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 _____	07/15/2025

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 #2025008478 and 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		

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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 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 (#1). Findings: Review of resident #1's record revealed a facility admission date . A 1823 health assessment indicated a medical history of , Prostatic Hyperplasia, , Hypercholesteremia, ambulates	A 025		

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A 025	Continued From page 2 with walker, ◡ decline, tremors, assistance with activities of daily living (ADL's), memory care, and precautions. The facility's Prevention & Intervention Policy states Director of Wellness and the Executive Director/Administrator are responsible for implementing prevention strategies. prevention begins at the time of the initial assessment and admission. Utilize the nurse call pressure sensor , to monitor sleeping patterns for the first 72 hours post-admission for memory care residents. If a occurs: identify possible antecedents to the and implement interventions to reduce the risk of future , increased attention and supervision will facilitate a better understanding of the resident's environment, health condition and needs, implement positive interventions to reduce the risk of any environmental factors that may have contributed to the , and amend the resident service plan to reflect any changes and to reduce the risk of future . A Service Plan Detail dated for resident #1 interventions indicated potential. A Service Plan Detail dated for resident #1 ◡ indicated long term memory / moderate , , resident has current or history of frequent or difficulty remembering and using information, requires directions and reminding from others. Orientation: severe , , resident is frequently disoriented and requires frequent supervision and oversight. Short Term . : resident has severe , , unable to remember or use information. An incident report dated indicated	A 025		

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A 025	Continued From page 3 or of bones or joints. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident. Location to which resident was transferred: Horizon Hospital. An Orlando Regional Medical Center (ORMC) hospital report dated admitting diagnosis: multiple , right side, initial encounter for closed . A discharged diagnosis multiple , right side, initial encounter for closed transferred to skilled nursing facility (SNF) with , of skilled care. A facility note on at 12:30 PM read on , nurse on unit called to state that resident's Power of Attorney (POA) left a voice message at the front desk that the resident had , . It was determined the resident had discharged from Orlando Regional Medical Center (ORMC) late Friday, and was transferred to Lake Bennett Rehab. A facility note on at 3:48 PM read, resident was transferred via emergency medical service ( ) to emergency room (ER) today due to severe right sided and right sided flank , . Spoke with ER nurse caring for resident and she stated that resident is being sent to ORMC ( ) for multiple right sided ( ), to the L1-L4 process, and a trace right side , . A facility note on at 6:46 AM read, resident complained of (c/o) lower , this morning 06:00. Resident demonstrated poor standing and walking balance during a walk to the	A 025		

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A 025	Continued From page 4 restroom using small steps. A facility note on at 4:16 PM read, resident is having in right upper quadrant (RUQ), right lower quadrant (RLQ), and right flank. Discussed some interventions to prevent with POA, such as a blanket or a scoop mattress. POA expressed concerns that resident would just kick off blanket and/or that the scoop mattress would create more of a problem of the resident getting out of bed. Asked about bed rails, and I discussed that we do not use bed rails in memory care but suggested a . A facility incident report on at 4:30AM read, incident type . A facility note on at 5:08 AM read, resident observed lying on his left side on the floor of his restroom during nurses' regular rounds. Resident denies hitting his . Range of motion (ROM) completed and resident c/o , all over and not to a specific location. Staff assisted the resident into bed, residents' gait is poor. A facility note on at 12:15 AM read, resident has returned to the facility. A facility note on at 10:24 PM read, resident is on leave of absence (LOA) hospital. A facility note on at 6:06 PM read, all clinical staff please have resident in the common area to be monitored and not in his room where he is by himself. A facility note on at 6:06 PM read, PA (personal assistant) was gathering residents for dinner, PA went into resident room, observed	A 025		

