

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
ZZ821	59A-35.110() FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPo rtal. 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?N o=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPo rtal.	ZZ821			

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: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
ZZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , which is hereby incorporated by reference and available	ZZ821			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
ZZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780 , and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal . 5. Residential Mental Health Providers: Crisis stabilization units, short-term residential treatment facilities, residential treatment facilities, and residential treatment centers for children and adolescents shall submit incidents as required by Section 394.907, F.S., and rules promulgated thereunder to the Agency within 1 business day of occurrence on Residential Mental Health Provider Incident Report, AHCA Form 3180-5008OL, _____, which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-18470 , and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal 6. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, _____, which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123 , and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal . 7. For the purposes of this rule, the following applies for submitting adverse incident reports:	ZZ821			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
ZZ821	Continued From page 3 a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to \$50 per day late not to exceed \$500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on the facility reviews and interviews the facility failed to electronically submit to the agency a preliminary report within 1 business day of incident and a full report within 15 days of the incident for 1 of 4 sampled residents. (#5) Findings:	ZZ821			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
ZZ821	Continued From page 4 On at 9:07 AM, during the entrance conference the Director of Nursing (DON) identified resident #5 out of the building due to a with Review of resident #5's record revealed a facility admission on A 1823 health assessment did not identify the resident as a risk. His activities of daily living indicated he was independent with toileting, needs supervision with ambulation, transferring, and needs assistance with bathing and A facility incident report dated at 7 PM, found resident on floor, resident found lying on the floor on his right side. Resident stated his right and right , hurt. Resident stated he was trying to go to the bathroom but was found in the kitchen. Resident sent to hospital. The Power of Attorney (POA) stated resident has a right , and and due to have surgery. A facility incident report dated at 4:30 PM, approx. 2:30 PM, went to check on resident in room, observed resident laying on the floor on his right side. Resident stated he hit his and his hurt. The family stated resident may go to a rehabilitation facility due to a On at 10:45 AM, the DON stated they did not do any incident reporting for resident #5. Further stating, there care plan indicated he was independent. (photographic evidence obtained) Unclassified	ZZ821			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765			
(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	Continued From page 5	A 000			
A 000	Initial Comments A re-licensure survey and generator monitoring was conducted at Lutheran Haven Extended Congregate Care on . The facility had deficiencies at the time of the visit.	A 000			
A 008 SS=D	429.26() FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 008	Continued From page 6 facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 008	Continued From page 7 her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , , require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or , , services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of , , , or any other communicable , which are likely to be transmitted to other residents or staff,	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765			
(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 008	Continued From page 8 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 008	Continued From page 9 on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, _____, or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida _____ Form, for residents who do not wish _____ to be administered in the case of _____ or _____. (f) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a health assessment form (1823) was complete for 1 of 4 sampled residents (#5). Findings: Review of resident #5's _____ 1823 health	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 008	Continued From page 10 assessment revealed the medical examiner's telephone number and address was missing. There was no documentation to indicate the facility contacted a health care provider to obtain the missing information. On at 2:27 PM, the DON stated there was no alternative 1823 for resident #5. On at 6:00 PM, the Administrator, DON, and Nursing Supervisor confirmed the findings. (photographic evidence obtained) Class III	A 008			
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	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 11 receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, 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.	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765			
