Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	75909	A. BUILDING: _____ B. WING _____	09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSKAWILLA NURSING AND REHAB CENTER	1024 WILLA SPRINGS DR WINTER SPRINGS, FL 32708

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS Complaint Investigation #2020014507 and Focused . . . . Control survey were conducted from to . Tuskawilla Nursing and Rehab Center had a deficiency at the time of the visit.	N 000		
N 101 SS=D	400.141(1)(j), FS; 59A-4.118(2), FAC Resident Medical Records 400.141(1)(j) FS Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the resident; and individual resident care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals. The records must be open to agency inspection. The licensee shall maintain clinical records on each resident in accordance with accepted professional standards and practices, which must be complete, accurately documented, readily accessible, and systematically organized. 59A-4.118(2) FAC Each medical record must contain sufficient information to clearly identify the resident, his or her diagnosis and treatment, and results This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain complete medical records that accurately reflected clinical status, changes in condition, and physicians' order for transfer for 1 of 4 sampled residents (#1). Findings:	N 101	This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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N 101	Continued From page 1 Resident #1 was admitted to the facility from the community on [redacted] with diagnoses including [redacted] and [redacted]. Resident #1's nurses' note, dated [redacted] at 2:46 PM, read, "Nurse called to shower room to observe area to residents left great [redacted]. Top of black...Call placed to MD (medical doctor) and MD ordered resident to be sent out to ER (emergency room)." On at 2:15 PM and at 8:07 AM, telephone interviews were conducted with resident #1's primary physician A. The physician was asked, did Unit Manager (UM) B requested her to check the resident's approximately 1 month ago? Physician A said, "The first time that I heard about his was when I went to the facility to see him on [redacted] and he was not there. The facility staff said he was sent to the hospital because of his [redacted]." Physician A stated in a second interview, "They do call me all the time, however they never called me when he went out to the hospital, such an important thing how did it slip their mind." A review of resident #1 medical record did not show any evidence in the physician, nursing or [redacted] notes that the physician was ever notified regarding area of redness on resident #1's left great [redacted]. The nurses' notes did not specify which physician was notified of transfer to the hospital on [redacted] and there was no physician order for transfer to the hospital. On at 1 PM, an interview was conducted with Licensed Practical Nurse C and the Director of Nursing (DON). The DON verified that she is	N 101	deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.Resident #1 was discharged from the facility on [redacted]. Education provided to UM B on by DON regarding documentation of change in condition in the medical record. Education provided to [redacted] D on [redacted] by Rehab Program Manager regarding documentation of change in condition in the medical record. Education provided to LPN C by DON on [redacted] regarding documentation of physician orders in the medical record. 2. Audit of current in-house residents by DON, Unit Manager and evening supervisor to identify residents with the potential to be affected by the same alleged deficient practice was completed on [redacted]. No other residents identified as being affected. Education to licensed nurses and [redacted] staff by DON/designee regarding documentation in the medical record of a change in condition and documentation of physician orders in medical record. 3. Licensed nurse orientation will include the education regarding documentation of change in condition in the medical record and documentation of physician orders in medical record. Random weekly audits will be conducted by DON/designee to validate that change in conditions and physician orders are documented in the medical record.	

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N 101	Continued From page 2 the nurse who wrote the nurse's note dated with time of 2:46 PM, regarding resident #1 going out to the hospital. The resident was assigned to LPN C who notified the physician of transfer. LPN C said that she spoke to the physician that was on call who was a female. However, she is not sure who she talked to and did not document the name of the physician she spoke to or write an order for the transfer to the hospital. The DON said that LPN C should have written a physician's telephone order or put one in the electronic medical record (EMR) when a resident goes out to the hospital. The DON went to check if they had a policy regarding transfers to the hospital and said they do not have a policy, however the nurse should have written an order as part of accurate and complete documentation. A review of Occupational ..., .. (.) D's note dated read, "Patient educated on use on new non-skid socks during ambulation...." The 's note did not include an observation regarding new redness of resident #1's left great . On at 12:26 PM, D was questioned regarding resident #1 and her encounter with him on . She said that on this date she saw redness to the left great .. ventral side approximately the size of a nail . She then got UM B to assess the .. . After looking at it, the UM indicated to her that she would follow up. The .. said, I should have included my observation of the resident's left great in the my documentation. The .. said she was only able to remember the date that she saw his because of the date on sock receipt. She had taken it upon herself to order special non-skid socks for him because the ones the facility provided kept sliding down his ankles. She had a	N 101	4. Results of audits will be reviewed during QA&A Committee monthly for 3 months by DON/designee. QA&A Committee will review audits and make recommendations based on outcomes. QAPI Committee will determine need for further auditing beyond 3 months.	

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N 101	Continued From page 3 note in the medical record which validated that she applied the socks on . On at 12:48 PM, an interview was conducted with UM B and the DON. The UM was asked why she did not document the change in resident #1 skin condition. She said, "The area was a pinpoint and blanchable redness. I don't even know whether it was the right or left . . . The asked me to look at his . The physician came in to look at his . . . the next day and there was nothing there." The UM did not remember what day she or the physician looked at resident #1's . The UM then said, "Had it been non-blanchable, I would have documented, but because it was blanchable and the doctor saw nothing is why I did not document it." The DON then stated, "Someone should have documented something, either the nurse or the , describe it and what was done about it." Review of the "Medical Record Management" policy last revised . . . . . read, "The facility must maintain medical records on each resident, in accordance with accepted professional standards and practice and state and federal law. Medical records must be complete, accurately documented....The medical record must contain enough information to show that the facility knows the status of the resident...." Class III	N 101		

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F 000	INITIAL COMMENTS Complaint Investigation #2020014507 and Focused Control survey were conducted from to . Tuskawilla Nursing and Rehab Center was not in compliance with 42 CFR 483 and 488, requirements for Long-Term Care Facilities.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and ( ) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842		

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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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F 842	Continued From page 1 operations, as permitted by and in compliance with 45 CFR 164.506; ( ) For public health activities, reporting of , neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; ( ) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain complete medical records that	F 842	This Plan of Correction is the facility's credible allegation of compliance.	

