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 _____	03/28/2023

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 complaint investigation #2022018934 was conducted at Watermark at Vista Willa on . The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=D	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 Resident Care Standards. 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		

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 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: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 5 sampled resident received a medication as prescribed by a health care provider (#3). Findings: Review of resident #3's 1823 health assessment form dated revealed she required assistance with self-administration of medications. During a medication pass for resident #3 on at 8:34 am, the resident asked med tech A where the big pill was. The med tech told the	A 025		

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A 025	Continued From page 2 resident it was out and had to be reordered. The resident then asked why it ran out and the med tech replied that she did not know but she would reorder it. The resident said she took the medication twice a day. Review of the medication observation record (MOR) revealed it was . . . . . Hippurate 1 gram, 1 tablet by twice daily (used to prevent or control returning . . . . . caused by certain . WebMd.com) On at 1:05 pm, the resident said she still had not received the morning dose of the medication. On at 1:20 pm, review of the MOR revealed med tech A signed that she did give it that morning. When asked about it she said she signed in error and the morning dose was not given to the resident. On at 1:33 pm, the director of nursing (DON) said the med techs were instructed to order refills through the electronic MOR system five days in advance of the medication running out. On at 2:30 pm, the DON provided a medication package that contained two tablets of . She said she requested a refill from the pharmacy today. Med tech A said that despite there being two tablets available she did not give the morning dose because "I thought she was out". Class III	A 025		
A 050 SS=D	429.256(2&6) FS;59A-36.008(1) FAC Medication - Self Administered Medications	A 050		

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A 050	Continued From page 3 429.256 (2) Residents who are capable of self-administering their own medications and performing other tasks without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. An unlicensed person may also provide assistance with other tasks specified in subsection (6). Assistance with self-administration of medication or such other tasks by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a resident or the resident's surrogate, guardian, or attorney in fact. For the purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, ... dosage forms, ... patches, and ... dosage forms including solutions, suspensions, sprays, and inhalers. (6) Assistance with other tasks includes: (a) Assisting with the use of a ... to perform ... level checks. (b) Assisting with putting on and taking off ... stockings. (c) Assisting with applying and removing an ... but not with titrating the prescribed ... settings. (d) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device.	A 050		

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A 050	Continued From page 4 (e) Assisting with measuring vital signs. (f) Assisting with , bags. 59A-36.008 Pursuant to sections 429.255 and 429.256, F.S., and this rule, licensed facilities may assist with the self-administration or administration of medications to residents in a facility. A resident may not be compelled to take medications but may be counseled in accordance with this rule. (1) SELF ADMINISTERED MEDICATIONS. (a) Residents who are capable of self-administering their medications without assistance must be encouraged and allowed to do so. (b) If facility staff observes health changes that could reasonably be attributed to the improper self-administration of medication, staff must consult with the resident concerning any problems the resident may be experiencing in self-administering the medications. The consultation should describe the services offered by the facility that aid the resident with medication administration through the use of a pill organizer, through providing assistance with self-administration of medications, or through administering medications. The facility must contact the resident's health care provider when observable health changes occur that may be attributed to the resident's medications. The facility must document such contacts in the resident's records. This Statute or Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 3 sampled residents who had an order to self-administer a medication was allowed to do so (#2).	A 050		

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A 050	Continued From page 5 Findings: Resident #2's 1823 revealed she had a diagnosis of [redacted]. A doctor's order allowed her to keep her [redacted] at her bedside and self-administer it. On at 10:18 am, the resident said she received her [redacted] late that morning. When I asked what time, she was supposed to receive it she said around 7:30 am or 8 am. She said she never knew when she was going to get it. Observations made during her med pass revealed med tech A gave it to her at 8:13 am. On at 1:20 pm, the resident said she did not know she was allowed to keep the [redacted] in her room. On at 1:30 pm, the DON said she knew about the order, but she had to take it from the resident because she was leaving it out. However, there was no documentation in the resident's record of this. The DON said she will give the medication to the resident and reassess her ability to safely store it. Class III	A 050		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it	A 052		

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A 052	Continued From page 6 to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid	A 052		

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A 052	Continued From page 7 medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and	A 052		

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A 052	Continued From page 8 must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with	A 052		

