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
	AL11969935	A. BUILDING: _____ B. WING _____	05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAKE AT HAMLIN, THE	4814 HAMLIN GROVE TRL WINTER GARDEN, FL 34787

(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 qualifications, to observe residents, to document	A 078		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 078	Continued From page 1 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 personnel record reviews and interview, the facility failed to ensure 3 of 5 sampled staff submitted a written statement from a health care provider documenting freedom from communicable . . . . . within 30 days after beginning employment (A, B & the administrator). Findings: 1. Caregiver A's personnel record revealed a hire date of . . . . The record contained an employment clearance form, dated , but the statement on the form that indicated the employee was free from communicable . .	A 078		

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A 078	Continued From page 2 was not checked. 2. Nurse B's personnel record revealed a hire date of . The record contained an employment clearance form, dated , but the statement on the form that indicated the employee was free from communicable was not checked. On at 3:05 p.m., the business office manager confirmed the findings and was unable to provide additional documentation. 3. The administrator's personnel record revealed a hire date of . The record contained an employment examination record, dated , but the form did not contain documentation that indicated the administrator was free from communicable . On at 6 p.m., the administrator confirmed the finding in her record and was unable to provide additional documentation. Class III	A 078		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility	A 081		

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A 081	Continued From page 3 must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:	A 081		

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A 081	Continued From page 4 (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [illegible] borne [illegible], may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident [illegible], neglect, and [illegible]. The facility must use its [illegible] prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs.	A 081		

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A 081	Continued From page 5 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to have documented evidence to indicate 1 of 5 sampled staff received a minimum of 1-hour training on reporting adverse incidents and facility emergency procedures including chain-of-command, training on the facility's resident elopement policy and procedures, and a minimum of 1-hour in-service training that covered recognizing and reporting resident [redacted], neglect, and [redacted] within 30 days of hire (B). Findings: Nurse B's personnel record revealed a hire date of [redacted]. The record did not contain documentation to indicate the nurse received a	A 081		

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A 081	Continued From page 6 minimum of 1-hour training on reporting adverse incidents and facility emergency procedures including chain-of-command, training on the facility's resident elopement policy and procedures, and a minimum of 1-hour in-service training that covered recognizing and reporting resident , neglect, and . On at 6 p.m., the administrator confirmed the findings and was unable to provide additional documentation. Class III	A 081		
A 090 SS=D	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to have documented evidence to indicate 1 of 5 sampled staff received at least one hour of training in the facility's policy and procedures regarding .	A 090		

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A 090	Continued From page 7 ( ) that included information in 59A-36.009, Florida Administrative Code (B). Findings: Nurse B's personnel record revealed a hire date of . The record did not contain documentation to indicate the nurse received at least one hour of training in the facility's policy and procedures regarding . On at 6 p.m., the administrator confirmed the findings and was unable to provide additional documentation. Class III	A 090		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse	CZ814		

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CZ814	Continued From page 8 before referring an employee or potential employee for electronic , submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on review of the facility's background screening clearinghouse roster and interview, the facility failed to report the employment status within 10 business days for 1 of 6 sampled staff (E). Findings: Review of the facility's , staffing schedule revealed Nurse E worked both the 3 p.m. to 11 p.m. and the 11 p.m. to 7 a.m. shifts. Review of the , schedule did not contain Nurse E's name on the schedule. A review of the facility's background screening clearinghouse roster on at 4:43 p.m. revealed that Nurse E was listed with only a provisional hire date of . An actual hire date and employment end date were not indicated. The findings were discussed with the administrator, who confirmed them and said Nurse E's employment ended on . Unclassified	CZ814		
A 000	Initial Comments	A 000		

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A 000	Continued From page 9 An Extended Congregate Care (ECC) initial survey, Complaint Investigation #2022003362, and an . . . . . Control Monitoring were conducted on . The Blake at Hamlin had deficiencies at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or . . . . . or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making . . . for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

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A 025	Continued From page 10 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, 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 to 1 of 3 sampled residents who eloped from the facility (#1). Findings: Resident #1's record revealed a facility admission date of [redacted]. An 1823 health assessment form, dated [redacted], indicated the resident's diagnoses were [redacted]'s [redacted], right-sided [redacted] ([redacted]),	A 025		

