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 _____	10/31/2023

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

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A 000	Initial Comments A Complaint investigation #2023011846 was conducted from to . Watercrest Winter Park Assisted Living and Memory Care 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		

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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 record reviews and interviews, the facility failed to ensure the , for 1 of 5 sampled residents was checked prior to administering a medication (#10), failed to ensure the correct dose of a medication was administered to 1 of 5 sampled residents (#6), and failed to have documentation to indicate follow up was made when a health care provider recommended , checks for 1 of 5 sampled residents (#7). Findings: 1. Review of resident #10's record revealed a facility admission date of . A health	A 025		

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A 025	Continued From page 2 assessment form (1823) dated indicated the resident required assistance with self-administration of medications. On a health care provider ordered , 25 milligram (mg) tablet, take one tablet by in the morning and one tablet before bedtime. Hold if , , ( ) <110. Review of the resident's Medication Observation Record (MOR) revealed , readings were not recorded. On at 10 am, a request was made of the Wellness Director to provide documented vital signs. The Wellness Director provided documentation of only one set of vital signs taken on . On at 12:20 pm, the Wellness Director said she was unable to provide additional , readings. 2. Review of resident #6's record revealed an admission date of . A 1823 from indicated the resident required assistance with medications. On a health care provider signed an order for 20 mg, one tablet by daily. Review of the resident's MOR revealed the resident was given 40 mg every day from /23. On at 4:15 pm, the Wellness Director confirmed the findings.	A 025		

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A 025	Continued From page 3 3. A record review of resident #7's chart revealed the following: A and , 's letter dated . . . . . noted for resident #7, "We recommend daily , checks for the above patient as she was recently hospitalized and multi-hypertensive medications were added to her daily regimen." On . . . . . at 12:30 pm review of resident #7's Medication Administration Records (MARs) and progress notes did not reveal daily . . . . , checks documented. On at 12:30 pm, the Wellness Director stated, "Do you see an order from the doctor. It says recommend; we normally don't do daily . . . . , ... checks. I did not contact the office to obtain clarity on the letter." On at 1:11 pm the Wellness Director stated, " I asked the APRN (Advance Practice Registered Nurse) today and she said she remembered. It would be too much to do it daily for everyone. We only do it for an incident or monthly. We try to recommend it for a short period. I called the doctor's group and spoke with the MA (Medical Assistant) who stated no we would not need to do it. I did not speak with the doctor or APRN. The MA goes around with them when they come to the facility. So, she would be familiar with the residents." Class III	A 025		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures	A 030		

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A 030	Continued From page 4 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use;	A 030		

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A 030	Continued From page 5 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . . , neglect, and . . ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:	A 030		

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A 030	Continued From page 6 (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No	A 030		

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A 030	Continued From page 7 religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care . , , ... , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally . . , ... , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other	A 030		

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A 030	Continued From page 8 person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.-	A 030		

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A 030	Continued From page 9 (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [illegible] or [illegible] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to provide [illegible] ( ) to 1 of 1 sampled resident who [illegible], without a [illegible] ( ) (#8), failed to ensure the staff who withheld had a valid certification and failed to ensure the Automated External Defibrillator ( ) was retrieved when the same resident was found unresponsive. Findings: Review of resident #8's record revealed a facility admission date of [illegible]. A health assessment form (1823) dated indicated the resident's medical history included [illegible] and [illegible]. The record did not contain a [illegible]. Review of an undated facility admission	A 030		

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A 030	Continued From page 10 form revealed the resident did not have a . A facility incident report indicated that on ... at 3 am caregivers C and E found resident #8 unresponsive. The caregivers immediately notified nurse D, who arrived at the location at approximately 3:02 am. The nurse found the resident unresponsive and without vital signs. The nurse instructed a caregiver to check for status while the nurse called 911 to report the resident's . Emergency Medical Services ( ) arrived at the facility at approximately 3:10 am and pronounced the resident . The resident was found by nurse D without a , and , . The resident's vital signs were unobtainable. The resident was to touch, , were blue, and all her extremities were stiff. Based on the nurse's judgement and assessment findings, it was determined there was no chance of viability. The nurse determined the resident's vital signs were unobtainable, , were blue, and the resident was to touch and appeared to be for some time. The nurse called 911 immediately and they did not instruct the nurse to initiate . When personnel arrived at the facility, they also did not initiate . did an strip and determined the resident was . The resident was last seen by facility staff laying in her bed at approximately 1 am. A facility note dated indicated that at approximately 3 am caregivers C and E reported to nurse D that the resident was unresponsive. Upon further examination the resident had expired. was called. At approximately 5:30 am the medical examiner picked up the resident's body.	A 030		

