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
	AL11965661	A. BUILDING: _____ B. WING _____	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS LAKE MARY	3655 W. LAKE MARY BLVD. LAKE MARY, FL 32746

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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		

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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. Residential Mental Health Providers: Crisis stabilization units, short-term residential treatment facilities, residential treatment facilities, and residential treatment centers for children and adolescents shall submit incidents as required by Section 394.907, F.S., and rules promulgated thereunder to the Agency within 1 business day of occurrence on Residential Mental Health Provider Incident Report, AHCA Form 3180-5008OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-18470, 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 6. 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. 7. For the purposes of this rule, the following applies for submitting adverse incident reports:	ZZ821		

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ZZ821	Continued From page 3 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 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 the facility reviews and interviews the facility failed to electronically submit to the agency a preliminary report within 1 business day of incident and a full report within 15 days of the incident for 2 of 6 sampled residents. (#1, #4). Findings:	ZZ821		

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ZZ821	Continued From page 4 1. Review of resident #1's 1823 health assessment indicated a medical history of , , insufficiency , , , , unsteady gait, risk, and receiving hospice care. The resident's activities of daily living indicated he was independent with ambulation, self-care, toileting, and transferring. A facility note on at 3:44 PM read, per resident's power of attorney (POA), resident passes away on Saturday in the hospice in-patient unit. A facility note on at 9:36 AM read, hospital. A facility note on at 6:54 PM read, patient in hospital. A facility note on at 7:48 AM read, hospital. A facility note on at 7:43 AM read, hospital. A facility note on at 6:07 PM read, hospital s/p . A facility note on at 3:46 PM read, per primary care, ok to send the resident to hospital for and no output. Protocol for symptoms per paramedic. A facility note on at 3:32 PM read, resident having difficulty verbalizing responses to question asked by staff. Primary care notified and sent the resident out. A facility note on at 3:27 PM read,	ZZ821		

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ZZ821	Continued From page 5 resident has change of status and unable to verbalize needs or answers questions in an appropriate manner. A facility note on at 10:40 PM read, resident from hospital awake alert to baseline in wheelchair. A facility note at 12:26 PM read, resident experienced unwitnessed . On at 2:15 PM, the Director of Nursing stated resident #1 did have a , hitting his , and she was advised that an adverse report was not needed. Further stating, the resident was sent out to the hospital for his and returned the same day. Adding, we sent him out the next day as he was having like symptoms. On at 4:14 PM, the Administrator confirmed the facility did not submit an adverse for the two incidents when resident #1 was sent to the hospital. On at 4:58 PM, the POA stated resident #1 had a down the stairs and the facility sent him to Orlando Health. After returning a few hours later. He was sent out the next day to another hospital, Health Central, and did not return to the facility. 2. Review of resident #4's record revealed a facility admission date of . His medical history included 's , and a lack of coordination. 1823 indicated a special precaution of . He required	ZZ821		

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ZZ821	Continued From page 6 supervision with ambulation and assistance with transfers. A facility note on at 5:12 PM read, resident observed laying on floor on his left side, soup noted to be all over floor. Resident had coming from of . Resident observed with small to of . 911 called resident transported to the hospital. A facility note on at 7:32 PM read, resident noted to be lying on floor near piano on his . Resident stated he hit his on the front and his elbows then rolled on his . Resident complaint of right , , . Emergency medical services called, resident transferred to hospital. There was no documentation to indicate incident reports were submitted, when the resident was transferred to a higher level of care after sustaining a on and . On at 12:26 PM, the findings were discussed with the Director of Nursing, who said she was not aware the incident reports needed to be submitted. On at 12:20 PM, during a phone exit, the Administrator confirmed the findings. (photographic evidence obtained) Unclassified	ZZ821		
A 000	Initial Comments A complaint investigation #2026000248 and generator monitoring was conducted at Spring	A 000		

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A 000	Continued From page 7 Hills Lake Mary on - . The facility had deficiencies at the time of the survey.	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and	A 008		

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A 008	Continued From page 8 Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator	A 008		

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A 008	Continued From page 9 whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or , , services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of , , , or any other communicable , which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and,	A 008		

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A 008	Continued From page 10 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care	A 008		

