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 _____	R 05/02/2023

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 A revisit to Complaint Investigations #2022012838 and #2022013471 was conducted on . The Blake at Hamlin had uncorrected deficiencies at the time of the visit.	{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, record reviews and interviews, 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 1 of 3 sampled residents (#8). Findings: Review of resident #8's record revealed a facility admission date of . Her medical diagnoses included . Health Assessment forms (1823s) dated , , and all indicated she	{A 025}		

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{A 025}	Continued From page 2 was at risk for . . Review of facility notes revealed the following: On at 1:37 PM, she had an unwitnessed earlier that day at 6 AM. The nurse on shift noted a small hematoma on the top left of her forehead. She was sent to a hospital at approximately 9:30 AM and returned at 11:50 AM. On at 2:13 PM, she was observed on the floor lying on her right side. She denied , or discomfort and no injuries were noted. The resident said she was getting up from her sofa and lost her balance. Staff assisted her off the floor, to her wheelchair then taken to the common area. Observation was to continue. On at 10 PM, safety precautions were in place. Staffl continued to monitor per facility protocol. On at 5:10 PM, she slid out of her wheelchair onto the floor. No injuries were noted. On . . . . . at 9:39 PM, she was found lying on the floor beside her bed. Her left thumb was . . . . . which, according to the note, may have been related to the . On at 3:20 PM, she was found sitting on the floor in her bedroom. She could not recall how she got there. No injuries were noted. She was assisted . . . onto her couch. On . . . . . at 6:58 AM, she was checked on every 2 hours. On at 9:55 AM, she was alert and . . . . . She was observed on the hallway floor in her room and close to her bed. She was	{A 025}		

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{A 025}	Continued From page 3 assessed and put [illegible] in her chair. She denied [illegible]. She spent most of the shift in the TV room for observation. On [illegible], she was on observation due to the previous [illegible]. On [illegible] at 3 PM, during rounds at the beginning of the shift, she was observed on the floor in front of her bathroom door. She could not recall what happened. She denied [illegible]. She was assisted off the floor to her wheelchair for evaluation. A small hematoma was seen on her forehead. She was sent to the hospital. A [illegible] Wellness Manager meeting form indicated the resident's [illegible] was discussed. On [illegible] at 5:30 AM, she was found on the floor next to her microwave stand. She had a [illegible] on the right side of her [illegible]. She was sent to the hospital. A [illegible] hospital computed [illegible] (CT) scan of her [illegible] revealed acute minimally displaced [illegible] of the right [illegible] and [illegible] pubic rami. A [illegible] hospital [illegible] of her [illegible] revealed a right frontal [illegible]. A [illegible] morning leadership meeting indicated the resident was at the hospital following a [illegible]. Her medications included [illegible], a [illegible], 2.5 milligrms (mg.) twice each day. From [illegible] through [illegible], she received physical and occupational therapies.	{A 025}		

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{A 025}	Continued From page 4	{A 025}		

From through , she received

On at 10:30 AM, the Director of Wellness said the facility completed service plans for each resident. A request was made to review any that were completed for this resident. None were provided.

On at 12:15 PM, a request was made to review any documentation to support the policy was followed for this resident, including any documentation to indicate the facility implemented any prevention interventions. No such documentation was received.

On at 12:48 PM, the Director of Wellness said interventions for the resident were a wheelchair, a walker, clutter free area, skid proof socks, grab bars and a lamp on at night. She was unable to provide documented interventions.

On at 1:54 PM, the Memory Care Director said the facility did not have a supply of pressure sensor pads to use for new memory care residents, as the policy indicated. She said post- trainings were given to staff, but she did not know where they were documented because they were in a binder somewhere. She said she held meetings with staff, a lot of them over the phone, about prevention interventions for this resident, such as frequent checks. She spoke with the resident's daughter about non-skid socks because usually she sat on her couch and went to the bathroom and that's how a lot of her occurred. The resident's daughter brought in the socks. The resident had physical and occupational therapies.

On at 2:25 PM, the Business Office

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{A 025}	Continued From page 5 Manager said staff received training via a web-based software company then all the department heads gave in-service training about their department. She said she provides the policy to new staff, and it's also mentioned in orientation training given by the Director of Wellness. An opportunity was given for her to provide proof of that training, but she returned and said that she could not provide the training documentation. The facility's " Prevention and Intervention" policy indicated, among other things, the following: The Director of Wellness and the Executive Director/Administrator are responsible for implementing prevention strategies. . . prevention begins at the time of the initial assessment and admission. Utilize the nurse call pressure sensor , to monitor sleeping patterns for the first 72 hours post-admission for memory care residents. If a occurs: Complete the Blake management incident report. The initial report and the management review will provide opportunities to assess the situation, identify possible antecedents to the and implement interventions to reduce the risk of future . . . Investigate the incident. Identify any environmental factors that may have contributed to the . Implement positive interventions to reduce the risk of any environmental factors that may have contributed to the . Amend the resident service plan to reflect any changes and to reduce the risk of future . Provide training to both staff and the resident on prevention strategies specific to the resident. Review all and incidents during the daily leadership meeting and the monthly safety committee meeting as listed in the company meeting agenda.	{A 025}		

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{A 025}	Continued From page 6 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?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be	{CZ821}		

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{CZ821}	Continued From page 7 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 electronically to the Agency within 15 calendar days after the occurrence of the incident as	{CZ821}		

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{CZ821}	Continued From page 8 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 calendar days after the day of the incident or more than 3 business days after the Agency	{CZ821}		

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{CZ821}	Continued From page 9 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 record reviews and interviews, 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 3 sampled residents being sent to the hospital following an episode of unresponsiveness (#7), and 1 of 3 sampled residents being sent to the hospital following three [redacted] (#8). Findings: 1. Review of resident #7's record revealed an admission date of [redacted] and a discharge date of [redacted]. A [redacted] 1823 indicated the resident's diagnoses included [redacted] and [redacted]. A facility note, dated [redacted] at 3:18 PM, indicated the resident was found unresponsive in the outside courtyard. His skin was red and hot to touch, and his body temperature was 105 degrees. Ice was applied to his forehead, under	{CZ821}		

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{CZ821}	Continued From page 10 both arms and ⌄ area. When a sternal rub was performed, the resident mumbled. 911 was called and the resident was transported to a 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 11:55 AM, the Wellness Director said a preliminary and full reports were not submitted to the Agency when resident #7 was sent to the hospital. 2. Review of resident #8's record revealed a facility admission date of . Her diagnoses included . . . . A . . . . at 1:37 PM facility note indicated she had an unwitnessed earlier that morning at 6 AM. The nurse on shift noted a small hematoma to the top left of her forehead. The daughter wanted her to be sent to the hospital. She was sent to a hospital at approximately 9:30 AM and returned at 11:50 AM. A . . . . . at 3 PM facility note indicated she was observed on the floor in front of her bathroom door during staff rounds at the beginning of the shift. She could not recall what happened. She sustained a small hematoma on her forehead and was sent to a hospital.	{CZ821}		

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{CZ821}	Continued From page 11 A at 5:30 AM facility note indicated she was found on the floor next to her microwave stand. She sustained a on the right side of her . . . and was sent to the hospital. On . . . . . at 11:55 AM, the Wellness Director said a preliminary and a full report were not submitted to the Agency when resident #8 was sent to the hospital, a facility unit providing acute care due to the . . . Unclassified	{CZ821}		