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 _____	11/13/2023

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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person 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. 2. Effective [illegible], or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before [illegible], initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective [illegible], initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	CZ814		

AHCA Form 3020-0001

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

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CZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic submission to the Department of Law Enforcement. The registration must include the person ' 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 the Background Screening (BGS) website, personnel record review and interview, the facility failed to register 1 of 7 sampled staff (E) on the BGS employee roster within 10 business days from date of employment as required. Findings: Cook E personnel record review revealed a hire date of . Review of the BGS website on at 6 PM for a Level 2 BGS eligibility date of revealed staff E was not added on the facility's BGS employee roster. On at 6:30 PM, an interview with the Business Office Manager confirmed the finding. Unclassified	CZ814		

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A 000	Continued From page 2	A 000		
A 000	Initial Comments A Complaint Investigation #2023016354 was conducted at The Blake at Hamlin Assisted Living Facility and Memory Care with Extended Congregate Care (ECC) on . . The facility had deficiencies at the time of the survey visit.	A 000		
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 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.	A 010		

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A 010	Continued From page 3 (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. (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	A 010		

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A 010	Continued From page 4 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 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	A 010		

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A 010	Continued From page 5 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 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,	A 010		

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A 010	Continued From page 6 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 review and interview, the facility failed to obtain a new 1823 Health Assessment, AHCA Form completed by a healthcare provider for continued residency after significant change (multiple) for 1 of 5 sampled residents (#1) and required a higher level of care. Findings: Resident #1's record review revealed an admission date of . . . . . The 1823 Health Assessment dated listed the medical history of Progressive Supranuclear . . . . This is a rare late onset that affects body movement, walking and balance, and . . . movements. Signs and symptoms include loss of balance, falling, bumping into objects, fast walking, lunging forward when mobilizing. Later symptoms include slurred speech, difficulty swallowing and difficulty moving the . . . He needed assistance with activities of daily living (ADLs) with ambulation, bathing, , toileting, and transferring and supervision with eating and grooming. He had a special diet with chopped meats, mechanical soft and nectar thick liquid. His physical limits required staying in the wheelchair for primary mobility. He needed assistance with self-administration of medication. (Photographic Evidence Obtained) In further review, resident #1 was at a high risk	A 010		

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A 010	Continued From page 7 for based on his Progressive Supranuclear , medical diagnosis, with falling at the facility nine (9) separate times documented and reported as an incident from admission. There could be possibly more undocumented . 1. on - (three days after admission into the facility) 2. on - no injury 3. on -no injury 4. on -went to hospital for injury 5. on -no injury 6. on -no injury 7. on -went to hospital for injury 8. on -went to hospital for injury 9. on -went to hospital for injury There was no documented evidence that facility explored or spoke with family to see if resident #1 needed a higher level of care and/or could continue residency at the assisted living facility. On at 4:50 PM, an interview with the Administrator and Director of Wellness confirmed the findings. 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	A 025		

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A 025	Continued From page 8 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 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.	A 025		

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A 025	Continued From page 9 (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 facility's documentation, resident record review and interview, the facility failed to ensure that appropriate supervision to meet the care and services by implementing a more defined systematic measures to maintain safety interventions and the well-being to 1 of 5 sampled residents (#1) for high risk for multiple ; and the facility failed to ensure appropriate supervision to 1 of 5 sampled residents (#2) regarding to an elopement from a secured memory care unit in a assisted living facility as required. Findings: 1. Resident #1's record review revealed an admission date of . The 1823 Health Assessment dated listed the medical history of Progressive Supranuclear . This is a rare late onset that affects body movement, walking and balance, and movements. Signs and symptoms include loss of balance, falling, bumping into objects, fast walking, lunging forward when mobilizing. Later symptoms include slurred speech, difficulty swallowing and difficulty moving the . He needed assistance with activities of daily living (ADLs) with ambulation, bathing, toileting, and transferring and supervision with eating and grooming. He had a special diet with chopped meats, mechanical soft and nectar thick	A 025		