(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 12 (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (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	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 13 receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a _____ may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner. 2. The condition is documented in the resident's record; and, 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	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 14 this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on 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 1 of 4 sampled residents (#5) as required in an assisted living facility (ALF). Findings: On at 9:07 AM, during the entrance conference the Director of Nursing (DON) identified resident #5 out of the building due to a with Review of resident #5's record revealed a facility admission on A 1823 health assessment did not identify the resident as a risk. His activities of daily living indicated he was independent with toileting, needs supervision with ambulation, transferring, and needs assistance with bathing and A facility note on at 8:42 AM, resident found on floor in room. A facility note on at 2:46 PM, resident	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 15 found on floor. A facility note on _____ at 3:37 PM, approx. 2:30 PM, resident observed laying on the floor on his right side. A facility note on _____ at 7PM, found resident on the floor lying on his right side. On _____ at 10:45 AM, the DON stated their care plan indicated he was independent when asked why a new 1823 was not obtained identifying the resident as a _____ risk after the _____ incident. On _____ at 6:00 PM, the Administrator, DON, and Nursing Supervisor confirmed the findings. The facility failed to obtain a new 1823 after a significant change occurred for resident #5 identifying him as a _____ risk. (photographic evidence obtained) Class III	A 010			
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 16 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 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	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 17 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 care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for and injuries for 1 of 4 sampled residents (#5). Findings: Review of resident #5's record revealed a facility admission on . A 1823 health assessment did not identify the resident as a risk. He uses a walker to ambulate. His activities of daily living (ADL's) indicated he was independent with toileting, needs supervision with ambulation, transferring and needs assistance with bathing and . The facility's revised Policy stated should a resident experience a , staff will provide or arrange for necessary emergency care and will follow up with necessary service plan updates. The ALF Nursing Supervisor or designee instructs caregivers to provide appropriate care and frequent residents checks. Any change in status is reported to the ALF Nursing Supervisor, who informs the physician or subsequent and instability. Medical intervention. . . . and/or gait analysis is arranged when residents remain a significant risk for . Ongoing may require relocation from the community.	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 18 A facility incident unwitnessed report, resident's room, dated at 7PM, went to answer pendant and found resident on the floor lying on his right side. Resident stated his right and right hurt. Resident stated he was trying to go to the bathroom but was found in the kitchen area. The POA stated resident is due to surgery and has a right and A facility incident unwitnessed report, resident's room, dated at 2:30 PM, approx. 2:30 PM, went to check on resident and observed resident lying on the floor on his right side. Resident stated he hit his , visibly in , stating his and his hurt. The family stated the resident may go to the rehabilitation facility due to A facility incident unwitnessed report, resident's room, dated at 2:26 PM, when staff arrived at resident room, found him on the floor near kitchen area. Resident stated he just lost his balance. Floor was noted to be wet in the area, and he was sitting on the floor. He was not using a walker or cane while standing. A facility incident witnessed report, resident's room, dated at 7:05 AM, nursing description, unwitnessed and resident not sure how he . Resident stated he was walking in the doorway of his room when he . Resident Service Plan dated with changes/date reviewed on and revealed I = independent and self for ambulation, bathing, , eating, toileting, and transferring. He needed S=supervision by staff for observing wellbeing and observing whereabouts.	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 19 A Functional Assessment dated _____ indicated a total score of 42 rating (independent). His mobility, moving from place to place, totally independent - needs no assistance. A facility note on _____ at 2:49 PM, alert charting _____ to right _____. A facility note on _____ at 5:11 PM, resident returned from doctor's office with new orders. A facility note on _____ at 10:45 PM, resident returned from the hospital about 5 PM. A facility note on _____ at 7:03 AM, resident complained that something was wrong "with his mental." Resident stated he wanted to go to the hospital. A facility note on _____ at 2:49 PM called doctor to see if they could order something for _____, and to help resident sleep. Resident complaining of _____. A facility note on _____ 4:18 PM, responded to residents' call multiple times. Resident stated, "I can't go to sleep." "I need something to help me sleep." A facility note on _____ at 2:49 PM, resident stated he has _____, this evening. A facility note on _____ at 2:43 PM, resident declined assistance with ADLs stating, "I was able to do it." Resident encouraged to call for assistance when needed and agrees. A facility note on _____ at 10:07 PM, resident ambulating with walker short distance.	