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 _____	11/14/2025

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
ZZ821	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.	ZZ821		

AHCA Form 3020-0001

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

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ZZ821	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	ZZ821		

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ZZ821	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	ZZ821		

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ZZ821	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 the facility reviews and interviews the facility failed to electronically submit to the agency a preliminary report within 1 business day of incident and a full report within 15 days of the incident for 3 of 5 sampled residents. (#1, #2, #6) Findings: 1. A record review of resident #1 revealed a facility admission date on . . A 1823 health assessment indicated a medical history of , , , and was not identified as a risk. The residents' activities of daily living notated she was independent with ambulation, toileting, and transferring. A facility note on at 2:43 PM read, per power of attorney (POA) the resident transitioned to hospice services Advent Health South inpatient. A facility note on at 11:22 AM read, the resident at Advent Health due to that occurred . 2. A record review of resident #6 revealed a facility admission date on . A	ZZ821		

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ZZ821	Continued From page 4 1823 health assessment indicated a medical history of , , , , receiving Vitas Hospice services and was not identified as a risk. The residents' activities of daily living notated she needs assistance with ambulation, toileting, and transferring. A facility note on at 11:43 AM read, resident received care today by Vitas Hospice left/right /left . Left covered secured with per Vitas nurse. A facility note on at 3:18 PM read, on Friday, around 1:15 PM, resident pressed her pendant and upon my arrival the resident was lying on her bedroom floor with all over her . A facility note on at 2:49 PM read, hospital. A facility note on at 2:45 AM read, around 2:45 AM, med tech called this nurse's attention to evaluate resident that had with no injury. She told the nurse that he was walking towards the bathroom and in the hallway hitting her on the floor. Resident was sent to Oviedo Medical Center ER. A facility note on at 8:11 AM read, as per staff and POA, resident is complaining of , in tailbone area and unable to move. POA agreed to send the resident to emergency room. A facility note on at 8:46 PM read, around 4:20 PM resident and is complaining of , in her tailbone area. As per resident, she slid to the floor while sitting in her recliner trying to stand up.	ZZ821		

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ZZ821	Continued From page 5 3. A record review of resident #2 revealed a facility admission date on . A 1823 health assessment indicated a medical history of , uses a walker and identified as precautions. A facility note on 8:05 PM read, resident returned from hospital to the community at 4:30 PM. Resident has hospital treated with . A incident report dated at 7:30 PM read, resident observed sitting upright in his recliner chair observed on carpet. The resident and crawled himself to his recliner chair without asking for assistance / pressing pendant. The resident, , voiced he was heading to get on the bus to see his wife (wife expired). Resident has a on his left /upper arm, and left skin . A facility note on at 8:26 PM read, aide went to routinely check on the resident, upon entering the door the resident observed sitting in his recliner chair, observed on carpet. The nurse was notified that the resident out of his bed and crawled himself to his recliner chair without asking for assistance / pressing pendant. The resident, , voiced he was heading to get the bus to see his wife. Resident transported to the hospital. On at 4:40 PM, the DON stated she did not do an adverse for the because resident #2 did not anything. Adding, we have 3 days to report the incident to determine if there's a . On at 11:25 AM, the DON confirmed that she did not submit 3 adverse reports for	ZZ821		

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ZZ821	Continued From page 6 resident #6 or report the 's resident #1 and #5. The DON was made aware that the day 1 report should be submitted within 1 business day of the incident which requires the transfer of the resident to a unit providing more acute care. On at 10:00 AM via phone exit, the Administrator and DON confirmed the findings. Unclassified	ZZ821		
ZZ875 SS=D	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date	ZZ875		

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ZZ875	Continued From page 7 of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers. (d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues. (e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b),	ZZ875		

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ZZ875	Continued From page 8	ZZ875		

employees must receive the following training:
1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).
2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information, and stress management.
3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning ,. For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning ,, chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing

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ZZ875	Continued From page 9 education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , , must complete the training required in this section before , , . Proof of completion of equivalent training completed before , , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview,	ZZ875		