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A 025	Continued From page 10 liquid. His physical limits required staying in the wheelchair for primary mobility. He needed assistance with self-administration of medication. He lived in the assisted living community with a [redacted] ([redacted]) dated [redacted] and a Living Will dated [redacted] onsite at the facility. (Photographic Evidence Obtained) In further review, resident #1 was at high risk for [redacted] based on his Progressive Supranuclear [redacted], medical diagnosis, with falling at the facility nine (9) separate times documented and reported as an incident from admission into the assisted living facility. There could be possibly more undocumented [redacted]. The facility failed and did not follow a systematic measure to supervise [redacted] precautions for high risk [redacted] residents. The facility's policies and procedures documented that the Director of Wellness or Administrator are responsible for implementing [redacted] prevention strategies. [redacted] prevention begins at the time of initial assessment and admission. [redacted] one-a facility incident report dated [redacted] at 2:15 PM (three days after admission into the facility), nurse staff went to resident #1's apartment after receiving a telephone call from resident #1's daughter telling her that he [redacted]. Observed resident #1 sitting on couch and papers items on the floor, asked resident #1 did he [redacted]? Resident #1 stated that he had lost his balance but was not hurt. No visible [redacted] or no injuries. Re-educated resident #1 to push his emergency pendant when he needs assistance. [redacted] two-a facility incident report dated [redacted] at	A 025		

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A 025	Continued From page 11 11:15 AM, in the common area theater room, nurse staff found resident #1 in sitting position on the floor with . . . against the wall, and his wheelchair facing in front of him. No injuries noted and no , . . . Resident #1 denies hitting his . . . The nurse explained safety precautions and to use emergency pendant when assistance was needed. the physician and family notified. An order for , , , , ( ) evaluation and treatment dated . . . . . for reminder to use call pendant. three-a facility incident report dated . . . . . at 2:55 PM, in the common area theater room, nurse staff documented that resident #1 was transferring himself from chair to wheelchair, he lost his balance and landed on the floor on his . . . . . The nurse assessed resident #1, he had no injuries noted and no complaint of , . . . Family and physician notified. An order for . . . . , ... , , (.) dated at 3 times a week for 90 days for re-education on placement of mobility devices when transferring to ensure resident safety. An order for , , , , ( ) dated . . . . . at 3 times a week for 90 days; visits will be tapered to 2 times a week by end of plan of care. An order for , ... , , (ST) dated at 3 times a week for 90 days; visits will be tapered to 1 time a week by end of plan of care. four-a facility incident report dated at 11:08 PM, resident #1 family member called the facility to report that resident #1 had	A 025		

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A 025	Continued From page 12 and hit his . . . . The nurse staff arrived at his room observing resident #1 sitting up in his bed with his . , . . closed. The nurse called out resident #1's name and he answered. Resident #1 stated he had , level 6 out of 10. Resident #1 stated he when he was walking to his bookshelf to put his cup down and he lost balance and headfirst. Resident #1 had an . . . . . on middle his forehead near the , and a red spot-on top of his . Resident #1 kept falling asleep. Called 911 and taken to hospital for evaluation and treatment. The family and physician notified. A facility note dated . . . . . at 10:21 PM, resident #1 returned to the facility earlier at 8:30 PM with no discomfort and no , . . Resident #1 had new orders for medication , 500 milligrams (mg) for 7 days 1 capsule by . . . . every 6 hours. Resident #1 was reminded of using his walker when ambulating. . five-a facility incident report dated . . . . . at 6:25 PM, caregiver staff assisted resident #1 to the bathroom and after assisted him . . . to his wheelchair. The caregiver staff turned her to get clothes out of the closet for a minute and resident #1 attempted to get in the bed and slipped falling on the floor. The nurse was called to assess him. No injuries noted. Both nurse and caregiver staff assisted him into bed. The family and physician notified. Resident #1 was reminded that he needs to request assistance when transferring, will speak with spouse to request ideas from . . . . . for . ideas. . six-a facility incident report dated . . . . . at 6:15 PM, resident #1 had and did not tell his wife or staff. He was trying to get dressed and . No further details are provided for this .	A 025		

