STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105404	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterford, The	601 Universe Blvd Juno Beach, FL 33408

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52127 Based on observation, interview, and record review, the facility failed to ensure accurate Minimum Data Set (MDS) assessments for 2 of 13 sampled residents, Resident #32 related to vision, and Resident #44 related to discharge status. The findings included: 1. Review of the record revealed that Resident #32 was admitted to the facility on [DATE]. Review of the Quarterly minimum data set (MDS) assessment dated [DATE] revealed the vision status for Resident #32 was adequate, and coded as (0), indicating the resident sees fine detail including regular print in newspapers / books. During an interview on 02/03/25 at 2:32 PM, Resident #32 stated she is unable to read the activities calendar that was on her bedside table or the dining menu provided at meal time. The resident explained that she has macular degeneration. Interview with the Activity Director on 02/05/25 at 10:45 AM, with Staff C, Certified Nursing Assistant (CNA) on 02/05/25 11:45 AM, and with Staff A, Dietary Assistant on 02/06/25 11:27 AM, all revealed that Resident #32 was visually impaired and unable to read regular print. During an interview on 02/05/25 at 10:30 AM, the MDS Coordinator stated that she had assessed Resident #32's vision and utilized a larger print sample to assess her vision. She reported that she knew that Resident #32 has macular degeneration and was visually impaired, but since the resident could walk around and make her needs known she felt her vision was adequate. When asked what the determination between adequate vision and inadequate vision was, the MDS Coordinator replied that if a resident can make her needs known and walk around independently then the vision is adequate. During a supplemental interview on 02/05/25 at 4:07 PM, the MDS Coordinator agreed with the inaccuracy. 38893 2. Record review revealed Resident #44 was admitted to the facility on [DATE] and discharged (d/c) home with family on 11/09/24. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #44's care plan for discharge, initiated on 10/15/24, documented, Discharge plan is to return home with her sons as caregivers A Health Status Note, dated 11/08/24 at 9:53, documented, Note Text: D/C (discharge) note: Resident will be d/c to home on 11-9-24. She will be followed by VNA [Visiting Nursing Association] and HH [Home Health]. Family will self-purchase transport wheelchair. Resident to be transported to home by son. Family will provide 24 hour care. Medicare notice of non-coverage was given and appeal rights were explained. Resident #44's Discharge Assessment - Return Not Anticipated Minimum Data Set, dated dated [DATE] documented that the resident's discharge was planned, and that Resident #44 was discharged to a short-term general hospital. During an interview, on 02/05/25 at approximately 10:00 AM, the MDS Coordinator was made aware of the discrepancy and stated that she would update the assessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on record review and interview, the facility failed to provide medications as per physician order for 1 of 6 sampled residents reviewed for medications, Resident #10, as evidenced by holding blood pressure medications without hold parameters or documented notification to the physician. The findings included: Review of the record revealed Resident #10 was admitted to the facility on [DATE]. Review of the current orders revealed Resident #10 was receiving two medications daily, amlodipine and metoprolol, that affected the residents blood pressure. Further review of these orders lacked any physician ordered parameters to hold the medications. Review of the February 2025 Medication Administration Record (MAR) documented both medications were held on 02/01/25 with a blood pressure of 98/54 and on 02/02/25 with blood pressure of 98/57. Review of the January 2025 MAR documented both medications were held on 01/17/25 with a blood pressure of 110/54, on 01/27/25 with a blood pressure of 103/58, and on 01/30/25 with no documented blood pressure. Review of the corresponding progress notes lacked any reason for not administering the medications and lacked any notification to the physician. During an interview on 02/06/25 at 11:33 AM, when asked the reason she held the above-mentioned medication for Resident #10 on 02/02/25, Staff B, Registered Nurse (RN) stated, I think she has parameters, but I don't see them. Typically, if the systolic (the upper number of the blood pressure reading) is low, below 110, we hold the medications. The RN stated she would call the physician if a medication was held. When asked how the call to the physician was documented, the RN explained she would write a progress note attached to the electronic MAR administration documentation.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52127 Based on observation, interview, and record review, the facility failed to provide interventions to enhance vision for 1 of 2 sampled residents, Resident #32, reviewed for vision. The findings included: Review of record revealed Resident #32 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the vision status for Resident #32 was adequate, and coded as (0) indicating the resident sees fine detail, including regular print in newspapers / books. This MDS also revealed that it was very important for Resident #32 to participate in music, keep up with the news, do things with groups of people, and to go outside. During an interview on 02/03/25 at 2:32 PM, Resident #32 stated she was unable to read the activities calendar that was on her bedside table. The resident stated she has macular degeneration, and would have attended the music show recently if she had known when it was scheduled. She further stated she cannot see the menu for her meals and therefore cannot make independent choices. When asked if the facility had provided any type of intervention, Resident #32 stated they had not provided anything. During this interview, Resident #32 asked for help to read a letter she had received in the mail as she could not see the print. An interview was conducted on 02/05/25 at 10:30 AM with the MDS Coordinator who stated she assessed Resident 32's vision and utilized a larger print sample to assess her vision. She reported she knew Resident #32 has macular degeneration and was visually impaired but since the resident could walk around and make her needs known she felt her vision was