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 _____	05/22/2025

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
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	CZ821		

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CZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	CZ821		

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CZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit a preliminary report within 1 business day and a full report within 15 calendar days after a resident experienced a with injuries that resulted in a transfer to a hospital for 2 of 5 sampled residents (5, 7.) Findings: 1. Review of resident #5's record revealed a facility admission date of . The resident's medical history included and . He had a , . No assessment for risk of was done at move in. A 1823 indicated alert and oriented to person, place, and time. There were no special precautions. He needed assistance only with bathing. A health care provider ordered physical and occupational therapies and skilled nursing. On at 8:45 PM the resident had an unwitnessed . He said he while attempting to transfer from his wheelchair to his motor scooter. His power of attorney (POA) assisted him off the floor. The resident complained of a and reported a nosebleed. He had a	CZ821		

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CZ821	Continued From page 4	CZ821		

on his right . He said he hit the of his . 911 was called and he was taken to a hospital. He returned to the facility on the same day.

On at 4 PM, a request was made to review the preliminary and full reports for the with injuries and subsequent transfer to a hospital. The memory care director said the reports were not submitted because the resident returned to the facility on the same day.

2. Review of resident #7's record revealed a facility admission date of . The resident's medical history included 's , , toxic , , , , and , . No assessment for risk of was done at move in.

A 1823 indicated the resident needed supervision with ambulation and transferring and assistance with bathing, , grooming, and toileting. He was alert and responsive with . There were no special precautions.

On the resident that morning inside the dining room. Upon getting up from his chair he lost his balance and to the floor. He complained of , . 911 was called but he refused transportation to a hospital. At approximately 2 PM he complained of , from the and asked to be sent to a hospital. The service plan was not updated. A post-investigation was not done.

On at 6:55 PM he returned to the facility. He was very unstable on his . He complained of , and , . A health care provider ordered patches 5% one patch daily as needed, 7.5 mg once daily as needed for , ,

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CZ821	Continued From page 5 and , / , 5-325 mg one tablet every six hours as needed for , . He sustained a , , in the region. On at approximately 8:20 PM the resident was assisted with toileting. He said he was not ready to go to bed and wanted to sit in his chair. He was given a call pendant and instructed to call if he needed assistance. On at 10:29 PM the resident in his bathroom. He walked without assistance, lost his balance and hit his . An open was seen on his . 911 was called and he was taken to a hospital. He returned to the facility on the same date. The service plan was not updated. A post- investigation was not done. On at 12:07 PM, a request was made to review the preliminary and full reports for the two with injuries and subsequent transfer to a hospital on . The administrator said he could not find reports for those . Unclassified	CZ821		
A 000	Initial Comments A complaint investigation (2025004711) and a generator monitoring were 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	A 025		

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A 025	Continued From page 6 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 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	A 025		

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A 025	Continued From page 7 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 review and interview, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for with injuries for 3 of 5 sampled residents (2, 5, 7.) Findings: The facility's reduction program and policy, last revised , indicated, among other things, an assessment for risk of will be done at move in. If a resident has more than one in any rolling 30-day period, the resident, family and/or the responsible party should have a meeting with the community interdisciplinary team to review and implement the negotiated risk agreement. Complete the applicable resident incident report. Investigate cause of and complete occurrence report. Update service plan with new interventions appropriate for level and relative to the conditions involving the . A new intervention must be developed for each , or a determination made that current	A 025		

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A 025	Continued From page 8 interventions are appropriate and root cause analysis is performed to identify potential breakdowns that lead to the . Establish resident-specific interventions. are to be evaluated and trended monthly using the Quality Improvement Statistics form and the Quality Improvement Care monitors for . Track on the incident tracking log to assist in determining root cause or patterns. Complete post investigation report after each . 1. Review of resident #2's record revealed a facility admission date of . The residents' medical history included . No assessment for risk of was done at move in. A health assessment form (1823) indicated the resident had no special precautions and was independent with ambulation, transferring, bathing, , grooming, and toileting. On a health care provider ordered , 81 milligrams (mg) once daily and , 2.5 mg twice daily (.) On a health care provider ordered and , , as needed for , and a Neuropsychiatrist consult for agitation. On a service plan was initiated. preventions interventions were care associates will observe/report resident/environment for risk and ensure clutter free hallways and clear walking paths. On a health care provider ordered physical and occupational therapies. On a health care provider ordered	A 025		

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A 025	Continued From page 9 for five days for a On the resident received a walker from On at 3:02 PM the resident while outside with staff. The was witnessed. The resident tried to smell the plants. A risk assessment scored moderate risk. On at 10:47 AM the resident was found sitting on the floor in the hallway. She said she lost her balance. The note indicated there were no injuries. The service plan was not updated. A post- investigation was not done. There was no documentation to indicate a meeting was held with the responsible party to develop and implement a negotiated risk agreement. A risk assessment scored high risk. On at 3:12 pm it was documented the first day post on the right re-bandaged due to bloody discharge seeping through. The resident was sleeping all day. was held. Arousable but not able to stay awake. A health care provider was notified. On a health care provider ordered a right and and held for three days. On at 10:50 AM the resident's family member reported the resident had an episode of shaking her arms like tremors lasting a few	A 025		

