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
	AL11970161	A. BUILDING: _____ B. WING _____	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MARY	410 CARING DR LAKE MARY, FL 32746

(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
ZZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	ZZ821		

AHCA Form 3020-0001

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

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ZZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	ZZ821		

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ZZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	ZZ821		

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ZZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to submit a preliminary report within 1 business day and a full report within 15 calendar days after a resident experienced a with injuries that resulted in a transfer to a hospital for 1 of 3 sampled residents (#2). Findings: A review of resident #2's record revealed a medical history of 's . A health assessment form (1823,) dated , indicated she was at risk for . She needed assistance with ambulation, transferring, and toileting. An 1823 form, dated , indicated the resident needed precautions. A facility note, dated at 7:21 PM, indicated the resident was observed lying supine on the floor at the of her bed. A caregiver assisted her to bed at approximately 6:30 PM. The resident said she hit the of her on the floor but could not explain the circumstances of the . She complained of , in the of her , lower , and both . was	ZZ821		

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ZZ821	Continued From page 4 called. Those who responded sat the resident on the side of her bed. She then complained of . She was transported to a hospital. A facility note, dated at 3:15 AM, indicated she returned from the hospital. A facility note, dated , indicated the resident was seen laying on the floor outside of her bathroom. She complained of and , . was called and she was transported to a hospital. She returned to the facility the same day. A risk assessment, dated , scored the resident at high risk for . A facility note, dated at 7:38 AM, indicated that on at 6:29 AM, the resident was observed on the floor next to her bed. When asked what happened, the resident replied, "bathroom and ." The resident was transported to a hospital. A facility note, dated at 11 AM, indicated the resident returned from hospital. A facility note, dated at 11:18 PM, indicated the resident was found lying on her right side on the floor near the of her bed. The resident was unable to explain how the occurred. She sustained a hematoma on the right side of her forehead and complained of , . was called and the resident was transported to a hospital. The note also indicated the resident was assisted to bed approximately twenty minutes before the . A facility note, dated at 3:30 AM, indicated the resident returned from the hospital.	ZZ821		

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ZZ821	Continued From page 5 During an interview on at 10:56 AM, the resident's family member said a camera in the resident's room showed that on the resident was on the floor for two hours. The Administrator and the Wellness Director said those who worked that night would no longer care for her, a new team of staff were brought in, and she would be checked on every night at 2 AM and 5 AM. The family member went on to say that on , no staff went in the room between 11 PM and 7 AM. The family member said that it wasn't until the that the hospital bed, side rails, scoop mattress, and high-wheelchair were put in place. During an interview on at 1:13 PM, the same family member said the incident she referred to occurred on at 3:54 AM and staff entered the room at 6:26 AM. During an interview on at 1:53 PM, the Administrator confirmed the resident was on the floor for an extended amount of time on . She stated caregiver A was assigned to the resident at the time of the . The Administrator went on to say caregiver A was suspended on pending an investigation. The Administrator stated that she did not view the camera footage of the incident. She also stated that caregiver A charted that she provided care to the resident when she never entered the room. On at 3:06 PM, the resident was seen in a recliner in the common area of memory care. Her , were closed. She had a quarter-sized purple hematoma on the right side of her forehead. During an interview on at 3:56 PM, the	ZZ821		

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ZZ821	Continued From page 6 Wellness Director said the bed alarm was on the bed and functioned correctly when the resident out of bed on . During an interview on at 1:20 PM, the Administrator said preliminary and full reports were not submitted for the . that resulted in a higher level of care on , , , and because the resident came right , did not suffer a , and was only sent to the hospital because the facility's procedure was that unwitnessed required the resident be sent to a hospital. Unclassified	ZZ821		
A 000	Initial Comments A complaint investigation (2025014631) and a generator monitoring were conducted at Lake Mary on . The facility had deficiencies at the time of the survey.	A 000		
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	A 025		

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A 025	Continued From page 7 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 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	A 025		

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A 025	Continued From page 8 additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, 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 with injuries for 1 of 3 sampled residents (#2). Findings: Observations made on at 9:24 AM revealed resident #2 was in a transport wheelchair at a dining room table in memory care. Her was down, and her , were closed. Gently touching her and calling her name caused her to begin verbally making non-sensical noises. A caregiver approached and rubbed her . The resident then repeated "stop it." The caregiver asked if she wanted more of her Ensure drink. The resident repeated "no." Her bed was seen with half side rails. Her mattress had elevated padding at the and . A bed alarm , was seen on a bedside table. A high- wheelchair was seen. A review of resident #2's record revealed a medical history of 's . A health assessment form (1823,) dated , indicated she was at risk for . She needed assistance with ambulation, transferring, and toileting. A facility note, dated , indicated the resident on her left side. Both of her were slightly bent. A walker was turned on its side next to her.	A 025		

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A 025	Continued From page 9 A facility note, dated , indicated the resident was admitted to hospice. An 1823 form, dated , indicated the resident needed precautions. A facility note, dated , indicated the resident was observed sitting on the floor next to the of her bed with her extended in front of her. Her walker was on the other side of the bed. The resident was wearing non-skid socks. She was last seen approximately 20-30 minutes prior sitting in a chair in her apartment. She complained of and was unable to report what caused the . Emergency Medical Services ( ) was called and upon their arrival, they determined it was unnecessary to take her to the hospital. A facility note, dated at 7:21 PM, indicated the resident was observed lying supine on the floor at the of her bed. A caregiver assisted her to bed at approximately 6:30 PM. The resident said she hit the of her on the floor but could not explain the circumstances of the . She complained of in the of her , lower , and both was called. Those who responded sat the resident on the side of her bed. She then complained of . She was transported to a hospital. A post- screening tool, dated , indicated a possible intervention was increased wellbeing checks. A facility note, dated at 3:15 AM, indicated she returned from the hospital. A facility note, dated , indicated the	A 025		

