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 _____	R 05/15/2024

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 revisit survey to complaint #2024003581, #2024001901, and #2023018412 was conducted at The Watermark at Vistawilla from - . . . . 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: DEFICIENCY REMAINED UNCORRECTED Based on record reviews and interviews, the facility failed to provide adequate supervision to 1 of 1 sampled resident who eloped from the facility by maintaining a general awareness of the resident whereabouts and emotional general well-being. (#7). Findings: A record review of Resident #7 revealed a facility's admission on . A 1823 Health Assessment Form indicated a	{A 025}		

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{A 025}	Continued From page 2 medical history of major , , restlessness, agitation, and was not identified as an elopement risk. A review of an incident report dated stated an event reported to law enforcement of a resident elopement. On at 10:28am caregiver E stated Resident #7 was out of the facility on a field trip. On at 10:35am caregiver F stated Resident #7 has been in memory care for about 2 - 3 months. On Resident #7 was observed entering the facility after returning from a field trip escorted by the Activities Director. Resident entered the private meeting area and was asked if he recalls when he left the facility in and the events that happened. On at approximately 11:25am Resident #7 stated, "I don't remember or recall when that happened. Resident #7 stated I don't recall going to the hospital or being picked up by the police. It wasn't worth remembering. It's not like an arm off or anything. No, I don't recall living in an Assisted Living. Do I live in Memory Care now?" On at 1:08pm caregiver J stated, "yes, I work on the 2nd floor during 2nd shift. Prior to Resident #7 leaving, I did not see any changes in his mental status. He would just walk around inside the building but never left. We always get an update from the 1st shift before starting our shift. Nothing was alarming when. I did not see Resident #7 at first. Probably within	{A 025}		

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{A 025}	Continued From page 3	{A 025}		

an hour or hour and a half, at dinnertime I usually see everybody. Resident #7 normally comes around 4:30pm -5pm. After Resident #7 never came to dinner, I started contacting the other staff that I was working with asking if they had seen him. No one had seen Resident #7. Then I contacted his Guardian around 5pm and there was no answer. After that I just tried to figure out what to do. We searched around and waited a little bit longer before contacting his 2nd and 3rd emergency contact. No, we did not try to contact the 1st shift. We reached out to the higher staff. At that point, we reached out to the police. So, the search kind of starts immediately. It's hard to know when to move forward with the policy because we had not heard from the family. I'm not exactly sure what the policy would say. We wait until we here from higher up to know the next step. I'm not familiar with the policy, just the base outline."

On at 1:10pm caregiver K stated, "I saw Resident #7 in the morning as he was coming down for breakfast around 8am. I last saw him around 9:00am after giving him his meds. He did not show any signs prior to exit seeking. He would go outside and sit with another resident. He never stated he did not want to be here or wanted to leave. He did around the 2nd floor but never went into anyone's room except Resident #9. We knew he was missing because Resident #9 was asking his whereabouts. After the Department of Children and Families (DCF) left around 12:00pm. We started looking for Resident #7. I went to the front desk to ask if he left with his family. We thought Resident #7 was out with his family. No, Resident #7 has never gone out with his family. I just assumed because that what the other residents do. I didn't know prior to his leaving he

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{A 025}	Continued From page 4	{A 025}		

had guardianship. After dinner around 4pm, Caregiver I asked me if I had seen Mark. Caregiver K asked caregiver I had she seen resident #7. Caregiver I stated not since I passed meds this morning. Instead of caregiver I, calling the guardian she had another caregiver call. After returning from break at 9pm, caregiver I told me they still had not found Resident #7. I thought they had taken care of it. She said she had Caregiver J to call the guardian, but she wasn't answering. I called the guardian and other family members myself, called the Administrator and Business Office Manger after 9pm. The Business Office Manager was in charge of the facility that day but was not made aware that Resident #7 was missing until after calling her at 9pm. No, we never put the elopement policy in place. I don't know anything about it and never had to deal with anything like this before. The facility never contacted the police until after speaking with the guardian who informed them too. The Director of the kitchen called the police. The police arrived and informed us that Resident #7 was in the Oviedo Hospital."

