STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969310	**08/08/2019**
NAME OF PROVIDER OR SUPPLIER **WATERMARK AT VISTAWILLA, THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1519 EAST SR 434** **WINTER SPRINGS, FL 32708**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

A Complaint Investigation #2019004323 was conducted on , , and . The Watermark at Vistavilla had a deficiency at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview, the facility failed to maintain a general awareness of the safety and well-being for 1 of 6 sampled residents (#5).

Findings:

A review on of the facility's incident report for Resident#5 reflected that the resident left the building on approximately 7:45 p.m. to see a dog that was outside. He then attempted to re-enter the facility at approximately 8 p.m. The doors automatically lock at 8 p.m. The resident could not re-enter the building after knocking on the doors. He did not see the bell on the side of the door. The bell would have alerted staff he was outside. The resident then on the path along the facility towards a trail approximately 500 from the facility. Nearby neighbors called 911 and the local law enforcement found him on the path behind the building and brought him to the facility. The facility nurse examined the resident and no injuries occurred. The facility did not have a log in or out book for the residents.

Resident #5's 1823 on revealed the resident had mild and was not an elopement risk.

In an interview on at various times starting at 10 a.m. with the Administrator, Human Resource Director and Staff A, B and C confirmed the facility now has a video camera placed on the exit doors that alert staff when someone is attempting to come inside the facility after hours. They confirmed the residents are free to come and go from the facility without supervision. They confirmed their policy is to monitor the residents every 2 hours and that they were unaware of Resident#5's whereabouts at the time of the incident.

In an interview on at 11 a.m. with Resident#5's family member, she confirmed the findings.

Class II

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Based on interview and record review the facility did not honor the resident's rights to be treated with consideration and respect, due recognition of personal dignity and individuality and admitted for alert and orientated resident (#5) to the secure memory care unit without a valid reason.

Findings:

A review on of the adverse incident report dated revealed an incident that around 10:02pm the resident left the building and then attempted to reenter the building several times after the doors automatically lock after 8 PM.

A review of the electronic facility notes dated revealed the resident was transferred from the assisted living side of building to the secure memory care unit side of the building.

Resident record review revealed the resident's health assessment form 1823 dated noted diagnosis that included and . There was no diagnosis of or . The Health care provided noted the resident was not an elopement risk.

Further record review of the facility's electronic progress notes revealed there was no documentation of the health care provider being contacted regarding the residents change in behavior that would have of resulted in the need of the resident being placed in a secure memory care unit.

In an interview with the administrator on at 12pm, he confirmed the findings.

Class III