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 _____	R 03/18/2026

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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{A 000}	Initial Comments A revisit to complaint investigation #2026000248 and generator monitoring was conducted at Spring Hills Lake Mary on - . The facility had an uncorrected deficiency at the time of the survey.	{A 000}		
{A 025} SS=D	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. 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	{A 025}		

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{A 025}	Continued From page 1 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 4 of 19 sampled residents (#4, #10, #11, #12). Findings: 1. Review of resident #4's 1823 health assessment indicated a medical history of , , , , lack of coordination, communication , uses a wheelchair, unsteady gait, and identified as a risk. The resident needs supervision with	{A 025}		

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{A 025}	Continued From page 2	{A 025}		

ambulation, and needs assistance with bathing, , toileting, and transferring.

A Service Plan Report date initiated indicated the resident is high risk for , gait/balance problems, lack of safety awareness. Revised , ensure the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. Follow community protocol.

A facility note on at 11:44 AM, patient ( ) post , assessed , related to at 2:30 as stated per caregiver, , alert with , denies , or discomfort at this time.

A facility note on at 10:25 PM, resident observed laying on floor near bed, on pillow. Resident appeared to be self-transferring into bed.

On at 11:25 AM, Caregiver E stated she believes resident #4 last night. Adding, he did not hurt himself, but he keeps falling.

On at 12:53 PM, Caregiver D stated resident #4 gets agitated at times. Adding, she keeps him in the common area during the day, engaging in conversation along with keeping on him.

On at 1:42 PM, Registered Nurse (RN) S stated she does not work in memory care a lot and believes the resident was trying to leave his room before home health arrived for his shower when he . Adding, that was her first encounter with resident #4.

On an attempt was made to contact resident #4's family for an interview and no return

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{A 025}	Continued From page 3 call was received. 2. Review of resident #10's 1823 health assessment indicated a medical history of , , uses a walker, and identified as a risk. Her ADL's indicated independent with ambulation, transferring and required supervision with self-care and toileting. A Service Plan Report dated stated the resident is moderate risk for , , , gait/balance problems initiated . Revision , be sure the resident's pendant is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Revision , educate the resident/family/caregivers about safety reminders and what to do if a occurs. Follow community protocol. A facility note on at 0:55, no complaints of , at this time, no physical indicators of , or discomfort noted or reported status post . A facility note on at 10:41 AM, resident returned from hospital for with complaints of arm , . A facility note on at 1:42 PM, resident was noted on the floor in her living room next to a table laying on her left side, awake and alert to baseline but unable to recall how the occurred. Resident stated she believes she's been on the floor approximately 10 minutes prior to assessment. A facility note on at 8:08 PM, resident stated she has , in her and says it's an 8.	{A 025}		

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{A 025}	Continued From page 4 A facility note on at 10:34 PM, resident said she trying to get into bed. Resident observed sitting on floor in front of bed. Resident observed to have on socks with no grip and rug on floor flipped up, trip on rug while walking over to bed. A facility note on at 7:45 AM, resident returned from hospital around midnight. A facility note on at 0:47, resident returned from hospital at this time due to . Resident and redirected a few times to not get out of bed due to unsteady gait and educated on the use of the pendant for assistance. A facility note on at 9:40 PM, resident transported to hospital due to , from . A facility note on at 11:23 PM, resident said she getting up. The resident in activity room and resident has unwitnessed getting up, complained of , . A facility note on at 10:10 PM, resident had a in the dining room yesterday and was sent to the hospital for , to the of . A facility note on at 5:42 PM, returned from hospital. A facility note on at 10:45 AM, resident hit in dining room, transferred to hospital. A facility note on at 9:57 AM, resident observed lying on her right side next to fireplace, chair and walker flipped over.	{A 025}		