adequate. When asked what the determination between adequate vision and inadequate vision was, the MDS Coordinator replied, If the resident can make her needs known and walk around independently then her vision is adequate. When asked if she had coded Resident #32's vision as impaired, would further assessment and or interventions have been provided, the MDS Coordinator replied, Yes. When asked if any interventions were in place or trialed for Resident #32, she said, no. During an interview on 02/05/25 at 10:45 AM, when asked how the residents know what activities are happening, the Director of Lifestyle replied there were activity calendars posted in the residents' rooms, and staff walk room to room with verbal reminders. The Director of Lifestyle confirmed she was aware of the resident's visual impairment and stated, We could do better with having a large print calendar for Resident #32. During an interview on 02/05/25 at 11:45 AM, Staff C, Certified Nursing Assistant (CNA), confirmed the visual impairment of Resident #32, and stated she needed help with TV [television] remote control since she cannot see the buttons. An observation on 02/05/25 at 12:00 PM in the main dining room revealed staff verbally assisted her with choosing her menu items. On 02/06/25 at 11:27 AM, Staff A, Dietary Assistant, stated Resident #32 needs help to know what is on the menu because she has difficulty seeing the choices. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/06/25 at 11:37 AM, when asked if she would be willing to try an intervention to assist her in reading print, Resident #32 stated she would like to try something.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167 Based on policy review, observation, interview, and record review, the facility failed to report an Influenza outbreak to the Florida Department of Health (DOH) for 1 of 2 sampled residents, Resident #197, reviewed for Influenza by lack of reporting to DOH. The findings included: The facility policy, titled, Infection Prevention and Control Manual Outbreak Management, dated 2019, revealed it is the policy of this community to recognize and contain infectious disease outbreaks. Outbreak measures will be instituted whenever there is evidence of an outbreak, as outlined below. The infection preventionist, or designee, will conduct the outbreak investigation and has the authority to implement outbreak measures to control possible transmission. These actions will be carried out in coordination with the medical director, administration, and medical team members as well as state and local health agencies. In the absence of the infection preventionist, the director of nursing or the assistant director of nursing, or designee will conduct the investigation. Appropriate notifications to the medical director, administrator, all departments, attending physicians, state and local agencies, and resident representatives will take place as soon as possible after and the outbreak has been identified. Outbreak monitoring and reporting will continue until the outbreak has resolved. The community will send all appropriate reports to state and local health department agencies in accordance with state requirements. For any given circumstances, the communities Medical Director and, infection Preventionist, and/or state guidelines will determine if an outbreak exist. CDC example for influenza: A confirmed, or suspected outbreak is defined as 2 or more ill residents or if there is one lab confirmed case with other respiratory infections that would indicate a potential may be occurring. As state law requires, public health codes or ordinances report illnesses and new or unusual infections to public health agencies as soon as possible. It was recorded in the Florida Department of Health Reportable Diseases / Conditions List that Influenza A was to be reported immediately 24/7 by phone upon initial suspicion or laboratory test order. The CDC guideline, titled, Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities, dated September 17, 2024, indicated Influenza can be introduced into a long-term care facility by newly admitted residents, healthcare personnel, and visitors. Spread of influenza can occur between and among residents, healthcare personnel and visitors. Residents of long-term care facilities can experience severe and fatal illness during influenza outbreaks. If one laboratory-confirmed influenza positive case is identified along with other cases of acute respiratory illness in a unit of a long-term care facility, an influenza outbreak might be occurring. The local public health and state health departments should be notified of every suspected or confirmed influenza outbreak in a long-term care facility, especially if a resident develops influenza while on or after receiving antiviral chemoprophylaxis. Clinical record review revealed Resident #197 was admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 01/29/25 at 9:21 PM documented that Resident #197's Lungs were clear throughout bilaterally-no difficulty breathing. No cough was noted. No shortness of breath [SOB] was noted. No oxygen required. Review of the physician orders revealed the following: 02/01/25, Tamiflu oral capsule 30 mg, one capsule by mouth twice daily for upper respiratory infection for 5 Days. 02/01/25 Isolation droplet Precautions for Influenza A. The care plan dated 02/02/25 recorded that Resident #197 has a diagnosis of Influenza A. Review of the progress notes dated 02/01/25 at 6:40 PM documented Resident #197 was observed with congested cough, nonproductive, complained of general malaise, warm to touch with an axillary temp of 99. 8, O2 sat [oxygen saturation] 96% on room air & no SOB, Rapid COVID-19 nasal swab was negative. A chest x-ray was completed with negative results. Influenza rapid swab test completed with positive results of Influenza A. The surveyor observed Resident #197 on the following dates: 02/02/25 at 11:39 AM, 11:52 AM, and 12:51 PM, and on 02/04/25 at 1:15 PM. During these observations, the resident exhibited symptoms of coughing and sounded congested. On 02/06/25 at 9:46 AM, the surveyor interviewed the infection preventionist (IP) regarding the documented reporting of an Influenza (FLU) outbreak to the Department of Health (DOH). The IP indicated that the FLU outbreak had not been reported because Resident #197 tested positive for Influenza three days post-admission and may have been exposed in the hospital setting. The IP stated that her organization's policy mandates reporting of an Influenza outbreak only when two or more residents exhibit illness.