

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	Initial Comments Six (6) complaint investigations #2026003775, #2026003791, #2026002963, #2026000382, #2026000300, #2025019038 and generator monitoring was conducted at Spring Hills Lake Mary on - . The facility had deficiencies at the time of the visit.	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,	A 010		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 010	Continued From page 1 additional care is provided by a licensed hospice, 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	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 010	Continued From page 2 applicable department. (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	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 010	Continued From page 3 record; and, 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	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 010	Continued From page 4 holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, resident record reviews and interviews, the facility failed to obtain a new AHCA Form, 1823 Health Assessment completed by the healthcare provider for continued residency after a significant change for 2 of 19 sampled residents (#6, #23) as required in an assisted living facility (ALF). Findings: 1. A review of resident #6's record revealed date of admission . A 1823 health assessment listed physical or sensory limitations as of unspecified part of right , subsequent encounter for closed with routine healing, presence of right , and unsteadiness on . Resident #6's ADL's requires supervision with ambulation and transferring, needs assistance with , and toileting. Review of a 1823 health assessment identified resident #6 as risk, guard and elopement risk. A facility note on at 10:21 AM, Power of Attorney states resident #6 has a . A facility note on at 4:25 AM, resident was on the floor, found partially underneath the bed, lying on her side with the lower half of her body under the bed. A facility note on at 6:34 PM, resident removed guard off left .	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 010	Continued From page 5 On at 3:46 PM, the Administrator stated she would check to see if resident #6 had another 1823. 2. A review of resident #23's record revealed date of admission . The last 1823 health assessment dated . listed medical history of and . Resident #23 was documented as a risk and needing supervision with bathing only, independent with all other activities of daily living (ADLs). She needs assistance with self-administration of medications. In further review, resident #23 was admitted to hospice care on . There was no new 1823 health assessment completed by the healthcare provider for significant change. An observation on at 11:45 AM, resident #23 was sitting in her wheelchair in the common area, 1st floor. She was unable to answer questions and unable to conduct an interview. At 11:50 AM, observed caregiver D pushing her in the wheelchair to the dining room for lunch. On at 2:50 PM, an interview with the Administrator confirmed the finding. On at 4:50 PM, the Administrator and Director of Resident Care confirmed the findings, providing no additional documentation. (Photographic Evidence Obtained) Class III	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 030 A 030 SS=D	Continued From page 6 59A-36.007(5) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; _____, Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida _____ Hotline, 1(800)96- _____ or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the	A 030 A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 030	Continued From page 7 facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 030	Continued From page 8 of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 030	Continued From page 9 prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . for health care services, the provision of or arrangement of transportation to health care . . . and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally . . . , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 030	Continued From page 10 (1) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without _____, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, _____, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder _____ Hotline operated by the Department of Children and Families, and, if applicable, _____, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder _____ Hotline operated by the Department of Children and Families, and _____, Rights Florida.	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 030	Continued From page 11 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated or under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, facility documentation, resident record reviews and interviews, the facility failed to honor resident rights and facility procedures for the following: 1} not having hot water for 8 of 19 sampled residents (#1, #2, #3, #8, #13, #16, #17, #18) to take a shower at any time. {2} not conducting a thorough investigation as required for 1 of 19 sampled residents (#7) for by two caregivers (G & H) by investigating all 83 other residents in the assisted living that were not affected by the and allowed caregivers (G & H) continue to work with all the residents. Findings:	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 030	Continued From page 12 On _____ at 10:30 AM, an interview with resident #8 complained that he had no hot