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A 025	Continued From page 5 resident on the ground. Nurse arrived and observed resident laying supine on the floor with socks and shoes on and coming from his right arm . Nurse asked what happened, per resident, "I out of bed". was called and agreed to take resident to ORMC. A facility incident report on at 4:00 PM read, incident type , arm - right, , call 911, transferred to ER. A facility incident report on at 5:00 AM read, incident type unauthorized out of bed, no , no medical treatment. A facility note on at 12:15 PM read, resident was seen by Enhabit for transfer training. A facility note on at 2:25 PM read, resident was seen by Enhabit on . focus, gait training indoors and on patio. A facility note on at 3:40 PM read, resident observed in dining room for lunch. Resident denies , from prior . Resident requested to go to his apartment. Redirected the resident to spend some time outside in courtyard, resident agreed. A facility note on at 10:36 PM read, resident observed in bed no c/o any , or discomfort will continue to regularly observe resident and report any changes. A facility note on at 12:59 PM read, resident observed in common area in memory care (MC) unit. Resident having difficulty standing up from sitting in chair.	A 025		

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A 025	Continued From page 6 A facility note on at 1:08 PM read, resident had a and hit his , sent out to hospital for further assessment. A facility note on at 10:58 PM read, resident found on floor by PA. Resident stated he rolled over and hit the floor also hitting his . . . . Resident sent to Horizon West. A facility incident report on at 10:30 PM read, incident type , call 911, transferred to ER. A facility note on at 9:00 PM read, resident observed in bed awake, compliant with medication, mild ⌣ noted on right . Facility note on at 8:30 PM read, during medication pass, resident observed by the nurse lying supine on the floor next to his bed on top of clothing, when asked what happened, resident stated that he meant to turn over not realizing where the mattress ended. A facility note on at 1:19 PM read, resident returned to the Orthopedics appt at 1:10 PM. A facility note on at 11:44 AM read, resident LOA with POA to appt. A facility note on at 12:03 AM read, resident had c/o , , given and no further c/o any more , at the moment (atm). Will continue to observe. A facility note on at 5:48 PM read, resident in room sitting in recliner, no complaints of , or discomforts. No today. A facility note on at 10:23 PM read,	A 025		

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A 025	Continued From page 7 repositioned patient to lay in the middle of the bed so he does not . A facility note on at 5:52 PM read, resident had no today. A facility note on at 11:09 PM read, resident observed in bed, adjusted resident to middle of the bed as he was sleeping close to the edge. Will continue to observe. A facility note on at 7:04 PM read, resident is alert, caregiver went to call resident for dinner, observed resident on the floor in front of his bed sitting down. Resident stated he slipped and . The old on his right re opened. A facility note on at 10:58 PM read, (UA) results received. is negative. A facility note on at 6:40 PM read, resident was seen by a registered nurse practitioner (ARNP). A facility note on at 6:03 PM read, new order: UA w culture sensitivity (c/s) diagnosis (dx): / A facility note on at 6:53 AM read, resident is awake and in good spirit, denies , demonstrates fair balance when ambulating to the dining room using a walker and staff at his side for assistance and safety. A facility note on at 7:30 PM read, incident type , no apparent skin or injury.	A 025		

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A 025	Continued From page 8 A facility note on at 7:30 PM read, during start of shift rounding, resident was observed by staff lying supine on the floor beside his bed. Resident stated that he wanted to turn over on his side when he off the bed. Staff assisted resident off the floor and into bed. A facility note on at 12:21 PM read, received order from Bluestone for , of left (L) , / . A facility note on at 6:56 PM read, nurse called into resident room and observed resident sitting down in front of his bed not able to explain to what happened. A facility note on at 12:25 PM read, LOA with community bus. A facility note on at 12:21 PM read, nurse walked into resident room observed resident lying on the floor near the bathroom door, skin checked, an existing on left reopened and on his pinky the ring cut his ᵕ . A facility note on at 6:27 AM read, resident had an unwitnessed last night without injury. Increasing frequency of checks. A facility incident report on at 9:45 AM read, incident type , cut ᵕ - left, right and left pinky. A facility note on at 1:39 AM read, resident last checked on at 11:30 PM. He was resting in bed with ˏ closed. A facility note on at 6:30 AM read, reported by PA the resident had a . Resident	A 025		

