

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2026
NAME OF PROVIDER OR SUPPLIER Tuskawilla Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1024 Willa Springs Dr Winter Springs, FL 32708	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to support the resident's right to voice a grievance concerning missing property for 1 of 2 residents reviewed for personal property, of a total sample of 32 residents, (#3). Findings: Resident # 3 was admitted to the facility on [DATE] with diagnoses that included encephalopathy (brain dysfunction), chronic respiratory failure, chronic obstructive pulmonary disease and unspecified obstructive sleep apnea. A review of the Quarterly Minimum Data Set assessment with reference date 5/07/26 revealed resident #3 had a Brief Interview for Mental Status Score of 15 out of 15, which meant her cognition was intact. On 5/18/26 at 10:38 AM, resident #3 said she was missing about three blankets, including an electric blanket and her Continuous Positive Airway Pressure (CPAP) machine used for sleep apnea. She said staff were aware of the missing items, but she had not heard back anything from them regarding the status of the grievance. The resident stated her blankets were labelled with her information. 5/20/26 at 3:20 PM, the Social Services Director (SSD) said she was also the Grievance Officer. The SSD said issues with misplaced clothing can happen often and facility staff would try to talk to resident and family to get more information. She explained sometimes the items were found. The SSD said if the items were not found, the facility would reimburse or replace the item based on the situation. The SSD explained grievances were acted upon immediately and the facility tried to resolve them within three to five days. She said that CPAPs were rented and the facility did not allow the use of electric blankets but would follow up immediately with resident #3 because she was unaware of the missing items and verified there were no grievances on file for resident #3 regarding missing property. On 5/20/26 at approximately 4:00 PM, the Infection Preventionist nurse, who was the assigned nurse for resident #3 on 5/18/26 and 5/19/26 confirmed the resident had previously informed her about missing blankets, including an electric blanket. She explained the Nursing Home Administrator (NHA) was aware and was working on it. On 5/20/26 at 4:20 PM, Certified Nursing Assistant (CNA) E said that if a resident complained of missing clothing she would first try to find it, then follow up with the laundry department. CNA E said she was aware of the resident's missing blankets including an electric blanket and had told the Laundry Manager of the missing items. On 5/20/26 at 5:13 PM, the NHA said he first heard about the resident complaint in the resident council and acknowledged a grievance should have been filed at that time for the missing items. On 5/20/26 at 5:25 PM, the Director of Nursing (DON) and NHA explained that they had recently spoken with the resident's son for clarification of the missing items. They acknowledged many staff members were aware of resident #3's complaint and a grievance should have been filed when they first learned about it. They both acknowledged a grievance would have been in progress or resolved prior to survey if they had followed their process for grievances. The facility's policy on Grievances, revised August 2023, stated in the Purpose was to, To support each resident's right to voice grievances and to ensure that after a grievance has been received, the center will actively work through a conclusion while communicating progress to the resident and /or anyone working on their behalf in a timely manner.		

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.

