PRINTED: 01/31/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-039	
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01, 05	(X3) DATE SURVEY COMPLETED
	105872	B. WING		12/17/2019
IAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	

1024 WILLA SPRINGS DR TUSKAWILLA NURSING AND REHAB CENTER WINTER SPRINGS, FL 32708 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY E 000 Initial Comments E 000 During the recertification survey conducted on December 17, 2019 at Tuskawilla Nursing and Rehab Center, a nursing home in Winter Springs. Florida the Emergency Preparedness Program was reviewed. Tuskawilla Nursing and Rehab Center is not in compliance with the Emergency Preparedness rule per Code of Federal Regulations (CFR) 42, Part 483.73. Requirement for Long-Term Care Facilities. E 035 LTC and ICF/IID Sharing Plan with Patients F 035 1/26/20 SS=F CFR(s): 483.73(c)(8) *(For ICF/IIDs at §483,475(c):) ((c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal. State and local laws and must be reviewed and updated at least every 2 years.1 The communication plan must include all of the following: *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal. State and local laws and must be reviewed and updated at least annually.1 The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents for clients) and their families or representatives. This REQUIREMENT is not met as evidenced Based on interview and record review, the facility 1. No residents found to be affected by

LABORATORY DIRECTOR'S OR PROVIDER/SLIPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed 01/23/2020 Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 05			SURVEY LETED	
			71. 50/2,0		.,		
		105872	B. WING			12/	17/2019
NAME OF PE	ROVIDER OR SUPPLIER		_	5	TREET ADDRESS, CITY, STATE, ZIP CODE		
			11	024 WILLA SPRINGS DR			
TUSKAWII	LLA NURSING AND REH	AB CENTER		N	VINTER SPRINGS, FL 32708		
(X4) ID		ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATURY OR I	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		0
			-				
E 035	Continued From page	. 1	F	035			
		maintain an emergency	-	000	alleged deficient practice.		
		inication plan that complies			aneged denoisit practice.		
	with Federal. State an				2. Letter regarding facility emergency		
	communication plan r	nust include all of the			plans and what to expect in the event	of	
	following: (8) A metho	d for sharing information			an emergency sent to current		
		olan, that the facility has			residents/responsible party.		
		riate, with residents and					
		sentatives, per 483.73(c)(8)			Education to facility staff by		
	and 483.475(c)(9).				Administrator/designee regarding lette	r	
	Findings:				sent to residents/responsible party regarding emergency plans and what t		
	i nioniga.				expect in the event of an emergency.	Ü	
	During the review of r	ecords on December 17.			Letter regarding facility emergency pla	ns	
	2019 at approximatel				and what to expect in the event of an		
		ergency Preparedness plan			emergency placed in Facility Admissio	n	
	was reviewed for com	pliance. The method for			and Financial Agreement for new adm	its.	
		bout emergency plans with					
		resentatives could not be			Random monthly audits will be		
		he plan. Interview with the			conducted by Director of		
		time, revealed that the			Admissions/designee to validate that		
		ents were informed as part			emergency plan letter is included in		
		that is conducted for each station could be located for			Facility Admission and Financial Agreement. Results of audits will be		
		icate that the facility had			reviewed during QA&A Committee		
	developed a method				monthly for three months by Maintena	nce	
		the residents and their			Director/designee. QA&A Committee v		
	families.				review audits and make		
					recommendations based on outcomes		
	These findings were r				and will determine need for further		
		he exit conference at 2:30			auditing beyond three months.		
	p.m.						
	EAC 402 72/aVe) 40	2.475(a)(0)					
K 000	FAC 483.73(c)(8), 48: INITIAL COMMENTS		12	000			
K 000	INTIAL COMMENTS		*	JUU			
	An unannoumed Fire	& Life Safety recertification					
	An unannounced Fire	o or the Dalety recentlication	1				

survey was conducted on December 17, 2019 at Tuskawilla Nursing and Rehabilitation Center, a