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A 025	Continued From page 10 resident was observed sitting on her butt on her floor. She was in front of her closet with her ⌄ extended. The resident said she . The note went on to indicate the resident's family member would review the camera footage to see how she . The family member reported that the resident attempted to sit on the side of the bed when she slid to the floor. A post- screening tool, dated , indicated possible interventions were increased toileting, night light, non-skid shoes and socks, enabler for transfers, and increased wellbeing checks. A facility note, dated , indicated the resident was seen laying on the floor outside of her bathroom. She complained of and , . was called and she was transported to a hospital. She returned to the facility the same day. A post- screening tool, dated , indicated a possible intervention was increased wellbeing checks. A facility note, dated at 3:45 PM, indicated the resident was observed laying supine on the floor at the of her bed. Her walker was to her left and against the wall. The note went on to indicate the responding caregiver placed it there after removing it from on top of the resident. The resident said "I got up and . I smashed my on the floor." was called and the resident was transported to a hospital. She returned to the facility the same day. The note went on to indicate the resident's family member reported the resident's was . A post- screening tool, dated ,	A 025		

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A 025	Continued From page 11 indicated a possible intervention was increased wellbeing checks. A facility note, dated , indicated the resident was observed on her on her room floor. A facility note, dated and written by the Wellness Director, indicated worked with the resident on strengthening. The note went on to indicate the resident's care plan was updated to reflect use of a recliner for afternoon naps and not leaving the resident alone in her room because she was impulsive and got up without help. The note went on to indicate the residents' was increased from twice daily to three times daily and a silent bed alarm was implemented to alert care staff when the resident got out of bed. A facility note, dated , indicated the resident was lying on her left side on her bathroom rug. Care staff reported they just gave the resident a shower then assisted her in the wheelchair. As the care staff reached for a towel, the resident scooted and caused herself to slide off the chair. A post- screening tool, dated , indicated a possible intervention was education to reduce . A risk assessment, dated , scored the resident high risk for . A facility note, dated at 7:38 AM, indicated that on at 6:29 AM, the resident was observed on the floor next to her bed. When asked what happened, the resident replied, "bathroom and ." The resident was	A 025		

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A 025	Continued From page 12 transported to a hospital. A post- screening tool, dated , indicated a possible intervention was increased checks. A facility note, dated at 11 AM, indicated the resident returned from hospital. A facility note, dated at 11:18 PM, indicated the resident was found lying on her right side on the floor near the of her bed. The resident was unable to explain how the occurred. She sustained a hematoma on the right side of her forehead and complained of , . was called and the resident was transported to a hospital. The note also indicated the resident was assisted to bed approximately twenty minutes before the . A post- screening tool, dated , indicated a possible intervention was "other: resident was just assisted to bed 20 minutes prior to . The resident could benefit from a private caregiver." A facility note, dated at 3:30 AM, indicated the resident returned from the hospital. A facility note, dated at 8:46 PM, indicated the care staff were educated to check on resident #2 while in her bed for safety. A care plan, dated , indicated interventions were hospital bed with scoop mattress, half side rails, mat, and make sure the bed was in the lowest position. During an interview on at 10:56 AM, the resident's family member said a camera in the	A 025		

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A 025	Continued From page 13 resident's room showed that on the resident was on the floor for two hours. The Administrator and the Wellness Director said those who worked that night would no longer care for her, a new team of staff were brought in, and that she would be checked on every night at 2 AM and 5 AM. The family member went on to say that on , no staff went in the room between 11 PM and 7 AM. The family member said that it wasn't until the that the hospital bed, side rails, scoop mattress, and high-wheelchair were put in place. During an interview on at 1:13 PM, the same family member said the incident she referred to occurred on at 3:54 AM and staff entered the room at 6:26 AM. During an interview on at 1:53 PM, the Administrator confirmed the resident was on the floor for an extended amount of time on . She stated caregiver A was assigned to the resident at the time of the . The Administrator went on to say caregiver A was suspended on pending an investigation. The Administrator stated that she did not view the camera footage of the incident. She also stated that caregiver A charted that she provided care to the resident when she never entered the room. On at 2:14 PM, a message on caregiver A's phone indicated there were calling restrictions that prevented completion of the call. On at 3:06 PM, the resident was seen in a recliner in the common area of memory care. Her , were closed. She had a quarter-sized purple hematoma on the right side of her forehead.	A 025		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MARY	410 CARING DR LAKE MARY, FL 32746

(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 During an interview on at 3:07 PM, caregiver B said the staff kept an , on the resident #2 during the 7 AM to 3 PM shift, kept her comfortable, and put her in the recliner when she agreed to it. During an interview on at 3:35 PM, caregiver C said the resident was checked on every two hours. The caregiver also said a camera was in the room and facility installed motion sensors to detect movement in the room. During an interview on at 3:56 PM, the Wellness Director said the bed alarm was on the bed and functioned correctly when the resident out of bed on . A review of the facility's risk assessment policy, revised , revealed a risk assessment would be completed after each . When a resident , their wellness plan will be reviewed and revised. Class II	A 025		