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

TITLE

(X6) DATE

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the intravenous (IV) dressing was changed as ordered for 1 of 2 residents, (#5), and failed to obtain orders for IV dressing changes for 2 of 2 residents, (#5 & #13), reviewed for IV therapy, of a total sample of 32 residents. Findings: 1. Resident #5 was admitted to the facility on [DATE] with diagnoses of end stage renal disease, endocarditis (infection of the heart), type 2 diabetes, & bacteremia (bacteria in the blood). A care plan for IV medication use was initiated on 5/04/26 that instructed staff to monitor the central line IV to his right chest, to receive antibiotics and fluids. Interventions included dressing changes as ordered, observe the site, and flush it. A central line-central venous catheter (CVC) is a long, flexible tube that is similar to an IV line, but stays in place longer. The tube is inserted into a vein in the neck, chest, arm or groin, and passed through until it reaches a large vein near the heart in the vena cava, (retrieved on 5/22/26 from https://www.hopkinsmedicine.org) Review of resident #5's Electronic Medical Record revealed a physician's order that instructed staff to change the central line dressing with transparent dressing every week. An antibiotic order dated 4/16/26 indicated Ceftriaxone two grams was ordered daily until 5/28/26. The Annual Minimum Data Set (MDS) assessment dated [DATE] showed the resident had a Brief Interview for Mental Status (BIMS) assessment of 14/15, which meant he was cognitively intact. On 5/19/26 at 9:35 AM, resident #5's central line dressing was dated 5/1/26 with an approximate 2 mm line visible after the 1. He stated he was on IV antibiotics for six weeks for an abscess they removed from his heart valve, he did not remember the last time his IV dressing was changed by staff. On 5/19/26 at 9:38 AM, Licensed Practical Nurse (LPN) A said she was unsure when the dressing was last changed. When she examined the dressing, she could not determine if the writing indicated either 5/01/26 or 5/11/26. The LPN didn't how often the IV dressings were supposed to be changed, but recalled an alert usually appeared on Treatment Administration Record (TAR). She said she would check the order and come back. On 5/19/26 at 9:42 AM, the Director of Nursing (DON) stated IV dressings should be changed weekly or as needed and confirmed it could pose a risk of infection if not done regularly. On 5/19/26 at 2:14 PM, the DON commented the last time resident #5's IV dressing had been changed was 5/11/26. She said she would check the TAR and come back with documentation. She stated she and the Unit Managers did IV audits weekly, and the nurses had just completed an IV certification class on 5/20/26, including how to put in orders and change the dressings. She stated the nurses should know how often to change them. The facility was unable to provide documentation of the TAR or progress notes to indicate resident #5's IV dressing had been changed since the resident arrived. (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/26 at 11:00 AM, the DON explained the nurse who got the order for the IV was responsible for entering in the batch orders for care of the IV, so that the alert would appear on the TAR to inform the nurses the dressing was due to be changed. She confirmed there were no batch orders in the TAR for IV care for resident #5. Review of the facility's Central Access Device Dressing Change Policy dated 1/15/04, the catheter insertion site was a potential site for bacteria to enter, that could cause catheter-related infection. The policy indicated sterile dressing changes should be performed at least weekly so the site was cleaned properly, and the nurse should document after care was given. 2. Resident #13 was admitted to the facility from an acute care hospital on [DATE] with diagnoses that included sepsis, systemic inflammatory response syndrome (SIRS), chronic kidney disease stage 3, and anemia. Review of the MDS Quarterly assessment dated [DATE] revealed resident #13 had a BIMS score of 7 out of 15, indicating severe cognitive impairment. The assessment noted he had an IV and was receiving medications through it. On 5/18/26 at 10:36 AM, resident #13 was in bed with eyes closed. He had a midline IV inserted on his left upper arm with a clear dressing dated 5/18/26. The Order Summary Report for resident #13 showed he had been receiving IV fluids intermittently on 12/08/25, 1/02/26, 5/08/26, and 5/11/26. Orders for midline IV insertion had been entered for each date but there were no orders for dressing changes or monitoring of the IV site to correspond with the IV insertion. On 5/18/26 at 3:45 PM, Registered Nurse (RN) B, the assigned nurse for resident #13, confirmed she was unable to find the orders for IV dressing changes or monitoring in the resident's medical record. She acknowledged there was no documentation in the Medication Administration Record (MAR) that showed dressing changes had been scheduled or that staff were monitoring the IV site. The [NAME] Wing Unit Manager was present during the interview and attempted to find the orders, but she confirmed they had not been entered and believed they might have been missed. On 5/20/26 at 9:43 AM, RN C confirmed she had received the orders from the physician on 5/11/26 to insert the midline IV for resident #13. She explained there were batch orders for IVs, which included dressing changes and monitoring, but said when she entered the order, she did not add them because she was unsure when the IV team would come to insert the midline IV. The RN said the IV team sometimes would come the next day and if she had entered the dressing change order it would have interfered with the 24-hour dressing change that had to be done after the initial IV insertion. She confirmed all nurses were aware that IV dressing changes were done in the first 24 