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 _____	R-C 08/21/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit to a complaint investigation (2026009465) was conducted at Watercrest Winter Park Assisted Living and Memory Care on and . An uncorrected deficiency was identified at the time of the survey.	{A 000}		
{A 025} SS=D	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}		

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 _____	R-C 08/21/2026

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

(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 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: DEFICIENCY REMAINED UNCORRECTED Based on observation, interview, and record review, the facility failed to provide adequate supervision when 1 of 4 sampled residents had repeated (#8) Findings: Review of Resident #8's record revealed a medical history of , , . A health assessment form (1823,) dated , showed the Resident needed precautions.	{A 025}		

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 _____	R-C 08/21/2026

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

(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 2 A facility note, dated at 10:20 AM, showed the Resident was observed sitting on the floor in her apartment with her against her bed. The Resident said she slid off the side of the bed. A facility note, dated , showed the Resident in her room. The Resident was encouraged to wear non-skid socks. A facility note, dated , showed the Resident was observed on the floor of another resident's room. The Resident was unable to say what happened. 911 was called and the Resident was taken to a hospital where she was diagnosed with a . A non-slip mat was placed on the floor next to the Resident's bed. A facility note, dated , showed the Resident returned from the hospital. A facility note, dated , showed the Resident sitting on the floor in her room while getting dressed. The staff were reminded to place her locked wheelchair within her reach. A facility note, dated , showed the Resident was observed on the floor in her room. A facility note, dated , showed the Resident was observed sitting on the floor in the dining room. The Resident's wheelchair was nearby and unlocked. The Resident said she slipped out of the wheelchair. The Resident was reminded to wait for staff to help her transfer. Care staff were instructed to increase the frequency of their safety checks. On at 4:15 PM, the Memory Care Director said the Resident was placed in a	{A 025}		

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 _____	R-C 08/21/2026

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

(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 3	{A 025}		

wheelchair because her gait was unsteady. The Memory Care Director said the Resident had behavior issues, so her , , medications were adjusted which caused her to be unsteady on her . The Memory Care Director explained that staff were present when the Resident in the dining room but was on the opposite side and did not see the Resident stand up.

On at 9:32 AM, Resident #8 was seen sitting in a wheelchair in the memory care dining room. She was pleasantly .

On at 9:34 AM, caregiver A said she did not know what interventions were put in place to prevent the Resident from falling. The caregiver said there was always one staff present in the common area with the residents.

On at 9:37 AM, caregiver D said she did not know what interventions were put in place to prevent the Resident from falling.

On at 9:41 AM, observations made in the Resident's room revealed three non-slip strips on the floor next to the left side of her bed. The right side was against the wall. A grab bar was on the wall next to the toilet and the raised toilet seat had handles. A detection camera system was seen on the wall. The Memory Care Director said it was put in place about two months ago.

On at 9:45 AM, caregiver M said she always conducted rounds on the Resident, kept her in the wheelchair, and supervised her as much as possible.

On at 9:49 AM, caregiver C said she kept an on the Resident.

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 _____	R-C 08/21/2026

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

(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 4 Class III	{A 025}		