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A 008	Continued From page 11 Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or . (f) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a health assessment form (1823) was complete for 2 of 6 sampled residents (#3, #4). Findings: Review of resident #3's 1823 health assessment revealed it was missing the medical examiner's address.	A 008		

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A 008	Continued From page 12 Review of resident #4's 1823 health assessment revealed it was missing the medical examiner's address. There was no documentation to indicate the facility contacted a health care provider to obtain the missing information. On at 12:20 PM, during a phone exit, the Administrator confirmed the findings. (photographic evidence obtained) Class III	A 008		
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 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.	A 025		

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A 025	Continued From page 13 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 additional services. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide adequate supervision and ensure safety through proactive measures to minimize the potential for and injuries for 1 of 6 sampled residents (#4).	A 025		

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SPRING HILLS LAKE MARY	3655 W. LAKE MARY BLVD, 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 Findings: Review of resident #4's record revealed a facility admission date of . His medical history included , and a lack of coordination. His 1823 health assessment indicated a special precaution of and required supervision with ambulation and assistance with transfers. Continued review of the record revealed the following: A facility note on at 3:23 PM, patient resting in wheelchair nurse practitioner on site, assessed resident. Status post, day 3, hospital day 3. Resident remains on acuity resident reminded to not transfer or stand alone. A facility note on at 12:53 AM, medication administered per health care providers orders for agitation, restlessness and sleeplessness. A facility note on at 11:16 AM, status post and hospital visit day 2, no ill effects noted no complaint of or discomfort, resident remains on acuity resident reminded to not transfer or stand alone. A facility note on at 10:03 PM, resident from the emergency room, on stretcher escorted by transport staff, stable no findings diagnosed. A facility note on at 5:12 PM, resident observed laying on floor on his left side, soup noted to be all over floor. Resident had coming from of . Resident alert with restlessness, resident denied c/o , or	A 025		

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A 025	Continued From page 15 discomfort. Resident observed with small to of . Pressure applied. Resident getting agitated sitting on floor. Resident assisted in the wheelchair. 911 called resident transported to the hospital. A facility note on at 8:16 PM, resident sitting in the bathroom doorway. Resident fully dressed and had shoes on at the time. Resident wheelchair in bathroom with resident. Resident alert able to make simple needs known, resident denies complaint of or distress, resident denies hitting . Resident reminded to not to stand without assistance and placed on acuity for 72 hours. A facility note on at 3:21 PM, patient unit in wheelchair, post , resident remains on acuity and reminded to not stand up alone. A facility note on at 6:35 PM, resident observed laying on floor in front of wheelchair. Resident fully dressed, with shoes on at time of incident, noted on resident right arm and noted to have increased . Resident then tried to stand up and almost again. Resident continued with and placed on acuity for 72 hours. A facility note on at 1:06 PM, resident had a on at 10 PM in his room, slipped from wheelchair. A facility note on at 8:15 AM, resident observed in memory care, spring cottage on floor, laying on his in hallway, and wheelchair next to door. The Caregiver stated that the resident out of wheelchair while in hallway, was restless and agitated throughout the night and would not	A 025		

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A 025	Continued From page 16	A 025		

stay in chair. Off going nurse stated that resident sustained a during shift which resulted in a to right . No active observed at this time. Caregivers assisted this nurse with lifting resident to wheelchair. Resident and staff stated he did not hit his . No or discomfort expressed at this time.

A facility note on at 12:22 AM, resident on night shift and is exhibiting behaviors.

A facility note on at 8:51 PM, resident around unit. The resident has a in healing states to lower . Resident observed to have a earlier this week.

A facility note on at 7:31 PM, resident walking around unit and non-complaint with wheelchair, post and hospitalization day 2. Resident continued with agitation and .

A facility note on at 11:02 PM, resident from hospital via transport in stretcher.

A facility note on at 7:32 PM, resident noted to be lying on floor near piano on his . Resident stated he hit his on the front and his elbows then rolled on his . Resident complaint of right , , . Emergency medical services called, resident transferred to hospital.

A facility note on at 2:43 PM, patient continues to in wheelchair. Post and transferred to memory care unit. Resident remains on acuity and to ask for help when needed.

