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 _____	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERCREST WINTER PARK ASSISTED LIVING AND	1501 GLENDON PARKWAY WINTER PARK, FL 32789

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A 000	Initial Comments A complaint investigation #2026007789 and generator 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 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		

AHCA Form 3020-0001

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

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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 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 with injuries for 1 of 4 sampled residents (#1). Findings: Review of Resident #1's record revealed a facility admission date on . A 1823 health assessment indicated a medical history of	A 025		

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A 025	Continued From page 2 , , , ambulates with rollator walker, receiving hospice services, and identified as precautions. Her activities of daily living (ADLs) indicated needs assistance with ambulation, bathing, , self-care, toileting, and transferring. An incident report dated revealed the outcome of 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, transferred to hospital. Following the evaluation, the resident was diagnosed with a right . The resident requires assistance with ADLs and is ambulatory with a walker, requiring cues and reminders to utilize the device. Resident was observed on the floor at approximately 5:30 AM by Caregiver C. A hospital report date of service , chief complaint, patient present with , female with a PMHx of advanced , , presents to the ED via for evaluation after a . They stated staff mentioned patient experiences frequent but noted that the patient said "ow" many times, which is unusual for her. She was admitted on following a at her assisted living facility resulting in right , , . Imaging, including radiographs and CT of the , , confirmed an acute, , , right sub capital . Orthopedic consultation recommended surgical intervention, and after discussion with her family and obtaining consent. She underwent a right , , , on . The facilities revised and Injuries states associates are alert to situations	A 025		

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A 025	Continued From page 3 that may cause , works to prevent , and treats quickly and correctly when they occur. Assess the resident's condition, calm yourself and the resident, and take the lead. Sometimes, a resident may suffer injuries as a result of a . Your role is to ACT as soon as a resident and to follow the advice of your supervisor or a nurse or the emergency rescue team. A facility note on at 3:30 PM, resident's family member was at the community today to clean out the resident's apartment. He stated he will be moving her to a SNF effective immediately. A facility note on at 10:52 AM, Memory Care Director received a call from resident's POA stating she does not want anyone from Watercrest to visit Resident #1 while she's at the rehab. A facility note on at 10:40 AM, Memory Care Director spoke with POA who states that the resident will be transferring from the hospital to the rehab facility today for in-house rehab. A facility note on at 8:14 PM, resident is in the hospital. A facility note on at 8:14 PM, hospital. A facility note on at 5:34 PM, Memory Care Director spoke with nurse at hospital. Resident was admitted with right s/p (status post) on . Surgery to repair the occurred on . A facility note on at 5:30 AM, at approximately 5:30 AM, resident was observed on the floor by associate Caregiver C. Resident	A 025		

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A 025	Continued From page 4	A 025		

was unable to explain how the occurred and could not clearly express needs, but vocalized , by stating "ow". The resident was evaluated on-site and 911 was called immediately.

On at 12:12 PM, the POA stated the mat was on the wall at the end of the bed prior to the . She said the aged the resident 10 years. Adding, if the nurse was making rounds every 2 hours, they should have known the mat was not there. The POA stated the could have been prevented being the mat is mandatory for hospice residents with the hospice bed.

On at 3:34 PM, Caregiver C stated she was doing her regular rounds and had about 4 - 5 rooms before arriving at the residents' room. She said she noticed the resident was on the floor with no underwear. She said she called another caregiver who was working in assisted living and told her what happened. She said she was asked if she grabbed the paperwork but told the staff no because she was new and not sure what paperwork she was talking about. Caregiver C said she then called the Administrator and he checked the camera to determine how resident #1 . She stated he told her the couch blocked the camera and he could not determine how she . Caregiver C stated the Administrator provided her with the POA' number so that she could call her. Caregiver C stated there was no mat on the floor but believes usually it is down. She said the mat was behind the bed up against the wall. She said she works the 11 -7 shift and does not put the resident to bed, and she usually change her during the night. Adding, the 3 - 11 shift puts the resident to bed and would be responsible for putting the mat down. Caregiver C stated the mat was not always on the floor. She said she checked on the resident when she arrived at 11

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A 025	Continued From page 5 and checked again between 12 -1 and the resident was asleep. Caregiver C stated the mat was not down at 11pm when she started her shift. Further stating, Resident #1's mat was not always down, and she was not told to put it down. Caregiver C was unable to state the last time she checked on the resident before finding her at 5:30 AM, A facility note on at 5:08 PM, resident observed sitting on couch watching television. Private sitter with resident at the time. A facility note on at 10:06 AM, patient observed in dining room with caregiver. A facility note on at 1:29 PM, private sitter advised residents has a foul odor. A facility note on at 6:40 AM, resident refused to get up this morning out of bed, stated she was still sleepy. A facility note on at 4:42 PM, resident observed sitting in a calm manner in a dining room chair. A facility note on at 3:25 AM, while changing resident staff noticed residents' , are chapped and . A facility note on at 2:45 PM, resident observes sitting in apartment on couch, caregiver was present. A facility note on at 6:11 AM, resident is s/p day #3 with no overt injuries. A facility note on at 10:50 PM, s/p day 2. no additional on day shift.	A 025		

