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 _____	07/22/2025

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 An control monitoring was conducted at Watercrest Winter Park Assisted Living and Memory Care on . The facility had a deficiency at the time of the survey.	A 000		
A 036 SS=D	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of . (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or , . hygiene may include the use of . . -based rubs, , handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an , exposure to transmissible . . agents in , , , , nonintact skin, and mucuous . . . . . during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow its control policy and procedure by failing to notify its local health	A 036		

AHCA Form 3020-0001

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

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A 036	Continued From page 1 department when 1 of 5 sampled residents (1) and 1 of 5 sampled staff (A) tested positive for Covid. Findings: The facility's control guidelines, revised on , indicated "appropriate conditions must be reported to local health departments." On at 9:10 AM, the wellness director said resident #1 was in the hospital for Covid. He said one staff member, later identified as nurse A, also tested positive for Covid. The administrator was present and said he did notify the health department of the Covid cases. A request was made to review proof of the notification. Review of resident #1's record revealed a diagnosis of and (.) On a health care provider ordered a , for and . On the resident complained of and not feeling well. Two rapid Covid tests were positive. The resident was sent to a hospital. Review of a rapid Covid test revealed nurse A tested positive on . On at 10:13 AM, the administrator said he did not notify the health department because he did not have access to the reporting portal. He said he did not call the health department for assistance or to verbally report the cases. Class III	A 036		

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