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A 025	Continued From page 13 seven-a facility incident report dated at 3:46 PM, resident #1 reported that he when trying to get a beer out of the refrigerator. The only complaint was he had a . No and a slight pink discoloration to the left lower area. The wife had visited him, and he told her he had , and she noticed he had and a knot on his left side . Resident #1 went to hospital for evaluation and treatment and returned same day and there were no and no new orders. Resident #1 was re-educated and reminded of the importance of self-reporting to ensure that treatment for injuries is addressed at the time of injury. eight-a facility incident report dated at 7:26 PM, resident #1 told nurse that he out of his wheelchair while getting out and hit his . The nurse observed a good size carpet on the left side of forehead. Resident #1 stated he got himself up without assistance and put himself in his recliner chair then . Called 911 and sent to the hospital. Notified the daughter and physician. On at 7:57 AM, resident #1 returned to the facility via ambulance transportation. Resident #1 was alert and responsive. Resident #1 is to keep ice on his and let nurse know when he is in . No signs of distress and denies . Resident #1 has an on the left side of his . A caregiver assisted resident #1 in his room and rested comfortably with setting the call light within reach. Resident #1 was re-educated not to sit until he feels of the chair at his to ensure he is completely in the chair. nine-a facility incident report dated	A 025		

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	AL11969935	A. BUILDING: _____ B. WING _____	11/13/2023

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A 025	Continued From page 14 at 4:06 PM, nurse answered resident #1's pendant call at 3:15 PM when noticed resident #1 was ... behind his ... and he was laying on his bed in supine on his ... . Resident #1 had three affected areas of injury, 1) ... behind his ... ; 2) ... on his earlobe and 3) ... on his ... . Resident #1 had ... from his toilet when transferring himself from his wheelchair. Called 911 and resident #1 taken to the hospital. Notified family and physician. On ... at 7:53 PM, resident #1 returned ... to the facility by daughter transporting him. Daughter told staff that resident #1 had received a few stitches on his left ... and had a small ... on left ... . No ... . New orders that skilled nursing home health will clean and change. The facility ordered auto brakes for wheelchair so if resident #1 stands, wheels will not move. The facility implemented the first service care plan for high risk for ... on resident #1 dated ... . This was 5 months after resident #1 was admitted into the facility and 9 ... later. On ... at 4 PM, an interview with both Administrator and Director of Wellness confirmed the findings for resident #1. 2. Resident #2's record review revealed an admission date of ... . The 1823 Health Assessment dated ... listed medical history of ..., Memory loss (amnesia), ..., and ... . Resident #2 resides in the facility's secured memory care unit and documented as an elopement risk with being independent with all activities of daily living (ADLs). He needs assistance with	A 025		

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A 025	Continued From page 15 self-administration of medications. On . . . . . at 5:38 PM, a facility incident was reported and documented by nurse D was called by the front desk concierge that resident #2 was outside the driveway in someone's car. Nurse D immediately went outside and checked on resident #2 and he was sitting in the passenger seat of a delivery van. The owner of the delivery van was standing on the driver's side and reported to nurse D that he made a delivery and was about to leave when he saw resident #2 sitting in his delivery van. Nurse D asked resident #2 to come with her. Resident #2 decided that he wasn't ready. Nurse D advised resident #2 to come out of van with her. Resident #2 agreed and came . . . inside the building safely. In further review, resident #2 had already had two documented incidents of resident #2 attempting to elopement as follows: On . . . . . at 6:58 PM, nurse K documented a close call incident, resident #2 was standing at memory care front entrance most of the day, despite the constant efforts of redirection. Once the front doors opened allowing a family member to enter, resident #2 was able to slip out but was immediately escorted . . . to the memory care by the front desk concierge staff and nurse K. Resident #2 was unharmed and cooperated with staff without incident. Resident #2 was now sitting in the common area enjoying a movie with other residents. Notified family and administrator. On at 6:42 PM nurse K documented a close call incident; nurse K was in the common living room area watching the floor when resident #2 was brought to memory care by a kitchen staff. Resident #2 was found in the kitchen	A 025		

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A 025	Continued From page 16 . . . . . After an investigation was completed and how resident #2 got out into the kitchen, it was found that an outside contractor was doing work inside the memory care near the kitchen area and thought resident #2 was a family member visiting a resident and opened the door allowing him out of the secured memory care lockdown unit. Resident #2 was returned immediately unharmed and one on one supervision was initiated. The outside contractor worker was informed to never allow anyone off the unit as staff should be notified for clearance. The family and administrator notified. The facility failed and did not follow a systematic measure of supervision for elopement of residents from the secured memory care unit. The facility's policies and procedures documented to ensure all proactive steps were taken for a resident or residents that are identified as elopement risk. Furthermore, the facility's elopement policies and procedures did not define "who are elopement risk residents"? (Photographic Evidence Obtained) On at 4:50 PM, an interview with both Administrator and Director of Wellness confirmed the findings. Class II	A 025		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as	A 030		