water to take a shower and must do a bird (sponge) bath because the water was too _____. He said that there were other residents in the facility that were also complaining about no hot water to take a shower in the facility. Resident #8 said that he did not submit a grievance to management because they already knew. On _____ at 1:55 PM, an interview with Caregiver A said that when she assists residents with showers, she was told by the Maintenance Director to turn on the bathroom sink faucet and the shower faucet together for a couple of minutes to let the water get hot for the shower before assisting. This process has been like this since she started working at the facility seven months ago. On _____ at 2:05 PM, an interview with Caregiver D stated that when she assists residents for showers, she turns on all the faucets in the resident's apartment (kitchen sink, bathroom sink and shower) all at one time for hot water to assist with showers. It usually takes about a minute to warm up hot water. She also said this was the normal process and that there was nothing that could be done about it according to the Maintenance Director directives. A grievance on _____ at approximately 5:30 PM was submitted by Caregiver I to management, regarding resident #7 reporting that two caregivers (G & H) came into her room to assist her to bed and Caregiver G told Caregiver H that resident #7 had hit Caregiver G in the Caregiver H leaned over into resident #7's and said, "fuck you".	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 030	Continued From page 13 A facility note dated _____ at 12:33 PM (late entry) by Licensed Practical Nurse (LPN) J documented resident #7 reported to her that on _____ for the 3pm-11pm shift, two caregivers (G & H) were working together. Resident #7 said that she heard one of the caregiver's (G) tell the other caregiver (H) that resident #7 punched her in the _____, then Caregiver H leaned into resident #7's _____ and said, "fuck you". Resident #7 reported the incident to her daughter, Caregiver I, the previous Director of Resident Care and the Administrator were all informed. Resident #7's record review revealed date of admission _____. The 1823 Health Assessment dated _____ listed medical history of _____ lymphocytic _____ and _____. She was admitted to Hospice care on _____. She ambulates with a wheelchair and needs assistance with all activities of daily living (ADLs) and assistance with self-administration of medications. On _____ at 12:45 PM, an interview with resident #7 said that last month on _____ at approximately 5:30 PM, 2 Caregivers G and H were getting resident #7 ready for bed and that the tall Caregiver G told the short Caregiver H that resident #7 had hit her in the _____. The short Caregiver G told her in her _____ "fuck you". Resident #7 said she was upset and shocked about this because all employees should act unprofessional while working in a professional setting. Resident #7 said that it should never happen, and no one had ever told her vulgar language, and it bothered her a lot. Further stating she could not believe it. Resident #7 said that she reported to another Caregiver I (who was	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 030	Continued From page 14 on vacation leave this week of investigation) and she told management and her family of the incident. On _____ at 2 PM, an interview with the Administrator about the incident and the Administrator gave a written reprimand to the two Caregivers G and H on _____, internally investigated, and concluded the internal investigation. The Administrator said that the two caregivers identified as (G) and (H), both denied the _____ claim against resident #7. The Administrator further stated that the two Caregivers G and H told her that they were playing around with resident #7 asking resident #7 for help to save one of the caregivers from each other in the room. The two Caregivers G and H said that this was a normal thing in the evenings when they got resident 7 ready for bed. The Administrator confirmed that she did not suspend Caregivers G and H. The Administrator confirmed that she did not conduct a thorough investigation to ensure that no other residents were affected by _____ by Caregivers G and H. The Administrator stated that she did not submit a referral to the _____ hotline because the facility found the grievance not substantiated with provided email written statements dated (two days later) by the two caregivers. The facility failed to conduct a thorough investigation regarding _____ to ensure the safety of resident #7 and the remaining 83 residents in the facility were not affected. During an interview on _____ at 11:15 AM, resident #1 said she did not have hot water in her shower since she moved in. She said she's had only one shower because of it. Observations	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 030	Continued From page 15 during the interview found the resident's appearance was clean. Review of the resident's record revealed a facility admission date of . During an interview on _____ at 11:30 AM, resident #2 said that sometimes the water was not hot in her shower. During an interview on _____ at 11:45 AM, resident #3 said that his shower water was not hot or was Lukewarm. Review of resident #13's record revealed an admission date of _____. During an interview on _____ at 11:25 AM, resident #13 said her hot water in the shower had not been hot for approximately 2 weeks. The resident said the previous Friday she informed the Maintenance Director of her hot water concerns. The resident said it has still not been resolved. Review of resident #16's record revealed an admission date of _____. During an interview on _____ at 11:48 AM, resident #16, said for approximately 3 to 4 weeks, her hot water in the shower takes a while to get warm when she turns it on. The resident said it gets a little better than Luke-warm, but it is not hot. The resident said the Maintenance personnel has been informed. Review of resident #17's record revealed an admission date of _____. During an interview on _____ at 12:09 AM, resident #17, said for approximately 1 month her hot water does not get hot. The resident said she has informed the staff.