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 _____	08/18/2026

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 Two (2) complaint investigations #2026012437, #2026006778, and generator monitoring were conducted on at Watermark at Vistawilla. 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 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,	A 010		

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A 010	Continued From page 1 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 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.	A 010		

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A 010	Continued From page 2 (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 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,	A 010		

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A 010	Continued From page 3	A 010		

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;
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

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A 010	Continued From page 4 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on resident record reviews and interviews, the facility 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 8 sampled residents (#1, #6) as required in an assisted living facility (ALF). Findings: 1. Review of Resident #1's 1823 health assessment indicated a medical history of , , , able to self-administer medications, and did not identify the resident as an elopement risk. The resident was observed in the secured memory care unit during the tour. On at 10:20 AM, the Activities Assistant stated Resident #1 is in the Bridge Program and comes during the day to memory care. On at 10:38 AM, Staff A stated Resident #1 comes every day to memory care now that she's on the Bridge Program. Adding, since she eloped, she stays still in the memory care unit until 8 PM and then returns to the assisted living (AL). On at 3:19 PM, the Wellness Director stated Resident #1, after returning from the hospital, was placed in the Bridge Program. Further stating, the doctor realized after the assessment that she had memory issues, On at approximately 6:15 PM, the AL	A 010		

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A 010	Continued From page 5 Director stated Resident #1 used to do her own medication but after she eloped, they realized she was not taking them. She said they started doing her medications in after she returned from the hospital. The facility's literature stated the Bridge Program by Watermark Retirement Communities is a specialized transitional care tier designed for residents who need more support than the traditional assisted living provides, but who do not require full memory care. The facility failed to obtain and updated 1823 for Resident #1 identifying her as an elopement risk and needing assistance with self-administration her medications. 2. Review of Resident #6's 1823 health assessment indicated n/a (non-applicable) as special precautions and independent with all activities of daily living. A facility note on at 4:20 AM, during rounds around 4:20 AM, found resident on the floor laying on her . Asked resident if she hit her and she said yes. A facility note on at 11:27 PM, resident independently ambulated to nurse cart stating she had . Resident left side of observed and , left appears broken, visible deformity. On at 1:25 PM, the Wellness Director stated he's provided all the 1823's for the residents and does not have an updated form for the . The facility failed to obtain an updated 1823 for	A 010		

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A 010	Continued From page 6 Resident #6's identifying her as a risk. On at 7:40 PM, the Administrator, AL Director, and Director of Health and Wellness confirmed the findings. The Administrator stated the resident is out and will obtain an updated form once she returns. (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 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	A 025		

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A 025	Continued From page 7 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 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 and injuries for 2 of 8 sampled residents (#2, #6).	A 025		

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A 025	Continued From page 8 Findings: On at 8:55 AM, during the entrance conference. The Administrator identified Resident #2 was out of the building due to a with . 1. Review of Resident #6 record revealed a facility admission on . The 1823 health assessment revealed a medical history of , , acute , injury, no limitations, follows directions, no special precautions, and was not identified as a risk. An incident report dated , or of bones or joints. Resident was unable to explain how she . She has advanced . POA reported the resident has a right , replacement. Resident was last seen at midnight by Caregiver D. During rounds around 4:20 AM, found resident on the floor lying on his . An incident report dated , or of bones or joints. Resident ambulated to nurse cart stated she had . Resident left side of observed & , small left arm first aid provided coverage with bandage, left appears broken R/T visible deformity, significant & limited mobility. A facility note on at 2:33 PM called hospital for an update status of the resident. The hospital Nurse stated the resident just returned to their unit with s/p ORIF of right , . A facility note on at 4:20 AM, during rounds around 4:20 AM, found resident on the floor lying on , the resident was asked if she hit her and she said yes. Call 911,	A 025		

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A 025	Continued From page 9 paramedics arrived, and while getting her up she screamed with , in the left . Resident was taken to hospital. A facility note on at 3:43 PM, resident incident endorsed nurse. No further limping /complaint at this time. A facility note on at 9:40 AM, resident observed laying on the floor in the dining room at approximately 9:10. The resident was observed rubbing the of her . The resident assisted sitting in a chair with 2 staff members. 911 called, arrived, evaluated the resident and determined ER was not necessary. Resident did not complain to paramedics that her right was hurting. A facility note on at 10:36 AM, resident observed yelling and upset. Care staff called the POA to provide comfort. A facility note on at 12:38 PM, resident had a follow- up appt with r/t intra of end of left given for -ROM / / / grip. A facility notes on at 6:01 AM, , to lower left arm intact with digits mobile & warm to touch. A facility note on at 10:13 PM, left arm , / intact throughout this shift (2p-10p). The resident refused ADLS and assistance changing clothes / grooming. A facility note on at11:47 AM, resident received a temporary arm from in 2 weeks follow up appt.	A 025		

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A 025	Continued From page 10 A facility note on at 9:29 AM, resident removed her located left arm. A facility note on at 10:20 AM, resident had an outside appt with Orthopedic. A facility note on at 11:53 AM, resident refused , , , stated she was exhausted. A facility note on at 12:46 PM, POA stated resident follow up appt with is , . A facility note on at 12:41 PM, resident refused , , to see her today due to resident yelling at . voicing out "no, no". A facility note on at 6:40 AM, resident ambulated in the hallway early this morning. on her left arm intact and clean. A facility note on at 11:02 AM, resident left lower arm observed dry and intact. Request for / orders from in-house physician. A facility note on at 10:17 PM, readmission note, returned to facility 1 PM via wheelchair accompanied by 2 ambulance attendance. Resident with to the left arm/ area. Left cheek , with . A facility note on at 1:03 PM, POA arrived in the community stated resident had surgery this morning at 7 AM. Resident will stay overnight at hospital. A facility note on at 2:07 PM, POA arrived in the community stated resident's left	A 025		