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ZZ875	Continued From page 10 the facility failed to ensure 3 of 7 sampled caregivers completed a 1-hour training program on and Related 's (ADRD) within 30 days after beginning employment (B, C, E.). Findings: A review of Caregiver B's record revealed a hire date on , Caregiver C's hire date on , and LPN E's hire date on . The records did not contain documentation to indicate the caregivers completed a 1-hour training program on ADRD within 30 days after beginning employment. On at 3:44 PM, the DON confirmed the training was missing for all 3 caregivers. On at 10:00 AM via phone exit, the Administrator and DON confirmed the findings. Class III	ZZ875		
A 000	Initial Comments A complaint investigation #2025013728 and generator monitoring was conducted at The Watermark at Vistawilla on - . The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness	A 010		

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of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility:
(a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.
(b) A facility may admit or retain a resident who requires the use of assistive devices.
(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.
(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the

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A 010	Continued From page 12 term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency	A 010		

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A 010	Continued From page 13 criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;	A 010		

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A 010	Continued From page 14 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record reviews, and interviews the administrator failed the responsibility for determining the continued appropriateness of placement for 1 of 5 sampled resident (#3); failed to obtain a new AHCA Form, 1823 Health Assessment completed by the healthcare provider for continued residency after a significant change for 2 of 5 sampled residents (#4, #6) as required in a assisted living facility (ALF).	A 010		

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A 010	Continued From page 15 Findings: 1. A record review of resident #3 revealed a facility admission date on . A 1823 health assessment indicated a medical history of 's with dyskinesia, , , walking up to 250 with a 2 wheeled walker with minimal assistance, and continuation of and , , services. Resident #3 was identified as a risk and needs assistance with ambulation, bathing, , self-care, toileting, and transferring. On at 10:52 AM, after review of resident #3's progress notes, the Administrator confirmed resident #3 still lives at the community and was scheduled to return today. On at 3:54 PM, Caregiver D stated resident #3 was supposed to return to the facility today. Adding, we would have to do everything because he could not stand. It takes 3 of us to get him up. He's and does not help. Further stating, sometimes we would have to call someone from assisted living to help with him. On at 8:36 AM, Caregiver G identified resident #3 in the dining room. Observation revealed resident #3 sitting in a high wheelchair eating breakfast. On at 8:44 AM, Caregiver G stated resident #3 returned to the facility last night or first thing this morning from rehab. He was gone for a long time because the staff was unable to lift him. She stated when they provided care this morning, he was unable to assist and went down. He was unable to lift himself and starting shaking. They had to call for the nurse to come assist the	A 010		

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A 010	Continued From page 16 other 2 caregivers. Adding, LPN H said that she's going to call his family and make them aware. On at 9:15 AM, LPN H stated resident #3 was sent out for strengthening and returned on to the facility. He was gone for about 2 months. LPN H added, resident #3 is a 3 person assist. He is unable to stand on his own and he starts to shake. LPN H stated she will notify resident #3's family and the DON. A facility note on at 4:05 PM read, resident picked up this evening at 3:31 PM to be transported to Encompass for rehab due to . A facility note on at 7:13 PM read, Legacy Pointe A review of resident #3's - Discharge Summary from Legacy Pointe at UCF stated patient's ability impacts patient's ability to maneuver throughout the environment safely without loss of balance. Patient present with global , impacting functional balance. Limited and truck mobility results in increased risk of . requires step by step slow cues to be able to complete any task and often not able to comprehend, needs Mod (moderate) to Max (maximum) depending on the day. Patient does not have sufficient upper extremity and strength to push up and stabilize in seated position. Supine To / From Sit Goal: LTG 3 (long term goal): Not Met Chair To / From Bed Transfers Goal LTG 4: Not Met Sit To / From Stand Transfers LTG 5: Not Met Gait LTG 8: Partially Met	A 010		

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A 010	Continued From page 17 On at approximately 12:45 PM, the DON stated the former director of memory care completed resident #3's assessment while he was in rehab. Adding, she was told resident #3 needs standby, but he was a 2 person assist and was able to walk while in rehab. Further stating, she was told this morning by LPN H as to what happened. On at 4:05 PM, the DON stated I will contact resident #3's family and start the discharge process. 2. A record review of resident #4 revealed a facility admission date on . An 1823 health assessment indicated a medical history of , , requires cueing for tasks and was not identified as a risk. His ADL's stated he needs supervision with ambulation, bathing, toileting, and transferring. A facility note on at 7:15 PM read, the resident had unwitnessed . A facility note on at 3:45 PM read, resident in his room due to ambulating to his bed with 4 wheeled walker. On at 4:05 PM, the DON provided an updated 1823 for resident #4. Further review revealed resident #4 was not identified as a risk. 3. A record review of resident #6 revealed a facility admission date on . A 1823 health assessment revealed a medical history of , , receiving Vitas	A 010		