Facility ID: 75909

		ID HUMAN SERVICES MEDICAID SERVICES			FORM): 01/31/2020 1 APPROVED): 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING 01, 0		(X3) DATE COMP	SURVEY
		105872	B. WING		12/	17/2019
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
TUSKAWI	LLA NURSING AND REH	AB CENTER	1 .	WILLA SPRINGS DR TER SPRINGS, FL 32708		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 900 K 914 SS=D	nursing home in Wint Tuskawilla Nursing at compilance with 42 C 488.307, and Nations (NFPA) 101 (2012 Ec nursing homes. Initial Plan Review: 1 NFPA 220 Constructi Number of Beds: 98 Census: 78 The facility was found time of this survey. Electrical Systems - 1 Hospital-grade recep locations and where	er Springs, Florida. Ind Rehabilitation is not in FFR 483 Subpart B, 42 CFR II Fire Protection Association littion) requirements for 1994 In on Type: II (222) In ot in compliance at the Maintenance and Testing Maintenance and Testing	K 000			1/26/20
	installation, replacem testing is performed a documented perform. Iisted as hospital-grae tested as intervals nisolation monitors (LII intervals of less than actuating the LIM tes which activates both LIM circuits with a	ent or servicing. Additional				

electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or

PRINTED: 01/31/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES CE STAT

DEPARTMENT OF HEALTH AND HUMAN SERVICES					
CENTERS FOR MEDICARE &	OMB NO. 0938-0391				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 05	(X3) DATE SURVEY COMPLETED		

			A. BUILDING C	11, 05	
		105872	B. WING		12/17/2019
NAME OF P	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				
			1	024 WILLA SPRINGS DR	
TUSKAWI	LLA NURSING AND REH	AB CENTER	١,	VINTER SPRINGS, FL 32708	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
K 914	Continued From page	3	K 914		
	area tested, and resu	lts			
	6.3.4 (NFPA 99)				
		is not met as evidenced			
	bv:				
	Based on observation	n and interview, the facility		1. No residents found to be affected by	,
	failed to follow its poli-	cy of annual electrical		alleged deficient practice. Plastic power	r
	testing. Per NFPA 99	Ch. 10.5.2.1.1, "The facility		strips removed immediately from beaut	у
	shall establish policies	s and protocols for the type		salon and beautician educated.	
	of test and intervals for	or testing for patient			
		equipment." And. NFPA 99		Audits completed by Guardian	
accordance with NFPA Findings:		s that "Installation shall be in		Angels/designee for power strips and n	
		A 70."		other issues noted. Maintenance Direct	tor
				audited patient-related electrical	
				equipment in therapy gym to ensure	
				testing was completed annually and	
		building on December 17,		electrical safety stickers current and in	
		y 1:00 p.m. the therapy gym electrical devices in the		tact. No other issues noted. Contractor	
		e observed. An electrically		conducted and passed electrical safety test on electrically operated table on	
		n therapy was observed to		January 2, 2020 and updated sticker	
	feature an electrical s			placed on equipment. Education	
		of 2017, a period of more		completed by Maintenance Director to	
		iew with the maintenance		facility staff regarding use of power strip	ne
		evealed that the inspection		not being allowed in facility. Education	
		and that the contractor may		Maintenance Staff by Administrator	
		ach a sticker. The written		regarding testing of patient care-related	1
		devices did not include a		electrical equipment to be completed o	
	recent inspection of the	ne table.		an annual basis and ensuring electrical	1
				safety stickers current and in tact.	
	At approximately 1:45	p.m. the beauty salon was			
	entered and the elect	rical connections were		3. Education to newly hired facility staff	
	observed. Two plastic	c power strips were		regarding use of power strips not being	
		neat producing devices		allowed in facility. Random weekly aud	its
	including a portable h	air dryer.		to be conducted by Guardian	
				Angels/designee for four weeks, then	
		h 10.5.2.1.1, NFPA 99 Ch		monthly thereafter to validate there are	
	6.3.2.1			power strips in assigned areas. Monthly	
				audits to be conducted by Maintenance)

Director/designee to validate

PRINTED: 01/31/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL(ER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01, 05 105872 R MING 12/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1024 WILLA SPRINGS DR TUSKAWILLA NURSING AND REHAB CENTER WINTER SPRINGS, FL 32708 SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 914 Continued From page 4 K 914 patient-related electrical equipment in therapy gym is completed annually and electrical safety stickers are in tact and current. 4. Results of audits will be reviewed during QA&A Committee monthly for three months by Maintenance Director/designee, QA&A Committee will review audits and make recommendations based on outcomes and will determine need for further auditing beyond three months.