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 030	Continued From page 16 Review of resident #18's record revealed an admission date of . During an interview on at 11:44 PM, resident #18 said for weeks her water in the shower would start out hot and then would get warm or . Resident #18 said this past Sunday when she was taking a shower it happened. The resident said it does not matter what time of the day; her shower will do the same. The resident said she has spoken to the Maintenance Director about her concerns. Resident #18 said she has not received an update yet. During an interview on at 3:09 PM, the Maintenance Assistant said he heard about resident #13's hot water concerns the previous week. The Maintenance Assistant said he has spoken to the Maintenance Director about it. Further stating, it is possible to adjust the water temperature. During an interview on at 10:08 AM, the findings of the hot water concerns were discussed with the Administrator. The Administrator said she was not informed about residents' hot water concerns. On at 11:25 AM, Caregiver E stated the water does not get hot when the residents take a shower. Adding, she must turn on the water in the sink to get hot water for the shower. Further stating, it has been that way since she started in of last year and she's told the prior Director of Resident Care on several occasions. Caregiver E stated she's now use to it and no longer reports it's because she knows they're going to tell her to turn on the water in the sink to get hot water in the shower.	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 030	Continued From page 17 On at 3:05 PM, the Maintenance Assistant stated he was recently made aware that # had an issue with hot water. Further stating, he heard something about it last Thursday regarding the hot water and had not heard anything prior. Adding, the facility has a tankless water heater, and the water comes from the city straight to the pipes. Observation of the five (5) panel tankless water revealed a reading of 120 F/C approx. water temp. On at 10:00 AM, the Maintenance Director stated the tankless water heaters have a temperature setting at 120 F/C on demand and cannot be adjusted higher. Adding, the water travels from the opposite side of the building into the panels to heat the water before output to different locations. Further stated, the water will never get hot like our homes, but it will be warm. He stated that due to the extreme weather outside for the past few months in Florida, the water sitting in the pipes was very . Adding, it takes a while to flush out the water from the pipes. The Maintenance Director stated the staff did not know they had to let the water run in the rooms for a bit before it gets warm. Therefore, he educated the residents and staff to turn the water on in the shower and in the bathroom sink , to get it hotter quicker. Adding, it will only get to 112 degrees max. The Maintenance Director stated he would recommend not putting the residents in the shower right way, allowing the water to run a bit. On at 4:50 PM, the Administrator and Director of Resident Care confirmed the findings.	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 030	Continued From page 18 (photographic evidence obtained) Class III	A 030		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known _____ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical _____, the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.	A 054		

Agency for Health Care Administration

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

(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 054	Continued From page 19 This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a MOR was accurately updated when a medication was administered to 2 of 3 sampled residents (#1, #25.) Findings: 1. Review of resident #1's record revealed a medical history of _____ type 2. Review of resident #1's _____ MOR revealed that on _____ at 11:30 AM, Unlicensed Caregiver A gave the resident 10 units of _____ 2. Review of resident #25's record revealed a medical history of _____, long term use. Review of resident #25's _____ MOR revealed that on _____ at 12 PM, Unlicensed Caregiver A gave 9 units of _____ During an interview on _____ at 12:14 PM, Unlicensed Caregiver A said it was Unlicensed Caregiver K who gave the _____ on _____ Unlicensed Caregiver A said she was signed in on the MOR so when Unlicensed Caregiver K signed it, it showed Unlicensed Caregiver A's initials. During an interview on _____ at 12:59 PM, Unlicensed Caregiver K confirmed that she, and not Unlicensed Caregiver A, gave the _____ on _____ On _____ at 4:50 PM, the Administrator and Director of Resident Care confirmed the findings. Class III	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 078	Continued From page 21 qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility allowed unlicensed staff to prepare and administer to 3 of 3 sampled residents (#1, #22, #25.) Findings: 1. Review of resident #1's record revealed a medical history of type 2. Review of resident #1's medication observation record (MOR) revealed that on at 11:30 AM, Unlicensed Caregiver A gave the	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 078	Continued From page 22 resident 10 units of _____ and at 4 PM, Unlicensed Caregiver Q gave 13 units of _____. Further review revealed that on _____ and _____ at 9 PM, Unlicensed Caregiver Q gave 14 units of _____. 