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A 025	Continued From page 9 stated, "he out of his bed." C/o , to left , , to left . A facility incident report on at 5:45 AM read, incident type from bed, , arm - left, A facility note on at 1:35 PM read, Enhabit came to assess resident today for / eval. A facility note on at 10:45 PM read, resident observed in room. Seemed a little when asked to sit up to take medications, no c/o any , or discomfort. Will continue to observe. A facility note on at 7:34 PM read, resident is alert returned from Horizon Hospital at 6:20 PM, no c/o , noted. There is a large on his and on his right due to the . A facility note on at 6:44 PM read, return from hospital. A facility note on at 6:33 PM read, resident has been transferred to in memory care. Staff educated on resident, frequent checks and assistance with all AD's. A facility incident report on at 1:00 PM read, incident type , while ambulating with/without assistive device, call 911, , arm - right, transferred to ER. A facility notes no at 1:30 PM read, resident was leaving dining room when he after completing a couple of steps. Dining staff reported that resident hit his on the dining	A 025		

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A 025	Continued From page 10	A 025		

chair when falling, but resident grabbed table and slowed down the . Resident observed to be shaking and dining staff reported he was shaking all through lunch.

A facility note on at 4:40 PM read, resident seen by Enhabit for discharge secondary to non-participation with services since decline in cognition. Resident has , memory with safety issues.

A facility note on at 1:03 AM read, resident returned to facility at 01:00.

A facility note on at 10:00 PM read, at 22:00 staff went to resident rooms to collect sample, resident was observed by staff lying right lateral on the floor between his bathroom and bedroom floor with against the bathroom door. Resident stated that he in the shower. Resident was not in the shower and clothes were dry. Staff assisted resident to a sitting position. The of resident is red, no or broken skin noted. Staff assisted resident to a standing position and resident is unable to hold his balance. Staff assisted resident to sit on his wheelchair (w/c), Resident is and could only state his name. Resident is unaware of his current location, does not know his date of birth (D.O.B.). activated.

A facility incident report on at 10:00 PM read, incident type , call 911, transfer to ER.

A facility incident report on at 8:30 AM read, incident type .

A facility note on at 9:32 AM read, Nurse went to administer resident medication, an observed resident on the ground laying supine on

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A 025	Continued From page 11 the floor in his bedroom near his dresser and walker was behind the door tipped over. Resident had a pillow and blanket that he wrapped himself with while lying on the floor and had 3 pieces of shirts on and no briefs or pants but had no skid socks on. Nurse asked what happened and resident was unable to tell what happened. Per resident " I did not " while he was laying on the ground. A facility note on at 8:35 AM read, resident seen by Enhabit . noted decline. next visit will be next week for discharge from . A facility note on at 8:23 AM read, resident observed in apartment bathroom hanging a towel, resident observed to be on how to hang the towel on the towel rack. Bathroom floors observed to be wet from /water near toilet and sink. A facility note on at 3:13 PM read, resident observed in his apartment, resident has no complaints regarding , nor discomfort at this time. POA is coming today to help resident in the shower. A facility note on at 4:25 PM read, resident seen by Enhabit . Completed ther-ex, transfers, and gait training. A facility incident report on at 9:30 AM read, incident type while ambulating with/without assistive device. A facility note on at 10:57 AM read, staff entered resident's apartment about 0930 and observed him sitting on his bottom beside kitchen island. Island chair was lying on floor, and	A 025		

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A 025	Continued From page 12 2-wheel walker was in front of resident tipped over. Resident properly dressed for the day with non-slip shoes on. Resident unable to verbalize what happened. A facility note on at 6:23 PM read, resident seen by Enhabit . Noted increased . A facility note on at 6:19 PM read, called resident's POA, conversation in regard to SLUMS score, noted increased , on floor and in bed, layering of clothing, wearing pants backwards. UA is negative. Discussed move to MC. A facility note on at 6:18 PM read, UA results are negative. A facility note on at 2:37 PM read, collected and prepared for lab pick up. A facility note on at 11:24 AM read, resident is wearing multiple layers of clothes, putting pants on backwards, on the floor. Requested order for UA and a SLUMs test from MD. A facility note on at 12:52 PM read, resident seen by Enhabit for discontinuation of services. A facility note on at 12:25 PM read, resident seen by Enhabit PTA on . Completed all ther-ex, transfers, and gait training. A facility note on at 1:18 PM read, resident seen by Enhabit for assessment. Progressing well with strength, balance and mobility.	A 025		