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A 010	Continued From page 18 Hospice services and was not identified as a risk. Her ADL's stated she needs assistance with ambulation, toileting, and transferring. A facility note on at 3:18 PM read, on Friday, around 1:15 PM, resident pressed her pendant. The resident said she lost her balance while she was trying to pull up her pants and forward first. A facility note on at 2:45 AM read, med tech called this nurse's attention to evaluate resident that had with no injury. A facility note on at 6:45PM read, resident had an unwitnessed this afternoon around 4:30 PM. On at 2:35 AM, the DON confirmed she did not obtain a new 1823 for resident #6 identifying her as risk. On at 10:00 AM via phone exit, the Administrator and DON confirmed the findings. (photographic evidence obtained) Class III	A 010		
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	A 025		

Agency for Health Care Administration

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A 025	Continued From page 19 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 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	A 025		

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A 025	Continued From page 20 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 observation, record reviews, and interviews, 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 and injuries for 3 of 6 sampled residents (#2, #4, #6). Findings: 1. On observation of resident #6 lying in bed revealed several large black and blue on the left side of her . A record review of resident #6 revealed a facility admission on . A 1823 health assessment indicated a medical history of , needs assistance with activities of daily living, , receiving vitas hospice services, and was not identified as a risk. A facility note on at 11:43 AM resident received care today by Vitas Hospice left/right /left . Left covered secured with . A facility note on at 3:18 PM on Friday, around 1:15 PM, resident pressed her pendant and upon arrival the resident was laying	A 025		

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A 025	Continued From page 21 on her bathroom floor with all over her . Resident said she lost balance while she was trying to pull up her pants and forward first. A facility note on at 2:49 hospital. A facility note on at 1:48 PM resident returned to community at about 12:15 PM from the hospital, reminded to use her pendant to call for assistance. Staff instructed to keep rounds. A facility note on at 6:17 PM hospital. A facility note on at 6:30 PM resident in hospital. A facility note on at 2:31 PM resident in the hospital. A facility note on at 7:18 PM hospital. A facility note on at 6:24 PM hospital. A facility note at 4:43 PM hospital. A facility note on at 2:45 AM, around 2:45 AM, medication technician called this nurse's attention to evaluate resident that had with no injury. She told the nurse that she was walking towards the bathroom and in the hallway hitting her on the floor, no visible injury, resident sent to Oviedo Medical Center ER. A facility note on at 4:34 PM hospitalized. A facility note at 6:45 AM hospital. A facility note on at 3:39 PM hospital.	A 025		

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A 025	Continued From page 22 A facility note on at 8:11 AM per staff and POA, resident is complaining of , in tailbone area and unable to move. POA agreed to send resident to ER. A facility note on 6:45 PM resident had an unwitnessed this afternoon around 4:30 PM. Resident was sitting in a position directly in front of her chair and she did not hit her . She said she slipped when she tried to stand up with her walker and to go to dinner. On at 11:07 AM, the Vitas Nurse observed providing care to the resident, stated she was on her way to the residents' room for care the day she which was last Friday. Adding, resident #6 requires assistance with toileting, transferring, bathing, and ambulation. Further stating, resident #6 sometimes forgets that she needs assistance, will try to get up and do it by herself, and has her pendant on her . On at 11:10 AM, the power of attorney (POA) of resident #6 stated she last Friday, and just returned around 4 PM on Sunday from the hospital. Adding resident #6 is on hospice and has . Further stating, this was not the first and resident #6 needs assistance but forgets to use her pendant which is in reach. The POA stated she has no concerns with the staff and the care they're providing to resident #6. On at 1:45 PM, observation in resident #6's room, escorted by Caregiver A revealed the resident had 2 signs posted on the closet doors across from her bed as reminders to press the call pendant for assistance when she needed to use the bathroom.	A 025		

