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 _____	03/19/2024

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 survey #2024003581, #2024001901, and #2023018412 was conducted at The Watermark at Vistawilla on - . The facility had deficiencies at the time of the 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 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	A 025		

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A 025	Continued From page 1 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 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 provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision to ensure safety through proactive measures and minimize the potential for harm related to the physical, and emotional well-being for 3 of 9 sampled resident (#1, #2 &, #10). Findings: Record review for Resident #1 revealed a facility's admission date of . Continued	A 025		

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A 025	Continued From page 2	A 025		

review noted a Health Assessment (form 1823) dated [redacted], indicating a medical history of [redacted] ([redacted]), [redacted] ([redacted]), [redacted] Fasting [redacted], OA ([redacted]), [redacted] ([redacted] prostatic hyperplasia), [redacted], and without mention of any [redacted] or Behavioral Status.

Further review of Resident #1's chart revealed a New Patient Assessment dated [redacted] at 3:30pm with a chief complaint as: establish/new/[redacted]. The assessment revealed the medication [redacted] ER ([redacted] XR) 150 mg capsule, extended release 24hr take 1 capsule(s) every day by oral route prescribed on [redacted]. The problems identified [redacted] onset [redacted], [redacted] onset [redacted], [redacted] onset [redacted], and Hypertensive [redacted] onset [redacted]. The patient [redacted] assessment noted: Psych: [redacted], and stress - no [redacted] swings.

The document listed an assessment/plan for the following and read:

1. Poor short-term memory - noting daughter has concern about short-term memory and indecisiveness. Mental status assessment completed with the provider today. Will continue to monitor at this time. Spoke with daughter and informed her that recent memory loss could be due related to [redacted]. Decision was to increase [redacted] and keep patient under observation.
2. [redacted] - new [redacted]/w/meds - Patient is currently on [redacted] 37.5 mg twice a day. He has a history of [redacted] thoughts. Patient mentions today he feels like a burden to his daughter, and he feels overwhelmed with the move and establishing to an assisted living

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A 025	Continued From page 3 facility. Decision to increase . . . . . to 150ER and monitor symptoms. A Medication Guide for Resident #1 dated . . . . . was revealed in his chart for . . . . XR (extended release) capsules. The document noted that the most important information to know about XR is that it may cause serious side effects, including increased risk of thoughts and actions. . . especially within the first few months of treatment or when the dose is changed. The guide also gave information on what to watch for and try to prevent thoughts and actions in a family members, noting paying close attention to any changes, especially sudden changes, in . . , behaviors, thoughts, or feelings. A review of Resident #1's Medication Administration Observation Records (MARs) for . . . . . on the dates of 8, 9, 10, 11,12, 13, 14,15, 16, 17, 18, 19, 20, 21, 22, 23, 24,25, 26, 27, 28, 28, 29, and 30. . . . . ER 150 mg Caps 0800 take 1 capsule by . . once daily (Indications for Use: . . , ...) was documented as administered. A review of Resident #1's MARs for . . . . on the dates of 1, 2, 3,4, 5, 6, 7, 8, 9, 10, 11,12, 13, 14, 15, 16, 17, 18,19, 20, 21, 22,23, 24, 25, 26, 27, 28, 29, 30, and 31. . . . . ER 150 mg Caps 0800 take 1 capsule by once daily (Indications for Use: . . , ...) was documented as administered. A review of Resident #1's MARs for on the dates of 1, 2, 3,4, 5, 6, 7, 8, 9, 10, 11,12, 13, 14, 15, 16, 17, 18,19, 20, 21, 22,23, 24, 25, 26, 27, 28, 29, 30, and 31. . . . . ER 150 mg Caps 0800 take 1 capsule by once	A 025		

