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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106119 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/01/2025 |
| NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Waterman | | STREET ADDRESS, CITY, STATE, ZIP CODE 4501 Waterman Way Tavares, FL 32778 | |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' preference for shower date and time was honored for 1 of 4 residents reviewed (Resident #107). Findings include: During an observation on 7/30/2025 at 8:50 AM, the communication board in Resident #107's room showed that the resident was scheduled to have two showers weekly on Wednesday and Sundays. During an interview on 7/30/2025 at 8:45 AM, Resident #107 stated that her usual shower days were Sundays and Wednesdays. This past Sunday (7/27/2025), she requested a shower, and the aide informed her that she could not have a shower, only a bed bath. The resident informed the aide that she did not want a bed bath, she wanted a shower, but the aide refused and informed her she would give a bed bath. The resident stated that she was never given a bed bath or a shower on 7/27/2025. During an interview on 7/30/2025 at 12:23 PM, Staff A, Certified Nursing Assistant (CNA), stated that she was the aide providing care for Resident #107 on the evening of 7/27/2025. Staff A stated, It was [Resident #107's name]'s shower day, but by the time I got to her, she said it was too late, and to just put her to bed, so I did. [Resident #107's name] asked to have her peri-area washed, and did not want her gown changed, as it was still clean. I asked if she was sure, but she said just wash my peri area. This occurred around 8:00 PM. She likes to shower right after dinner. If I remember right, we only had two CNAs that night. Normally, we have three, so it took longer for me to get to her. During an interview on 7/31/2025 at 9:08 AM, the Director of Nursing (DON) stated, I interviewed [Resident #107's name] and [Staff A, CNA's name]. [Staff A's name] should have documented the bed bath for [Resident #107's name] as refused if the bed bath was not completed. During an interview on 7/31/2025 at 10:10 AM, Staff B, Registered Nurse (RN), stated, I was the nurse on shift for [Resident #107's name] on the evening of 7/27/25. I review and sign the shower sheets at the end of the shift. [Staff A, CNA's name] never informed me that [Resident #107's name] refused a shower or a bed bath. I expect the CNAs to inform me when a resident refuses a shower or bed bath. Review of Resident #107's ADL (Activities of Daily Living) task records showed the resident preferred Wednesdays and Sundays at 3-11 shift for bathing. Review of Resident #107's Minimum Data Set (MDS) assessment dated [DATE] showed the resident was dependent for showering and bathing under Section GG- Functional Status. Review of Resident #107's care plan dated 5/22/2025 read, Focus: Resident has specific preferences r/t [related to] day to day activities. Goal: Staff need to be aware of resident preferences and incorporate them into daily care. Review of the facility policy and procedure titled Activities of Daily Living (ADL), Supporting with the last review date of 12/10/2024 read, Policy Statement: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care).</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, interview, and record review, the facility failed to provide respiratory services consistent with professional standards of practice for 3 of 4 residents reviewed for oxygen therapy (Residents #46, #136, and #139).</p> <p>Findings include:</p> <p>1. During an observation on 7/28/2025 at 10:30 AM, Resident #46 was sitting in the recliner, receiving oxygen via nasal cannula at 3.5 liters per minute (LPM).</p> <p>During an observation on 7/29/2025 at 10:11 AM, Resident #46 was receiving oxygen via nasal cannula at 3.5 LPM.</p> <p>Review of Resident #46's physician orders showed an order dated 7/1/2025 for administration of oxygen at 2 LPM every shift.</p> <p>During an interview on 7/29/2025 at 10:11 AM, Resident #46, stated, I never touch the setting on the concentrator. I do not know how or where to adjust.</p> <p>2. During an observation on 7/28/2025 at 9:16 AM, Resident #147's nebulizer mask was clipped on the nebulizer machine sitting on the resident's bedside table. The mask was not bagged. The resident was receiving oxygen at 4.5 LPM with humidification (Photographic evidence obtained).</p> <p>During an observation on 7/29/2025 at approximately 8:54 AM, Resident #147 was receiving oxygen at 4 LPM with humidification.</p> <p>Review of Resident #147's physician orders showed an order dated 7/24/2025 for continuous administration of oxygen at 5 LPM via nasal cannula.</p> <p>Review of Resident #147's physician orders showed an order dated 7/24/2025 for Levalbuterol 0.63 MG (milligram)/3ML (milliliter) nebulization solution; 3 ml inhale orally via nebulizer every 8 hours for hypoxia.</p> <p>Review of Resident #147's physician orders showed an order dated 7/24/2025 for Budesonide Inhalation Suspension 0.5 MG/2ML; 1 vial inhale orally in the morning for shortness of breath, rinse mouth after.</p> <p>During an interview on 7/29/2025 at approximately 8:54 AM, Resident #147 stated, I do not touch the oxygen concentrator, or the mask. Nurses come in and work on it and tell me what to do.