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F 842	Continued From page 2 accurately reflected clinical status, changes in condition, and physicians' order for transfer for 1 of 4 sampled residents (#1). Findings: Resident #1 was admitted to the facility from the community on with diagnoses including , , , and . Resident #1's nurses' note, dated at 2:46 PM, read, "Nurse called to shower room to observe area to residents left great . Top of black...Call placed to MD (medical doctor) and MD ordered resident to be sent out to ER (emergency room)." On at 2:15 PM and at 8:07 AM, telephone interviews were conducted with resident #1's primary physician A. The physician was asked, did Unit Manager (UM) B requested her to check the resident's approximately 1 month ago? Physician A said, "The first time that I heard about his was when I went to the facility to see him on and he was not there. The facility staff said he was sent to the hospital because of his ." Physician A stated in a second interview, "They do call me all the time, however they never called me when he went out to the hospital, such an important thing how did it slip their mind." A review of resident #1 medical record did not show any evidence in the physician, nursing or , notes that the physician was ever notified regarding area of redness on resident #1's left great . The nurses' notes did not specify which physician was notified of transfer to the hospital	F 842	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.Resident #1 was discharged from the facility on . Education provided to UM B on by DON regarding documentation of change in condition in the medical record. Education provided to D on by Rehab Program Manager regarding documentation of change in condition in the medical record. Education provided to LPN C by DON on regarding documentation of physician orders in the medical record. 2. Audit of current in-house residents by DON, Unit Manager and evening supervisor to identify residents with the potential to be affected by the same alleged deficient practice was completed on . No other residents identified as being affected. Education to licensed nurses and , staff by DON/designee regarding documentation in the medical record of a change in condition and documentation of physician orders in medical record. 3. Licensed nurse orientation will include the education regarding documentation of change in condition in the medical record and documentation of physician orders in	

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F 842	Continued From page 3 on [redacted] and there was no physician order for transfer to the hospital. On [redacted] at 1 PM, an interview was conducted with Licensed Practical Nurse C and the Director of Nursing (DON). The DON verified that she is the nurse who wrote the nurse's note dated [redacted] with time of 2:46 PM, regarding resident #1 going out to the hospital. The resident was assigned to LPN C who notified the physician of transfer. LPN C said that she spoke to the physician that was on call who was a female. However, she is not sure who she talked to and did not document the name of the physician she spoke to or write an order for the transfer to the hospital. The DON said that LPN C should have written a physician's telephone order or put one in the electronic medical record (EMR) when a resident goes out to the hospital. The DON went to check if they had a policy regarding transfers to the hospital and said they do not have a policy, however the nurse should have written an order as part of accurate and complete documentation. A review of Occupational [redacted] D's note dated [redacted] read, "Patient educated on use on new non-skid socks during ambulation...." The [redacted]'s note did not include an observation regarding new redness of resident #1's left great [redacted]. On [redacted] at 12:26 PM, [redacted] D was questioned regarding resident #1 and her encounter with him on [redacted]. She said that on this date she saw redness to the left great [redacted] ventral side approximately the size of a nail [redacted]. She then got UM B to assess the [redacted]. After looking at it, the UM indicated to her that she would follow up. The [redacted] said, I should have included my observation	F 842	medical record. Random weekly audits will be conducted by DON/designee to validate that change in conditions and physician orders are documented in the medical record. 4. Results of audits will be reviewed during QA&A Committee monthly for 3 months by DON/designee. QA&A Committee will review audits and make recommendations based on outcomes. QAPI Committee will determine need for further auditing beyond 3 months.	

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F 842	Continued From page 4	F 842		

of the resident's left great . . . in the my documentation. The said she was only able to remember the date that she saw his . . . because of the date on sock receipt. She had taken it upon herself to order special non-skid socks for him because the ones the facility provided kept sliding down his ankles. She had a note in the medical record which validated that she applied the socks on . . . . . .

On . . . . . at 12:48 PM, an interview was conducted with UM B and the DON. The UM was asked why she did not document the change in resident #1 skin condition. She said, "The area was a pinpoint and blanchable redness. I don't even know whether it was the right or left . The asked me to look at his . . . . The physician came in to look at his the next day and there was nothing there." The UM did not remember what day she or the physician looked at resident #1's . . . . The UM then said, "Had it been non-blanchable, I would have documented, but because it was blanchable and the doctor saw nothing is why I did not document it." The DON then stated, "Someone should have documented something, either the nurse or the . , describe it and what was done about it."

Review of the "Medical Record Management" policy last revised read, "The facility must maintain medical records on each resident, in accordance with accepted professional standards and practice and state and federal law. Medical records must be complete, accurately documented....The medical record must contain enough information to show that the facility knows the status of the resident...."