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A 025	Continued From page 23 On at 1:45 PM, Caregiver A stated she assist resident #6 when she presses her pendant. Adding, the signs have been posted for a while, but resident #6 still forgets to call. On at 9:15 AM, Nurse LPN H stated resident #6 last Friday and we got an order to send her out. I was told by hospice she had an orbital . On at 11:44 AM, the Director of Nursing (DON) stated she met with resident #6's POA and they made the decision to switch to assistance due to the resident falling and not asking for help. Further stating, resident #6 beforehand used a walker. The DON stated the resident still wants to be independent and try to do things on her own. The staff started using the wheelchair escorting her to the dining room and doing 2-hour safety checks. Resident #6 does use her pendant, but when we ask why she doesn't wait for the staff, she replies she can do it. 2. On during the entrance conference, the Administrator identified resident #2 out of the facility due to a . An incident report dated stated or of bones or joints. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident. Location to which the resident was transferred: Encompass Health Rehabilitation. A record review of resident #2 revealed a facility admission on . A 1823 health	A 025		

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A 025	Continued From page 24	A 025		

assessment indicated a medical history of , physical limitations walker, and identified as precautions. His activities of daily living requires supervision in ambulation, bathing, , self-care, toileting, and transferring.

Review of the Risk Assessment effective date with a move date on identified resident #2 as a high risk.

A facility note on at 8:34 AM resident in rehab.

A facility note on at 4:47 PM the resident is in the hospital.

A incident report dated at 7:47 AM resident was taken a shower; Caregiver F was drying him off as he was sitting in the wheelchair in the bathroom. Caregiver F was bending down to dry him. The resident threw himself out of the wheelchair. He was having , and , . The resident on top of Caregiver F, and they both hit the floor. The resident has some injury to the .

On at 10:25 AM, the DON stated resident #2 on and that he had more prior to that time. She added the are documented in the incident reports.

On at 4:28 PM, at attempt was made to interview Caregiver F regarding the incident and she refused to be interviewed. She stated she refused to speak with me and was tired of talking about it. Further stating, the surveyor could speak with her lawyer and asked if we needed the phone number. The caregiver was made aware, and we do not speak with lawyers, and the

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A 025	Continued From page 25 interview was terminated. On the Administrator provided a copy of Caregiver F's statement date of incident , Incident time at 7:30 AM in resident room. Before the incident the resident was sitting in the wheelchair, and she was drying him in the bathroom. A facility note on at 9:59 PM checked and changed at 9:10 PM. The resident is stable with no complaints. A facility note on at 10:22 PM the resident was checked and changed at 9:29 PM. The resident was alert and oriented. A facility note on at 9:54 PM, the resident was checked and changed at 9:35 PM. A facility note on at 6:32 PM, the med tech voiced to this nurse during showering today that the resident left observed on the backside of . A facility note on at 8:02 PM, the resident's right observed a little compared to his left . A facility note on at 7:57 PM, post , has not experienced any changes since their . Resident uses assistive device properly. Provided verbal cues for proper utilization of assistive devices. A facility note on at 4:55 PM, post , has not experienced any changes since their . Resident uses assistive device properly. Provided verbal cues for proper utilization of assistive devices.	A 025		

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A 025	Continued From page 26 A facility note on at 9:42 PM post , has not experienced any changes since their . Resident uses assistive device properly. Provided verbal cues for proper utilization of assistive devices. A facility note on at 9:53 post , has not experienced any changes since their . Resident uses assistive device properly. Provided verbal cues for proper utilization of assistive devices. A incident report dated at 11:29 the resident pushed his emergency pendant, so staff went to room and found resident lying on the floor beside his kitchen sink. The resident has a small on left arm that was reopen from a previous . Resident stated he was trying to go to the bathroom. A facility note on at 6:47 PM the resident had a prior scab located left , voiced to nurse he scratched the site and the scab peeled . A facility note on at 4:16 PM the resident refused dinner and refused to have food delivered to his room. A facility note on at 12:09 PM post , has not experienced any changes since their . and . Resident does not use assistive device properly. The resident was encouraged to wear proper footwear. Provided verbal cues for proper utilization of assistive devices. A facility note on at 8:30 PM post , has not experienced any changes since their	A 025		