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A 025	Continued From page 11 ( ), ( ), , that the resident had short-term memory loss and that she was not an elopement risk. A facility admission note, dated , indicated the resident was admitted to the assisted living side of the facility. She was alert, oriented to self, and had short-term memory decline. An initial resident care evaluation, dated , indicated the resident had memory , and sundowning. "The term sundowning refers to a state of occurring in the late afternoon and spanning into the night. Sundowning can cause a variety of behaviors, such as , , aggression or ignoring directions." (retrieved mayoclinic.org). A facility note, dated at 2:51 p.m., indicated the resident was alert and oriented to self. Her short-term memory was poor, she "repeats verbalizations almost immediately after she communicates thoughts. Must be cued for all activities of daily living (ADLs) and cued to dining room." A facility note, dated at 2:21 p.m., indicated the resident was forgetful, had to be reminded often to wear her , and had to be directed to and from both meals and activities due to her being unable to remember where her room was. A service plan, dated , indicated the resident had a current or history of occasional disorientation to person, place, time, or situation, even in familiar surroundings and required	A 025		

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A 025	Continued From page 12 supervision and oversight for safety. It indicated she had severe , , was unable to remember or use information, and may require repeated verbal prompts and/or direction. A facility note, dated at 11:56 p.m., indicated the resident was found by law enforcement walking on a street outside of the facility. An officer returned the resident to the facility. Review of a facility incident report indicated that on at 5:30 p.m., the resident ate dinner in the dining room. At 8 p.m., she received medications. At 9 p.m., she received bedtime care. At 11 p.m., she was seen by a police officer on the 4-lane street located in front of the facility. On 11:45 p.m., the police officer returned her to the facility, where staff saw that the resident had her walker with her but, she was not using the . The resident said she was looking for her family member. On at 2:42 p.m., caregiver F said that the resident was always forgetful and oftentimes repeated herself. The caregiver said that although the resident lived on the first floor of the assisted living side, on approximately two or three occasions the caregiver found the resident on the second floor saying that she was going to her room. On at 4:25 p.m., the administrator said following the resident's elopement, one on one supervision was placed with her until she was moved to the secured memory care unit, which was on . On at 5:12 p.m., caregiver G said when she cared for the resident on the assisted living	A 025		

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A 025	Continued From page 13 side, the resident was . . . . . at times and caregiver G would see the resident on the second floor saying she was looking for her home. Caregiver G said she saw the resident around the facility at times but never saw the resident exit-seeking or leaving the facility. Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969935	A. BUILDING: _____ B. WING _____	05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAKE AT HAMLIN, THE	4814 HAMLIN GROVE TRL WINTER GARDEN, FL 34787

(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 032	Continued From page 14 at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to follow its resident elopement policy and failed to make a daily effort to ensure 1 of 4 sampled residents, who was identified as an elopement risk, had identification	A 032		

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A 032	Continued From page 15 (ID) on their person that included their name and the facility's name, address, and telephone number (#1). Findings: Resident #1's record revealed the resident eloped from the facility on . On at 10:20 a.m., the resident was seen in her room in the secured memory care unit. She did not have ID, such as a bracelet, on her person. The resident's record did not contain documentation to indicate the facility made a daily effort to ensure the resident had ID on her person. Review of the facility's resident elopement policy, dated , read in part that a "resident's walker should be labeled with the resident's first and last name, name of community and community phone number . . . place alert notices at guest memory care entrance/exit egress doors. Notices are to remind guests to ensure door closed behind them and to immediately report any resident remaining near an exit." On at 4:10 p.m., resident #1 was seen sitting on a couch in the common area of memory care. Her walker was in front of her and although it was labeled with her first and last names, it was not labeled with the name of the community and the community's address and phone number. There were no alert notices placed at the guest entrance/exit egress door. The director of nursing was present at the time, confirmed all the findings, and said the daily efforts made by the staff to ensure residents had ID were not documented anywhere. Class III	A 032		