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A 030	Continued From page 17 described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and	A 030		

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A 030	Continued From page 18 6. Administrative and housekeeping schedules and requirements; 7. [illegible] control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical [illegible]. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from [illegible] and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity,	A 030		

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A 030	Continued From page 19 individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate	A 030		

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A 030	Continued From page 20 and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right	A 030		

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A 030	Continued From page 21 includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated	A 030		

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A 030	Continued From page 22 or under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on facility's documentation, resident record and interview, the facility failed to honor rights for 1 of 3 sampled residents (#1) regarding his ( ) as required. Findings: Resident #1's record review revealed admission date . The 1823 Health Assessment dated listed the medical history of Progressive Supranuclear . This is a rare late onset that affects body movement, walking and balance, and movements. Signs and symptoms include loss of balance, falling, bumping into objects, fast walking, lunging forward when mobilizing. Later symptoms include slurred speech, difficulty swallowing and difficulty moving the . He needed assistance with activities of daily living (ADLs) with ambulation, bathing, toileting, and transferring and supervision with eating and grooming. He had a special diet with chopped meats, mechanical soft and nectar thick	A 030		

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A 030	Continued From page 23 liquid. His physical limits required staying in the wheelchair for primary mobility. He needed assistance with self-administration of medication. He lived in the assisted living community with a ( ) dated . . . . . and a Living Will dated . . . . . onsite at the facility. (Photographic Evidence Obtained) On at 12 PM (noon), a facility incident was reported that resident #1 was found unresponsive. Resident #1 was provided . . . . . ( ) on . . . . . about 12:01 PM by first responders and facility nurse B despite having a order and Living Will. The first responders were already in the facility tending to another resident, when they were called to aid resident #1 who became unresponsive when he was eating lunch. The male became unresponsive and was found lying on his side with staff holding him on left lateral recumbent position. The staff explained resident #1 was just eating and became unresponsive and slumped over. The agency nurse C performed the Heimlich maneuver on resident #1, no food objects were found. The first responders brought resident #1 to the ground and started and tried to clear his airway. Resident #1 did not have any large food objects in his airway. Resident #1 had no , . . . and was . During , nurse B remembered that resident #1 might have a order. The first responders explained to nurse B that if resident #1 had a order, it had to be produced with the required signature. At this point, the wife of resident #1 was on the phone and first responders asked about the order.	A 030		

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A 030	Continued From page 24 The wife explained resident #1 had a order on file at the facility, and resident #1's wishes were not to be . . . . . The first responders fire rescue station #44 discontinued at 12:22 PM. Resident #1 , ... , on at the facility. The first responders provided and did not honor resident #1's right when he had an executed and signed onsite at the facility that facility staff should have provided immediately to the first responders. On at 2:48 PM, an interview with nurse B confirmed these findings and acknowledged the facility staff should know the location of a and know how to correctly identify each resident that has a , ensuring their wishes are honored. The facility ' s . . policies and procedures documented "A is honored by assisted living (communities). Therefore, this community will withhold or withdraw . . , ... if the resident and/or resident ' s legal representative provides Blake management with the state required . . form with a physician ' s signature. includes . . . . . , ... , ... , and ". Class I	A 030		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS.	A 032		

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A 032	Continued From page 25 (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 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	A 032		

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A 032	Continued From page 26 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 facility documentation, resident record review and interview, the facility failed to complete an elopement risk assessment and have photo identification on file for 1 of 1 sampled resident (#2) as required for a high-risk elopement resident in a secured memory care unit. Findings: Resident #2's record review revealed an admission date of [redacted]. The 1823 Health Assessment dated [redacted] listed medical history of [redacted], Memory loss (amnesia), [redacted], and [redacted]. Resident #2 resides in the facility's secured memory care unit and documented as an elopement risk with being independent with all activities of daily living (ADLs). He needs assistance with	A 032		