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A 025	Continued From page 27 . . Resident does not use assistive device properly. Provided verbal cues for proper utilization of assistive devices. A facility note on at 1:40 PM home health order faxed to trilogy for care A facility note on at 10:59 AM per POA voiced to this nurse if we could provide first aid due to the resident left that occurred from his previous . . A facility note on at 8:22 AM 5% patch, resident bed because he . A incident report dated at 7:30 PM at approximately 7:30 PM after checking on the resident fifteen minutes prior to resident was heard screaming for help by staff in the hallway. The resident was observed on the floor in a left lateral position. observed on left . Resident stated he did not hit his and was trying to walk to the bathroom and that's when he on the floor. A facility note on at 10:34 PM observed resident lying on the floor on his left arm in his room. He stated he tried to go to the bathroom by himself. Denied pressing his pendant before or after the incident. He was yelling out for help by staff and was observed on the floor by the caregiver. Resident was assisted to sit in his wheelchair. A facility note on at 3:47 PM post , has not experienced any changes since this . No injuries, Resident does not use an assistive device. A incident report dated at 3:30 PM	A 025		

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	AL11969310	A. BUILDING: _____ B. WING _____	11/14/2025

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A 025	Continued From page 28	A 025		

after doing my rounds 30 min later staff kept hearing screaming and thought it was the TV. Started checking every room and saw the resident lying inside on his room floor of his door. When staff opened the door, the resident was lying on a pillow balled up asking for someone to come help him off the floor. When getting the resident up, the staff noticed he had a scratch or torn skin on his left . The resident stated there was a bug he was trying to run away from.

A incident report dated at 8:10 PM resident was observed sitting upright against the refrigerator. The resident wheelchair, walker positioned in the bathroom not in use. Resident voiced to a nurse that he was going to the bathroom. Resident voiced lower , .

A facility note on at 8:57 PM notified nurse resident was observed sitting upright against the refrigerator. The resident wheelchair, walker positioned in the bathroom not in use. The resident alert but due to repeated not within normal limits. Resident voiced he was going to the bathroom, voiced lower , , and was sent out to the hospital.

A incident report dated at 5:50 PM resident had a witnessed in the elevator. Resident observed lying on his left side in the elevator, wheelchair positioned beside him. Resident alert voiced he was pushed by the server to the elevator. He went to press the button in the elevator and .

A facility note on at 6:49 PM resident had an unwitnessed in the elevator. Resident observed lying on his left side in the elevator, wheelchair positioned beside him.

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A 025	Continued From page 29	A 025		

A incident report dated at 11:01 AM read, walked in and saw the resident lying on the floor on his right side. Resident said he was trying to go to bed on his own.

A facility note on at 11:10 AM read, per staff resident, was noted on the floor.

A incident report dated at 3:00 PM read, at approximately 3:00 PM, the resident was observed on the floor in a left lateral position. The resident stated that he was trying to go to the bathroom.

A facility note on at 11:48 PM read, resident paged, entered room and he was on the floor lying on his left side. He stated that he needs to get in his chair to see his sister.

A facility note on 8:05 PM read, resident returned from hospital to the community at 4:30 PM. Resident has hospital treated with

A incident report dated at 7:30 PM resident observed sitting upright in his recliner chair observed on carpet. The resident and crawled himself to his recliner chair without asking for assistance / pressing pendant. The resident, , voiced he was heading to get on the bus to see his wife (wife expired). TResident has a on his left /upper arm, and left skin .

A facility note on at 8:26 PM aide went to routinely check on the resident, upon entering the door the resident observed sitting in his recliner chair, observed on carpet. The nurse was notified that the resident out of his bed and crawled himself to his recliner chair without

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A 025	Continued From page 30	A 025		

asking for assistance / pressing pendant. The resident, , voiced he was heading to get the bus to see his wife. Resident transported to the hospital.

A incident report dated at 00:00 walked into resident's room, he was laying on the floor behind the door. Resident stated he was going to open the door for his wife.

A incident report dated at 7:51 PM, at approximately 7:51 PM, resident was observed on the floor on his right lateral position next to his recliner. Resident stated that he was trying to go to the bathroom in his wheelchair and he bounced away.

