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 _____	02/27/2025

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

(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 #2025002368 and generator monitoring was conducted at Watercrest Winter Park Assisted Living and Memory Care on - 04, 2025. The facility had a deficiency 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 adequate supervision to prevent resident to resident for 3 of 4 sampled residents (#1, 2, 3.) Findings: Review of resident #3's record revealed a medical history of . On at 3:07 pm nurse A documented caregiver D witnessed resident #3 was in the dining room eating lunch when resident #2 approached resident #3 and punched him in his	A 025		

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A 025	Continued From page 2 upper left arm. On at 12:10 pm, caregiver D said that on resident #3 was sitting in a chair in the dining room when resident #2 approached him then said "you don't belong here. I'm the only man here." Resident #2 then hit resident #3 on his arm. Resident #3 responded "I've been here a long time." Caregiver D said nurse A was coming down a hallway, so caregiver D told her what happened. Nurse A then removed resident #2 from the situation. On at 12:55 pm, nurse A said that when caregiver D alerted her to the incident she looked at resident #3's arm and did not see an injury. The nurse escorted resident #2 to his room where he sat down. The nurse said that while going to the room resident #2 kept repeating "he should not be here." The nurse said resident #2 was always friendly towards her and she never saw him be aggressive towards staff or other residents prior to this incident. On at 2:40 pm, resident #3 was seen laying in his bed. He wore a short-sleeved T-shirt. There were no visible injuries on his left arm. Dry scabbed areas that appeared to be healing scratches were on his right upper arm. He said it was from him scratching himself. He was pleasantly and did not remember the incident with resident #2. Review of resident #1's record revealed a medical history of . An incident report on at approximately 2:00 pm, read the memory programming witnessed an altercation between	A 025		

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A 025	Continued From page 3 residents #1 and resident #2, both residing in our memory care unit. Resident #2 reclined resident #1 and made physical contact with her on the and on the left-side temple. In an attempt to protect herself, resident #1 covered her and he made contact with her . The memory programming , immediately intervened by moving resident #1 away from the situation while nurse A redirected resident #2. Nurse A called 911 due to the resident sustaining contact to the and being on a . An Advent Health Winter Park on at 14:55 read, battery (- from Watercrest Nursing facility. Patient (.) got involved with an altercation with a new patient from the Memory Clinic. Someone saw the patient. being punched in the by a new patient. Noticeable on the right side of the . Patient known and is at her baseline. . with multiple as well. A facility note on at 11:55 am read, resident #1 is showing signs of healing to areas of discoloration. Right temple and right , yellow in color and right purple in color. Continues to show signs of healing. A facility note on at 8:24 pm read, resident's #1 right side of lower area purple discoloration and the resident's right has purple discoloration no other . A facility note on at 6:08 pm read, resident #1 came to facility around 5 pm. No new orders emergency room (ER) unable to computed , , (CT) scan due to resident being unable to sit still. No on the , , or noted at this time.	A 025		

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A 025	Continued From page 4	A 025		

A facility note on at 5:23 pm read, resident #1 returned to community at approximately 5:09 pm.

A facility note on at 4:11 pm read, nurse A was notified by staff that another male resident hit her multiple times in the and left side temple. Resident #1 was covering and got hit on her . Nurse immediately called 911. Due to the resident getting hit in the and on a . Emergency medical services ( ) took resident.

On at 11:30 am, nurse A stated I was on duty for both residents #1 and #3. They were eating in the dining room. Resident #2 hit resident #3 on the arm. I walked resident #2 to his room and he stayed there. I'm not a doctor but resident #2 was a very nice gentleman. Maybe he got triggered by his post- stress ( ). I can't say for sure. Afterwards, I called management, the administrator and clinical , and they got involved. I started doing an incident report. While I was on the phone calling resident #3's family to tell them about resident #2 hitting him. While the residents were in the activity room resident #2 hit resident #1. Maybe he had another trigger. He was sent out to the hospital, but he returned to the facility. He hit a staff a few days later, the staff told management, and then resident #2 had to go. We called emergency services and 911. When resident #2 left he didn't come .

Caregiver B was asked if she recalls the incidents between resident #1, #2, and #3.