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	AL11969935	A. BUILDING: _____ B. WING _____	11/13/2023

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

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A 032	Continued From page 27 self-administration of medications. On . . . . . at 5:38 PM, a facility incident was reported and documented by nurse D. Nurse D was called by the front desk concierge that resident #2 was outside the driveway in someone's car. Nurse D immediately went outside and checked on resident #2 and he was sitting in the passenger seat of a delivery van. The owner of the delivery van was standing on the driver's side and reported to nurse D that he made a delivery and was about to leave when he saw resident #2 sitting in his delivery van. Nurse D asked resident #2 to come with her. Resident #2 decided that he wasn't ready. Nurse D advised resident #2 to come out of van with her and she will bring everything in later. Resident #2 agreed and came inside the building safely. (Photographic Evidence Obtained) In further review, resident #2 had already had two attempted elopements on . . . . . and . . . . . prior to the staff being alerted that the resident was outside sitting in a delivery van on . . . . . . There was no documented evidence in resident #2's record, a large photo identification picture and no documented evidence of a completed elopement assessment for resident #2 provided. On at 5:20 PM, an interview with the Administrator confirmed the finding. Class III	A 032		
A 076 SS=J	59A-36.009 FAC . . . . . ( )	A 076		

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A 076	Continued From page 28 (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to [illegible] ([illegible]). An assisted living facility may not require execution of a [illegible] as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission: 1. Form SCHS- [illegible], "Health Care Advance Directives - The Patient's Right to Decide," [illegible], or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in chapter 765, F.S. Form SCHS- [illegible] is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and, 2. DH Form 1896, Florida [illegible] Form, [illegible], 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04005. (b) There must be documentation in the resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the	A 076		

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A 076	Continued From page 29 resident's record that it has requested a copy. (c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency. (2) LICENSE REVOCATION. An assisted living facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896. (3) PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows: (a) In the event a resident experiences or , staff trained in , , ( ) or a health care provider present in the facility, may withhold , , (and). (b) In the event a resident is receiving hospice services and experiences or , , , facility staff must immediately contact hospice staff. The hospice procedures take precedence over those of the assisted living facility. This Statute or Rule is not met as evidenced by: Based on review of facility's policies and procedures, documentation, record review, and interview the facility failed to 1} honor it's { } policies and procedures for 1 of 1 sampled residents (#1) when was initiated although he had a and a Living Will to withhold or withdraw , , ( ), 2} facility's ( ) policy failed to explain the implementation and location of that are found in the facility for all residents that have a signed by their	A 076		

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A 076	Continued From page 30 healthcare provider; and 3} failed to immediately present the to the first responders upon arrival to ensure the resident's was properly executed and to ensure resident rights regarding 's were honored as required by Florida Statute. Findings: Resident #1's record review revealed admission date . The 1823 Health Assessment dated listed the medical history of Progressive Supranuclear . This is a rare late onset that affects body movement, walking and balance, and movements. Signs and symptoms include loss of balance, falling, bumping into objects, fast walking, lunging forward when mobilizing. Later symptoms include slurred speech, difficulty swallowing and difficulty moving the . He needed assistance with activities of daily living (ADLs) with ambulation, bathing, toileting, and transferring and supervision with eating and grooming. He had a special diet with chopped meats, mechanical soft and nectar thick liquid. His physical limits required staying in the wheelchair for primary mobility. He needed assistance with self-administration of medication. He lived in the assisted living community with a signed ( ) dated and a Living Will dated onsite at the facility. On at 12 PM (noon), a facility incident was reported that resident #1 was found unresponsive. Resident #1 was provided ( ) on about 12:01 PM by the first responders and facility nurse B despite having a	A 076		

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A 076	Continued From page 31	A 076		

order and Living Will. The first responders were already in the facility tending to resident #4, when they were called to aid resident #1 who became unresponsive when he was eating lunch. The , male became unresponsive and was found lying on his side with staff F holding him on left lateral recumbent position. Staff F explained resident #1 was just eating and became unresponsive and slumped over. The agency nurse C assisted and performed the Heimlich maneuver on resident #1, there were no food objects found. The first responders brought resident #1 to the ground and first responders started and tried to clear his airway. Resident #1 did not have any large food objects in his airway. Resident #1 had no , and was . During , nurse B remembered that resident #1 might have a . The first responders explained to nurse B that if resident #1 had a order, it had to be produced with the required signature. At this point, the wife of resident #1 was on the phone and first responders asked about the . The wife explained resident #1 had a on file at the facility, and resident #1's wishes were not to be . The first responders fire rescue station #44 discontinued at 12:22 PM. The first responders provided on resident #1 when he had an executed and signed at the time of rescue. Resident #1 , , at the facility on .

