Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969935	A. BUILDING: _____ B. WING _____	R 10/14/2024

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

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{A 025}	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED 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 2 sampled residents (#7.) Findings: A review of resident #7's record revealed a facility admission date of . The resident's medical history included , , and	{A 025}		

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{A 025}	Continued From page 2 . A health assessment form (1823) indicated the resident was alert and oriented x3, had a mild to moderate speech , used a rollator for ambulation, had poor safety awareness and needed precautions. The 1823 indicated the resident was independent at that time with ambulation, toileting and transferring, needed supervision with and grooming and assistance with bathing. On at 1:20 am a facility note indicated precautions were put in place. The note did not indicate what the specific precautions were. On the resident was moved from assisted living to the secured memory care unit. On at 12:09 am the resident was found on the floor in the hallway sitting on her bottom in front of her door. When asked if she hit her , she shook her no. She complained of right , and was medicated with . No . Two were seen on her left upper arm, one above and one below the . On a evaluation was done for gait and mobility, balance and . On and the resident was alert to self, in her room and observed using an assistive device. The resident was encouraged to call for assistance. On a collaborative care meeting was held with home health. The resident was participating well with . On the resident was discharged from .	{A 025}		

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{A 025}	Continued From page 3 On at 7:02 pm, the resident was observed sitting on the floor in front of her closet. A measuring approximately 1.5 centimeters was seen above her left . The resident denied , elsewhere and denied hitting her . . On . . at 8:45 pm the resident was observed sitting on the floor at the of her bed. She was seen in bed ten minutes prior. She was unable to explain what happened. She had a lump and redness on the of her . She complained of and , . She was sent to a hospital. On at 7:34 am the resident returned from the hospital. A , hematoma was seen on a hospital . . . . Nurse F documented she went into the resident's room to evaluate her and to let a personal assistant know to get the resident ready for breakfast. Ten minutes later, nurse F heard someone screaming for help. The nurse observed the resident sitting on the floor in front of her bed. (This was not documented on the resident's service plan.) On at 1:46 am the resident was sitting in a wheelchair at the start of the shift. The resident was monitored in the common area but kept attempting to stand up and walk. She was unstable when standing. Her bed was too high for her to get in it alone or with one person assist. Two-person assistance needed to safely help her get to the middle of the bed. Care was rendered and the resident would be monitored more frequently during the shift. She complained of , when the of her was touched. She was assisted to lay on a pillow on her side to help with the , from the injury on the of	{A 025}		

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{A 025}	Continued From page 4 her . On at 3:46 am during rounds the resident was observed on the bathroom floor positioned in front of the sink in a supine position with her right trapped under a board coming from the sink. The resident was yelling. The resident's right was removed from under the board and redness was noted right away. The resident started groaning and holding the of her . A new lump to the of her was noted. The resident was sent to a hospital. On at 8:10 am the resident returned from the hospital. Redness was noted to the of her from the previous . On at 1:05 am the resident was monitored in the common area for safety needs not being met when she was in her room alone. She did grimace when the of her was touched. Scattered discoloration was present to the of her and . The resident was encouraged to use a wheelchair when ambulating. was noted and the resident was unstable. On at 8:58 am the resident's family member reported the resident complained of left , , since her first that was radiating into the front of her to the top of her . A doctor was notified. On at 6:10 pm the resident had an unwitnessed and was seen laying in front of her closet. were seen on both of her elbows. She was unable to say how she and complained of , to the of her . 911 was called and she was transported to a hospital. (This was not documented on the resident's	{A 025}		

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{A 025}	Continued From page 5 service plan.) On at 9:30 pm the resident returned from the hospital. A hematoma was present on the of her from the . On a doctor discontinued the resident's , due to low , and recent . On at 12:52 pm the resident had an unwitnessed in the main restroom located behind the main dining area. She complained of right , . An ice pack was applied. Review of the resident's service plan revealed the following documentation: - maintain a clutter free environment, ensure night light is working, and that rollator is within reach. Encourage resident to wear closed , closed heel non-skid shoes. on - request , , evaluation. (This was the only documentation in the record that a occurred on . There was no documentation in either the record or provided by the administrator to indicate a , , , evaluation was ever done.) - resident encouraged to wear well-fitting closed heel, closed shoes. Resident to be placed on , , again. - with no shoes on. Encouraged to wear nonskid socks when ambulating without shoes. - spoke with family about the of the bed. Family to order a lower bed.	{A 025}		

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{A 025}	Continued From page 6	{A 025}		

- safety review of all items in room to ensure no further hazards are noted.

- resident to be assisted to the bathroom when using the public restroom for safety.

The facility's prevention and intervention policy indicated, among other things, if a occurs, amend the resident service plan to reflect any changes and to reduce the risk of future . Provide training to staff on prevention strategies specific to the resident.

On at 9:35 am, resident #7 was seen sitting in a wheelchair in the memory care dayroom. She confirmed having prior . She said "I had a bad and balance." She then said "I learned to (the rest was unintelligible, even when asked to repeat herself.)

On at 12:04 pm, the resident was seen rounding a hallway by using her to propel her wheelchair. She was alone. She wore proper shoes. A night light was seen plugged in her room. Her room was free of clutter.

On at 2:28 pm, caregiver G was seen assisting resident #7 from her wheelchair to a dining room chair. The caregiver said she worked at the facility for one month. She said resident #7 needed assistance with Activities of Daily Living (ADLs,) which are bathing, , grooming and toileting. When asked if she had access to resident service plans, she turned to another caregiver and asked "do we have access to service plans?" Caregiver G said she had not seen resident #7's service plan. The caregiver said she was instructed by her supervisor to watch the resident, to transfer her, to keep an

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{A 025}	Continued From page 7	{A 025}		

on her and to assist her to her room, all to decrease the resident's risk for . She said three caregivers and one nurse work during the 7 am-7 pm shift.

On at 2:49 pm, caregiver H said she worked at the facility for approximately thirty days. She said she was aware residents had a service plan, but she'd not yet been shown how to access them. She said resident #7 needed assistance with all ADLs and with transferring. She said she was told to watch the resident and to not leave her unattended. She said three caregivers and one nurse worked during the 7 pm-7 am shift. However, the schedule indicated only two caregivers, and one nurse were scheduled on most days.

On at 2:59 pm, caregiver I said resident #7 needed assistance with all ADLs and with transferring. When asked if she'd ever seen the resident's service plan she replied, "you're gonna have to elaborate on what a service plan is." She said the resident had triggers, so the caregiver made sure the wheelchair was unlocked, that the resident was given a key to her room and the room door was left unlocked. The caregiver said three caregivers and one nurse worked during the 7 am-7 pm shift.

On at 3:23 pm, caregiver J said resident #7 never bounced after her first . The caregiver said the resident needed assistance with ADLs but could wash her and brush her own with cuing. The caregiver said the resident could not balance herself and could not be left in her room alone. The caregiver said the resident gets up during the night and goes to the bathroom alone. The caregiver said that by the time she did her checks every two hours the

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{A 025}	Continued From page 8 resident was already on the floor. The caregiver said a book of resident service plans was in the nurse's station in memory care. She said she had the code to get in the nurse's station. She said she never saw resident #7's service plan. She said the facility staffed two caregivers and one nurse during the 7 pm-7 am shift and every now and then three caregivers. Class II	{A 025}		