On at 2:28pm caregiver I stated, "Resident #7 was always walking around the 2nd floor. I realized he was gone after my shift started. So, after I didn't see him. I started asking around asking the other staff and Resident #9. Afterwards, I came downstairs and asked the front desk. She said she wasn't sure and hadn't seen him. I didn't suspect that he was out of the building. So, at dinner time, I asked caregiver J to call his family to see if he was with them. Prior to that, he had never gone out with family. We didn't get an answer after contacting his family around 4pm. Resident #7 is not a resident that would leave. Yes, it was 2 hours or so in between the first call to his family that we didn't get an answer,

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{A 025}	Continued From page 5 so we called again. The other staff told me the last time they saw him was right before lunch. When it reached 9pm, I called again. I called the Guardian and still had no answer. Resident #7's family called . . . , and they said he was not with them. So, then I called my boss and then called 911. I don't know what the elopement policy says about time and how long to wait. I mean I read it, but it was a long time ago." On . . . . . at 9:47am A request was submitted to Oviedo Police Department to obtain a copy of the report pertaining to Resident #7's elopement. A review of a printed copy of Google Maps, the route taken by Resident #7 revealed he walked 2.6 miles. The route would take about 57 minutes. On . . . . . at 10:00am Resident #9 stated, "I had to constantly tell Resident #7 the times of the meals. He was getting weird, and his mind got really bad. Resident #9 stated, Resident #7 would tell me he wanted to go . . . to Orlando where his house was. He asked about getting a cab and how much it would cost. He said he wouldn't mind running away from the facility. There's a guy at the front desk on the weekends who told me that Resident #7 had tried 2 times before that same week to leave the facility." On . . . . . at 10:17am Resident #7's Guardian stated, "the first call came in around 11am when he didn't show up for lunch. No, I didn't speak with anyone. They just wanted to verify that I had not been there to pick him up. No, I had not picked him up before to take him from the facility since moving him in. The police stated they found him _ around looking	{A 025}		

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{A 025}	Continued From page 6 for his house. Resident #7 came from a rehabilitation facility, and it was a semi-locked facility." On . . . . . at 10:58am the Sales Director stated, "no, I am not the sales director that they're talking about, and I had not seen Resident #7 that day. Yes, there was an assessment done prior to him moving in. I connected the family with the nurse who completed a virtual assessment." The weekend front desk staff was contacted to confirm the statement provided by Resident #9 and stated the following: On at 11:54am the front desk staff stated, "I don't recall and have no need to deal with the residents. I did not tell anyone Resident #7 tried to leave before. I only help out on the weekends and that happened during the week." The facility's Elopement Policy states, " Suspected Resident Elopement b. If elopement is suspected, and the whereabouts of a resident cannot be established: 1. Associates shall immediately report the elopement to their supervisor or the Manager on Duty. The supervisor or Manager on Duty should immediately notify the Executive Director. 2. The supervisor or Manager on Duty should organize and conduct a thorough search of the community under the direction of the Executive Director, or designee. On . . . . . at 12:05pm the Administrator stated, Resident #7 was not an elopement risk when he moved in and had no history of mental health. Resident #7 was usually on the 2nd floor	{A 025}		

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{A 025}	Continued From page 7 with Resident #9. He would sometimes walk outside and attend activities. Yes, we kind of do monitoring but most of our residents are independent and have their rights. We do check every hours, but nothing is documented. On Resident #7's care plan it actually says 1 -2 hours to be checked on. The Administrator was asked about the delay in the staff implementing the elopement policy and stated, "the investigation is their statements of what happened and that's all I can go on. Yes, all residents have the right to leave. I can see they didn't follow the policy. The answer I got was he's an Assisted Living (AL) resident who showed no signs of eloping." On at 1:15pm the Administrator confirmed the findings stating I can see that they didn't follow the policy and it is an elopement. (photographic evidence obtained) Class II	{A 025}		