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
	AL11969310	A. BUILDING: _____ B. WING _____	R 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERMARK AT VISTAWILLA, THE	1519 EAST SR 434 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
{A 000}	Initial Comments A revisit to Complaint Investigation #2020013281, an [redacted] Control survey, and a Generator Monitoring visit were conducted on [redacted]. Watermark at Vista Willa had an uncorrected deficiency at the time of the visit.	{A 000}		
{A 025} SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of [redacted] or [redacted], or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel	{A 025}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 025}	Continued From page 1 independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on 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 7 sampled residents (#14) who was a risk. Findings: On at 10 AM, the director of nursing (DON) said resident #14 had a and was currently in a rehabilitation center. Resident #14's record revealed a health assessment form 1823, dated , and a updated 1823 dated . The health care provider noted on both assessment forms that the resident was a risk. The resident had diagnoses that included , , , and . The health care provider noted she was oriented to self only and was agitated at time. The resident resided in	{A 025}		

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{A 025}	Continued From page 2 the secured memory care unit. Review of the electronic notes revealed the resident had the following , some with injuries: at 7:23 AM - "Doing rounds at 2 AM and resident was observed on the floor in bathroom with on both arms sitting in a puddle of . Initiated first aid care. Resident complaining of , administered 2 , . Resident stated she was trying to go to the bathroom and dripped." at 11:23 PM - "About 7 PM staff had responded to resident calling for assistance. Noted sitting up on the floor next to the toilet. Denies any complaints of , or discomfort. Denies any to ." at 3:35 AM - "Resident called for assistance. Staff noted resident at side of her bed, lying in supine position, denies any complaints of , or discomfort, but stated to her , 911 was summoned, daughter made aware and will follow resident to hospital." At about 7:50 AM, "daughter informed community resident will be returning sometimes today.... to her was sustained, which does not require aggressive treatment." At about 8 AM, "Reports received from nurse that resident is having transportation arranged and will be returning with a to T-3, which does not require any treatment." at 8:48 AM - "Resident was observed with on left arm and with at approximately 5:50 AM, resident stated she in bedroom overnight and managed to get herself up off the floor. Stated , level was a 6."	{A 025}		

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{A 025}	Continued From page 3 at 9:38 PM - Resident #14 "was found on the floor of her apartment this afternoon. She stated her shoes have poor and she slid out of her chair. Large and noted on left and upper arms, complaints of in right orders received from on call ARNP (Advance Registered Nurse Practitioner). Left and results negative for acute . Right showed non-displaced of radial styloid, the ARNP was asked if out could it, to which she agreed. was notified and will bring a tomorrow. Until then, he asked that her be wrapped with and bandage to stabilize it." at 5 AM - "[Resident] was sent out due to and hitting her with the toilet. at 11:08 PM - "[Resident] arrived at the facility via stretcher transported by (hospital) transportation from the Emergency Room. Resident was assessed and no new injuries sustained." at 6 AM - "During rounds at about 6:50 PM, noted resident sitting up on the floor by of the bed, in another resident's room. With wheelchair on her , sandals kicked off and the resident belonging to the room was attempting to assist her up. After confirming that resident is able to move all extremities without or difficulties, assisted up to her wheelchair. Then noted a large to her outer left lower and small hematoma to her right occipital area. DON and daughter informed, 911 was summoned and was taken to the hospital for further managements (at about 7:30 PM)." at 11:25 PM - "During rounds at 11:25	{A 025}		

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{A 025}	Continued From page 4 PM, noted resident was founding sitting on the floor in her bedroom, with the wheelchair next to her. Resident said she was trying to go to the restroom and slid to the floor, no injuries noted." On at 2 PM, the License Practical Nurse (LPN) stated that the resident went out to the hospital on . She said the resident received a bad . It was not noted on the electronic notes. She said the nurses who witnessed the incident provided an email statement as follows: The home health agency nurse that was a witness, email dated , noted she arrived to her shift at 3 PM on Sunday the 8th ( ). She and one of the aides arrived at the same time. They went into the office where the day shift nurse was waiting. The aide left and a few moments later came and informed us that resident #14 was on the floor from a cut to her . The aide stated that she went to the room because the resident was yelling when we both arrived for work. She and the other nurse proceeded to the resident's room where she was found sitting in the bathroom doorway from a . The Watermark nurse went to call 911. She applied a towel to the resident's and held it there until EMT arrived." The facility's nurse who was a witness, email dated , noted resident #14 "observed on the floor near doorway of her apartment by caregiver. Nurse notified and provided assistance. Resident observed with large skin on her forehead, skin hanging over her right . Also, small seen on left . Wheelchair observed on left side of bed with brakes applied. Bench near the bottom of bed observed with small amount of on the of bench. Trail of observed near bedside to	{A 025}		

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{A 025}	Continued From page 5 the hallway of her apartment 911 call, daughter notified and stayed on the phone until the arrival of EMT. DON notified and message left for physician. Resident sent to...emergency room at family request." The DON was asked to provide interventions that were put in place, for the resident was identified as a . risk on her 1823. She provided a care plan that addressed the . It reflected that risk requires observations for safety needs. Dates initiated , and revised on . The desired outcome was initiated on . It noted to reduce frequency of by providing necessary assistance. Resident will remain safe while in room. The actions column only listed the . that occurred on , , , , . There was nothing noted as to how the facility planned to monitor the resident to ensure that she was safe. The DON was asked to provide documentation of proactive measures to minimize the . . She stated she could not locate any other documentation's. The resident continued to have that resulted in and other injuries. There was no evidence that the facility had in place any proactive interventions that could assist in minimizing the resident's . . Class II	{A 025}		