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A 025	Continued From page 6 A facility note on at 2:08 PM, resident had a reported on bedside in her apartment. Wellness Director spoke with hospice nurse; we will implement the following interventions with hospice HME. Hospice to order a low positioned hospital bed, concave/bolster mattress and bedside mats. Interventions to be discussed today with residents POA and if she agrees with interventions, hospice will order the HME to be delivered. A facility note on at 1:15 PM, resident is s/p unwitnessed day #1 with no overt injuries. A facility note on at 12:39 PM, at 6:30 AM, resident was observed laying on the floor on the side of her bed with , closed and appeared to be sleeping. No injuries were noted and with assistance of 2 caregivers the resident was able to stand and walk to her sofa. On at 4:18 PM, licensed practical nurse (LPN D) stated she probably was working the 11 - 7 shift that night. She said she went into the residents' room to give her medications. She observed the resident lying on the floor with her pillow. She said the resident would do that a lot and she assessed the resident for injuries and helped to stand to a sitting position. LPN E said she did not recall that day, but the rule of thumb is to check on her regularly as she was one of the morning get up residents. LPN E called to say that she did recall that day and the mat was not on the floor when she went in because she would trip over it at time and that didn't happen that day. She said she was not sure if the resident was able to move it but does not believe so. A facility note on at 9:45 PM, day #3 s/p	A 025		

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A 025	Continued From page 7 ; resident is lying on her resting with , closed. A facility note on at 7:54 AM, resident is s/p day 3 with no overt injuries observed. A facility note on at 6:38 AM, resident said, No! No! No! and turned her away from the medicine pill cup. A facility note on at 8:39 PM, day #2 s/p ; resident is in bed lying on her resting with , closed. A facility note on at 8:29 AM, resident is stable at this time. A facility note on at 11:01 PM, entered the room and observed the resident lying on her in the bathroom. The resident is unable to communicate what happened. A facility note on at 1:17 PM, resident had a on in her apartment. Wellness Director spoke with the resident's family regarding the room furniture and possible risk with a chair that is in the resident's apartment and rolls. Family looking to remove the chair or rearranging the furniture in the apartment. A facility note on at 3:22 PM, resident is s/p day 2 with no overt injuries observed. A facility note on at 4:53 AM, post day 2 resident observed in her bed with , closed. A facility note on at 9:55 PM, observed resident sitting on her fully dressed in pajamas in front of her tv.	A 025		

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A 025	Continued From page 8	A 025		

A facility note on at 9:39 PM, day #3 s/p resident in bed resting with , closed.

A facility note on at 3:26 PM, post interventions; resident continues on services with hospice care. The resident is also currently on services for and outpatient with rehab.

A facility note on at 11:01 PM, day #2 s/p ; resident in bed resting with , closed.

A facility note on at 9:27 PM, day #1 s/p ; resident in be resting with , closed.

A facility note on at 12:22 PM, resident is stable at this time. Hospice Nurse came out and assessed resident.

A facility note on at 9:49 AM, at 6:00 AM, nurse on duty went to resident #1's apartment to check on her and give her medication. Observed resident sitting on the floor, sitting upright facing TV. She was wearing pajamas but did not have any shoes on her . Nightshift stated they last saw her at 3:45 am laying her bed.

On at 10:24 AM, Caregiver A stated she knows Resident #1 but not sure what happened. Further stating, she's been out for a while.

On at 3:58 PM, the Administrator was asked if the facility completed any incident reports for Resident #1's on , , , , and .

On at 4:12 PM, the Administrator stated their system has an option to import the incident reports into the progress notes. Further stating, he checked with regional and their incident reports are internal documents and are unable to

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A 025	Continued From page 9 be provided. On at 4:37 PM, an attempt was made to ask LPN E about the resident and her . LPN E stated she did not send Resident #1 out on and the Administrator informed her of the nature of the call and what to say. Further stating, she had not been at the facility that long. On at 4:48 PM, the Memory Care Director stated Resident #1 had a caregiver during the day and then increased safety checks after the caregiver leaves. She said typically for a resident who is a high risk they're able to turn up the alert system which indicates movement. Adding, she was not sure it had been turned up for Resident #1. The Memory Care Director stated she started in , and unaware of the , , and 25 . She stated that if the resident had returned after the on she was planning to put interventions in place. She said the facility does not document the safety checks. On at 5:55 PM, the Administrator stated the caregiver (private sitter) for Resident #1 was for engagement during the day. He said the facility implemented the detection system in and her lessen. He stated there is no documentation, just the expectation of the staff to do 2-hour checks on the residents. Adding, the Wellness Director would probably have more information as to if an intervention was implemented. He said the POA at one point stated the mat may have been seen as a trip hazard being that the resident was so mobile. The mat was in the room but may have not been implemented being that she was on hospice and they would have brought it in but did not use it.	A 025		

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A 025	Continued From page 10 On at 6:10 PM, the Administrator and Memory Care Director confirmed the findings. (photographic evidence obtained) Class II	A 025		