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A 025	Continued From page 4 daily (Indications for Use: . . , ...) was documented as administered. A review of Resident #1's MARs for . . on the dates of 1, 2, 3,4, 5, 6, 7, 8,9, 10, 11,12, 13, 14, 15, 16, 17, 18,19, 20, 21, 22,23, 24, 25, 26, 27, 28, and 29. . . . . ER 150 mg Caps 0800 take 1 capsule by . . once daily (Indications for Use: . . , ...) was documented as administered. A review of Resident #1' MARs for on the dates of 1,2,3,4,5,6,7,8,9, and 10. . . . . ER 150 mg Caps 0800 take 1 capsule by once daily (Indications for Use: . . , ...) was documented as administered. On at 10:35am Observation of the door opened to resident #1's room to speak with resident #9 revealed she was not present. The housekeeper, while cleaning, stated they had not seen her in a couple of days, indicating they didn't think she was here. On . . . . /20204 at 11:09am The Administrator stated resident #1's wife (resident #9) was out of the facility with her family on a Leave of Absence (LOA). On at 11:45am Staff B stated, they recalled that day resident #1 committed . . . . , stating it was her, Staff C, and Staff D all in the triage room. She said she arrived at work that day and went to triage to get the report for the day, heard a knock at the door, opened the door, and resident #9 stated resident #1 had just killed himself. Continued to say she thought Staff C called 911 and Staff B and her ran to the room. When they arrived, they found resident #1 on the floor and already . Resident #9 stated	A 025		

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A 025	Continued From page 5 she had taken the belt from his . . . trying to save him. Resident #1 was already stiff, , , half closed, and dried . . . on the side of his . . . . The officer arrived with the box (the defibrillator), started . . . , and she started . . . . . , ... She stated they had to get a razor to shave him because he was very hairy so the pads could stick to his . . . . The first officer was getting the . . . ready. The 2nd officer arrived and took over the . . . . . , ... The paramedics arrived to assist as well. Stated they were trying to keep resident #9 calm as she was frantic on the phone calling her daughter and family. We contacted the daughter and her husband, and they arrived at the facility. Stated she thought she wrote a statement, but wasn't sure. The Administrator was asked to provide their investigation report and the statements the staff completed about the incident. On . . . . . at 12:09pm The Administrator stated, "we didn't do any investigation. We interviewed the staff and used the information provided to complete the Adverse Incident Report (AIRs). They did not make a statement. We didn't keep anything, and we didn't do anything else. The police came in, took over, and did their investigation." On . . . . . at 12:30pm Staff C stated, "we (referring to Staff B and Staff D) were all in the triage room on the 2nd floor. Around 7:15am - 7:20am, resident #9 knocked on the door and stated resident #1 just killed himself. We ran down to the room, Staff B, and me. Staff D was walking with resident #9. I arrived in the room and Staff B was right there with me. Staff B touched resident #1 stating he's . . . and not breathing. I called Staff I and Staff D called 911 while she was	A 025		

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A 025	Continued From page 6	A 025		

walking down the hall with resident #9. Resident #9 told us that she took the belt off before coming to the triage room. I saw the belt hanging on the ottoman. The ottoman was standing up and the belt was hanging on the left side. Resident #9 stated after removing the belt she laid resident #1 down in the bedroom. Staff C stated I just saw him and resident #9 that Sunday and we talked. He was fine. Yes, I give Resident #1 his medications sometimes when I'm working on the 2nd floor. I don't know if I wrote a statement, but we all came downstairs and spoke with the administrator one at a time and gave her the information."

On at 1:15pm Attempts made to contact Staff D to obtain her statements.

On at 9:10am Review of Resident #1's Progress Notes did not reveal any documentation of observation or monitoring of his activity prior to the incident.

On at 9:15am The Administrator stated, "yes, these are all the notes for resident #1. Residents #1 and #9 were a normal couple. They were always together, would come downstairs for their meals, but mostly stayed to themselves. They attended a few activities, and their family was very involved. They seemed fine the day before and their daughter was just here on Sunday to visit. I did overhear resident #9 tell the police she removed the belt from his ."