PRINTED: 01/31/2020 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01, 05 B MING 75909 12/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1024 WILLA SPRINGS DR TUSKAWILLA NURSING AND REHAB CENTER WINTER SPRINGS, FL 32708 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 INITIAL COMMENTS K 000 An unannounced Fire & Life Safety re-licensure survey was conducted on December 17, 2019 at Tuskawilla Nursing and Rehabilitation Center, a nursing home in Winter Springs, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2015 Edition) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C.) 69A-3, F.A.C. 69A-53, F.A.C. 59A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2015 Edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. Tuskawilla Nursing and Rehabilitation Center was not in compliance at the time of survey. K 914 NFPA 99 Electrical Systems - Maintenance and K 914 1/26/20 SS=D Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed

testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per

locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 01/23/20 Electronically Signed

STATE FORM if continuation sheet 1 of 3 BR9K21

Agency f	or Health Care Adminis	tration				: 01/31/2020 I APPROVEI
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPE A. BUILDING:	E CONSTRUCTION 01, 05	(X3) DATE SURVEY COMPLETED		
		75909	B. WING		12/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
TUSKAWI	LLA NURSING AND REH	AB CENTER	LA SPRINGS D SPRINGS, FL			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
K 914	electric distribution sy maintained of require repairs or modification area tested, and resu consistence of the state of t	pair or renovation to the stem. Records are of tests and associated ns, containing date, room or its. is not met as evidenced by: and interview, the facility cy of annual electrical Ch. 10.5.2.1.2, "All patient equipment shall be tested 23.5.3" And. NFPA 99 Ch at "Installation shall be in A 70." building on December 17, y 1:00 p.m. the therapy ym electrical devices in the e observed. An electrically on therapy was observed to	K914	1. No residents found to be affected to alleged deficient practice. Plastic powstrips removed immediately from bea salon and beautician educated. 2. Audits completed by Guardian Angels/designee for power strips and other issues noted. Maintenance Dire audited patient-related electrical equipment in therapy gym to ensure testing was completed annually and electrical safety stickers current and it tact. No other issues noted. Contract conducted and passed electrical safet test on electrically operated table on January 2, 2020 and updated sticker placed on equipment. Education completed by Maintenance Director it on government.	no ector	

AHCA Form 3020-0001

director, at that time revealed that the inspection

have neglected to attach a sticker. The written

inventory of electrical devices did not include a

At approximately 1:45 p.m. the beauty salon was entered and the electrical connections were

NFPA 70. NFPA 99 Ch 10.5.2.1.2. 10.3.5.3. NFPA

observed. Two plastic power strips were observed to connect heat producing devices

recent inspection of the table.

including a portable hair dryer.

interval was one year and that the contractor may

not being allowed in facility. Education to

regarding testing of patient care-related

electrical equipment to be completed on

an annual basis and ensuring electrical safety stickers current and in tact.

3. Education to newly hired facility staff regarding use of power strips not being

to be conducted by Guardian Angels/designee for four weeks, then

allowed in facility. Random weekly audits

monthly thereafter to validate there are no

Maintenance Staff by Administrator

Agency f	or Health Care Adminis	tration				: 01/31/2020 I APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: 0	CONSTRUCTION 01, 05	(X3) DATE S COMPLE	
		75909	B. WING		12/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE		
TUSKAWI	LLA NURSING AND REH	AB CENTER	ILLA SPRINGS DI			
			R SPRINGS, FL 3	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K 914	Continued From page	2	K 914			
	99 Ch 6.3.2.1			power strips in assigned areas. Month audits to be conducted by Maintenant Director/designee to validate patient-related electrical equipment in therapy gym is completed annually are electrical safety stickers are in tact an current. 4. Results of audits will be reviewed d QA&A Committee monthly for three months by Maintenance Director/designee. QA&A Committee review audits and make recommenda based on outcomes and will determin need for further auditing beyond three months.	oe nd d luring will tions e	

AHCA Form 3020-0001