hours after insertion and every seven days after that. RN C said she reported to the 11 PM to 7 AM nurse that the IV team would come to insert the IV and said she expected the nurse would enter the dressing change and monitoring orders after the IV team had completed the insertion. RN C explained the nurse must have missed it and acknowledged the orders were missed by every nurse who cared for resident #13 since, for almost eight days. On 5/20/26 at 3:53 PM, the DON acknowledged there were no orders for dressing changes or monitoring of resident #13's IV. She said she expected nurses to follow the process for entering IV orders to ensure all associated orders, including dressing changes and monitoring of IV site, were (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included. She said this would ensure IV dressing changes were not missed. The facility's Procedural Guidelines for Physician Orders dated 6/28/24 instructed staff to enter new orders into the TAR as soon as they were received.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain resident medical records in accordance with accepted professional standards and practices that are accurately documented and complete for 1 of 2 residents reviewed for personal property, of a total sample of 32 residents, (#3). Findings: Resident #3 was admitted to the facility on [DATE] with diagnoses that included encephalopathy (brain dysfunction), chronic respiratory failure, chronic obstructive pulmonary disease and unspecified obstructive sleep apnea (OSA). A review of the Quarterly Minimum Data Set (MDS) assessment with reference date 5/07/26 revealed resident #3 had a Brief Interview for Mental Status Score of 15 out of 15 which meant her cognition was intact. The MDS assessment also indicated the resident used a noninvasive mechanical ventilator. Continuous positive airway pressure (CPAP) is a non-invasive ventilation machine that involves the administration of air usually through the nose by an external device at a predetermined level of pressure, (retrieved from State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities on 5/22/26). On 5/20/26 at 9:54 AM, resident #3 stated she did not use her CPAP machine for a while and was not sure why the staff removed it or if she still needed it. Review of the physician orders started on 12/16/25 showed an order for CPAP at 10 with fraction of inspired oxygen (Fio2) at 8 at bedtime and as needed (prn) via full face mask at bedtime for OSA. The order was discontinued on 5/18/26 at 4:30 PM. A review of the Treatment Administration Record (TAR) for the month of April 2026, showed resident #3 received CPAP therapy every day except on 4/28/26. For the Month of May 2026, the TAR showed she received CPAP therapy every day except on 5/8, 5/9 and 5/15. Review of the nurses' corresponding progress notes for 5/08/26 read, Resident stated she no longer has a CPAP machine. The corresponding progress notes for 5/15/26 read, No device available. An excerpt from a Pulmonary Note on 4/09/26 indicated, Patient is noncompliant with CPAP use and states she does not wish to continue therapy despite counseling. Discussed in detail the risks of untreated OSA. At this time, CPAP will be discontinued per patient preference. Review of the resident's plan of care showed no refusal of care. On 5/20/26 at 3:48 PM, the East Wing Unit Manager (UM) said that resident # 3 had declined to use the CPAP machine and believed the order was discontinued a while back, however, she said it was actually discontinued on 5/18/26. The East Wing UM explained the CPAP was a rental and did not belong to resident #3. She said she would find out what date the machine was returned to the rental company. The East Wing UM reviewed the TAR for April and May as well as the corresponding progress notes and could not explain why nurses were documenting the treatment was given when there were inconsistencies in documentation over whether the machine had been returned. Licensed Practical Nurse (LPN) D who was standing at the nurse's station, reviewed the TAR and acknowledged she signed the TAR on 5/16/26 and 5/17/26. The nurse stated she documented the resident had the CPAP at the bedside because she believed it was there and applied it. After LPN D explained she provided the therapy over the weekend, the East Wing UM said she tried to figure out what happened and was able to show the other discontinued batch orders for the CPAP was on 4/18/26. She explained the order should have been discontinued then, but it seemed as though it remained and was actually discontinued on 5/18/26 but should have been discontinued with all the others on 4/18/26. She said she was still trying to see when the CPAP was returned to the rental company. She continued to explain it seemed like the doctor came in and discontinued the order on 5/18/26 after realizing it was still an active order. On 5/20/26 at 4:20 PM, Certified Nursing Assistant (CNA) E said she had worked at the facility for over a year and usually worked evening and night shift. CNA E said she was familiar with resident #3 and she would often refuse the CPAP. CNA E said she had not seen the CPAP machine at resident #3's bedside for about one month. On 5/20/26 at 4:58 PM, the Director of Nursing (DON) said nurses were documenting that CPAP therapy was (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided, but it seemed as though they were just signing off on the treatment form. She said it might have been because it was a batch order, she did not know if they could have missed or may not have even looked at it because it was only one out of the batch orders for CPAP. The DON said her expectation for documentation on treatments is the same for medication administration where you cannot just sign off as administered without any verification. The DON acknowledged the medical record was inaccurate. The facility could not provide a policy on documentation or accuracy of medical record.		