On at 9:30am The Administrator and surveyor entered the apartment of Resident #1 to observe where the resident was found unresponsive. The Administrator stated the bench, now located next to the wall, was behind the bed on its side when she entered the room

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A 025	Continued From page 7 the day of the incident. The administrator stated the staff informed her that resident #9 was in her bed as the residents shared separate rooms. On . . . . . at 1:39pm A copy of the local police report #FL0590600 dated Mon, at 7:28am read, . . . spoke with resident #1's wife. . . . She stated she went into resident #1's room this morning and found him sitting on the floor at the of the bed, with his against the bed, and there was a belt around his . . which was attached to a bench that was standing on its side. She removed the belt from his . . . and tried to lay him down but stated he was stiff and she was struggling. She went downstairs and told staff that her husband had committed and was up in the room . . . Staff immediately went to the room and contacted 911 for assistance. Resident #1 had previous . . . . . attempts in . . / . . . , and . . , . In , . . , resident #1 tried to hang himself with a belt at his daughter's home in Chuluota, however, the belt broke and resident #1 hit his . . . He was subsequently from . , , . . . , to . . . . . , ... Thereafter, he and his wife began living at the Watermark. Watermark staff stated his previous . . . . . attempts were not disclosed to them. He had only recently begun taking , . , ... medications. . . . . . at 3:36pm Resident #9's daughter stated during a phone interview Resident #1 just recently had thoughts of . . . . . She stated Resident #1 was resident #9's caregiver and the last surgery Resident #9 had changed her state of mind. Resident #9's daughter stated she moved them in with her for about 6 months. She stated Resident #1 attempted to commit at her house one time and decided to move them into an Assisted Living Facility. She stated,	A 025		

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A 025	Continued From page 8 something just triggered him to do it. She stated she's not sure if she told the facility or not about the prior attempt. She stated Resident #1 was fine the day before according to Resident #9. He was his normal self and kissed Resident #9 good night before going to bed. On at 5:15pm The Administrator stated she didn't document anything or see any documents. There was no monitoring or observations done for Resident #1. I know he had an with the Psychiatrist on . Staff I would have completed the assessment of resident #1's admission. I didn't know the Patient Assessment or Medication Guide was in his chart. I didn't see it until after the incident on . I don't know if the form was faxed or if the family brought it in during his admission. A review of the progress notes dated at 5:50pm for Resident #1's Interval History, states this is a medication management and follow up visit with Resident #1. I certify, within reasonable degree of medical certainty, that the benefit of using medication to manage this 's symptoms outweighs its risks. Information for this assessment was obtained from multiple sources, including review of medical records, as well as reports from nursing staff. The medication list was reconciled and updated, as well. As per nurse, continues "adjusting well to the facility". He is compliant with medication and care, and no side effects are reported or in evidence. Otherwise, no , , , or symptoms and or active / ideas or behaviors are reported. Exam: He denies or self-injurious ideas or impulses. Assaultive ideas or intentions are also denied.	A 025		

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A 025	Continued From page 9 Diagnoses: Major , single episode, moderate. Content / Clinical Summary: The focus of today's session was patient's symptoms of . He was validated, reassured and emotional support was given. Stress management strategies such as relaxation and breathing techniques, practicing mindfulness and meditation, as well as assertive time management were also addressed with . Pt was counseled about the rational for treatment maintenance of his medication regimen. Instructions/ Recommendations/ Plan: Continue current regimen. Behavioral measures should be used to manage this 's behavioral disturbance by the least restrictive means deemed safe and effective. Return weeks, or earlier as needed. On at 5:35pm The Administrator stated we do not have an actual facility psych doctor, but the psychiatrist would come to the facility to see our patients. I'm unable to find the report but I know he had an . On at 9:50am Staff I stated, yes, she did resident #1's assessment, with resident #9 and resident #9's daughter. Resident #1 did not have any family. They came for a tour, and I was pulled to do the assessment. I asked about resident #1's mental health and was told by resident #1 and resident #9's daughter there were no mental health issues. They were there for the tour and did not have a med list. Resident #9's daughter did most of the talking and stated resident #1 has after the loss of losing his first wife. I don't remember when the assessment plan was provided by their primary doctor, and it may have come in with the 1823 Health Assessment. After admission, I spoke with resident #9's daughter after reviewing	A 025		

