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
	AL11970119	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BLAKE AT VIERA	5700 LAKE ANDREW DR MELBOURNE, FL 32940

(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 survey for complaint #2024007168 was conducted on [redacted] and [redacted] at The Blake at Viera Assisted Living Facility. There were deficiencies identified at the time of the survey.	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. (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	A 010		

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A 010	Continued From page 1 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 placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

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A 010	Continued From page 2 (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 [illegible]-to-[illegible] 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 [illegible] 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 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	A 010		

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A 010	Continued From page 3 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, 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.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to update resident #1 Health Assessment Form 1823 with risk within 30 days of a . Findings: On a review of resident #1 record revealed she was admitted on . Further review of her record found she sustained a on , , , , and . Her record contained 2 Resident Health Assessment Forms (1823). The most recent dated . The 1823 did not document resident was at risk for . On at am/pm the administrator confirmed the finding. 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 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	A 025		

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A 025	Continued From page 5 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. (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	A 025		

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A 025	Continued From page 6 changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on 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 with injuries and for 1 of 4 sampled residents who experienced multiple with injuries and (#1) Findings: A review of resident #1 record revealed she was admitted on . Her record contained a Resident Health Assessment (1823) dated . Her diagnoses included , right lower extremity, , , and . She required assistance with bathing and supervision with ambulation, , and grooming. She was not documented as a risk on admission. There was no documentation of a on the heel or , , or on admission. However, the health assessment from the facility where the resident previously lived in a diagnosis of was documented. Review of the facility notes revealed the following: On resident #1 moved from the assisted living area to the Memory Care Unit. On documented at 5:30pm by staff (H) Licensed Practical Nurse (LPN). Resident was on	A 025		

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A 025	Continued From page 7 the floor after falling. Complained of and , . Transferred via 911 to the hospital. Returned around 8pm. The scans were negative. On documented at 9:01pm by LPN (F). Resident was laying on the floor next to her bed. Resident stated she . Resident complained of , and arm , . She was transferred to the hospital at 4:10pm. Returned at 10:10pm with a diagnosis of right and , . On documented at 8:32pm unlicensed care staff (I) at 5:34pm. The resident had rolled out of bed. Complained of , . On at 6:53am LPN (E) documented resident complained of , when lifting right arm. Reported to day shift. On documented at 12:27pm by LPN (K). Resident laying on her left side in the dining room. No visible injury. On documented by RN- Registered Nurse (J) at 5:08pm. Resident was observed on the floor by her bed on her right side. No injuries observed. On documented by LPN (K) at 3:38pm. Resident has a on her right heel. Provider notified and order for skin prep 3x daily. On an order to see Doctor for right heel / . POA notified and will call to make an , , . On documented by RN (J) at 5:50pm. Daughter concerned about mothers' . pads not working. On documented by LPN (E) right heel skin check dry/peeling/intact noted dark red/purplish discoloration. On documented by LPN (E) at 10:15pm resident sustained 3 and a , to her right lower extremity while trying to get from bed to wheelchair. On Sister-in-law took resident to the	A 025		

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A 025	Continued From page 8 hospital at 2:30pm due to right lower extremity . On documented at 6:41am by LPN (K) home health care nurse stated tissue on heel is . On documented by RN (J) at 5:56pm. Son concerned about the area on her bottom according to the shift report home health was notified about area to on Friday. They will take care of that area, right lower extremity, and heel. On documented by LPN (K) at 3:15pm. Bandage to intact. On documented by LPN (F). Son visited the resident at 4:15am and found resident on the floor. Reported to the nurse she out of bed, complained of right , . 911 transfer to the hospital. Review of hospital records dated document resident #1 had an unwitnessed , rolled out of bed. Reports right , , . Diagnosed with right and , . On a hospital record revealed resident #1 was transferred to the hospital by private vehicle due to a right lower extremity . , was negative. A review of the service plan for resident #1 revealed it was activated on and last modified on by the Director of Wellness (DOW). The type of modification was not indicated or dated. The Plan documented resident had poor judgement issues. She needed protection and supervision because of unsafe or inappropriate decisions.	A 025		

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A 025	Continued From page 9 Also documented - resident independent with transferring. Does not require assistance with transfer. 07. potential - with ER transfer, no injury. Walker at bedside, lights on in room, and frequent rounding. Schedule , , for appropriate services. Schedule , , eval. Initiate installation of additional grab bars where needed. Place the wheelchair within reach. No documentation of where or when grab bars would be installed. A review of the facility policy titled Prevention & Intervention dated found it documented the Director of Wellness and the Executive Director/Administrator are responsible for implementing prevention strategies. Amend the resident service plan to reflect any changes and to reduce the risk of future . Provide training to both staff and residents on prevention strategies specific to residents. The resident sustained a total of six with injuries. 2. A review of resident #1's record found third party home health notes which documented resident #1 started service with home health on for an unspecified open on right . On a was documented by a home health RN mid , and a right , . On home health RN documented she placed a call to the primary care provider to	A 025		