On at 11:36 am, caregiver B stated, I was here that day resident #2 hit resident #1 and resident #3. I didn't witness it. I just heard about

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A 025	Continued From page 5 it. Resident #2 was fairly new, maybe a week when the incident happened. No, he had never done anything like that before. An attempt was made to interview resident #1 about the incident that occurred between her and resident #2. On at 11:45 am, resident #1 smiled and began to giggle when asked if she recalled the incident. Resident #1's private caregiver stated, she doesn't remember what happened. She has . Her family hired me to come 2 hours every day and every other weekend due to the incident. The private caregiver stated resident #1 had on the side of her , , and . Nurse A was asked to clarify the timeframe in between taking resident #2 to his room after hitting resident #3 and the on resident #1. On at 1:00 pm, nurse A stated, I took resident #2 to his room after hitting resident #3. While in the nursing station which was close by resident #2's room. I could see his room from the nursing station. I was on the phone talking to resident #2's family telling them he hit resident #3. Resident #2's daughter stated, he's never had an incident like before. While on the phone, someone came to tell me resident #2 was hitting resident #1. After resident #3's incident, I didn't actually see resident #2 come out of the room but he did at some point. With everything happening, it's possible I didn't call right away after the first incident during lunch. I was trying to get the incident reports completed, letting the management know what happened and calling the resident's family. I remember telling resident #2's daughter, I have to go, resident #2 just hit	A 025		

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A 025	Continued From page 6	A 025		

another resident. By the time I got there someone had already broken it up. We called 911 because that was the second incident on the same day. Resident #2 was talking belligerent. When I got on the scene with resident #2 and resident #1. I was looking at resident #1 and they kind of pushed resident #2 away. I feel like I escorted resident #1 away from the incident. I believe resident #1 was never pushed to the ground. She had some redness on her lower , . Maybe possibly some , . She had some redness to the temple. I didn't see resident #2 hit her in the temple. They were just telling me that. Resident #1 was just there saying I'm sorry, I'm sorry. I know 100% after the resident #1 incident we could not leave resident #2 unattended. I remember telling the other staff that resident #2 could no longer be left unattended. I'm not sure who the staff was. I'd have to see them to know for sure. The clinical , told us we could not leave resident #2 alone until he got a sitter. Once resident #2 returned from the hospital he had a 24-hour sitter, and someone had to be with him at all times.

On at 1:39 pm, the memory programming , stated, resident #2 was napping in the community room in the chair by the TV. I brought all the residents out for an activity in the marketplace. Resident #1 was sitting out there and when resident #2 woke up he came out to the marketplace area around 2 pm. I was sitting at a different table at the moment helping another resident and was not sitting with resident #1. Resident #2 was upset because he said there were colored people, and we needed to do something about it. It wasn't normal behavior for him. He then sat down beside me. We laughed it off. I didn't think anything of it when he made the comment. The aid was black who

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A 025	Continued From page 7	A 025		

was with another resident. So, we thought he was talking about her. He then said, "I'll do something myself and started walking towards the living room area. He then stopped and started getting physical with resident #1. He pulled her wheelchair, reclined it, and she was lying flat on her . He started hitting her on her and her temple area. As soon as he reclined her wheelchair. I jumped up and started to move her, but it was locked, and he tried to pull her out of her chair. Once I started yelling trying to calm resident #2 down. I then asked if someone could help, and housekeeper F came and redirected resident #2 down the hall to his room.

The memory programming was asked about the incident of resident #2 hitting resident #3 during lunch. She replied, "No, I was not aware that resident #2 hit resident #3 and that resident #2 needed to be watched."

Review of resident #2's record revealed a medical history of , and unspecified severity with agitation.

Review of resident #2's medication observation record (MORs) indicated tab 500 mg give 1 tablet by every morning and bedtime for behaviors 8 am, 8 pm and tab 25 mg give 1 tablet by once daily for at 8 am.

Review of resident #2's service plan detail dated at 5:23 pm read, behavior support, assistance with behaviors:
with behaviors, observe for changes in behavior. Needs occasional behavior support services a few times per week.

An incident report on at 1405 read, at

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A 025	Continued From page 8	A 025		

approximately 2:00 pm, resident #2 was involved in an altercation with another resident, resident #1, both residents reside in our memory care unit. Resident #2 made physical contact with the resident multiple times in the and on the left-side temple. Nurse A intervened by redirecting resident #2 away from the situation while the memory programming , moved the other resident to safety. Due to the nature of the incident and concerns regarding resident #2's mental status, the nurse called 911. Emergency medical personnel and law enforcement arrived to assess the situation.