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medications and was told they did not want any in-house services on site and would continue to use MD House Calls. I saw residents #1 and #9 every day for breakfast and lunch as they walked by my office to go downstairs. They would stop by my office, and we would have conversations about their grandkids, and they seemed fine. I didn't chart anything because there were no existing issues identified. I saw Resident #1 on that Friday and asked if the grandkids were coming, and he replied most likely. Their family was always coming to the facility and was very involved. I called the psych doctor to make him aware of the incident that occurred on [redacted].

A review of the Facility's Resident and Visitor Incident Response and Reporting Policy dated [redacted] stated, "It is the policy of Watermark Retirement Communities, LLC (WRC) and its affiliates that when an incident occurs, an incident review is completed, and incident report is prepared, and a plan of action is implemented to reduce of recurrence. An incident is a usual occurrence or event that may or did cause harm to a resident, associated, visitor, vendor, and/or other person. All incidents are to be reviewed and documented. The extent of the review will be dependent upon the severity or potential severity of the incident(s) and injury(ies) and may require a full investigation. Whenever an incident occurs the following steps are taken.
A. assessment and response.
B. reporting and notification.
C. Incident review; and
D. Follow up, if applicable.
. Incident Reports for Incidents Involving Resident(s):
a. The supervisor receiving information about an incident shall be responsible for completing an

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incident report on the date of the notice of the incident Reports for Assisted Living are completed in PointClickCare.
VI. Investigation
a. Any incident that is likely to result in liability against the community, an action against the community's license or a significant disruption to the community shall require an investigation at the direction of the Risk Management Department.
b. The Executive Director, or designee, shall start an investigation as soon as practical, which shall include:
i. Review the type of incident, including who and what is involved, the extent and severity of incident and injuries. Review all applicable policies related to the type of incident and who is involved. If the injury is an associate injury review the associated injury policy.
b. Interview all witnesses, residents, associates, and/or third parties, who were involved, present at the time of the incident and/or may have knowledge about the incident and obtain written, signed, and dated witness statements.
On . . . . . at 3:40pm The facility's psychiatrist's office who provided a , , progress notes report dated . . . . . was contacted. The call was transferred to the office manager and received a voice message.

On . . . . . at 3:47pm The primary doctors' office who completed Resident #1's 1823 Health Assessment was contacted for a phone interview. The call was transferred and received a voice message.

On . . . . . at 3:17pm The primary doctor called stating the last visit and only , , his office had with Resident #1 was on . . . . . . He stated Resident #9's daughter

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A 025	Continued From page 12 was very well known to him, she explained the situation about her father, and accepted Resident #1 as a patient. He stated Resident #1 was hospitalized after the visit to his office and was advised to follow up with a psychiatrist. He stated during the visit to his office he increased Resident #9's . . . . ER to 150 mg. On . . . . . at 1:53pm The medical records for Resident #1 were received stating the following: On . . . . . at 4:36pm Resident #1 was admitted to Orlando Health South Seminole Hospital Behavioral Inpatient Psych with a Diagnosis of . . . . Attempt, underlying major . . . . . , and continued management as per . . . . . The resident level of risk is high and was admitted on a . . . . . The chief complaint "me trying to hurt myself" as stated by patient. . . . . reads, "Patient reported attempted . . . . but then his daughter found him passed out on the floor. This is the patient's second attempt." He does report that he tried to hurt himself by tying something around his . . . . He does report feeling depressed, reports anhedonia, decreased energy, disturbed sleep, also reporting attempting . . . . as above. Patient report history of at least 1 previous admission to mental health facility. Treatment plan of daily medication management by psychiatrist, daily individual . . . . . by psychiatrist, 24/7 monitoring and care of patient by nursing staff. On . . . . at 1:39pm Resident #1 was discharged with long term goals, "establish or follow-up with established outpatient psychiatrist and maintain improvement in the above conditions. Certifications: I certify that the patient	A 025		

