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 _____	12/06/2022

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 000	Initial Comments Complaint Investigations #2022012838 and #2022013471, and a Generator Monitoring were conducted from . 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 resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 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, interviews and record reviews, the facility failed to provide adequate supervision and provide care and services appropriate to meet the needs of residents by failing to ensure safety through proactive measures to minimize the potential for and injuries for 2 of 4 sampled residents (#5 & #7), failed to provide adequate supervision to 1 of 4 sampled residents who eloped twice from the facility's secured memory care unit (#4), and failed to provide adequate supervision to 1 of 4 sampled residents who hit another resident (#7) . Findings:	A 025		

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A 025	Continued From page 2 1. Review of resident #5's record revealed a facility admission date of . An 1823 health assessment form, dated , indicated the resident's diagnoses were moderate to advanced . The resident required precautions. An 1823, dated , indicated the resident had a history of falling. The resident's record revealed the following: A facility " Risk Assessment", dated , scored the resident's risk as "6" with a total score of 10 or more considered at risk for . On at approximately 3:20 AM, the resident was found on the floor from her and with a very small cut over her right . The resident appeared to be wearing sunglasses when she as she normally wore them. was observed in her living room near where she sat on her couch. The resident was transported to the hospital at 3:55 AM. A hospital discharge summary, dated , indicated a computerized (CT) scan of the resident's revealed osseous deformity of the bridge. A facility note, dated at 10:30 PM, indicated the resident on and broke her . She had around her and above her . She would be seeing an oral/ doctor the following week. On at 5:16 AM, the resident was found on the floor on her . It was unknown whether she or just sat on the floor. On at approximately 8:15 PM, the resident was observed lying on her right side on the floor. She refused to be assessed by the staff. The resident's family member was called and	A 025		

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A 025	Continued From page 3 came to the facility. The resident then allowed an assessment to be done and no injuries were noted. On [redacted] at 11:20 AM, the resident's family member reported seeing on a camera set up in the resident's room that another resident pushed this resident to the floor on the evening of [redacted]. A health care provider was in the facility at the time of the family's report, assessed the resident and gave an order to send the resident to the hospital. 911 was called and the resident was transported to the hospital. A hospital discharge summary indicated the resident was admitted on [redacted] following a [redacted]. A [redacted], performed on [redacted], revealed an acute displaced left [redacted]. The resident underwent surgery to repair the [redacted] on [redacted]. On [redacted] at approximately 7:30 (no indication of whether in the am or pm), the resident was found sitting on the floor. She slid from a wheelchair. No injuries were noted. On [redacted] at 9:35 PM, the resident was found in a seated position on the floor beside her bed. No injuries were noted. On [redacted] at 1:06 PM, the resident's family member called the facility to report seeing the resident on the room camera on the floor in front of her closet. Staff found her on the floor. She was unable to say what happened. No injuries were noted. On [redacted] at 8:47 PM, the resident was seen scooting on the floor in the dining/common area. No injuries were noted.	A 025		

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A 025	Continued From page 4 On [illegible] at 3:20 PM, the Memory Care Director said that she viewed the camera footage from [illegible], which showed resident #7 entered this resident's room. This resident rose from the couch, then followed resident #7 into her bedroom then into the living room. She used a pillow to hit resident #7, then used [illegible] motions to get resident #7 out of her room. She went to hit resident #7 with the pillow again, at which time resident #7 pushed her and she [illegible]. This resident then yelled out in [illegible]. The Memory Care Director said she never knew of a safety committee meeting being held, as indicated in the facility's " Policy". On at 10:40 AM, agency Nurse B said that when she entered resident #5's room on , she found the resident on the floor. She attempted to assess the resident, but the resident was agitated and wouldn't talk to her. The nurse called the resident's family member, who came to the facility, and it was then that the resident allowed an assessment to be conducted. The nurse said the resident was unable to say what happened. When the nurse first entered the room, she said there was no one other than resident #5 in the room. On [illegible] at 11:07 AM, Nurse C said measures put in place to minimize resident #5's risk for [illegible] was frequent checks on her, low bed with bedside mats and keep close [illegible] on her when she was in common areas. 2. Review of resident #7's record revealed an admission date of and a discharge date of [illegible]. An 1823, dated [illegible], indicated the resident's diagnoses included [illegible], and [illegible].	A 025		