2. Review of resident #22's record revealed a medical history of _____ type 2. Review of resident #22's _____ MOR revealed that on _____ and _____ at 8 PM, Unlicensed Caregiver Q gave the resident 10 units of _____. 3. Review of resident #25's record revealed a medical history of _____, long term use. Review of resident #25's _____ MOR revealed that on _____ and _____ at 8 PM, Unlicensed Caregiver Q gave the resident 38 units of _____ and on _____ at 5 PM, gave 10 units of _____. Further review revealed that on _____ at 12 PM, Unlicensed Caregiver A gave 9 units of _____. During an interview on _____ at 12:14 PM, Unlicensed Caregiver A said it was Unlicensed Caregiver K who gave the _____ on _____. Unlicensed Caregiver A said she was signed in on the MOR so when Unlicensed Caregiver K signed it, it showed Unlicensed Caregiver A's initials. Unlicensed Caregiver A said a nurse was not available to give _____ on _____. Unlicensed Caregiver A said the Administrator met with her and Unlicensed Caregiver K then said one of them could give the _____. During an interview on _____ at 12:59 PM, Unlicensed Caregiver K confirmed that she, and	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 078	Continued From page 23 not Unlicensed Caregiver A, gave the on . Unlicensed Caregiver K said the Administrator instructed her to give the Unlicensed Caregiver K said she gave the by putting a needle on the prefilled pen, dialing the pen to the prescribed units, prepping the skin with ., then administered it by injecting the resident then pushing the plunger until the pen showed zero units. During an interview on at 3:50 PM, Unlicensed Caregiver Q confirmed that she administered the . Unlicensed Caregiver Q said the Administrator told her the facility's owner gave permission to do so. Unlicensed Caregiver Q said she prepared the . then injected it. Unlicensed Caregiver Q said she was not licensed to administer . During an interview on at 9:40 AM, the Administrator said she made attempts to find a nurse to work on without success. The Administrator said she told the unlicensed caregivers to administer the . Review of Caregiver K's and Q's personnel record confirmed neither were licensed to administer . On at 4:50 PM, the Administrator and Director of Resident Care confirmed the findings. (photographic evidence obtained) Class III	A 078		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt	A 084		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 084	Continued From page 24 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfillment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule	A 084		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 084	Continued From page 25 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, _____ dosage forms, and _____ and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with _____ syringes that are prefilled with the proper dosage by a pharmacist and _____ that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with _____; j. Use a _____ to perform _____ testing; k. Assist residents with _____ and continuous positive airway pressure (CPAP) devices, excluding the titration of the _____ levels; l. Apply and remove _____ stockings and hosiery; m. Placement and removal of _____ bags, excluding the removal of the _____ or manipulation of the _____ site; and, n. Measurement of _____ rate,	A 084		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 084	Continued From page 26 temperature, and _____ rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled unlicensed caregivers (K) who assisted with self-administration of medications obtained, annually, a minimum of two hours training on	A 084		

Agency for Health Care Administration

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

(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 084	Continued From page 27 providing assistance with self-administered medications and safe medication practices in an assisted living facility. Findings: Review of Unlicensed Caregiver K's personnel record revealed the caregiver received six hours of medication training on _____ and two hours on _____. Further review revealed no documented two hours of annual training during 2025. During an interview on _____ at 3 PM, the Administrator said Unlicensed Caregiver K did not obtain two hours of annual update training during 2025. Class III	A 084		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.frlrules.org/Gateway/reference.asp?No=Ref-04003 , and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx . Therapeutic diets must meet these nutritional standards to the extent	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 093	Continued From page 28 possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 093	Continued From page 29 facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of _____ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on _____. (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has _____ with residents to serve, must be on _____ at all times. The quantity must be based on the resident census and not on licensed capacity.	