A facility note on at 11:50 PM, paged to room, resident on floor next to bed. The resident

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A 025	Continued From page 17 has to right arm, first aid applied. A facility note on at 7:48 PM, resident observed sitting on floor in front of wheelchair. The resident has to right arm, first aid applied. A facility notes on at 7:08 PM, resident continues with increased and . The resident moved to memory care due to safety. A facility notes on at 9:40 PM, resident observed walking in room with unsteady gait and no walker. A facility notes on at 5:48 PM, resident arrived at community via personal care accompanied by family. The resident ambulates with wheelchair. The facility's undated reduction and response to policies, revised , indicated, among other things, residents are evaluated for conditions and factors that increase their risk for falling. The evaluation is performed on admission, annually, changes in condition, and after a . The risk evaluation score or risk will be entered on the individualized service plan. After a , the Director of Resident Care, or qualified designee, must show documentation of an analysis of the circumstance of the and interventions that were initiated to prevent or reduce the risk of subsequent . On the Morse evaluation, a score of 45 or higher was considered a high risk for . Resident #4's evaluations conducted ,	A 025		

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A 025	Continued From page 18 and all scored 55. There were no evaluations for residents' on and . No additional evaluations were provided. Review of resident #4's service plan, revised , revealed interventions were to , and meet the residents' needs and ensure residents' pendant is within reach and encourage the resident to use it for assistance as needed. Review of resident #4's health care plan, with a start date of , indicated resident had a history of related to . Interventions were to , and meet the residents' needs, Morse evaluation after each , frequent safety checks at least every 2 hours and as needed. Review of resident #4's Orlando Health Lake Mary hospital visit note, indicated resident had a closed injury without loss of , initial encounter . Review of resident #4's Orlando Health Lake Mary hospital visit note, indicated resident had a hematoma with a mild to the top of . On at 11:17 AM, Caregiver L said, most of resident #4's happen when he is assisting another resident. On at 11:27 AM, Caregiver M said resident #4 would on the 3PM to 11PM shift. During her shift she would try to monitor the resident to prevent his . On at 11:41 AM, Licensed Practical Nurse (LPN) B said resident #4's has	A 025		

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A 025	Continued From page 19 progressed rapidly since he has been admitted. LPN B added, it seems as though resident #4's mind is always racing. LPN B said the staff tries to predict the resident needs prior, try to keep the resident busy, and try to redirect to prevent . LPN B said she is not sure if the resident is receiving , , , . On at 12:09 PM, the Director of Nursing (DON), said the resident was transferred to memory care from assisted living in due to behavior concerns. The DON added, there has been a medication reconciliation and increased monitoring to prevent resident . The DON said, the resident was receiving , , , when he was admitted to the facility. The DON added the resident is not receiving , , , presently due to trying to get the resident , ready to participate in , , , . On at 12:28 PM the DON was asked for investigation or analysis that was done into resident #4 . No documentation received. On at 1:46 PM LPN H said, resident #4 is always on the move and he has a behavior concern. LPN H added the resident was transferred from the assisted living unit to the memory care unit for closer supervision. On at 2:06 PM, resident #4's Power of Attorney (POA) said the resident was residing in the assisted living unit when he was admitted to the facility. He added, the resident #4 did not have any while in assisted living. Resident began when he went to the memory care unit. The POA said, the resident has more than 6 times. Two of the resulted in a hospital visit. He does not understand why	A 025		

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A 025	Continued From page 20 resident #4 is falling so often and he would like there to be a solution to prevent the . On at 3:13 PM, Caregiver N said she is uncertain of the interventions to prevent resident #4's . She knows that his room is not cluttered. On at 4:19 PM, Caregiver L said, "Resident 4 frequently, sometimes the resident would be in his room. Resident #4 needs to be monitored frequently. Caregiver L said he does not remember the dates. He does recall in on the shift, after resident #4 was assisted to bed he heard a noise coming from his room. He was on the floor. The nurse was called to come and assist. On at 5 PM, Caregiver O said, on at approximately 4:30 PM, resident #4 was sitting at the dining room table in his wheelchair. Then the chair moved and he backwards. Caregiver O said, Caregiver C was next to resident #4 when it happened. On at 8:37 PM, Caregiver C said, on resident #4 approximately 4 PM to 5 PM at dinner time, in the dining room. Resident #4 was sitting in his wheelchair at one of the dining room tables. Resident is not to stand alone or be without his wheelchair. He would always try to stand by himself. Caregiver C said she was standing at the dining room counter, when she turned to see resident #4 standing up from his wheelchair with the soup bowl in his . She went to assisted resident #4 and he became agitated. Resident #4 then stumbled backward and tripped over the front wheel of his wheelchair, falling backwards and hitting the of his on the , of a dining room chair behind him.	A 025		

