30 PM, staff in the memory care unit who assisted the resident with toileting on in the morning said that if there was feces in the toilet, it was the housekeeping's responsibility to clean it. She said they would report it to house keeping and they would clean it. She said she was not told there was feces on the toilet in order to report it.

Class III