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A 025	Continued From page 5 The resident's record revealed the following: On [redacted], the resident was sitting in the outside courtyard, [redacted] asleep, [redacted] out of the chair, and hit his [redacted] on the ground. 911 was called and the resident was transported to the hospital. On [redacted] at 10:50 AM, the resident returned from the hospital with an [redacted] on his right forehead. On [redacted] at 2:45 PM, the resident was noted with a cut and [redacted] on his left index [redacted]. At the time of the finding, he was sitting on a couch in another resident's room. The pajama pants he wore were ripped from the pocket area on both the left and right sides. The cause of the injury to his [redacted] was unknown. On [redacted] at 3:18 PM, the resident was found unresponsive in the outside courtyard. His skin was red and hot to the touch, and his body temperature was 105 degrees. Ice was applied to his forehead, under both arms and [redacted] area. When a sternal rub was performed, the resident mumbled. 911 was called and the resident was transported to the hospital. A hospital discharge summary, dated [redacted], indicated the facility called 911 because the resident was unaccompanied outside and staff felt he was more altered. In the emergency department he was [redacted] with a [redacted] temperature of 102 degrees and was initially hypoxic and [redacted] A late entry note, dated [redacted] at 1:50 PM, indicated that on [redacted], resident #5 raised her right [redacted] to prevent this resident from coming near her. This resident then grabbed resident #5's right arm then punched her in the [redacted] and [redacted] three times. The residents were separated	A 025		

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A 025	Continued From page 6 and 911 was called to transport resident #7 to the hospital. Resident #5 was not injured. On at 10:11 AM, the administrator informed resident #7's family member that he would not be able to return to the facility due to being a danger to others. On at 11:07 AM, Nurse C said she witnessed the incident between resident #5 and resident #7. She saw resident #7 approach resident #5, who raised her right arm. Resident #7 then grabbed resident #5's arm and began hitting the resident on the right side of her . The nurse said she immediately separated the two residents. The facility's " Prevention and Intervention" policy, dated , indicated that following a , the incident would be investigated. The resident's service plan would be amended to reflect any changes and to reduce the risk for future . Training would be provided to both staff and the resident on prevention strategies specific to the resident. A 2-day post follow-up would be completed to ensure the intervention put in place was preventing and assisting the resident. All and incidents would be reviewed during the monthly safety committee meeting. Review of both resident #5's and resident #7's records did not contain documented evidence to indicate those aspects of the policy were followed, including evidence to indicate the facility held any monthly safety committee meetings. 3. Resident #4's record revealed an admission date of and a discharge date of . An 1823, dated , indicated the resident's diagnoses included type 2, and	A 025		

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A 025	Continued From page 7 , and that the resident was not an elopement risk. An 1823, dated , indicated the resident's diagnosis was and was an elopement risk. The resident's record revealed the following: A facility report indicated that on at "6:45 PM resident observed in hallway by PA's prior to leaving for the day. Resident receives PM meds. Nurse exits community for break and is outside community. 7:29:04 PM stairwell one door utilized with access code and was not closed properly. This is an exit in the corridor that leads to a stairwell and another set of exterior doors which exit by the generator and diagonal to the dumpster. 7:29:25 PM door event indicates it was "left open" where resident was able to push door open. Exterior doors are not alarmed/secure to outside. 7:36 PM resident was observed outside in front of community. Resident presumably walked around to the front of the building where he was observed by patron and almost , observed by nurse returning from break. Nurse brought resident to memory care neighborhood without incident. 7:38 PM Executive director notified of incident. 7:40 PM all memory care egress doors checked with resident placed on 30-minute checks through night." On at 2:36 PM, the resident continued seeking a way out of the facility and repeatedly asked staff and visitors for help to go home. He was redirected multiple times. On at 2:29 PM, the resident continued exhibiting exit-seeking behavior and continued asking staff and visitors to let him out. The door to the unit was opened to allow visitors out and the resident grabbed the handle and placed his	A 025		

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A 025	Continued From page 8 . . . in front of the door. He was redirected multiple times with little success. On at 1:13 PM, the resident was pounding on a door and yelling "let me out". Staff were unable to redirect him to his apartment. Staff were unable to reach his family. 911 was called and the resident was transported to the hospital. On . . . . . at 2:20 PM, the resident returned from the hospital. On at 12:49 PM, the resident was exhibiting exit-seeking behavior, yelling, and upset with staff who would not let him out. He sat by the door with another resident and stated they could bust through the door together. On at 10:59 AM, the resident was exhibiting exit-seeking behavior and pounding, pushing, and pulling on doors. He asked staff and visitors to help him get out. He was redirected with little success. On at 10:27 AM, the resident was in the dining room yelling at staff and other residents "let me outta here, I want to go home with my family". He stood at doors and yelled "Call the police, I'm being held hostage". 911 was called and he was transported to the hospital. On , the resident returned from the hospital. He became agitated when staff prevented him from opening the door to leave. He pounded on the door and stated, "let me out". Attempts were made to redirect him with little success. On at 3:09 PM, the facility's concierge notified staff that the resident was seen by a visitor crawling out of a window. The concierge then said the resident was seen walking outside of the facility. The resident was redirected	A 025		