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 093	Continued From page 30 The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observations, facility's documentation and interviews the facility failed the following: (1) to have cycle menus dated and planned one week advance for all regular and therapeutic diets in the assisted living facility and posted conspicuously and easily available to the residents;(2) not providing and delivering breakfast for 5 of 19 sampled residents (#2, #22, #32, #33, #34) as required;(3) to maintain therapeutic diet menus approved by the registered dietician annually for and / residents that the healthcare provided ordered in the assisted living facility;(4) to maintain a substitution log that served comparable nutritional value meals and (5) did not adhere to the regulations for interval dining times for all meals that must be distributed throughout the day no less than 2 hours apart at minimum and not more than 6 hours apart from the end of one meal to the beginning of the next meal as required. Findings: An observation on at 9:10 AM, there were no posted menus in the dining room that was dated in a week advance (week cycle -) as required for residents to visibly review. An observation on at 10:19 AM, there	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 093	Continued From page 31 were five (5) breakfast meal plates wrapped up on a tray ready for delivery to resident's #2, #22, #32, #33 and #34. The Dining Director cooked them and was ready from 9:45 AM. The Dining Director called the caregiver staff twice on the walkie to come pick up the meals for delivery. A review of a 4 cycle week menus approved and signed by the registered dietician on that was designed as a family restaurant style menu serving the duplicate menu items every day in the entire week cycle. In further review, the residents must choose the same everyday items cooked and served for the entire week from a table menu. Both sets, the approved menus by the registered dietician and the table menu did not list any therapeutic diets for and / condition residents that the healthcare provider issued special diet orders. There are a total of 24 residents and 16 / condition residents at the facility. There was no substitution log maintained in the facility for the past 6 months due to the facility's chefs always cooking everything on the same meal items menus (family restaurant style) every day therefore they never have substitutions, however this does result in a huge amount of food being thrown away every day. The facility's dining mealtimes are listed: Breakfast 7AM-10AM; Lunch 11:30AM-2:30PM; and Dinner 3:30PM-6PM. The facility did not adhere to the minimum of 2 hours in between mealtimes as regulated. This causes a delayed cooking and serving of the next meal to the residents on time. An interview on at 11:05 AM, the Dining Director stated she was not able to deliver the	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 093	Continued From page 32 breakfast to those five residents because she was cooking in the kitchen; one of the cooks had called out sick and the Cook could not deliver the meals because she was serving and assisting with breakfast in the dining room to the residents that were dining in. On at 10:19 AM, an interview with Dining Director about the menus, the substitution logs, and meals prepared & served to the residents. The Dining Director said that she was hired on so she was new and that some of the cooks & servers quit and left with the previous Director of Resident Care and previous Administrator. The Dining Director stated that she is now able to hire new staff for the kitchen and dining services. The Dining Director said she was fully staffed with now a Lead Cook and 3 other cooks in the kitchen. She now has 4 servers to assist and serve meals daily to the residents. The Dining Director stated that she was told by corporate office to continue using the menus (set up as family restaurant style) in which the cooks must cook everything listed on the menu. The Dining Director further stated that this menu process causes a huge amount of food waste. The Dining Director said the approved menu dated by the registered dietician were already approved this way before she started working at the facility and saw that the same exact meals were repeated every day for one whole week cycle and that many of the residents eating in the dining room expressed they did not like the menu in a food chat meeting with the residents in . The Dining Director agreed and understood the residents wanting to change the menus to: two choices of meal entree's offered daily and two different entree meals offered every day with a choice of the	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 093	Continued From page 33 everyday fare menu (quick meals) that offers grilled chicken sandwich, hot dogs, French fries, chicken tenders, peanut & butter sandwiches, salads, burgers, omelets and more in case the residents did not want the two choice entrée meals for the that day or meal. The Dining Director further said that this was how the facility she worked at