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A 025	Continued From page 21 After the resident , LPN B was called to assist the resident. Caregiver C said the mistake was, resident #4's wheelchair was not locked. Caregiver C added, resident #4 placed himself at the dining room table while in his wheelchair. When the resident moved to the memory care unit he needed more help. Caregiver C said the intervention to prevent the resident from falling is to constantly monitor the resident. When the resident was on the assisted living side unit, he did not need a lot of help. On at 12:20 PM, during a phone exit, the Administrator confirmed the findings. (Photographic Evidence Obtained) Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement	A 032		

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A 032	Continued From page 22 for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement.	A 032		

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A 032	Continued From page 23 (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to make a daily effort to ensure 1 of 1 sampled resident who was identified as being at risk for elopement had identification (ID) on their person that included their name and the facility's name, address, and telephone number (#3). Findings: On a review of an incident report dated documented the resident elopement. The resident walked out of the building unassisted by any devices or with family or staff. Review of resident #3's 1823 health assessment indicated a medical history of agitation due to , risk, guard, and identified as an elopement risk. A facility note on at 6:34 PM, resident removed guard off left . guard placed on right with new strap. A facility note on at 3:00 PM, guard placed on right . A facility note on at 3:10 PM, resident eloped from building this morning after receiving her medication. On at 11:16 AM, the power of attorney stated he's aware of the guard placed on the resident but has no knowledge if it has the residents' name and address of the facility.	A 032		

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A 032	Continued From page 24 On at 11:50 AM, Nurse J stated the guard is an alert to notify staff when the resident is nearing the exit door and will alarm when the resident is about 15 from the exit. Further stated, I'm not sure if it has the residents' name, address, and telephone number of the facility. On at 3:04 PM, Caregiver N stated she saw the guard on resident #3 after she eloped but does not know if it had her name on it. The facility's undated and Elopement Policy stated if a resident is determined to be at risk for elopement, an identifying Community ID Bracelet will be placed on his/her person that includes the community's name, address, and telephone number and resident's name when required by State Regulations. On at 2:24 PM, the Director of Nursing stated resident #3 had a guard placed on her after the elopement and the facility would replace each time she removed it. Further stating, resident #3 did not have an ID bracelet on and the guard did not include the community's name, address, telephone number, and the residents' name. On at 3:22 PM, the Administrator reviewed the facility's policy and was made aware there was no ID bracelet placed on the resident that included the required information after resident #3 eloped from the facility. On at 12:20 PM, during a phone exit, the Administrator confirmed the findings. (photographic evidence obtained)	A 032		

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A 032	Continued From page 25 Class III	A 032		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this	A 052		

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A 052	Continued From page 26 section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described	A 052		

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A 052	Continued From page 27 in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:	A 052		

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SPRING HILLS LAKE MARY	3655 W. LAKE MARY BLVD, 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 052	Continued From page 28 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to report medication refusals to a health care provider for 1 of 6 sampled residents (#5). Findings: Review of resident #5's health assessment form (1823) revealed the resident needed assistance with self-administration of	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965661	A. BUILDING: _____ B. WING _____	01/14/2026

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A 052	Continued From page 29 medications. The , medication observation record (MOR) indicated resident #5 refused 8.6 MG tablet on and . There was no documentation on MOR or the residents' record to indicate the refusals were reported to a health care provider. On at 1:48 PM, the findings were discussed with the Director of Nursing, who confirmed the findings. The facility's medication policy revised , indicated the resident's health care provider will be notified should the resident refuse their medications. On at 12:20 PM, during a phone exit, the Administrator confirmed the findings. (Photographic Evidence Obtained) Class III	A 052		