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A 025	Continued From page 9 inside and to the Memory Care Unit. On ..... at 10:15 AM, the administrator initiated one-on-one supervision with the resident from 12 PM to 8 PM, which the note indicated was the time frame the resident's exit-seeking behavior increased. A discharge notice was issued to the resident's family. On at 3:33 PM, the Memory Care Director said she was not sure how the resident was able to open the window when he eloped through it on ..... She said one-on-one supervision was not implemented until the ..... elopement, despite the resident's earlier elopement on and behaviors since. On at 4:10 PM, the window used by the resident to exit the facility on ..... was observed. The maintenance director was also present. The window had two locks on either side of the window that could be manually turned to unlock it. Once those were unlocked, the window could be opened only approximately 4 inches unless two additional clip style locks were , pushed in, which then allowed the window to be fully opened. On ..... at 4:38 PM, the Human Resource Director said she was the manager on duty when the resident eloped through the window on . She said she asked the resident to show her how he got out. The resident took her to in Memory Care and demonstrated how he unlocked the window, then pushed in the additional clip style locks to allow the window to open completely. She said the resident said he left through the window because he saw two puppies and a cat outside and wanted to bring them inside but once there, he could not	A 025		

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A 025	Continued From page 10 remember how to get . . . inside. On . . . . . at 10:40 AM, agency Nurse B said she did not know how resident #4 got out of the Memory Care Unit on . . . . She said she was coming inside the facility from her break when she saw the resident outside near the front entrance door. She assisted him inside. She said she last saw the resident in the dining room before he eloped. On at 11:07 AM, Nurse C said when the resident eloped on . . . . . , she last saw him in the dining room just minutes prior to his elopement. She said the resident oftentimes exhibited exit-seeking behaviors and always banged on doors. On . . . . . at 11:30 AM, Caregiver D said that on her shift started at 3 PM and although she could not recall the specific time, she did recall seeing him in the unit when she arrived for her shift. The facility's "Resident Elopement Policy", dated , defined elopement as "per state regulations". The policy indicated that elopement prevention strategies were to engage one-to-one supervision for residents who were exhibiting high risk elopement behaviors and that windows were secured and could not be opened more than 4 inches. Despite facility documentation indicating resident #7 eloped from the facility on . . . . . and his high-risk elopement behaviors, the facility did not engage one-to-one supervision until the resident's second elopement on . In addition, the facility's policy indicated the windows were secured and could not be opened more than 4	A 025		

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A 025	Continued From page 11 inches however, this resident was able to do so. Class II	A 025		
CZ821	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/SingleSignOnPortal: 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	CZ821		

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CZ821	Continued From page 12 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/SingleSignOnPortal. 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	CZ821		

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CZ821	Continued From page 13	CZ821		

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 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. 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.

6. For the purposes of this rule, the following applies for submitting adverse incident reports:

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

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 _____	12/06/2022

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
CZ821	Continued From page 14 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 interview and record review, the facility failed to electronically submit to the agency, a preliminary report within 1 business day and a full report within 15 days of 1 of 4 sampled residents being sent to the hospital following an episode of unresponsiveness (#7). Findings: Resident #7's record revealed an admission date of and a discharge date of . An 1823 Health Assessment form, dated , indicated the resident's diagnoses included , and . A facility note, dated at 3:18 PM, indicated the resident was found unresponsive in the outside courtyard. His skin was red and hot to the touch, and his body temperature was 105 degrees. Ice was applied to his forehead, under both arms and area. When a sternal run	CZ821		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CZ821	Continued From page 15 was performed, the resident mumbled. 911 was called and the resident was transported to the hospital. A hospital discharge summary, dated , indicated the facility called 911 because the resident was unaccompanied outside and staff felt he was more altered. In the emergency department he was with a temperature of 102 degrees and was initially hypoxic and . Review of the facility's preliminary and full reports previously submitted to the Agency revealed none of them were regarding this incident. On at 4:30 PM, the director of nursing said neither a preliminary nor a full report were submitted to the Agency, as required. Unclassified	CZ821		