previously did the menus. On _____ at 10:46 AM, an interview with the Dining Director confirmed the findings above and said that she will reach out to the registered dietician to work on changing the menus that will be appropriate for the residents. On _____ at 4:02 PM, there was a telephone interview with the registered dietician about the approved menus at the facility. She stated that the previous Administrator and previous Dining Director wanted a family restaurant style menu. The registered dietician was not aware that the residents were not happy with this style of menu, and she was not aware that there was new management (Administrator and Dining Director) since signing and approving the menus on _____ (last year, about 5 months ago). In further conversation, the registered dietician said that she was willing to complete a new approved menus to make the residents happy, ensuring there was a nutritional value for special therapeutic diets and to help not waste food. It was explained that the were 24 _____ residents and 16 residents with _____ / _____ conditions that their healthcare provider ordered special diets for them to follow. The registered dietician apologized and said that she will get it figured out right away with the Dining Director.	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 093	Continued From page 34 Observations made on _____ at 11:03 AM revealed resident #22 was lying in his bed with only a shirt and _____ brief on. The resident said he had not gotten out of bed yet and did not have breakfast. During an interview on _____ at 11:30 AM, Caregiver L said that resident #2 wanted to get out of bed but said she did not want breakfast. Observations made on _____ at 11:36 AM revealed resident #2 was lying in her bed. The resident had a bowl of partially consumed biscuits and gravy on a table in front of her. The resident said the food was just brought to her. The resident said she did not tell Caregiver L that she did not want breakfast. Observations made on _____ at 11:39 AM revealed residents #32 and #33 were sitting on a sofa in their apartment. Resident #32 was eating a plate of breakfast foods. An empty plate was on a table next to resident #33. They both said the food was just brought. Resident #33 said that "a long time ago," a staff member came into their room to tell them to go to the dining room for breakfast. They said they weren't going down. The staff member offered a room tray but never returned. Observations made on _____ at 11:41 AM revealed resident #34 was lying in his bed. An uneaten plate of bacon, scrambled eggs, and toast was on a bedside table in front of him. He said the plate of food was just brought to him. He said he told a staff member earlier that morning that he wanted breakfast. During an interview on _____ at 11:44 AM, Caregiver M said that at approximately 9 AM she	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 093	Continued From page 35 took room tray orders and gave them to the kitchen. She said the kitchen usually called over the walkie talkie when their trays were ready but today, she did not hear them call. The caregiver said she did not go to the kitchen to check because she got busy with something else. Observations made on _____ at 10:45 AM revealed resident #22 was lying in his bed. He said he did not receive breakfast. A plate with breakfast food covered with clear plastic was on his counter. Caregiver O said she brought the plate to his room about 40 minutes prior and the resident was sleeping. Observations made on _____ at 10:50 AM revealed residents #32 and #33 were in their room. They said no one offered them breakfast. During an interview on _____ at 10:56 AM, Caregiver O said she did not know residents #32 and #33 were not given breakfast. The caregiver said she thought they went to the dining room. The caregiver said the process was that someone at the front desk checked each resident's name on a list who came to the dining room and were responsible for notifying the care staff if a resident did not show. During an interview on _____ at 11:03 AM, the Dining Director said the server was responsible for checking off each resident's name who came to the dining room. She also said the server was required to find out the status of those residents who did not show up. During an interview on _____ at 11:25 AM, Server P said that for those residents who did not come to the dining room she normally asked the caregiver if the resident was coming down or if a	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER SPRING HILLS LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 093	Continued From page 36 to-go meal was needed. She said that today she did not do that. Review of the check-off list revealed residents #32 and #33 did not go to the dining room. Review of resident #22's record revealed a medical history of _____ type 2. Review of a health assessment form, dated _____, revealed the health care provider ordered a _____-controlled diet. Review of the menus revealed no therapeutic diet options. Review of the dietary communication forms maintained in the kitchen revealed the kitchen was not informed of the residents' diet. During an interview on _____ at 9:40 AM, the findings were discussed with the Administrator, who did not provide additional documentation. On _____ at 4:50 PM, an exit interview with the Administrator and Director of Resident Care confirmed the findings. (photographic evidence obtained) Class III	A 093		