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 20 A facility note on _____ at 4:16 PM, resident readmit and medication list sent for review. A facility note on _____ at 3:43 PM, approx. at 1:10 PM, resident admitted to facility. Resident ambulating with his walker for short distances, longer wheelchair. According to the resident's POA the resident needs help with ADLs. A facility note on _____ at 3:37 PM, approx. at 2:30 PM, staff when to check on resident in room. Resident observed laying on the floor on his right side. The resident stated he hit his _____. The resident was visibly in _____, stating he hit his _____, his _____ hurt, and was transported to hospital. A facility note on _____ at 12:25 PM, resident left and returned from doctor's _____ with new orders. A facility note on _____ at 7:23 AM, staff entered residents' room, checked vitals, temperature reading 101.9. Resident stated he does not feel sick, has no _____, and does not want to go out to hospital A facility note on _____ at 7:21 AM, resident complained of _____ with movement. Inquiring about getting evaluated for his _____. A facility note on _____ at 5:18 PM, for _____, resident refused vitals to be taken this shift. A facility note on _____ at 4:43 PM for _____, vitals taken. A facility note on _____ at 7:18 AM, resident complained of _____ around 5:50 AM.	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 21 A facility note on _____ at 7:55 PM, for _____, resident denies any _____ or discomfort. A facility note on _____ at 9:29 PM, for _____, resident denies any _____ or discomfort. A facility note on _____ at 2:46 PM, resident found on floor, no injuries, vitals taken. A facility note on _____ at 2:57 PM, faxed over orders for _____. Resident complaining of some _____ since his _____. A facility note on _____ at 11:47 AM, spoke with resident after returning from the hospital. He had an _____ of the right _____ and CT of _____. Resident stated he was walking in the doorway of his room and _____. The staff gave the resident his pendant and requested he call for assistance when transferring or anytime he feels weak. The resident agreed and went over the use of _____ pendant. A facility note on _____ at 9:09 AM, received report from the hospital that the resident will be returning to ALF. Resident had an _____ of the right _____ and _____ of _____, _____ done. No acute findings. A facility note on _____ at 8:42 AM, the resident was found on floor in room and transported to hospital. On _____ at 3:07 PM, Caregiver E stated she has provided assistance to resident #5 and reminded him to ask for help before getting up. Caregiver F further stated, the day he _____, she did not see it but went to assist after resident #5's wife pressed the pendant. Adding, she believes the resident collided while pushing her in the _____.	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 22 wheelchair. On at 4:26 PM, Caregiver B stated she knows resident #5 but did not work with him during any of his . On at 5:02 PM, the DON stated they documented in the incident reports for the residents' transport to the hospital, any , and not in the progress notes. Adding, they followed their care plan for resident #5 and he was independent with his ADL's. The DON was then asked why the resident did not receive any assistance or supervision after the on he made them aware that he . She stated the in , which the resident his , he was independent. Adding, he was still walking independently with his walker. Further stating, he was also alert and oriented, had the pendant around his , and did not ask for help. The DON stated in , he was still ambulating with his walker without assistance and did not ask for assistance when ambulating. After review of the resident service plan and no updates after . The DON stated we will update his plan of care, , , reeducation when calling for assistance, to use his pendant and everything else will be determined when he returns. The DON did not provide any additional information about why the service plan was not updated after the on with continued stating the resident was independent. The DON was made aware the resident's admission 1823 indicated he was independent with all ADL's but the 1823 indicated he needs supervision with ambulation and transferring. On at 5:18 PM, the Administrator stated they will do an assessment before resident #5	A 025			

If continuation sheet 24 of 37

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765			
(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 24 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. This Statute or Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to ensure the Medication Observation Record (MOR) was updated each time a medication was administered to 1 of 4 sampled residents (#7.) Findings: Review of resident #7's , and MORs revealed omissions. There was no documentation to explain the omissions. On at 1:30 PM, the Director of Nursing confirmed the findings and said there was no additional documentation. (photographic evidence obtained)	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765			
(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 25 Class III	A 054			
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	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 26 certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their 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 interview and record reviews, the facility failed to ensure 1 of 5 sampled staff (C) submitted a written statement from a health care provider within 30 days after beginning employment documenting that the individual does not have any signs or symptoms of communicable and failed to ensure 1 of 4 sampled staff (A) had documentation of a negative . . . () on an annual basis.	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765			