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A 025	Continued From page 10 minutes. The resident was . Her were closed, and her was down. She replied to verbal stimuli with a nod or yes or no answers. 911 was called and she was taken to a hospital. A hospital history and physical indicated the chief complaint was . The resident suffered a two days prior but appeared to be uninjured, so medical treatment was not sought at that time, however, she had significant and of the right and were negative for . On the resident returned from the hospital. A 1823 indicated the resident needed precautions and was independent with ambulation and grooming. She needed supervision with transferring, bathing, , and toileting. A risk assessment scored moderate risk. On the service plan was updated to include care associates will assist resident to/from bathroom as needed and will encourage resident to remove throw rugs from apartment, resident will use call pendant for assistance with transfers and associates will ensure personal belongings are within reach to reduce risk of Refer to physical and occupational therapies for safety evaluation. On a health care provider ordered physical and occupational therapies and skilled nursing for right care. On at 12:10 PM, a request was made to	A 025		

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A 025	Continued From page 11 review an incident report and post-investigation report for the and . On at 2:03 PM, a second request was made to review the incident reports and post-investigation reports. The documents were not provided. 2. Review of resident #5's record revealed a facility admission date of . The resident's medical history included and . He had a , . No assessment for risk of was done at move in. A 1823 indicated alert and oriented to person, place, and time. There were no special precautions. He needed assistance only with bathing. A health care provider ordered physical and occupational therapies and skilled nursing. On a healthcare provider ordered , 81 mg once daily and 5 mg once daily (.) On at 8:45 PM the resident had an unwitnessed . He said he while attempting to transfer from his wheelchair to his motor scooter. His power of attorney (POA) assisted him off the floor. The resident complained of a and reported a nosebleed. He had a on his right . He said he hit the of his . 911 was called and he was taken to a hospital. He returned to the facility on the same day. The service plan was not updated. A post- investigation was not done. A risk assessment scored moderate risk.	A 025		

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A 025	Continued From page 12	A 025		

On at 4:17 PM the resident had an unwitnessed . He said he was transferring from his wheelchair to his couch. The service plan was not updated. A post- investigation was not done.

On at 1 AM the resident had an unwitnessed . He said he was getting out of bed when he slipped and . The service plan was not updated. A post- investigation was not done.

There was no documentation to indicate a meeting was held with the responsible party to develop and implement a negotiated risk agreement.

On at an unknown time staff went into the resident's room and found him sleeping on the floor. He said he was helping his wife with something when he . The service plan was not updated. A post- investigation was not done.

On at 11:30 AM the resident pushed his call pendant. He was found lying on the floor. He said he tried to get in his motorized chair when he slipped and . The service plan was not updated. A post- investigation was not done.

On at an unknown time the resident was found on the floor in his room. He said he tried to get in his chair when he slid from the bed. The service plan was not updated. A post-investigation was not done.

On at 8:27 PM the resident had an unwitnessed . He was found on the floor in his room. He was sitting upright against the couch. He did not have his , on. He said he was transferring to the wheelchair when he

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A 025	Continued From page 13 slipped off the couch. He said the couch was slippery. The service plan was not updated. A post- investigation was not done. On at 6:39 AM the resident was found on the floor in his room. He said he reached over and slid from the chair. The service plan was not updated. A post- investigation was not done. On at 6:15 AM the resident called for help. He was observed on the floor in his room. He said his hurt from a previous . The service plan was not updated. A post-investigation was not done. On at 9:41 AM the resident complained of severe left , . There was no visible . The resident said it was uncomfortable to sit upright. A healthcare provider was notified and ordered a stat , which revealed an acute left fifth . A care evaluation indicated the resident was at high risk for and had a history of . prevention interventions were documented. The risk evaluation portion was not completed. A 1823 indicated special precautions of , and the resident needed assistance with ambulation, transferring, bathing, , grooming, and toileting. A health care provider ordered home health services. On at 12:04 PM the administrator documented moving the resident and his wife to memory care was discussed with the POA, who said they would discuss it with other family members.	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 14 On at 7:30 AM the resident was found sitting on the floor next to his bed with his against the nightstand. He said he tried to transfer from the bed to his wheelchair. The service plan was not updated. A post-investigation was not done. On at 3:30 PM the resident was found on the floor in his room. He said he tried to change his clothes and wanted his wife to help him change. The service plan was not updated. A post- investigation was not done. On at 5:22 PM the resident was observed sitting in his wheelchair in his room. He said he while transferring himself from the bed to the wheelchair. He did not use his call pendant for help. The service plan was not updated. A post- investigation was not done. On at 12:12 PM the administrator documented the POA was still waiting to discuss a memory care transfer with family. On the resident said he at 2 AM. The service plan was not updated. A post-investigation was not done. On at 11:30 AM a caregiver responded to the resident's call for assistance and observed him sitting upright on the floor with his against the dresser at the end of his bed. The resident said he while transferring himself out of bed to his wheelchair. was seen on the wheelchair , extender. The resident said he hit his on the wheelchair. A was seen near his right , . His right , was and red. Two were on his right . Only one of the two wheelchair brakes was engaged. Emergency medical service ( )	A 025		

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	AL11969310	A. BUILDING: _____ B. WING _____	05/22/2025

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A 025	Continued From page 15	A 025		

was called, and he was taken to a hospital. The service plan was not updated. A post-investigation was not done.