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A 025	Continued From page 13 needs 24 hours of medical supervision to improve the above-described conditions in the history of present illness. 2. A review of Resident #2's chart revealed a facility's admission on . A Health Assessment indicated a medical history, of one , left side, injury of , , other specified of , and structure, intercostal , , unspecified , unspecified severity, without behavioral disturbances, , disturbance, disturbance, , needs assistance with bathing, , toileting, and assistance with medication self-administration. On at 11:55am a phone interview with Resident #2's family revealed that resident #2 was left without showers for weeks at a time. She stated she would take resident #2 home for showers and to do her laundry. She stated a male resident later identified as resident #10 was left unsupervised to into resident #2's room daily, exposing himself and on the floor and resident #2 was afraid of him. On at 12:40pm Staff F stated yes, she thought there was a resident here by that name (referring to Resident #10). He might have moved out or he may be the one that , , I don't know resident #2 and I've only been here a few weeks. Yes, we give the residents their showers and change them. On at 12:44pm Staff G stated, yes there was someone here named Resident #10, but he , a few months ago. Resident #10 would into other resident's room. I never saw resident #10 go into resident #2's room, but heard about it. Staff H should be able	A 025		

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A 025	Continued From page 14 to tell you about it. Resident #10 meant no harm; he was a gentle giant. He was such a big guy so I could see others being afraid of him. They would keep overalls on him to try to prevent him from pulling down his pants and peeing, but it didn't always work. He didn't know what he was doing. He would just pull his pants down and pee wherever he was. We would call out his name to stop him, but it didn't work. On . . . . . at 12:48pm Staff H stated, Resident #2 would refuse showers. Stating she didn't do her showers and wasn't assigned to her, but knew she always refused. We have a shower book, or we could use POC (point of care) on the computer to update the assessments. I'm not sure where the shower assessment book is. Resident #2 would always say there's someone outside the window of her room, peeing, and that someone was in her room. She said it all the time, so it was hard to believe her because we would go look and there was no one outside. So, when resident #10 did pee in her room she was freaked out. Yes, Resident #10 did go into her room and pee on the floor. We would just redirect him. On at 3:50pm The Administrator provided a 10-page POC Legend Report for bathing/showering dated - which did not list any resident names or room number, stating she was unable to find any additional documentation for the shower logs or resident #2's refusal. A review of the shower Assessment book revealed resident #2 received only 2 showers on and . On at 4:55pm The Administrator	A 025		

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A 025	Continued From page 15	A 025		

stated she didn't know if resident #2 received or refused showers. Resident #2 was only in memory care for four months before her family moved her out. They would have to contact the IT department to determine how to obtain the report to show the residents updated in POC for their care.

A review of Resident #2 Progress Notes did not reveal any documentation of the incident of resident #10 entering resident #2's room.

3. A review of Resident #10's chart revealed a facility's admission on . A Health Assessment Form indicated a medical history of , dyslipidemia, needs supervision for all activities of daily living, and daily reminders for observing well-being, observing whereabouts and reminders for important tasks.

The Administrator was asked what measures were put in place for resident #10 to prevent from entering resident #2's room.

On at 4:55pm The Administrator stated Resident #10 was redirected from Resident #2's room. it's common behavior in memory care to pee when and wherever. Resident #10 was constantly redirected by the staff. Resident #10's family brought in overalls to help with him peeing, but it had a zipper, so it didn't prevent fully. He wore briefs as well. The staff did not document anything as they don't have access to PCC (point care click) just POC so they would just redirect him.