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A 030	Continued From page 11 A facility note dated . . . . . at 8 am (late entry for) signed by nurse D indicated upon entering the room, the nurse observed the resident on the floor on her . The resident's right arm was extended, and her left . . was on her abdomen. The resident was diagonal with her . . . near her bed and her . . . towards the bathroom. She was , her were open and glazed, her , . were blue, and she was ashen in color. The nurse checked the resident's radial and carotid pulses and there were none. A sternal rub was done without a response. There was no documentation to indicate any of the responding staff retrieved the facility's Automated External Defibrillator ( ), which was located in the memory care unit where the resident resided. An is a medical device designed to analyze the . . . rhythm and deliver an electric to victims of . . . . . to restore the . . . rhythm to normal. (www.Osha.gov). During an interview on at 10:56 am, caregiver C said she walked into the resident's room to deliver laundry on when she found the resident laying on her . . . on the floor in front of her bed. She said she immediately called out for caregiver E, who responded to the room. Caregiver C stated she remained with the resident while caregiver E went to get nurse D, who was in the memory care unit at the time. Caregiver C said she was not . certified at the time of the event. Caregiver C said she checked on the residents every 2 hours and last saw the resident at 11 pm, when the resident appeared to be sleeping in her bed with her , . . closed. Caregiver C indicated she did not round on the resident at 1 am because at that time, she and caregiver E took turns doing the rounds.	A 030		

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A 030	Continued From page 12 Caregiver C said she had received training on the policy. A policy dated was provided by the administrator that read, in part, if the resident does not have a , you must begin immediately. A /Hospice policy dated provided by the administrator noted, in part, a emergency must be handled quickly and correctly to minimize the damage to the resident. All associates must know how to act in a emergency. emergency procedure- contact the nurse on duty, initiate (if certified to do so), the nurse or designated associate must verify is in place for to cease. If no is in place, will continue until emergency medical personnel arrive. A policy dated included in the resident's contract read, in part, "it is the policy of the community to follow any legally executed directive provided to us, including a ." Caregiver C's valid had expiration date of and she received training on the facility's policy on . Nurse D's was obtained online and not in person. In person training was required so the person is able to demonstrate the ability to perform . The nurse received training on the policy on and was also listed as a participant during a training. Caregiver E did not have a valid and received training on the policy on . During an interview on at 2:27 pm, the	A 030		

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A 030	Continued From page 13 Administrator said when she questioned nurse D about why she did not initiate , the nurse replied that in her nursing judgement the resident had been for a long time. The Administrator stated she had not questioned the nurse as to why she did not use the to determine if activity was present. The Administrator explained that following the incident and subsequent trainings on and , facility managers randomly chose staff to ask where were kept and a binder was created for Agency staff. Class I	A 030		
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 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	A 052		

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A 052	Continued From page 14	A 052		

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 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

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A 052	Continued From page 15	A 052		

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 [illegible] or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and 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

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A 052	Continued From page 16 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 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.	A 052		

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A 052	Continued From page 17 This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure unlicensed staff who assisted 1 of 1 sampled resident with medications followed the correct procedures, (#6). Findings: Observations made during medication pass for resident #6 on [redacted] at 11:15 am revealed unlicensed Med Tech B placed the medication into a cup while standing at the medication cart and not in the presence of the resident, as required. Immediately following the medication pass, the findings were discussed with the Med Tech, who confirmed she did not prepare the medication in the resident's presence. She then said, "my [redacted] I know what to do but when someone is watching you, you know". The medication policy provided was dated [redacted]. The policy did not address the procedures to be taken by unlicensed staff when assisting residents with medications. Review of Med Tech B's personnel record revealed she received 6-hours of medication assistance training on [redacted] and 2-hours on [redacted]. Class III	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records	A 054		

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A 054	Continued From page 18 (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on interview, and record review, the facility failed to ensure 1 of 1 sampled resident who received assistance with self-administration of medication maintained a daily accurate medication observation record, (#7)	A 054		

Agency for Health Care Administration

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Findings:

A record review of the Medication Administration Record (MARs) revealed the following:

On at 1:30 pm resident #7's MARs revealed two orders for tablet 60 milligrams (mg) extended release 24-hour one time per day in the AM every day at 8:00 am.

On at 1:30 pm, resident #7's MARs revealed the two orders were updated on , , , , , , , , , , , , , , , and as administered by staff A and Staff F.

On at 1:45 pm Staff A stated, "I did not give 2 doses. I know for a fact I didn't give it. It's the same drug. The nurse has to go into the system for duplicates. I just didn't update the MARs properly. I charted it twice, but I didn't give it. The system is so confusing."

On at 1:49 pm Staff F stated, "from what I remember it should have been the one time. We do so much stuff. I don't remember if I gave it twice or if I was supposed to."

Class III