(Photographic Evidence Obtained)

Interview on at 11:57 AM with Med Tech A regarding the assisted living dining room incident on with resident #1 noted she was the first person who was notified by caregiver F. Med Tech A stated she was on break at the nurses' station, and the telephone rang with staff

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A 076	Continued From page 32 F stating that resident #1 was choking and collapsed. Med Tech A then called nurse B (on duty) who was assisting resident #4 in his room with first responders who were already onsite at the facility to transport resident #4 out to the hospital. Med Tech A stated that she was the staff that took resident #1's record with the . downstairs to nurse B and paramedics. Med Tech A further stated that she had the . training when she was hired a year ago. A telephone interview on 11/3/2023 at 2:36 PM was conducted with agency nurse C about the incident on with resident #1. Agency nurse C stated he was passing by to get lunch near the assisted living dining and noted staff F yelling for help, we need a nurse, he is choking. The agency nurse C observed that caregiver F was holding resident #1's . on her . and resident #1 was already turning blue. The agency nurse C put resident #1 in sitting position and agency nurse C got behind resident #1 and began the Heimlich maneuver. Agency nurse C stated the Heimlich maneuver was not working and thought of the next step to start , , ( ) but by this time the first responders had taken over and began and used the machine. Agency nurse C stated he did not know resident #1 had a until a copy was brought to the first responders about 3 minutes later. Agency nurse C stated he did not touch and did not give to resident #1. Agency nurse C also stated that he only worked at the facility a total of three times and was . certified. A telephone interview on 11/3/2023 at 2:48 PM, with nurse B stated that she was upstairs assisting resident #4 with the first responders when Med Tech A called her on her cell phone to	A 076		

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A 076	Continued From page 33	A 076		

tell her that resident #1 was choking and collapsed downstairs in the assisted living dining room. Nurse B took over doing the Heimlich maneuver from agency nurse C and yelled out to staff to get the first responders in . . . #. . . who was with resident #4. The first responders came right away and started . on resident #1. Nurse B called Med Tech A to get resident #1's chart to check if resident #1 had an . . or not. Nurse B stated she thought resident #1 had a but was not sure. Nurse B presented the . to the first responders and they asked nurse B to call the wife (resident #1) and ask the wife if she wanted done. Nurse B called the wife and the wife told everyone that resident #1's wish was not to be . .

Nurse B confirmed that she had training and a . certification. Nurse B confirmed the finding and understood that the facility staff should have known the location of a . . and correctly know how to identify each resident that has a . , to ensure their wishes were honored.

A telephone interview on 11/4/2023 at 9:46 AM, supervisor cook H confirmed he was in charge for dining on . He stated that he did not have a in resident #1's incident, he had just gone into the dining room and saw the paramedics, nurse B and staff F assisting resident #1. The supervisor cook H stated that he glanced over the dining room and remembered the ticket order that resident #1 ordered that day was meatballs and the server had only written special diet on ticket order. He stated he just had the . . training not long ago and does not have certification. He stated that he will ask his boss, food director if all kitchen staff can receive training and a refresher course in

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	AL11969935	A. BUILDING: _____ B. WING _____	11/13/2023