On at 9:10 AM the administrator documented the resident needed a higher level of care and was discharged from the facility.

On at 11:10 AM, a request was made to review a negotiated risk agreement, post-investigation reports, and root cause analysis.

On at 12:40 PM, the administrator said post- investigations were documented on the incident reports. He said the post-interventions may not have populated on the service plan since the resident no longer lived in the facility.

On at 2:03 PM, a request was made again for any additional risk assessments, a negotiated risk agreement, and a root cause analysis.

No additional documents were provided.

3. Review of resident #7's record revealed a facility admission date of . The resident's medical history included 's , , , toxic , , , , , and , , . No assessment for risk of was done at move in.

A 1823 indicated the resident needed supervision with ambulation and transferring and assistance with bathing, , grooming, and toileting. He was alert and responsive with . There were no special precautions.

On the resident that morning inside

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A 025	Continued From page 16 the dining room. Upon getting up from his chair he lost his balance and to the floor. He complained of , . 911 was called but he refused transportation to a hospital. At approximately 2 PM he complained of , from the and asked to be sent to a hospital. The service plan was not updated. A post-investigation was not done. On at 6:55 PM the resident returned to the facility. He was very unstable on his . He complained of , and , . A health care provider ordered patches 5% one patch daily as needed, 7.5 mg once daily as needed for , , and , / , 5-325 mg one tablet every six hours as needed for , . He sustained a , , in the region. On at approximately 8:20 PM the resident was assisted with toileting. He said he was not ready to go to bed and wanted to sit in his chair. He was given a call pendant and instructed to call if he needed assistance. On at 10:29 PM the resident in his bathroom. He walked without assistance, lost his balance and hit his . An open was seen on his . 911 was called and he was taken to a hospital. He returned to the facility on the same date. The service plan was not updated. A post- investigation was not done. There was no documentation to indicate a meeting was held with the responsible party to develop and implement a negotiated risk agreement. On at 6:11 PM the resident was very	A 025		

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A 025	Continued From page 17 unsteady and unable to stand on his own. On at 6:38 PM the resident was in bed that morning complaining of , . He could not move without assistance from two people. A health care provider and family were notified. The resident was transported to a rehabilitation facility due to recent and generalized . A facility assessment indicated the resident had a history of multiple . Use every measure available consistently. Observe/report resident/environment for risk. Reduce the frequency of by providing necessary assistance. On at 4 PM the resident returned to the facility. On the resident was checked on every two hours. He was instructed to use the emergency call button if he needed assistance. On at 7:23 AM the resident slid out of his chair. When he got off the floor he complained of lower , . At 8:41 AM a health care provider was notified of the resident's decline since his return from rehabilitation. A request was made for physical and occupational therapies. The service plan was not updated. A post-investigation was not done. On the resident had an unwitnessed that morning. He was observed on the floor beside his wheelchair and recliner chair. He said he was transferring to the wheelchair. He lost his balance and . He sustained a on his right . The service plan was not updated. A post- investigation was not done.	A 025		

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A 025	Continued From page 18 On at 10:13 AM the resident was agitated due to . A health care provider was notified, who said the with was discontinued due to the resident being weak and a high risk for . An order was written for a one-time dose of due to agitation. On at 5:30 AM the resident became aggressive towards staff and hit one of them. On at 11:32 AM the resident was found lying on the floor in his room. His wife said he tripped on the of a chair. He sustained a superficial on his right outer . The service plan was not updated. A post-investigation was not done. On at 2:07 PM the resident complained of and in his when it was lifted. 911 was called and he was taken to a hospital. He returned the same day. On the resident was transferred to memory care. On a home health said the resident had low safety awareness and would need supervision when ambulating with his walker. An service plan had no specific prevention interventions. On the resident was observed ambulating with his walker and a at his side. A risk assessment scored high risk. On at approximately 5 PM the resident's	A 025		

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A 025	Continued From page 19 wife took him to the assisted living dining room for dinner. At approximately 6:15 PM his wife took him to a bathroom near the dining room. After leaving the bathroom he left his walker there then proceeded to walk without it. His wife alerted the concierge that he . He was lying on the floor in the lobby. He complained of left , , . He was alert and responsive. 911 was called and he was taken to a hospital where it was determined he had a left , . A risk assessment scored high risk. On the resident , , in the hospital. On at 12:07 PM, a request was made to review a negotiated risk agreement, post-investigation reports, and root cause analysis. On at 4:02 PM, no additional documentation was provided. Class II	A 025		