(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 27 Findings: Review of caregiver C's personnel record revealed a hire date of . The record did not have a written statement from a health care provider within 30 days after beginning employment documenting that the individual does not have any signs or symptoms of communicable . On at 4:40 PM, the Director of Nursing said the caregiver did not submit the statement. Review of unlicensed caregiver A's personnel record revealed a hire date of . The last negative examination was on . On at 2:44 PM, the Director of Nursing said the caregiver did not have a exam. Class III	A 078			
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 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	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 28 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 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;	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 29 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, 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	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 30 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 observation, interview, and record review, the facility failed to ensure that 1 of 1 sampled unlicensed caregiver (A) who assisted with the self-administration of medications completed annually two hours of continuing education. Findings: Observations made on . . . at 10:05 AM revealed unlicensed caregiver A gave medications to resident #9. Review of unlicensed caregiver A's personnel record revealed she completed two hours of continuing education on . . . On . . . at 2:45 PM, the Director of Nursing said the caregiver did not complete two hours	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 31 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.flrules.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 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 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 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 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.	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 (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. 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 observation, record review, and interview, the facility failed to maintain 6 months' worth of menus. Findings: Review of a 5-week _____ and winter 2025 cycle menu did not indicate a duration of 6 months.	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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 During an interview on _____ at 12:04 PM, the Food Service Manager said he used a 5-week cycle of menus which are reviewed and signed by a licensed dietician. The Food Service Manager added he makes daily menus using the cycle menus. During an interview on _____ at 12:55 PM, the Food Service Manager said he does not keep the daily menus for 6 months. The Food Service Manager said after the daily menu is used, he would throw them away. The facility failed to keep menus on file for 6 months. On _____ at 6:00 PM, the Administrator confirmed the findings. (photographic evidence obtained) Class III	A 093			
AE208 SS=D	59A-36.021(8) FAC 429.07(3)(b)3, FS ECC - Records 59A-36.021(8) RECORDS. (8) RECORDS. In addition to the records required in rule 59A-36.015, F.A.C., a facility providing extended congregate care services must maintain the following: (a) The service plans for each resident receiving extended congregate care services; (b) The nursing progress notes for each resident receiving nursing services from the facility's staff; (c) Nursing assessments; and, (d) The facility's extended congregate care policies and procedures.	AE208			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765		
(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	
AE208	Continued From page 35 429.07 (3)(b), FS 3. A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives such nursing services from the facility's staff which describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse, or appropriate designee, representing the agency shall visit the facility at least twice a year to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules. One of the visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects the facility. The agency may waive one of the required yearly monitoring visits for a facility that has: a. Held an extended congregate care license for at least 24 months; b. No class I or class II violations and no uncorrected class III violations; and c. No ombudsman council complaints that resulted in a citation for licensure. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record reviews, the facility failed to ensure nursing progress notes described the type, amount, duration, scope, and outcome of services that were rendered to 1 of 3 sampled residents (#7) who received an Extended Congregate Care	AE208			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/01/2026
---	--	--	--

NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN EXTENDED CONGREGATE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2035 W RD 426 OVIEDO, FL 32765
--	--

(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
AE208	Continued From page 36 (ECC) service. Findings: On at 9:50 AM, resident #7 said he had a that facility nurses managed and gave him and medications through. On at 11:50 AM, Licensed Practical Nurse D was observed giving a feeding and water through the Review of nursing progress notes revealed they did not thoroughly describe the type, amount, duration, scope, and outcome of the care given to the insertion site and administration of the feedings and medications. On at 1:30 PM, the Director of Nursing confirmed the findings and could not provide additional documentation. Class III	AE208		