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
	AL11969671	A. BUILDING: _____ B. WING _____	R 09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERCREST WINTER PARK ASSISTED LIVING AND	1501 GLENDON PARKWAY WINTER PARK, FL 32789

(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 #2021008822 was conducted at Watercrest Winter Park on . A deficiency was identified at the time of survey.	{A 000}		
{A 025} SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . 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 must notify the resident ' s representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for 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	{A 025}		

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{A 025}	Continued From page 1 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 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: DEFICIENCY REMAINED UNCORRECTED Based on observation record review, the facility failed to ensure to provide care and services appropriate to meet the needs of 1 of 7 sampled residents (#7) who eloped from the secure memory care unit. Findings: During the entrance interview on at 9:30 AM the resident care director said an adverse report had been submitted to the Agency because a resident eloped from the memory care unit (MCU).	{A 025}		

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{A 025}	Continued From page 2 Health assessment report 1823 dated listed diagnosis of . . . . . and was at risk of elopement. Updated health assessment report dated listed diagnosis of . . . . . , verbally aggressive at times and was not at risk of elopement. Facility notes dated: . . . . . at 7:20 PM indicated that after dinner, the resident displayed increased agitation towards staff and other residents. She yelled for help and "let me out of here". . . . . . at 2:45 PM indicated the resident was . . . . . , was yelling at residents telling them to get out. /201 at 4:52 PM indicated the resident was returned to the facility, she was outside looking for her car as she thought it had been stolen. An individual brought her . . . to the facility. She had a to her right . . . . . . 6:53 PM the resident walked around unit, exit seeking. Incident report dated indicated the outcome was a resident elopement if the elopement placed the resident at risk of harm or injury. The report indicated that on . . . . . at approximately 3:28 PM resident #1, who was memory care resident was outside the facility, on the sidewalk, next door to a storage facility. An individual said he heard the resident say she needed the police because her car was stolen. At approximately 3:30 PM, the individual escorted the resident into the community. The staff escorted the resident . . . . to the MCU at approximately 3:33 PM. A skin evaluation was done and a nickel size hematoma to the right area was noted. The resident denied , .	{A 025}		

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{A 025}	Continued From page 3 Fluids and food were offered. The resident was last seen at 3:15 PM when she was assisted to the bathroom. Incident report dated . . indicated the resident exited by a door that . . . The locking mechanism displayed it was locked indicated by a red light. The lock company was called. Invoice dated . . . 21 for service done . . . indicated all maglocks in the MCU were checked. The paint on top of the door frame needed to be scrapped and filed to allow maglock to engage when closing. The facility's elopement policy and procedures defined elopement as an occurance when the facility staff determined a resident was missing or whenever a resident left the secured confines of the memory care portion of the facility unattended by facility staff or family. Interview with the administrator on at 2:50 PM who asked had the resident care director provided the work order for the MCU doors. Class II	{A 025}		