A facility note on at 9:29 PM resident observed on the floor next to his recliner in a right lateral position. Resident stated that he was attempting to go to the bathroom on his own.

On at 10:36 AM, Caregiver A stated resident #2 is a risk and has had a lot of before this last one on that sent him out. She stated the resident uses a wheelchair and requires assistance using the bathroom, transferring, and toileting. Further stating, the resident usually calls for help after he has .

On at 10:45 AM, Caregiver B stated she provides care to resident #2 and he needs assistance with toileting, transferring, and bathing. Adding, she reminds resident #2 to use his pendant when he needs assistance. Further stating, she checks on the residents every hour during her shift.

On at 9:15 AM, Nurse LPN H stated she was aware that resident #2 was a risk due to

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A 025	Continued From page 31	A 025		

his . We put him on / . The DON would send him out for strengthening.

On at 11:57 AM, the DON stated she spoke with resident #2's POA recently before the stating that the resident needed a private sitter. Adding, now that resident #2 is out of the facility they will further look into it once he returns from rehab due to his and . The DON added she used to be over memory care, recently moved over to assisted living and was unaware of the prior from admission to approximately or .

On at 3:25 PM, the POA stated resident #2 was in rehab due to his . Adding this was his first injury and he was with staff. She stated after his last on she spoke with the staff to make sure his wheelchair, and walker was not within reach. Adding, during an activity he returned to his room and left in his wheelchair. The staff was someone new who did not know how to put resident #2 in his recliner. Further stating, resident #2 has a call pendant and forgets to push it for assistance and remembers to push it after he has . The POA stated resident #2 in the early stages of , has no concerns with the staff, and they are keeping her informed with resident #2's care.

Resident #2 has had a total of 11 since his admission on to the facility.

3. A record review of resident #4 revealed a facility admission on . An 1823 health assessment indicated a medical history of , , , some , and was not identified as a risk. His ADL's stated he required supervision with ambulation, bathing,

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A 025	Continued From page 32 toileting, and transferring. An incident report dated revealed care staff alerted the nurse to where the resident was found in a supine position on the floor, resident awake, alert to self but unable to recall or provide an account of what occurred. Resident was transported to Advent Health Altamonte Springs. A medical report from Advent Health Oviedo dated revealed resident #4 was admitted on and discharged at 9:43 PM with results as no gross acute body , no acute , and no acute . A risk assessment, effective date revealed a score of 19, high risk. A risk assessment, effective date revealed a score of 13, moderate risk. A incident report dated at 6:45 PM the resident noted in a supine position on the floor. Awake & alert to self. Not able to make an account of what occurred. Resident was kept stable until 911 arrived. A facility note on at 7:15 PM the resident had unwitnessed . A incident report dated at 3:45 PM the resident in his bedroom due to ambulating to his bed with 4 wheeled walker in use r/t losing his balance. Resident observed sitting upright on his bottom side beside his bed 4 wheeled walker tilted over. A facility note on at 3:45 PM read the	A 025		

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A 025	Continued From page 33 resident in his room due to ambulating to his bed with 4 wheeled walker. On at 11:58 AM, the POA stated resident #4 returned to the facility after going to rehab for the . Further stating, she had no concerns with care or . On at 9:15 AM, Nurse LPN H stated she was aware that resident #4 had a couple of because she would have to go to assisted living when the med techs needed help. On at 4:05 PM, the DON stated when resident #4 was to return from rehab the staff was to do more checks on him. Further stating, when he was discharged from the hospital the POA took him home with her. The DON was asked if an updated 1823 was obtained from resident #4's return to the facility. She replied yes, resident #4 has an updated 1823 identifying him as a risk. On at approximately 4:15 PM, The DON provided an updated 1823 for resident #4. Further review revealed resident #4 was not identified as a risk. The facility's Reduction Policy states ensure residents are assessed for risk on admission, 30 days post admission, every six months and at change of condition or quarterly if required by state regulations. If a resident has more than one in any rolling 30-day period, the Administrator and/or designee should arrange a meeting with the resident, family and/or responsible party to review and implement a Negotiated Risk Assessment. Update care plan with NEW interventions appropriate for level and relative to the conditions involving the . A new intervention must be developed for	A 025		

