Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965661	A. BUILDING: _____ B. WING _____	R 08/06/2026

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 000}	Initial Comments A second revisit to complaint investigation #2026000248 and generator monitoring was conducted on - at Spring Hills Lake Mary. The facility had an uncorrected deficiency at the time of the visit.	{A 000}		
{A 025} SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	{A 025}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965661	A. BUILDING: _____ B. WING _____	R 08/06/2026

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 025}	Continued From page 1	{A 025}		

resident diets in accordance with Rule 59A-36.012, F.A.C.
(b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.
(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.
(d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change.
(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
(f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
DEFICIENCY REMAINED UNCORRECTED

Based on record reviews and interviews, the facility failed to provide adequate supervision and ensure safety through proactive measures to minimize the potential for and injuries for 1 of 7 sampled residents (#13).

Findings:

Review of Resident #13's record revealed a facility admission date on . A health assessment indicated a medical history of mixed,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965661	A. BUILDING: _____ B. WING _____	R 08/06/2026

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 025}	Continued From page 2 type II , , right 2nd , special precautions , , ( ), and independent with all activities of daily living. The resident is able to administer his medications. The resident agreement dated on page 21 states all residents will be checked on every 2 hours during the 11 - 7 shift unless they have a "Do Not Disturb" sign on their door. The service plan report initiated on stated the resident is moderate risk for and has ADL performance/lifestyle . The interventions state ensure resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. Rubber soled shoes. Continue interventions on the Intervention Plan. Staff to ensure the resident has the call bell within reach. On at 9:45 AM, the power of attorney (POA) stated she called the facility the night resident #13 to make them aware because after he pressed his pendant no one came to help him. A facility note on 4:45 AM, family called stating Resident #13 was on the floor. Entered room, observed resident laying on his side beside bed, barefoot, and . He was verbally aggressive and refusing care/assessment from staff. Emergency medical services arrived and resident was taken to the hospital. A facility incident report dated at 3:30 AM, this nurse was called at 3:30 by family member stating they received a call that resident was on the floor. contacted due to lack of resident cooperation, appearance of , resident on and .	{A 025}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965661	A. BUILDING: _____ B. WING _____	R 08/06/2026

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 025}	Continued From page 3 A facility note on at 10:41 AM, resident has a of 101.8, warm to touch on lower . Resident stated it started overnight. ARNP made aware and ordered . A facility note on at 10:37 AM, POA onsite states resident has a and she gave him . A facility note on at 2:48 PM, asking for imaging results. A facility note on at 12:56 PM, call placed to medical imaging to follow up on order for , , and for and ordered by primary. A facility incident report dated at 10:30 AM, patient found on the floor in his room stated he was going to the bathroom and lost his balance. Patient has a on left and right . A facility note on at 2:44 PM, no complaints / resident is stable s/p , continue precaution. A facility note on at 3:54 PM, no complaints / resident in room and does not want to be disturbed after 9:30 PM. Per POA, resident started this afternoon, she believes it's for in lower but there was no definitive diagnosis. A facility incident report on at 11:00 PM, on floor beside bed. Resident stated, "he feels like he may have slid off the side of the bed, he does not know." contacted by off going shift, 44, states he does not check	{A 025}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965661	A. BUILDING: _____ B. WING _____	R 08/06/2026

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 025}	Continued From page 4 sugar every day. Resident transient noted during conversation with and family. A facility note on at 00:49 - resident on the floor beside the bed, laying on /left side with on bed rail, denies hitting , stated he's on , and does not want to go to hospital. Resident verbally when nurse was attempting to talk to resident about , called and the resident allowed them to take vitals and was lifted into bed. Resident refuses to allow staff in room to check on him. The POA states we can listen outside the door when we make rounds and states, we can listen when we walk by to see if we hear him. Staff were informed to keep an out in case he calls out. On at 9:45 AM, Caregiver D stated she was unaware of the resident having any . Adding, he had an , went to the hospital and the POA called and said he was not coming . Further stating, he even though he didn't want us in his room. She would go and check on him, change his linen, and remove his trash. On at 10:28 AM, Caregiver R stated she did not provide care but would do safety checks. She stated the day before he it was reported to LPN H that he had some and she reported it to the POA. Further stating, LPN H wanted to send the resident to the hospital, but the POA and doctor said to wait. She stated there was a note left to check on the resident overnight but there was no evidence found. Caregiver R stated when a resident is sick, they're supposed to get a room tray delivered by the aid. On at 10:39 AM, the Director of Resident Care stated usually when a resident request not to be checked on they must sign a negotiated	{A 025}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965661	A. BUILDING: _____ B. WING _____	R 08/06/2026

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 025}	Continued From page 5 risk. Further stating, she spoke with the Administrator and Resident #13 did not have one. Adding, the staff should have checked on him. She stated the staff who worked the overnight shift on that date no longer work at the facility and there was no evidence that the resident received a room tray or ate dinner on . . On at 11:06 AM, LPN H stated the resident had issues with his and had several . She said she spoke with the POA the day before the resident . Adding, the POA said he was starting the , and she did not want to send him out. She stated she was in constant communication with his doctor, the POA, discussed sending him out and they both refused. On at 11:26 AM, Caregiver E stated she did not provide care to the resident. Adding, she would do routine checks even though he didn't want them in his room. Further stating, she was not present during his 3 and only heard about it when she returned. The facility's undated Reduction and Response to states after a , the Director of Resident Care or qualified designee must show documentation of an analysis of the circumstance of the and interventions that were initiated to prevent or reduce the risk of subsequent . The reduction plan is communicated to care providers, family, and other staff involved then implemented. The Risk Evaluation score or risk will be entered on the Individualized Service Plan. There was no evidence of the risk evaluation score or if the reduction plan was communicated with the providers, family, or staff.	{A 025}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965661	A. BUILDING: _____ B. WING _____	R 08/06/2026

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 025}	Continued From page 6 On at 2:40 PM, the Administrator and Director of Resident Care confirmed the findings. (photographic evidence obtained) Class III	{A 025}		