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{A 025}	Continued From page 5 A facility note on at 10:19 AM, resident observed sitting on the floor in closet, out straight. On at 12:45 PM, Caregiver K stated hourly checks are done on resident #10. Adding, they removed the carpet from the room which was causing the and hospice brought in a bedside commode which was placed near the bed to help with minimizing the . On at 12:47 PM, the resident stated she uses her call pendant when she needs help from the staff. Adding, the staff helps her and everything is fine. Further stating, she does not like to bother them as she knows they're busy. On t 2:24 PM, the Case Manager for resident #10 stated she's aware there is a problem with . Adding the resident needs to be in memory care but the family oversees the finances and are reluctant to move. Further stated, the family put resident #10 on hospice. The Case Manager states that when the resident , she is made aware and when necessary, will send the resident to the hospital and the family does not hold the facility responsible. 3. Review of resident #11's 1823 health assessment indicated a medical history of , paraparesis of both lower , 's repeated , tremor, , of region, unsteady gait, mobility, and identified as a risk. His ADL's indicated supervision with ambulation, self-care, transferring and needs assistance with bathing, , and toileting. A Service Plan Reported dated stated the resident is high risk for , ,	{A 025}		

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{A 025}	Continued From page 6 gait/balance problems, and unaware of safety needs initiated . A facility note on at 7:30 PM, , has a witness in the living room. has right , and small open area, sent out to hospital. A facility note on at 9:40 AM, unwitnessed from wheelchair, resident on floor in dining room, resident leaning in wheelchair throughout the shift and just gazing straight ahead. A facility note on at 10:52 PM, resident has been leaning to the left and shaking along with agitation. A facility note on at 10:32 AM, resident stated he , denies , or discomfort, resident found lying on side. A facility note on at 1:24 AM, about 10:30 PM resident was found on floor in room, supine position next to bed. On at 12:53 PM, Caregiver D stated the resident likes to lean a lot in his wheelchair, so they place him near the wall. Adding, she keeps him the common area during the day, engaging him in conversation. On at 2:04 PM, the power of attorney stated he appreciates the resident's situation. Adding, resident #11 is slipping more so than falling from his wheelchair. Adding, the resident is using his own . Therefore, he's not too strong, which could result in more incidents. The POA stated he likes the approach the facility is taking and has no concerns with the care they're providing.	{A 025}		

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{A 025}	Continued From page 7 Review of the facility's revised Reduction and Response to states resident evaluation for risk is performed on admission, annually or change in condition, if necessary, a plan shall be implemented to minimize risk of . 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 . The reduction plan is communicated to care providers, family, and other staff involved then implemented. Acuity documentation post 72 hours (about 3 days) protocol must be followed. On at 3:48 PM, the Administrator was asked about the interventions put in place for residents #4, 10, and #11 and the continued . She stated clearly the interventions are not working if they continue to . Adding, we've got some work to do. 4. Review of a facility note, dated at 7:46 PM, revealed the resident was observed laying on his on the floor with his walker nearby. Review of a facility note, dated at 11:11 AM, revealed the resident was lying on the elevator floor with his resting against the wall. The note indicated the resident was initially alert then became unresponsive for 10 to 15 seconds. The note indicated that emergency medical services were called and the resident was taken to a hospital. Review of a facility note, dated at 1:41 PM, revealed the resident returned from the hospital.	{A 025}		

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{A 025}	Continued From page 8 Review of a facility note, dated at 2:21 PM, revealed the resident was observed on the floor in his room with his wheelchair near the bathroom door. Review of a facility note, dated at 8:31 PM, revealed the resident was observed sitting on the dining room floor with his walker next to him. Review of a facility note, dated at 5:54 PM, revealed the resident continued to leave his walker and walk without it. Review of a facility note, dated at 4:02 PM, revealed the resident in the dining room and hit the of his . Review of a facility note, dated at 5:39 PM, revealed the resident was observed sitting on the floor in front of his room. Review of a facility note, dated at 3:48 PM, revealed the resident had an unwitnessed . The note indicated that redness and was seen on his left . Review of facility risk assessments, dated , , , , , , and , revealed they all scored the resident high risk of falling. During an interview on at 4 PM, the Administrator said there was no additional documentation of proactive measures taken by the facility to minimize the potential for further . On at 4:50 PM, the Administrator and Director of Resident Care confirmed the findings.	{A 025}		

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{A 025}	Continued From page 9 Class III	{A 025}		