A Winter Park Police Department report dated at 14:09 read, responded to 1501 Glendon Parkway (Watercrest Winter Park) FL in reference to a disturbance. Upon my arrival, I made contact with management, the memory programming , , who provided me a sworn written and verbal statement advising, she was in the lounge with other residents when resident #2 approached her at the table she was sitting at and stated, "those colored people don't belong here" and pointed at resident #1. Resident #1 was sitting at a table when resident #2 aggressively approached her and reclined her wheelchair causing resident #1 to lay flat on her . Resident #2 began punching resident #1 on her , temple, , and briefly her when she was trying to defend herself. The memory programming , stated that she jumped up and tried to pull resident #1 away from resident #2 but he grabbed her sweater which caused an injury to her . The memory programming , advised, she told resident #2 "I will take care of her and she's fine" to which resident #2 response was "She's not fine because she's still alive." Another staff member approached and re-directed resident #2 away

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A 025	Continued From page 9 from resident #1 and she went to get help. A facility note on at 12:01 pm read, resident #2's Power of Attorney (POA) was informed that the resident would be an immediate discharge as of . A facility note on at 8:51 pm read, brother of resident came with family and emptied out resident's room. A facility note on at 6:01 pm read, resident #2 was walking into the dining room area. The nurse went to redirect resident away from the women. Resident #2 started to walk with this nurse as the resident passed the nurse, he stumbled. The resident caught himself using the handrails. When the nurse went to assist the resident to help stabilize him. The resident turned around and swung at the nurse's . This nurse used his arm to the punch. The resident then swung again missing the nurse's . Nurse E then walked about 5 . . where the resident calmed down and started to walk to his room. 911 was called, and the resident was sent to advent health winter park. The administrator ordered immediate discharge. A facility note on at 7:22 am read, resident #2 went to when staff and his caregiver tried to exit him out the room, he was trying to hit us at around 3:45 am. A facility note on at 3:05 pm read, resident is status post (s/p) return from hospital day #3. Private sitter is present. His is quiet and calm. A facility note on at 3:25 pm read, resident is s/p return from hospital following	A 025		

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A 025	Continued From page 10 behavior issues. A facility note on at 2:45 pm read, resident observed with private care takers no behavior noted. A facility note on at 11:55 am read, resident is alert and oriented to self, with to place and time and situation. The resident has a one-on-one sitter with him 24 hours a day for the next days while the community assists the POA with finding alternative placements with an LMH license. POA is in agreement with the resident needing to go to another community. A facility note on at 6:55 am read, new admit day #3, resident is stable. A facility note on at 10:36 pm read, resident came from hospital around 10 pm. Resident is alert and oriented with periods of A facility note on at 5:21 pm read, incident 7904 and 7908 both reported have been reported to department of children and families (DCF) reporting online for review. A facility note on at 3:48 pm read, aid came and got nurse stated resident #2 was sitting in the living room area and resident got up and started punching another female resident in the and pulling her wheelchair . The nurse called 911. A facility note on at 1:24 pm read, during lunch at 12:15 pm, nurse was notified by caregiver D that resident hit another resident on his left arm. Nurse went to dining area and	A 025		

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A 025	Continued From page 11	A 025		

observed resident's behavior and resident was yelling, "I will kick his ass" and get him out of here. The nurse immediately redirected the resident to his room. Resident was upset he should be the only man. The resident is in his room and is calm at this time.

A facility note on 5:50 pm read, new admit day #2, resident is stable.

A hospital report from Advent Health Orlando Emergency Department on read, reason for visit , diagnoses without hematuria, and episode of behavioral change.

On at 3:16 pm, housekeeper F stated, I was on the hallway cleaning on the first floor. I hear some screaming and go over there to the marketplace area, but I don't see anything. I talked to resident #2 and called him to come to me. I told the memory programming , I'll take resident #2 to his room. I called caregiver C, and she runs to the area. The caregiver was asked if she knew about resident #2 hitting resident #3. Housekeeper F stated, "I didn't see anything about resident #3 and didn't know about him getting hit by resident #2.

Review of the facility's and Neglect policy dated states, we will not tolerate any form of , neglect, or , . Associates must be skilled in working with residents so that challenging behavior is whenever possible and handled with dignity and compassion when it occurs. Maintain a ZERO tolerance for any form of , neglect, or , . Protect residents from by anyone, including but not limited to other residents. Provide a safe, comfortable, and