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BLAKE AT HAMLIN, THE	4814 HAMLIN GROVE TRL WINTER GARDEN, FL 34787

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A 076	Continued From page 34 certification, therefore the kitchen staff will know what to do if another incident in future occurs like this one in the facility's dining rooms. A telephone interview was conducted on at 3:40 PM with the Business Office Manager, who was also the administrative manager on duty for the day of incident occurrence with resident #1. The manager on duty stated that she heard a lot of -and-forth commotion over the walkie talkie radio. She went to the front desk concierge and asked what was going on. The front desk concierge answered and stated that it was about a resident choking in the assisted living dining room. When the manager on duty went up to the front desk, she saw agency nurse C coming out of the Memory Care and asked him to help with resident #1 choking in the dining room. Both the manager on duty and the agency nurse C went to the assisted living dining room and saw resident #1 turning blue color and unresponsive laying on caregiver staff F as she was asking for help. The agency nurse C started doing the Heimlich maneuver to resident #1. The manager on duty said that she notified the Administrator and the Director of Wellness via text about what happened to resident #1. The manager on duty explained that the first responders were already onsite and in the facility for an early call for resident #4. The manager on duty stated that she did not put on resident #1 nor was involved with the care of resident #1 at that time because nurse B and the first responders were already assisting resident #1. An attempted telephone interview was made to caregiver F on at 4:03 PM and there was no response.	A 076		

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A 076	Continued From page 35 The facility failed and did not follow the systematic measures for supervising residents that have a . . . The facility's . . . . ( ) policy undated stated "Blake Management Group (BMG) 1.09 FL . . ( ) a is honored by assisted living (communities). Therefore, this community will withhold or withdraw . . . , ... , ... if the resident and/or resident's legal representative provides Blake management with the state required form with a physician's signature. . includes . . . . . , ... , and . . . . . ". (Photographic Evidence Obtained) The facility did not follow their own . policies and procedures, and was given to resident #1 by first responders against his wishes after he had a signed for execution on site at the facility. The next day on . . . . . , an all-staff in-service training about was discussed. On at 6:10 PM, an interview with the Administrator confirmed the findings and further stated that she was not working and off duty and could not provide any additional information for that day . (Photographic Evidence Obtained) Class I	A 076		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service	A 081		

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	AL11969935	A. BUILDING: _____ B. WING _____	11/13/2023

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A 081	Continued From page 36 429.52(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 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	A 081		

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A 081	Continued From page 37 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) 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 control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , 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.	A 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 081	Continued From page 38 2. Recognizing and reporting resident . . . . . , neglect, and , . The facility must use its . . . . . 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. 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 review and interview, the facility failed to ensure that 1 of 7 sampled staff (D) completed 1} 2 hours pre-service training that include resident rights, facility type, and care and services offered by the facility, and must be signed by the employee and the administrator	A 081		

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A 081	Continued From page 39 prior to interacting with the residents and; 2} completed the in-service elopement training within 30 days of employment as required. Findings: Nurse D personnel record review revealed a hire date of . Nurse D was terminated on . There was no documented evidence that the 2 hours preservice training was completed in Nurse D's personnel file. Further review revealed there was no documented evidence of an elopement training completed. On at 6:30 PM, an interview with the Business Office Manager confirmed the findings. 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.	A 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 090	Continued From page 40 This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure that 1 of 7 sampled staff (D) completed one hour ( ) training within 30 days after employment as required. Findings: Nurse D personnel record review revealed hire date and terminated on . There was no documented evidence of the 1-hour training completed in the file. On at 6:30 PM, an interview with the Business Office Manager confirmed the finding. Class III	A 090		
AE210 SS=D	59A-36.011(8) FAC ECC - Training (8) EXTENDED CONGREGATE CARE (ECC) TRAINING. (a) The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months of beginning employment in a currently licensed ECC facility as an administrator or ECC supervisor. Successful completion of the assisted living facility core training shall be a prerequisite for this training. ECC supervisors who attended the assisted living facility core training prior to , , shall not be required to take the assisted living facility core training competency test. (b) The administrator and the ECC supervisor, if	AE210		

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 _____	11/13/2023

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BLAKE AT HAMLIN, THE	4814 HAMLIN GROVE TRL WINTER GARDEN, FL 34787

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AE210	Continued From page 41 different from the administrator, must complete a minimum of 4 hours of continuing education every two years in topics relating to the physical, , or social needs of frail elderly and persons, or persons with 's or related . (c) All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and the delivery of personal care and supportive services in an ECC facility. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure that 1 of 7 sampled staff (D) completed two hours of in-service training in Extended Congregate Care (ECC) receiving care under this specialty license within 6 months of employment as required. Findings: Nurse D personnel record review revealed a hire date of and was terminated on . There was no documented evidence of the 2 hours ECC training completed in the file. On at 6:30 PM, an interview with the Business Office Manager confirmed the finding. Class III	AE210		