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 _____	08/23/2022

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 Complaint Investigation #2022012315 was conducted on ..... and ..... Watermark at Vistawilla had a deficiency at the time of the visit.	A 000		
A 090 SS=J	59A-36.011(11) FAC Training - . . . . . . (11) . . . . TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding . . within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to perform . , ... (.) life functions on resident #1 during an emergency. Findings: Resident #1's admission record and health assessment revealed an admission date of . There was no required . . . . . (. .) paperwork in the record. The record had a "Full CODE" status sheet in the front of the record that alerted staff to perform . The record also included an	A 090		

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 _____	08/23/2022

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 090	Continued From page 1 Advance Directive in the admission record, which stated the resident did not want performed in an emergency. It was signed by the resident. However, a physician's order and signature of the physician were not in the resident's record. The health assessment dated confirmed resident #1's medical diagnoses were high prostatic hyperplesia, sleep , , , , and forgetfulness. The resident required medication assistance and had a history. A facility report dated reflected that on at 1:02 PM, Medication Technician (med tech) B went to the resident's apartment to administer scheduled medications and found the resident on the bathroom floor in a pool of . Staff B notified licensed practical nurse (LPN) A to respond to the emergency. LPN A went to the apartment and observed the resident lying on the bathroom floor in a large pool of , a knife in left with the blade of the knife inserted into a wide, deep to the right . She noted on the toilet, floor, and walls in the bathroom. LPN A could not obtain a , or , . At 1:03 PM, 911 call initiated by LPN A. Police arrived at 1:08 PM. Emergency Medical Services ( ) arrived at 1:10 PM and initiated . Signs of life were not obtained. pronounced the resident's time of as 1:13 PM. The facility's policy revealed that is to be initiated on any Assisted Living resident who does not have a "No Code", a " " from the resident's physician, or does not have a written	A 090		

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 _____	08/23/2022

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 090	Continued From page 2 set of Advanced Directives on file that specifies that is not to be delivered in the event of is to be performed only by an associate certified to do so. The facility's policy on " " reflected that should be clarified upon admission. must be signed by the resident's attending physician on the physician order sheet and maintained in the resident's medical record. A form must be completed and signed by the attending physician and the resident or legal surrogate and placed in the front of the resident's medical record. The care team will review the status during the service plan review process every 6 months or sooner. The must be in the front of the resident's chart. A Florida sheet will also be in the binder and there should be a sheet for each resident denoting "Full Code" or " ". The facility's staffing schedule at the time of the incident revealed staff A, B, C and D as well as the Regional Registered Nurse (RN), and the Director of Nursing (DON) were all witnesses to the incident. Personnel record review revealed all staff listed above were currently certified in and First Aid. Review of Law Enforcement's report dated indicated that on , at approximately 1:08 PM, "I responded to . . . My response was in reference to an apparent at an assisted living facility . . . Upon arrival, I observed two female employees, standing in the hallway outside the apartment door. They are administration employees. Once I made way into the apartment, I observed Officers standing near the doorway of the bathroom. I observed a white male, laying on the bathroom	A 090		

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 _____	08/23/2022

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 090	Continued From page 3	A 090		

floor in a pool of . . . . , on his . . . and facing up. The male had a large on his right which appeared as if he cut himself. The white male at that time was unresponsive and motionless. Paramedics with the Fire Department arrived on scene, entered the bathroom, and began lifesaving procedures. Paramedics . . . called the time of at 1320 hours (1:20 PM). While on scene, Sergeant spoke with an employee who found the . That employee was later identified as staff B. She explained the following, verbally and in a written sworn statement. The resident was last seen outside on the front porch at 1100 hours (11 AM). [Med Tech B's name] stated around 1300 hours (1 PM), it was time for the resident to take his medication. Staff A knocked on the resident's door, but the resident did not respond. [LPN A's name] called [the] resident's name, but he did not respond. [LPN A's name] then proceeded to enter the apartment and noticed the bathroom light on. [LPN A's name] said she opened the bathroom door and noticed him lying in a pool of . . . . on the bathroom floor. [LPN A' name] said she ran out of the room and notified the nurse on duty. Detective and Sergeant arrived on scene and started their investigation. I then contacted the medical examiner via phone. They arrived shortly after and began their investigation. The knife which was presumably used was collected and submitted into evidence. No police video."