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A 025	Continued From page 10 request a consultation for a physician to evaluate . She documented a to the and described the depth as partial thickness. The measured 1x1x1cm with , measuring 1cm and partial maceration to surrounding tissue. On a note documented by the home health LPN described the as a measuring 1x1x1cm without , or maceration. Another home health documented on the heel has an open area, might need treatment. The on the right , measured 2x1.5cm. The / measured 1x1x1cm. On the home health LPN documented a right , with no measurements documented, A right heel with no measurements documented and a mid- A review of the service plan for resident #1 revealed it was activated on and last modified on by the Director of Wellness (DOW). The type of modification was not indicated or dated. The Plan documented resident had poor judgement issues. She needed protection and supervision because of unsafe or inappropriate decisions. Also documented - resident independent with transferring. Does not require assistance with transfer. 07. potential - with ER transfer, no injury. Walker at bedside, lights on in room,	A 025		

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A 025	Continued From page 11 and frequent rounding. Schedule . . . , , for appropriate services. Schedule , , eval. Initiate installation of additional grab bars where needed. Place the wheelchair within reach. No documentation of where or when grab bars would be installed. Further review of the service plan found no documentation for the . . . . on the right heel, right lower extremity, or the / area. On at 10:00pm via return telephone employee E stated that she does not remember ever being told by the unlicensed staff that resident #1 had an open on her . . . / . . Employee E stated that can recall resident #1 having a right heel . . . and one to her right . The right was sustained due to a . she had taken where her . was caught between the wheelchair and the bed. Employee E stated that home health was responsible for taking care of the , and to the best of her knowledge she was not told about any to the . On at 10:45 AM the DOW stated that she was not aware of any . . . . . pertaining to resident #1. The DOW recalls her having . . . . . and a right heel . . . and a right . . . nothing else. The DOW stated that the licensed staff is very good at documenting on the residents. The unlicensed staff are good at letting the licensed staff know what they may or may not see. On @ 11:53am, employee F stated resident #1 was an assist of two when being transferred from bed to chair and toileting.	A 025		

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A 025	Continued From page 12 Employee F stated that skin checks are completed when a resident is new to the unit/ coming from another ALF or coming . . . from the hospital. Resident #1 had frequent . . Employee F stated that when a resident . . . it is the licensed staff's responsibility to conduct a . . . -to- . . assessment. This is to determine if the resident needs to go out for observation/ hospital. When asked how you conduct a full body assessment employee F stated that it is practice for the licensed staff to check the . . . , even move their hair around to see if there is any discoloration, move down to the front of the patient checking arms . . and . . , then go to the . . . and do the same thing again. Also asking the resident if they are experiencing any , . . or discomfort. Employee F stated that resident #1 was . . . . . and needed assistance of two. On . . . . . at 4:47pm the DOW stated that she was unaware of a . . . . . on resident #1's . . . . . , she remembers her having . . . . . on her right . . but nothing else. On . . . . . at 3:40pm an interview with staff D was conducted. She said resident #1 required assistance of one or 2 staff to transfer. The staff would assist her to and from her wheelchair and bed. She was not aware of any open area on her bottom/. . . . . except the . . . . . that were being treated. On . . . . . at 4:45pm the administrator stated that she knew nothing about a . . . . . on resident #1. The administrator stated that the DOW would have said something. On . . . . . at 12:09pm spoke with the third-party RN (home healthcare), that did the initial consult	A 025		

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A 025	Continued From page 13 of resident #1. The initial consultation was done on for on the resident's . There were two , a on the right heel and an open area on the right . On at 3:48pm spoke with another third-party RN, who stated that she does not remember much about resident #1. She stated that whatever she wrote she would stand by it. On the third-party RN documented a decubiti on resident #1, per her documentation. A review of the facility policy titled Skin Integrity Monitoring and Treatment dated found it documented the skin assessment shall be completed as a part of the initial nursing evaluation. Under section V "The resident's service plan should address interventions and strategies that promote skin integrity and skin healing as necessary. On at 5pm in an interview with the Administrator and the Director of Wellness, they confirmed resident #1 sustained multiple resulting in injuries. They also said they were not aware home health was treating a on her / . They confirmed they did not know resident #1 had any open areas on her / . There was no documentation of updated care plans related to or skin integrity at the time of the survey. The resident was sent out to the hospital on due to a . Class II	A 025		