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A 052	Continued From page 9 this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the unlicensed med tech who assisted 3 of 3 sampled residents with medications followed the correct procedures (#1, #2, #3). Findings: 1. Observations made during a med pass for resident #1 on at 8:05 am revealed med tech A sanitized her , unlocked a cabinet in the resident's room then removed three medication bottles. While standing at the counter she poured the meds into a cup. The resident exited the bathroom then sat in a chair. The med tech took only the cup of pills to him then said "I'm here to give your morning meds. Two for and one for your ". The resident took the pills himself. The med tech returned to the cabinet and secured the bottles inside. She sanitized her then signed the MOR.	A 052		

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A 052	Continued From page 10 The med tech did not take the bottles to the resident, say the name and dosage of each med aloud and pour them in his presence. 2. On at 8:13 am med tech A sanitized her , unlocked the cabinet in resident #2's room then removed six bottles of meds. She turned to the resident, who was sitting in a chair next to her bed and asked her if she would like to take her and pills. The resident declined the , said she wanted the med then said she also needed her . During the med pass the med tech showed the director of nursing (DON), who was present, one of the bottles and the DON instructed her to give two of the pills. The med tech took the bottle to the resident, who placed two squirts into each nostril herself. The med tech returned to the counter and poured the pills into a cup. She took only the cup to the resident then told her she was giving her , , "some I can't pronounce", , , spray, pill. The resident took them one at a time. The med tech did not take the bottles to the resident, say the name and dosage of each med aloud and pour them in her presence. 3. On at 8:34 am resident #3 sat in a chair across the room. Med tech A sanitized her , unlocked the cabinet then removed med packages. She asked the resident if she wanted her cream. The resident said she used it only at night. The med tech asked her again two more times and the resident said she would use it. While standing at the counter, the med tech popped four pills into a cup. She bumped the cup with her which caused the cup to tip and the	A 052		

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A 052	Continued From page 11 and and to on the floor. The , remained in the cup. She picked up the three pills off the floor then went into the resident's bathroom and flushed them down the commode. She popped new ones into the cup. While standing at the counter the med tech told the resident she was giving her , . The resident did not appear to hear her then turned the volume up on the TV. The med tech took only the cup of pills to the resident, who asked where the big pill was. The med tech told her it had to be reordered. The resident asked why it ran out and the med tech responded that she did not know but she would reorder it. The resident then said she was supposed to take it twice a day. The med tech did not take the packages to the resident, say the name and dosage of each med aloud and pour them in her presence. On at 8:50 am the med tech said she received training on assisting with meds. She said she remembered learning that she was required to take the med packages to the resident, say the name and dosage of each med aloud and pour them in the resident's presence but, she was nervous. The DON was present during the entire med pass for residents #1 and #2 and during part of the one for #3. She was present during the conversation with the med tech about not following the proper procedure. On at 1:05 pm, resident #3 said the staff do not tell her what they're giving her when they bring her medications. Class III	A 052		

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A 056	Continued From page 12	A 056		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must	A 056		

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A 056	Continued From page 13 be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and,	A 056		

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 _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERMARK AT VISTAWILLA, THE	1519 EAST SR 434 WINTER SPRINGS, FL 32708

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A 056	Continued From page 14 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 3 sampled resident's medication containers were properly labeled (#2). Findings: 1. Observations made during a med pass for resident #2 on [redacted] at 8:13 am revealed med tech A sanitized her [redacted], unlocked a cabinet in the resident's room then removed six bottles of meds. She turned to the resident, who was sitting in a chair next to her bed and asked her if she would like to take her [redacted] and [redacted] pills. The resident declined the [redacted], said she wanted the [redacted] med then said she also needed her [redacted]. During the med pass the med tech showed the director of nursing (DON), who was present, one of the bottles and the DON instructed her to give two of the pills. The med tech took the [redacted] bottle to the resident, who placed two squirts into each nostril herself. The med tech returned to the counter and poured the pills into a cup. She took only the cup to the resident then told her she was giving her [redacted], "some I can't pronounce", [redacted], spray, [redacted] pill. The resident took them one at a time. When asked following the med pass what	A 056		

Agency for Health Care Administration

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A 056	Continued From page 15 medication she asked the DON about, she said she asked her about the , because the prescription label indicated give one 20 milligram (mg) tablet but the MOR indicated give 40 mg, which was why the DON told her to give two of the 20 mg tablets. Neither the , nor the Multaq bottles had a prescription label. The DON said the resident's son gets them both from CVS. On at 1:10 pm when asked about a change in directions alert label for the , , med tech A said "I've never seen those before". On at 1:45 pm, the DON said she got a clarification order for the , to give two of the 20 mg tabs. She said the facility does have alert labels. She said she'll talk to the resident's son about the , and Multaq not being properly labeled. Class III	A 056		