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 _____	08/14/2024

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 complaint investigation #2024007867 and a generator monitoring was conducted at The Blake at Hamlin on . The facility had a deficiency at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

AHCA Form 3020-0001

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

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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 care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for and injuries for 1 of 3 sampled residents (#5.) Findings: A review of resident #5's record revealed a facility admission date of . The resident's medical history included , and type 2.	A 025		

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A 025	Continued From page 2 An . . . . . health assessment form (1823) indicated the resident could not walk or stand for more than a few minutes, she had short term memory loss and was unsteady on her . Both a and a health assessment form 1823 indicated the resident was a risk. On . . . . . at 3:57 pm the resident reported to a nurse that she was walking throughout the dining room and got hooked on a chair, losing her step. The nurse found no injuries. The nurse educated the resident about safety measures and asking for assistance. On at 2:24 pm the resident was found on the floor in front of her wheelchair by caregivers who were doing morning rounds. No injuries. The resident said she wanted to get in her wheelchair and was not able to lock the wheels. On . . . . . at 2:07 am the resident was found by a caregiver on her bathroom floor. The nurse observed the resident laying on her . . . with her bent. The resident said, "I laid down on the floor." The resident was assisted to a standing position and walked to her bed without complaints of , . . She had a . . . . on her right arm. On . . . . . at 6:15 am the resident reported to staff that she and knocked herself out. The nurse responded and found the resident sitting in her wheelchair at a table. The resident told the nurse she , hit her . . and knocked herself out. A knot was on the of the resident's . . . . 911 was called and the resident was transported to a hospital. On at 7:30 pm the resident was found	A 025		

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A 025	Continued From page 3 sitting on the floor, in front of her wheelchair, by the bathroom door in the common area. She was alert with . . . . . She said she wanted to go to the bathroom. Staff was away helping another resident and was not able to help the resident in a timely manner. A was noted to the resident's left . . . On . . . . . at 1:30 am the resident was observed laying on her right side on the floor and covered in feces. A . . . . was on her right . . The resident said she tried to poop and and hurt her . . . . Redness was noted on her forehead. 911 was called and the resident was transported to a hospital. On . . . . . at 12:53 pm a nurse documented the resident had two that month. The resident was working with . . . . . for stability. She was seen at the hospital on the previous night for her most recent . and returned from the hospital with no new orders. On at 8:17 am the resident tried to sit down, but there was no chair behind her. She . on the floor and hit her on the side of the chair. 911 was called. The resident told the emergency personnel her hurt. She was taken to a hospital. On . . . a pharmacy consultant conducted a medication review due to . On at 9:02 pm the resident was found in her room by the caregiver on the floor in front of her recliner with her shirt off. She had no injuries. On at 7:50 pm the resident was constantly observed for potential hazards and kept in non-slid socks or shoes at all times.	A 025		

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A 025	Continued From page 4 On at 6:23 am nurse C documented the resident was noted to have a on her right with dried . The right side of the resident's was to her . The resident complained of a level of 10 out of 10. The resident said she was not sure what happened. The resident was transported to a hospital. A hospital history and physical indicated the resident had displaced at the anterior body of the right and left (jaw.) On at 12 pm the resident returned to the facility from the hospital. On a evaluation was conducted. On at 9:59 am, resident #5 was seen laying on a sofa in the dayroom. Her were closed. She wore only regular socks and no shoes. Staff were present in the dayroom. On at 12:35 pm, the resident's family member said it was still a mystery surrounding how the resident sustained the injuries and broken jaw on . He said a care conference was held with the administrative staff, including the administrator, on at 1 pm to discuss the resident's . He said during the meeting he was told the staff would check on the resident every 30 minutes. He said when the incident occurred the administrator said she did not recall telling him that during the care meeting. He said getting a hospital bed was discussed but ruled out due to risk of injury from the side rails. He said the facility ordered a bed sensor, but it's been unsuccessful, he believed	A 025		

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A 025	Continued From page 5 due to staff's lack of understanding on how to use it. A review of emails revealed the family member notified the director of nursing concerns the family member had regarding the bed alarm on , , , , , and . On at 3 pm, resident #5 was seen sitting on a sofa in the dayroom. She wore only regular socks and no shoes. She stood up from the sofa and caregiver A retrieved the resident's wheelchair and assisted the resident to sit in it. On at 3:02 pm, caregiver A said the resident did not have a during the 7 am-7 pm shift on . The caregiver said she put the resident to bed at approximately 6:30 pm and the resident did not have injuries at that time. The caregiver said the resident does not sit still and required reminders to do so. The caregiver said the resident was now put to bed during the 7 pm-7 am shift. During the interview with the caregiver, a bed alarm, was seen on the resident's bed. It was unplugged from the alarm box. The caregiver said she was never trained on its use and did not know anything about it. She was not sure how or where to reconnect the box to the . She said the resident did not have a bed alarm on . The caregiver's written witness statement indicated the administrator asked the caregiver if she put the bed alarm underneath the resident when she put her to bed on . The caregiver's reply was that she was not aware the resident had an alarm . The only service plan provided, dated , did not indicate the resident had a bed alarm. On at 5:20 pm, the administrator said the	A 025		

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A 025	Continued From page 6 use of the bed alarm was not documented anywhere. She said the facility did not have a policy on use of a bed alarm. She confirmed a care meeting was held with the resident's family on [redacted] at 1 pm, but there was no documentation the meeting took place. She said staff were trained on use of the alarm, but it was not documented. On [redacted] at 10:55 am, caregiver B said she worked from 7 pm-7 am on [redacted]. She recalled seeing the resident in her bed at the beginning of the shift. She was unaware of any incidents occurring that night with the resident, including a [redacted]. She said she did not hear yelling or any other noise coming from the resident's room during the shift. On [redacted] at 11:02 am, nurse C said she worked from 7 pm-7 am on [redacted]. She said she saw the resident out of bed between 7 pm and 8 pm and there were no injuries. She said she looked in on the resident at approximately 11 pm and the resident was in bed, facing the window and covered with a blanket. She said the resident was breathing and appeared to be sleeping. She did not look at the resident's [redacted]. She said when staff alerted her of the injuries the next morning, she entered the room to find the resident lying in bed, facing the wall and covered with a blanket. She pulled the blanket [redacted] and saw [redacted] on the pillow and sheet. She asked the resident what happened, and the resident said she did not know. When she looked at the resident's [redacted], she observed the [redacted] and [redacted] injuries. She said no one reported during the shift of the resident falling or any other incidents. She said she did not know about the bed alarm and believed it was not implemented until after the [redacted] incident. She said the resident gets up	A 025		

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A 025	Continued From page 7 without help all the time and staff had to keep reminding her not to. On at 12:19 pm, caregiver D said it was when she and the other two caregivers on shift went into the resident's room at 5:45 am on to get her up that she saw the and injuries. When asked for the last time she saw the resident prior to 5:45 am, she responded "every two hours." She then said she did not feel comfortable discussing it further over the phone. On at 1:25 pm, caregiver E said she worked from 7 pm-7 am on . She said she, along with caregivers B & D all checked on the resident every two hours, but only by looking in on her. She said the resident did not require care during the night. She said it wasn't until they all went into the resident's room on the morning of to get her out of bed that they saw the injuries. She said the on the bed linen was dry and she did not see anywhere else in the room. She said the resident did not during the shift nor did the caregiver hear any noise coming from the resident's room. Class II	A 025		