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 _____	07/31/2025

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
A 000	Initial Comments A complaint investigation #2025007482 and generator monitoring were conducted on at Watermark at Vistawilla, Winter Springs. A deficiency was found 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 review, observations and interviews, the facility failed to provide supervision to 1 of 2 sampled residents (#1) to prevent elopement and . Findings: In a record review of resident#1 revealed a date of admission of to the secured memory care unit. In addition, the resident's health assessment dated confirmed a medical history of 's, , unsteady gait, , , , general a and elopement risk. Resident#1 was oriented to	A 025		

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A 025	Continued From page 2 person and time and needed assistance with activities of daily living to include the following: assistance with ambulation, bathing, supervisor with , self-care, toileting, transferring and assistance with medication. In further review the record revealed the following facility's observation notes: at approximately 1:10am while doing checks and changes, resident was observed on the floor in a supine position. The resident had no visible injuries on the or of the . Resident had an unwitnessed slip and . Denies , Staff A informed management around 7:05am that resident#1 was up and early this morning. Resident was found in another resident's room. Staff went again to look for the resident and could not be found. Search was started in rooms, closets and showers, kitchen, empty rooms and under the beds. Resident was found outside leaning against the community wall of the property. Resident was found at 7:40am. The resident was assisted to her room. Resident looked and tired. No injuries 3:36pm Resident is observed exit seeking and voiced she wanted to leave and go home. Resident was redirected to her room. Resident observed exit seeking and voiced she wanted to go home. Resident redirected to game activity. 10:38am resident is no longer able to go on outings anymore due to the resident would not come inside the facility after activity director took	A 025		

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A 025	Continued From page 3 the resident outside for fresh air on the porch. resident was ambulating to the bathroom with her wheelchair and lost balance and on her bottom. The resident was observed on the ground beside her toilet. No injuries. Review of the individual care plan dated showed the following: Behaviors- one to one supervision required to address behaviors. - caregivers will closely observe and supervise and cue for safety. Caregivers will engage resident as needed. Resident care director will evaluate resident ability to stay in current environment and will provide supportive services. There were no updates to the plan after the elopement incident on . In review of the facility's staff schedule before and up to the elopement incident on , only one staff person for the overnight shift is scheduled in the memory care unit. Reviewed the facility's elopement policy states, memory care residents need not be assessed as they already have been determined to be appropriate for a secure area. The resident should be monitored for exit seeking behaviors and additional interventions should be implemented as well as updating the individual service plan. The community will verify that alarm exit doors are working properly each shift and work orders submitted for repair if not functioning as designed. Door alarms are recorded on the 24-hour report. In event of an elopement, risk management must be consulted before the	A 025		

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A 025	Continued From page 4	A 025		

destruction of any related 24-hour report. Omission and discrepancies will be reported to the Executive Director (ED) and there will be additional training, review of policies and appropriate disciplinary action taken.

In an interview on at 11am with staff A, she stated she was on duty the early morning of the incident. She stated it was around the time my shift was almost over when the incident occurred. The resident came over to me and was combative and stated she wanted to use the bathroom, I informed her to use the bathroom in her room, she said OK. She stated she went to assist another resident. At 6:30am after she was finished, she went to check on resident#1 and found she was not in her room. She started at about 6:35am and she kept looking for her. She didn't realize the alarm that went off was the fire door alarm. The next shift came in and helped look for her. Then they figured out that she must be outside. The staff found her outside around 6:45am, around the building near a gate, close to the facility wall. She had no injuries. She stated that resident #1 had , tendencies. She stated she was never informed to supervise her more or put her one on one after the incident. She stated she was not aware of any changes in supervising the resident more frequently. She stated the resident was always combative with staff. She stated there was only person on duty at that time overnight. She stated after the incident they scheduled 2 staff on the overnight shift. She stated she only works part time, and she stated she was suspended for 2 days due to the incident when it was not her fault as they only have one staff on the overnight shift for memory care. She stated the memory care is full with 23 residents and to have 1 staff person on overnight shift is not right and there is no way the residents are

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A 025	Continued From page 5 receiving the quality of care they need. In an interview on at 11:30am with staff B, he stated the emergency exit door resident #1 eloped through, had a due to a gap/space between the door jamb which allowed the resident to place her in the space and open the door. He stated the alarm did go off and the staff was able to obtain her after she completely exited the building. He stated since then he put a door jam in between the space so that could not happen again. He stated you need a fob to exit the door. He then demonstrated this. He stated unfortunately he could not show the video of the incident as the video expired 15 days after the incident. In an interview on at 12:30 with staff D, she stated there are not enough staff in memory care to care for and supervise the residents properly. She stated before the incident the overnight had only one staff, and the daytime had 2 staff caring for the residents. She stated that even with 2 staff on duty at a time and if one calls in sick, it is only one staff on duty. She stated resident #1 is always agitated and aggressive and wanted to go home. She stated the census at this moment is 23 residents. She explained it is difficult to care for residents with risks and and keep an on the residents that need more supervision like resident#1. In an interview on at 12:45pm with staff E, she stated there are not enough staff to meet the needs of the residents. She stated resident #1 is aggressive and exit seeking. She stated she does not stay in the common area she likes to go to in her room. She stated the medication has not helped and she remains the same. She stated that if a staff member calls out no one replaces	A 025		

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A 025	Continued From page 6 them. In an interview on at 10am with the Program Director/Director of Nursing for the Memory Care Unit, stated since the incident the fire door in memory care has been fixed and extra security cameras have been added to the fire exit door. She stated they also added a system to all management and staff phones that alert them if anyone uses the fire exit without a fob. She stated at the time of the incident there was only one staff member on the schedule for memory care and 2 staff for assisted living for the overnight shift. She stated that it has been changed since the elopement incident. She stated they now have 2 in the memory care unit and 2 on the Alf side for the overnight shift. After the incident the care plan was updated, and more supervision checks were added to the residents' chart. In an observation on at 11am with the maintenance staff, of the fire door in memory care unit, it revealed the fire exit goes to a stairwell that has an exit door to the front of the building. The door has an alarm when opened without fob. At the time of the incident the door had a gap in between the door jam, and the door was able to be opened when someone put their in between the space. More security cameras were added to the area and all management and staff phones are alerted when the door is opened. In an observation of resident#1 on at 12:20pm, the resident was around the memory care unit with her walker with no supervision. In an interview on at 1pm with the	A 025		

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A 025	Continued From page 7 administrator, he confirmed the findings. Photographic evidence taken Class II	A 025		