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A 025	Continued From page 11 broken and surgery tomorrow. A facility note on at 11:27 AM, resident independently ambulated to nurse cart stated she had . Resident left side of her observed and , small left arm first aid provided, covered with bandage. Left appears broken R/T visible deformity, significant & limited mobility. Resident stated she from bed. On at 1:25 PM, the Wellness Director stated he provided all the 1823's for the residents. Further stating, he did not have an updated 1823 from the identifying the resident has a risk. On at 4:15 PM, the Wellness Director stated he was told to inform agency representative that he could not provide the incident reports for review as those are legal documents. On at 5:30 PM, the Program Director stated the on was unwitnessed. She said the resident came to her telling her that she . Adding, the resident's was visibly broken. 2. Review of Resident #2's record revealed an admission date of . Review of Resident #2's health assessment form indicated the resident was at high risk for . Her medical history included and . Review of the only risk assessment with an effective date of revealed the resident had a score of 19 and was high risk. Review of a facility note dated at 5:50	A 025		

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A 025	Continued From page 12 PM, Resident #2 was found lying down near the exit door in the common area, the resident said she hit her . Resident #2 was sent to a hospital. Review of a facility note on at 2:58 PM, Resident #2 had a in the morning. Review of a facility note on at 4:51 AM, at 6:20 AM, Resident #2 was found on floor with coming from her . The resident was sent to the hospital. Review of a facility note on at 10:17 AM, Resident #2 had an unwitnessed . The resident was found lying on the floor in the television room on her . The resident said she was in , . The resident was sent to the hospital. Review of a facility note on 8:20 PM, the resident and sustained a large hematoma to the right side of her forehead. The resident was sent to the hospital. Review of a facility note on at 6:20 AM, at approximately 5:20 AM, Resident #2 was found on the floor at the of her bed lying on her right side. The resident had on her and was sent to the hospital. Review of a hospital record revealed Resident #2 was evaluated on due to an unwitnessed . The resident had a to both frontal and , , intraparenchymal , and hematoma to her . During an interview on at 5:25 PM, the Director of Health and Wellness said Resident #2 walked with her pointing down,	A 025		

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A 025	Continued From page 13 rotated down and always looked at the ground. The Director of Health and Wellness said the interventions in place for Resident #2 was to ensure she had one person assist while ambulating, try to ensure the floors were clean constantly because Resident #2 would pick up stuff off the ground. Also, they were to continue to monitor the resident. During an interview on at 5:30 PM, The Director of Health and Wellness said Resident #2 had a on and was sent to the hospital. The Director of Health and Wellness added, Resident #2 was evaluated at the of the hospital due to sustaining hematoma. Review of the facility's policy last revised indicated residents are assessed for risk for on admission, 30 days post admission, every six months, and at the change of condition. If a resident had 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 and the community interdisciplinary team to review and implement a negotiated risk agreement. The care plan is to be updated with new interventions appropriate for level and relative to the conditions involving the . Review of Resident #2's service plan revealed a prevention. The service plan was not updated with new prevention interventions after the Resident's on , , , , , and . During an interview on at 5:34 PM, with the Director of Health and Wellness, the negotiated risk agreement and interventions	A 025		

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(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 025	Continued From page 14 were requested. During an interview on at 5:50 PM, with the Assisted Living Facility Director, an update was requested for the negotiated risk agreement. During an interview on at 5:53 PM, the Director of Health and Wellness said he would need to look at the resident's documentation to see if he had the negotiated risk agreement. The Director of Health and Wellness added, it is a sign document, and he may not have it. During an interview on at 7:06 PM, the findings were discussed with the Administrator. The Administrator said that interventions were not updated on Resident #2's service plan. No additional documentation was received. (photographic evidence obtained) Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A	A 032		

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 _____	08/18/2026

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A 032	Continued From page 15 resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 032	Continued From page 16 manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to make a daily effort to ensure 1 of 1 sampled resident who was identified as being at risk for elopement had identification (ID) on their person that included their name and the facility's name, address, and telephone number (#1). Findings: On at 10:20 AM, during the tour of memory care. Resident #1 was observed participating in an activity with several other memory care residents. On at 10:38 AM, Caregiver A stated she's not sure if Resident #1 has an ID on her unless it's under her jacket. She proceeded to approach the resident asking her if she had an ID all while pulling up the resident's sleeves and unzipping her jacket. The resident replied that no and no ID was observed on her , ankles, or any type of lanyard around her . On at 3:43 PM, Resident #1 was observed reentering the building with another resident and the Activities Assistant. On at 3:45 PM, the Activities Assistant	A 032		

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A 032	Continued From page 17 stated they walked to the store to get slushy. Adding, the nurse put the ID on the resident after the agency representative during this morning visit. Review of the ID revealed the residents' name and AL room #. There was no facility address or phone number listed. On at 4:15 PM, the Wellness Director stated when asked if the resident had ID on with the facility's name, address, and her name. He said the residents' family put an AIR tag on her. Further stating, the resident has an ID on. He was made aware the was not present this morning nor did we observe an AIR tag lanyard. On at 5:15 PM, the POA stated Resident #1 has AIR tags in her wallet, on her necklace, and her keys. Adding, he has the residents' keys and needs to return them. On at approximately 7:20 PM, the Administrator and agency representative exited the stairwell door located on the 2nd floor to the parking lot located in the front of the facility. The Administrator stated due to fire safety codes the exit door may not be locked from the inside due to it being an emergency exit. The exit door on the 1st floor that leads out is locked from the outside preventing entry. On at 7:40 PM, the Administrator, AL Director, and Director of Health and Wellness confirmed the findings. Class III	A 032		