On at 9:50am Staff I stated Resident #2 would refuse her showers. The staff did not always do the residents' showers or document in

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A 025	Continued From page 16 POC. Resident #2's family was very involved and always there. I'm not aware of Resident #2 being left to sleep all day or missing any meals. I know that she did not want to participate in activities. As for Resident #10 he would do whatever he wanted. I'm not aware of him pulling his pants down and peeing in Resident #2's room. We would try to keep him in overalls, but if he didn't have them own, he would pull down his pants and pee. Resident #10's family did not want him medicated and he was difficult to change. We were constantly redirecting him. On at 4:05pm The Administrator confirmed the findings via a phone exit. Class II	A 025		
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	A 052		

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A 052	Continued From page 17 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 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	A 052		

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A 052	Continued From page 18 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 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,	A 052		

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A 052	Continued From page 19	A 052		

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 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

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A 052	Continued From page 20 . . . . 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 (#3, #4, #5). Findings: 1. Observations made during a med pass for resident #3 on at 9:50am revealed Staff A entered resident #3's room with the med cart. The resident who was sitting in her recliner near the window was identified by name and informed it was time for her morning meds. Leaving the med cart near the kitchen area, Staff A sanitized her , unlocked the med cart, and removed one pill pack card. Staff A proceeded to pre-pop the medication into a cup with her . . . . towards resident #3. The med tech proceeded to the locked medicine cabinet located in the kitchenette. The cabinet was unlocked, one pill pack card removed, and pre -popped the medication into the cup at the counter with the other medication. The med tech returned to the cart with the pill pack card, unlocked the computer and reviewed the Medication Observation Record (MORs) to confirm the pre-popped pills previously dispensed for the resident. The med tech turned and walked towards the resident who was sitting in the recliner, acknowledging by name again, stating the name, dose, and purpose of the medications. Staff A handed the medicine cup to the resident with a cup of water. After the resident was	A 052		

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A 052	Continued From page 21 observed taking the medications, Staff A returned to the cart to update the MORs. Staff A did not review the MORs prior to preparing nor did she take the medication cards to the resident to prepare in her presence. 2. On [redacted] at 1:45pm Staff A entered resident #5's room with her computer. She acknowledged the resident by name and stated it's times for your 2:00pm medication. Staff A sanitized her [redacted], unlocked the medication cabinet located in the kitchenette, and removed 1 pill bottle. She turned and walked towards the resident who was sitting in his chair and poured one pill into the lid of the pill bottle. The medication was then placed in resident #5's and handed him his cup of water. The resident took the pill and staff A returned the pill bottle [redacted] to the cabinet. Staff A did not review the MORs prior to preparing or read the label before administering the medication to the resident. 3. On [redacted] at 1:50pm Staff A entered resident #4's room with her computer. She acknowledged the resident by name and stated it's time for your 2:00pm medication. Staff A sanitized her [redacted], unlocked the medication cabinet located in the kitchenette, and removed 1 pill pack card. Staff A took the pill card to the resident, popped the medication into a cup in his presence and handed him a cup of water. Staff A stated the name and dose of the medication. Staff A returned the medication to the cabinet. Staff A did not review the MORs prior to administering the medication to the resident. On [redacted] at 1:55pm Staff A stated "Yes, I have received the 6hr initial training for assistance with self-administration of medication. I know I'm supposed to take the medications to	A 052		

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A 052	Continued From page 22 the residents and prepare in their presence. I guess I was just nervous because I've never done that before." On [redacted] at 4:05pm The Administrator confirmed the findings via a phone exit. Class III	A 052		
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	A 056		

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A 056	Continued From page 23 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 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	A 056		