On . . . . . at 9:30 AM, the Administrator stated she worked the day of the incident. She stated the resident did not have a . . She stated / First Aid was not performed because there was no fluid coming out of the . . . and the nurse determined it was beyond . /First Aid. She stated . did . She stated the resident had never displayed any behaviors that would

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 _____	08/23/2022

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 090	Continued From page 4 lead to this, he drove, he would go on vacations, he was independent in activities of daily living but needed assistance with medications. She stated they are still doing an internal investigation. She stated the Department of Children and Families (DCF) were not called. On 10:30 AM, LPN A stated that she was called by Med Tech B to come to the resident's room. She stated she knocked on the door and no one answered. She then went in and saw the resident on the floor with next to him. She stated she did not do or apply First Aid as the resident was beyond that. She stated it was a very confusing time. She stated she was the nurse on duty and had a difficult time being in the room looking at the resident and just waited for to come. She stated the policy is to apply when a resident is unresponsive. She confirmed she is certified in and First Aid. On 10:45 AM, Med Tech B stated she went into the resident's room that day to give him his medications. She stated she knocked on the door and no one answered. She stated she then opened the door and went in. She stated she noticed him on the floor up next to a pool of . She stated she ran out the room to get the nurse and was too upset to enter the room again. She stated she has certification for and First Aid, but she left it to the nurse to make that determination. She stated she was not sure what the facility policy was for and First Aid, then stated the policy is to apply when a resident is unresponsive. She stated she thought the nurse would decide that. On 11:45 AM, the Human Resource Director stated that she was a witness to what happened around 1:05 PM and was told by the	A 090		

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 _____	08/23/2022

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 090	Continued From page 5 DON that someone committed . . . . . She stated the DON did not want to go into the room. She then called 911 and asked the DON to get the automated external defibrillator ( ). She then said she went into the room with the DON and saw the resident on the floor and a pool of next to him; and they waited for . . . No . or First Aid was done. On 1:16 PM, Med Tech D stated the day of the incident she was coming off the elevator on the second floor and saw Med Tech B on the bench and looked distressed and sleepy. She stated she saw LPN A on the phone with 911 and seemed very upset. She stated that LPN A asked her to go to the resident's room but was not sure why. She didn't know what was going on but just went in the resident's room. She stated she saw the resident on the floor and started crying and was never asked to perform or First Aid. She stated she did not know if anyone did. She stated she left at that point. She stated and First Aid is supposed to be applied when a resident is unresponsive. She stated she is certified. Staff D worked the 7 AM to 3 PM shift on . On at 2 PM, Med Tech C said she saw Med Tech B crying and LPN A asked her to go to the resident's room. She stated when she went in, she saw the resident in the bathroom lying on the floor with a pool of , unresponsive, and his . . slit. She said LPN A never asked her to do . She stated the policy is if the person is unresponsive, do . On . . . . . at 3:30 PM, the DON stated she was in her office at about 1 PM. She stated Med Tech B stated to her there was an emergency in the resident's room and to come right away. She	A 090		

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 _____	08/23/2022

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 090	Continued From page 6 stated she went to the room but did not go in. She heard LPN A on the phone with 911. She stated she went to the room and saw the resident on the floor in a pool of , unresponsive. She stated it happened so quickly that everything was a blur. She confirmed neither she nor the staff did , First Aid, or requested an . She stated they just waited for to arrive. She stated she did not know the facility policy on and . She stated when a resident is unresponsive, they do or use the . She stated she does not know why it was not performed that day. She stated the staff was very shaken and she was trying to calm them down. She stated all the staff involved that day are certified in and First Aid. On at 4 PM, the Reginal Director RN stated that about I PM, a staff person came to her visibly shaken and stated the resident committed . She stated to get the . She stated she then went into the resident's room and saw the resident on the floor down, facing the direction of the door, and open. There was a significant amount of on the floor. There was no coming out of the so there was no need for a torniquet. She stated with the amount of on the floor she stated there was nothing more that could be done. She stated she made the determination not to do and the would not help. She stated this was comparable to someone that jumped out of a building and there is nothing that can be done. She stated the facility policy is if it is full code resident, do . She stated there was nothing I could do to help. I would have done if it could have helped. She stated LPN A and Med Tech B also made the determination that there was nothing that could be done. She stated the paramedic came about 2 minutes later and did	A 090		

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 _____	08/23/2022

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 090	Continued From page 7 . . . . compulsions, advised not to . . . , and stated there is nothing to be done. On at 3 PM, the Administrator stated she does not know why the staff did not follow policy and perform on resident #1 when he was unresponsive. She confirmed all the above findings. Photographic evidence was obtained Class I	A 090		