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
	AL11922334	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HAVEN SENIOR LIVING	1225 HAVENDALE BLVD NW WINTER HAVEN, FL 33881

(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 complaint investigation (complaint number: 2023016982) and a generator monitoring were conducted at Spring Haven Senior Living on . Deficiencies were identified at the time of 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922334	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HAVEN SENIOR LIVING	1225 HAVENDALE BLVD NW WINTER HAVEN, FL 33881

(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 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922334	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HAVEN SENIOR LIVING	1225 HAVENDALE BLVD NW WINTER HAVEN, FL 33881

(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 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		

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
	AL11922334	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HAVEN SENIOR LIVING	1225 HAVENDALE BLVD NW WINTER HAVEN, FL 33881

(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 010	Continued From page 3 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	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922334	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HAVEN SENIOR LIVING	1225 HAVENDALE BLVD NW WINTER HAVEN, FL 33881

(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 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 record review and interview, the facility failed to obtain an interdisciplinary care plan that described the care and services that hospice provided and those that the facility provided and agreed upon by hospice, the facility, and the resident (or responsible party) for one Resident (#1) one sampled resident admitted to hospice services. Findings Included: A record review for Resident #1, conducted on , revealed that Resident #1 was admitted to the facility on .. Resident #1 was admitted to hospice services. The date of admission to hospice services was not noted in the resident's record. There was no interdisciplinary care plan that described the care and services that hospice provided and those that the facility provided and agreed upon by hospice, the facility, and the resident (or responsible party). During an interview with the Administrator, conducted on at 02:57pm, the Administrator agreed that Resident #1's record did not include an interdisciplinary care plan that described the care and services that hospice provided and those that the facility provided and agreed upon by hospice, the facility, and the resident (or responsible party). Class III	A 010		
A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922334	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HAVEN SENIOR LIVING	1225 HAVENDALE BLVD NW WINTER HAVEN, FL 33881

(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 034	Continued From page 5 (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure the safe and proper usage of a wheelchair assistive device for five Residents (#1, #2, #5, #6, and #7) of five sampled residents. Furthermore, the facility failed to follow their assistive devices policy and procedures by not ensuring that footrests were stable and secure and not recommending repairs and/or replacement of wheelchairs and footrests. Findings Included: A review of a self-reported incident for Resident #1, conducted on . . . . . , revealed that Resident #1 was wheelchair bound. On . . . . . , Resident #1 forward out of her wheelchair while Staff A was pushing the	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922334	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HAVEN SENIOR LIVING	1225 HAVENDALE BLVD NW WINTER HAVEN, FL 33881

(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 034	Continued From page 6 wheelchair. Resident #1 sustained . . . bone . During observations in the Memory Care Unit, conducted on . . . . . from 02:04pm through 02:46pm, Staff C was observed pushing Resident #1 in a wheelchair from the activity room to the resident's room down the hall. There were no footrests attached to the wheelchair. Staff C kept telling Resident #1 to hold your up. Residents #2, #5, #6, and #7's wheelchairs were observed and none of the wheelchairs had footrests attached/secured to their wheelchairs. Resident #1's footrests (left and right) were found inside the resident's television stand. Resident #2 did not have footrests in the resident's room. Resident #5's footrests (left and right) were in the resident's room on top of the resident's walker. Resident #6's left footrest was found on the floor by the resident's bed and did not have a right footrest. Resident #7 did not have footrests in the resident's room. At 02:46pm, a third-party home health occupational . . . , . . was observed pushing Resident #2 in her wheelchair. There were no footrests attached/secured on the resident's wheelchair. The third-party home health occupational . . . , . . told Resident #2 to lift her . Resident #2 told the third-party home health occupational . . . , . . that she was sleepy. During an interview with the Memory Care Director conducted on at 02:25pm, the Memory Care Director stated that she did not know the reason that Resident #7 did not have footrests. The Memory Care Director stated that Resident #6 did not have a right footrest. The Memory Care Director stated that Resident #2's wheelchair was donated without footrests. A record review for Resident #1, conducted on	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922334	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HAVEN SENIOR LIVING	1225 HAVENDALE BLVD NW WINTER HAVEN, FL 33881

(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 034	Continued From page 7 . . . . . , revealed that Resident #1 was admitted to the facility on . Resident #1's health assessment form dated . . . . . noted that the resident was unable to ambulate safely and the physical limitation of needing a wheelchair was not noted. A review of the facility's policy and procedures dated . . . . . entitled Assistive Devices Policy and Procedures, conducted on , it was noted on page one that staff would ensure that all assistive devices were in working order and appropriate for the resident. It was noted on page two that direct care staff would receive training on assistive devices regarding care and maintenance for each device used in the facility. It was noted that the training must be completed prior to the staff providing care to the residents. It was noted that a training certificate for the training would be in employee records and that the training would include, but not limited to: A. How the facility communicates the type of devices used to the direct care staff B. Proper use of the assistive devices for RSs C. Checking the assistive devices for the following: 1. Making sure the wheelchairs lock handles are working properly 2. Making sure the . . . pedals are stable and secure E. The facility staff must follow its procedures for recommending assistive devices repairs and/or replacement An employee record review for the Health and Wellness Director, the Memory Care Director, former Staff A, and Staff B, conducted on , revealed that there were no certificates for training regarding assistive devices.	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922334	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HAVEN SENIOR LIVING	1225 HAVENDALE BLVD NW WINTER HAVEN, FL 33881

(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 034	Continued From page 8 During an interview with the Administrator, conducted on [redacted] at 02:35pm, the Administrator stated that safe transport of a resident in a wheelchair included that the residents do not lean forward, push the wheelchair slowly, and ensure footrests were secured for safety. The Administrator stated that footrests should be used when pushing residents in wheelchairs. The Administrator agreed that employee records for the Wellness Director, the Memory Care Director, former Staff A, and Staff B did not include training for assistive devices according to the facility's assistive devices policy and procedures. Class III	A 034		