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A 056	Continued From page 24 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, 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 record reviews and interviews, the facility failed to ensure medications were refilled in a timely manner to ensure doses were not missed for 1 of 9 sampled residents who required assistance with self-administration of medications (#8). Findings: On [redacted] at 10:25am during an interview with Resident #8 she "stated the facility does my medications. No, they don't tell me what I'm taking. They just bring it to me in a cup. No, I don't know if I've missed any doses." A record review of Resident #8 revealed a facility's admission date on [redacted]. A Health Assessment Form 1823 indicates known [redacted] of [redacted], Sulfur drugs, with a medical history of [redacted], HLD, [redacted], DM2, and needs assistance with	A 056		

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A 056	Continued From page 25 self-administration of medications. On [redacted] at 10:55am a review Resident #8's Progress Notes revealed from [redacted] the following medications were not administered or refilled: On [redacted] at 17:51 stated, [redacted] Oral Tablet 40 mg. Give 1 tablet by [redacted] in the evening for [redacted], medication not on [redacted]. On [redacted] at 16:57 stated, [redacted] Oral Tablet 40 mg. Give 1 tablet by [redacted] in the evening for [redacted], medication not on [redacted]. On [redacted] at 07:14 stated, [redacted] 75mcg tabs. Give 1 tablet orally one time a day for [redacted], medication not on [redacted]. On [redacted] at 06:00 stated, [redacted] 75mcg tabs. Give 1 tablet orally one time a day for [redacted], medication unavailable. On [redacted] at 18:33 stated, [redacted] Oral Tablet 40 mg. Give 1 tablet by [redacted] in the evening for [redacted], awaiting pharmacy delivery. On [redacted] at 06:07 stated, [redacted] 75mcg tabs. Give 1 tablet orally one time a day for [redacted], meds to order. On [redacted] at 11:10 stated, [redacted] 75mcg tabs. Give 1 tablet orally one time a day for [redacted], call granddaughter. On [redacted] at 17:23 stated, [redacted] Oral Tablet 40 mg. Give 1 tablet by	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 _____	03/19/2024

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 26 in the evening for medication not on . On at 17:22 stated, ER 600mg Tabs Give 1 tablet orally two times a day for , medication not on . On at 07:43 stated, ER 600mg Tabs Give 1 tablet orally two times a day for , medication not on . On at 07:29 stated, 75mcg tabs give 1 tablet orally one time a day for , medication not on . On at 17:05 stated, Oral Tablet 40 mg. Give 1 tablet by in the evening for medication not on . On at 17:04 stated, ER 600mg Tabs Give 1 tablet orally two times a day for , medication not on . On at 08:41 stated, ER 600mg Tabs Give 1 tablet orally two times a day for , medication not on . On at 07:01 stated, 75mcg tabs give 1 tablet orally one time a day for , medication not on . On at 17:14 stated, Oral Tablet 40 mg. Give 1 tablet by in the evening for medication not on . On at 2:22pm several calls were made to Resident #8's family to determine if they were aware of the unadministered medications.	A 056		

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 _____	03/19/2024

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 27 but no return call was received. A review of the facility's . . . . . Ordering Medications Policy states, Medication Order (outside pharmacy service): if a situation occurs wherein the delivery of medications from an outside pharmacy is delayed or uncertain, the community reserves the right to order a short supply from its preferred pharmacy. Medications orders are to be refilled when a five-day supply of the prescription remains. On . . . . . at 5:10pm The Administrator stated I will have to follow up with the nurse and see why there's a delay in the medication refills. I'm not familiar with Resident #8's medications. Maybe the family is responsible for refills. Sometimes the pharmacy will contact the doctor for a new script, and we're not notified. After reviewing the chart, the Administrator stated, oh, she didn't miss all her meds, just the ones from the Veteran's Affairs (VA). She gets some of her meds from another pharmacy and the family picks them up when ready. No, we have not contacted the doctor to inform him that the resident has not had those medications since . . . . . . I'm not sure why it took so long to contact the family. The family does not want and refuses to pay when we order them from our pharmacy. They say the medication is free at the other pharmacy. I've spoken with the family, and they said they will pick them up when ready. On at 4:05pm The Administrator confirmed the findings via a phone exit. Class III	A 056		