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A 025	Continued From page 34 each . On at 10:00 AM via phone exit, the Administrator and DON confirmed the findings. (photographic evidence obtained) Class II	A 025		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate	A 152		

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A 152	Continued From page 35 keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: On at 10:52 AM, Resident #5 observed in the hallway using a rollator stated she could not go downstairs. The resident asked if the elevators were still down as they are always down and never work. The resident stated she was able to walk and does not know why she can't go down the stairs. On at 11:07 AM, the Vitas Nurse observed exiting the stairwell stated elevator #2 has been down for about 2 -3 weeks. On at 11:10 AM, the POA of resident #6 stated elevator #1 was working when she arrived at the facility on around 4 PM. Adding elevator #2 has been broken this time for about 2 -3 weeks. It seems as though one of them is always down. Further stating, she would have kept the resident out a little longer before returning her to the facility. The POA stated, the Maintenance Director told her that a part was ordered and the facility was waiting for it to arrive. She added, she spoke with the Fire Chief of Seminole County around 6 PM on 1026 as the fire department was called to come and assist with getting the residents upstairs. On at 11:30 AM, Resident #7 observed	A 152		

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A 152	Continued From page 36 using a rollator stated the elevators not working happens too frequent for him and something needs to be done about it. He stated he was ok and walks up and down the hallway since he's unable to go downstairs. Adding, he just can't sit in his room all day and asked if anything could be done about the elevators. On at 11:52 AM, the Maintenance Director stated at 9:50 AM he was given an ETA of 1 hour by the technician. Further, when asked if he specifically called the fire department to come and assist the residents downstairs. He replied yes that he did call the fire department due to both elevators not working to get the residents on the heavier side up the stairwell. On at 12:00 PM, the Maintenance Director was asked to provide a copy of the elevator contract agreement and phone number. On at 1:55 PM, the Front Desk Receptionist stated the technicians just arrived and are probably in the mechanical room. On at 1:58 PM, the elevator technician stated he received the notification this morning at 10 AM for the facility and is not aware if a call was placed on . On at 2:00 PM, the supervisor of KONE Company stated the call came in over the weekend and the facility was on a credit hold. Due to the hold the dispatch unit did not transfer the call to his department. He stated when he saw the numerous calls come in over the weekend. He advised another supervisor that they needed to override the hold as he was aware the facility already had one elevator not working due to awaiting parts.	A 152		

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A 152	Continued From page 37 On at 2:10 PM, the Administrator was made aware of the delay in services and advised to reach out to the elevator company to get an update on the credit hold due to lack of payment for prior services rendered. He was asked to provide a copy of the elevator contract, invoice for elevator #2's part, and date the elevator stopped working. On at 2:55 PM, the Administrator stated the elevator company was sending the invoices to a former employee. He stated elevator #2 went down on and at that time the facility switched to another company to access and order parts for repair. Elevator #1 went down on , which is why we're moving to another company due to the delay in their response. On at 3:55 PM, the elevator was working, tested by the Administrator along with the technician. On at 10:00 AM via phone exit, the Administrator and DON confirmed the findings. (photographic evidence obtained) Class III	A 152		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce	A 160		

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A 160	Continued From page 38 the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by	A 160		

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A 160	Continued From page 39 Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.;	A 160		

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A 160	Continued From page 40 (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on facility record review and interview, the facility failed to maintain a no violation fire and safety inspection. Findings: Review of the Seminole County Fire Inspection Report dated revealed violation count 1 for a complaint investigation. Inspector called Battalion (B2) Chief and was advised that both elevators at location are non-functional at time of incident and engine crew was assisting residents to their rooms on the second and third floors. Maintenance Director was on site and had already called the elevator contractor. Contractor had an ETA of 4 hours. On at 10:23 AM, the Maintenance Director stated he had contacted the elevator company KONE at 6:30 PM on when elevator #1 stopped working. He added, he was told the ETA was 4 hours and he called every hours for an update. On at 10:00 AM via phone exit, the	A 160		

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 _____	11/14/2025

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 160	Continued From page 41 Administrator and DON confirmed the findings. (photographic evidence obtained) Class III	A 160		