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A 025	Continued From page 12 home-like environment. On at 10:43 am, caregiver C stated, I didn't see anything. I just heard people talking asking for my assistance. I just sat with resident #2 in his room after the last incident with resident #1. I heard about him resident #3. No one asked me to keep an on resident #2 after hitting resident #3. I was asked if resident #2 had his medication. I asked to watch him after hitting resident #3. Resident #2 didn't go to his room until after the last incident of hitting resident #1. Resident #2 was kind of quiet and didn't like to sit with everyone. He spoke when spoken too. He had sat with the other men and resident #3 before and he was fine. Resident #2 had a 24-hour sitter after the second incident. At first, he was allowed to come out and sit with the sitter by himself, but then it changed, and he was made to stay in his room. On the last day, he had a fight with nurse E. When the sitter came that day, she was late, and we had to take turns sitting with resident #2. The sitter kept coming out of the room and then we told her that she couldn't bring him and would have to stay in the room. The incident that happened with nurse E, the sitter was out with him, and they were trying to redirect resident #2 to his room. On at 12:25 pm, an attempt was made to contact resident #2's POA but the number listed was no longer in service. An incident report on at 1615 read, resident #2 who resides in memory care, was walking into the dining area when nurse E observed him approaching a group of female residents. To ensure the safety and comfort of all residents, nurse E attempted to redirect resident #2. The resident began walking alongside the	A 025		

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(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 025	Continued From page 13	A 025		

nurse but lost his balance slightly as he passed, catching himself on the handrails. Nurse E reached out to assist him in regaining stability. At that moment, resident #2 turned toward the nurse and made abrupt movements in his direction. Nurse E instinctively raised his arm to avoid contact. Resident #2 then made another motion toward the nurse but did not make contact. In response, nurse E took a few steps , allowing resident #2 the space to de-escalate. The resident then calmed down and proceeded to walk toward his room independently.

On at 12:36 pm, nurse E stated during a phone call, yes, I was aware of the incidents that happened on between resident #1, #2, and #3. After the incidents, resident #2 had a 24-hour sitter. On , resident #2 hit me. He was walking out of his room, and I was redirecting him. He was walking towards the dining room where the other residents were. Yes, resident #1 and resident #3 were present. Resident #2 was stumbling, caught himself on the railing. Then he started swinging. The sitter was with him and maybe she didn't know he couldn't be around the residents. Resident #2 had no behavior issues prior to the first incident. I called the administrator and clinical , to make them aware. Resident #2 was sent out to the hospital and did not return.

The administrator was asked about the incidents between resident #1, #2, and #3 and what measures were put in place.

On at 1:39 pm, the administrator stated, the first incident occurred, and nurse A took the lead and had taken the residents to their apartments because we didn't know the

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	AL11969671	A. BUILDING: _____ B. WING _____	02/27/2025

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WATERCREST WINTER PARK ASSISTED LIVING AND	1501 GLENDON PARKWAY WINTER PARK, FL 32789

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A 025	Continued From page 14	A 025		

norm for resident #2. I found out a little bit after the incident with resident #2 and resident #3. By the time, I found out it was after the resident #1 incident. The clinical , was the one who gave the nurse instructions. I don't want to speculate, and it be better if she told you.

The clinical , was asked to clarify the incidents between resident #1, #2, #3, the measures put in place, and resident #2's admissions assessment.

On at 1:43 pm, the clinical , stated, initially nurse A had already redirected resident #2 to his room. I went to resident #3 and looked at his left arm and asked what happened. Resident #3 couldn't tell me, and the nurse called the doctor. The staff initially stayed with him and then an associate. Resident #2 was immediately placed on one to one. It was more explained to me, it was just a push to the arm, not a punch. We were in the process, putting things in place to start the one on one. Later, on he came out of his room after taking a nap and was in the common area to the market street. That's when he walked up to resident #1. He was taken to his room and 911 was called. They didn't want to take him because they didn't have any medical reason. The POA wanted him to go. After he returned to the facility from hitting resident #1 a 24-hour sitter was put in place until we were able to assist resident #2's family with finding a new location as he was being discharged from our facility. Our resident wellness director did both assessments on resident #2. During the first assessment, we told the POA we could not accept him. After the 2nd assessment resident #2 was cleared.

On at 2:15 pm, the resident wellness

Agency for Health Care Administration

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	AL11969671	A. BUILDING: _____ B. WING _____	02/27/2025

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A 025	Continued From page 15 director stated, the first assessment didn't go well. The POA came and resident #2 didn't want to get up or talk. I went one week for a 2nd visit and he was different, up moving around. Resident #2 was kind of where he was. I asked the staff who was providing care at the rehab, and they said they really didn't have any issues with him. He had only been there for a short time. The resident wellness director was asked about the functional evaluation for level of care (LOC) dated pre-admit, specifically for behavioral support as it indicated - needs occasional behavior support services a few times per week. The resident wellness director stated behavior support- that question is geared towards more resistance to care more for his ADL's. So, if he's able to wash himself, get dressed. The facility failed to follow their and neglect policy by maintaining zero tolerance for any form of by protecting residents from resident-to-resident . (photographic evidence obtained) Class II	A 025		