</p> <p>During an interview on 7/31/2025 at 8:40 AM, the Director of Nursing (DON) stated, "My expectation is the oxygen settings to be correct."</p> <p>3. During an observation on 7/28/2025 at 9:42 AM, Resident #139 was sitting in a wheelchair in his room. There was a nebulizer mask sitting on top of the nebulizer machine on the bedside table unbagged.</p> <p>(continued on next page)</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 7/28/2025 at 9:58 AM, Staff C, Registered Nurse (RN), stated that Resident #139's nebulizer mask should have been stored in a plastic bag with a date written on the bag.</p> <p>During an interview on 7/28/2025 at 11:30 AM, the Director of Nursing (DON) confirmed that nebulizer masks should be stored in a plastic bag when not in use.</p> <p>Review of Resident #139's physician orders showed an order dated 7/9/2025 for Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% (Albuterol Sulfate); 3 ML inhale orally via nebulizer every 6 hours as needed for shortness of breath or wheezing.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and policy and procedure review, the facility failed to prevent the possible spread of infection and communicable diseases when failing to place a resident on contact precaution during testing for possible C-Diff (Clostridium difficile) toxin (Resident #94), and failing to ensure staff donned appropriate personal protective equipment (PPE) and performed appropriate hand hygiene upon entering and exiting the resident's room. Findings include: During an observation on 7/28/2025 at 11:13 AM, there was no isolation signage on Resident #94's room door and there was no PPE available. During an interview on 7/28/2025 at 11:13 AM, Resident #94 stated, I have been having loose stool, and they did a test on it for me. I had that C. diff before. Review of Resident #94's physician orders dated 7/28/2025 read, Need Stool r/o (rule out) possible recurrent C-diff one time only for check for possible recurrent C-diff for 3 Days. During an observation on 7/29/2025 at 9:18 AM, Staff F, Certified Nursing Assistant (CNA), entered Resident #94's room, used hand sanitizer, exited room after 3 minutes, and used hand sanitizer. There was no isolation signage or PPE supplies on door of the room. During an observation on 7/30/2025 at 9:30 AM, Staff F, CNA, entered Resident #94's room, used hand sanitizer, exited the residents room after 3 minutes, used hand sanitizer, and entered a different resident's room. There was no isolation signage or PPE supplies on the door of the room. During an observation on 7/30/2025 at 10:32 AM, Staff D, Licensed Practical Nurse (LPN), entered Resident #94's room, used hand sanitizer on entry, and exited 3 minutes later and used hand sanitizer. Staff D returned to the medication cart. Review of Resident #94's infectious disease consult note dated 7/30/2025 read, Patient is a 95 y/o [year old] male who was admitted into [Name of a local hospital] back in May 2025 for weakness. Patient has had hx [history of] C-diff in the past. He now resides at Solaris skilled nursing facility; he was recently treated for C-diff and stool was normally formed. Now reported patient is having ongoing watery stools and C-diff was positive. ID [Infectious disease] consulted for antibiotics management. Seen today up in the chair awake responsive. He reports watery stools. Denies abdominal pain, no tenderness or distention noted. During an interview on 7/30/2025 at 12:15 PM, Staff E, Registered Nurse (RN), stated, He [Resident #94] was positive for C diff, and we need to place him on isolation. He should have been placed on isolation on the 28th when we got the order. We always do that. The nurse, that day, forgot to do it. During an interview on 7/30/2025 at 12:45 PM, Staff F, CNA, stated, I did not know until now that he has C diff. We should wash our hands and not use the sanitizer. I know a resident on precautions when I see the signs. During an interview on 7/31/2025 at 7:15 AM, the Director of Nursing (DON) stated, We should have placed him [Resident #94] on precautions right away when we got the order. Review of the facility policy and procedure titled Clostridium Difficile with the last approval date of 12/17/2024 read, Policy Statement: Preventive measures will be taken to prevent the occurrence of Clostridium difficile infections among residents and precautions will be taken while caring for residents with C. Difficile (to prevent the transmission of C. Difficile to others). Policy Interpretation and Implementation: 1. Clostridium Difficile infection will be considered in residents with acute onset of diarrhea (three or more unformed stools within 24 hours) or abdominal pain. 2. Residents considered at high risk for developing symptoms associated with C. Difficile include those with: a. Advanced age. c. Previous gastrointestinal illness caused by C. Difficile. 10. Residents with diarrhea associated with C. Difficile will be placed on Contact Precautions. D. Residents with diarrhea and suspected C. Difficile while awaiting laboratory results. 11. When caring for residents with diarrhea or fecal incontinence caused by C. Difficile, staff will maintain vigilant hand hygiene. Hand washing with soap and water is superior to ABHR (alcohol-based hand rub) for the mechanical removal of C. Difficile spores from hands.</p> | | |