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A 025	Continued From page 13 A facility note on at 8:50 AM read, resident seen by Enhabit PTA on . Completed all ther-ex, transfers and gait training. Performed very well. A facility note on at 3:33 PM read, resident seen by Enhabit , LE strengthening, increased gait with 2ww. Nice progression post , surgery. A facility note on at 5:30 PM read, resident seen by Enhabit PTA. Completed ther-ex, transfers and gait training. Exercises outdoor today. Resident performing well. A facility note on at 4:09 PM read, order: UA w rflx c/s dx: (AMS) per doctor. A facility note on at 1:07 PM read, resident was seen by Enhabit PTA. Completed ther-ex, transfers and gait training. A facility note on at 2:29 PM read, FOX collaborative care meeting, resident receives , resident has slow, , gait, working on balance, endurance and proper use of walker. A facility note on at 8:42 PM read, care plan reviewed and updated. A facility note on at 7:46 PM read, resident was seen by Enhabit for evaluation. Resident will benefit from for AE training, LB and training on bed mobility. A facility note on at 5:33 PM read, resident observed in his apartment, resident had no complaints of , or discomfort. Resident	A 025		

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A 025	Continued From page 14 ambulates through the halls well and socializes with others. A facility note on at 10:22 PM read, resident went out to dinner with son earlier. He is resting in bed with , closed. Staff educated to check on resident every few hours. A facility note on at 6:24 PM read, new orders: d/c . A facility note on at 2:04 PM read, resident seen by PCP today. New orders: UA w/rflx c/s dx: AMS, HH / /SN eval and treat Dx: , left , , , left A facility note on at 11:41 AM read, during morning medication administration residents bed observed to be bloody. Resident stated he and got himself in bed. to left observed. Resident able to stand and walk independently. A facility incident report on at 8:30 AM read, incident type , , arm - left A facility note on at 4:46 PM read, orders for and received. A facility note on at 1:03 PM read, informed Bluestone group of residents return on . Requested orders for and assessment. A facility note on at 4:15 PM read, resident observed ambulating independently without walker in hallway. Reminded resident he should be using his walker to avoid another .	A 025		

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	AL11969935	A. BUILDING: _____ B. WING _____	07/15/2025

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A 025	Continued From page 15 A facility note on at 11:25 PM read, resident seems well and in no distress. A facility note on at 5:59 PM read, resident is alert and oriented. independently ambulated to all meals with walker. A facility note on at 7:08 PM read, resident returned to the community from rehab with POA. Resident is alert and oriented. Resident independently walks with walker. A facility note on at 3:06 PM read, resident will be returning to the community on via transport by POA. Received 1823 and physician signed med list. A facility note on at 12:37 PM read, received call from SkyTop Rehab. Resident has been cleared to return to the community on . A facility note on at 2:04 PM read, visited resident at SkyTop Rehab on . Resident is ambulating with a 2-wheel walker. A facility note on at 3:48 PM read, visited resident at Horizon's West Hospital. Resident had surgery yesterday. A facility note on at 2:53 PM read, visited resident at Horizon's West Hospital. Resident is scheduled for left , surgery at 2pm. Per POA, the surgeon is placing 3 pins. A facility note on at 1:34 PM read, spoke to POA, stated resident was admitted to hospital. Sustained left , , possible surgery, awaiting evaluation from .	A 025		

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A 025	Continued From page 16	A 025		

A facility note on at 12:48 PM read, during morning medication administration resident was observed on floor. Resident observed to be very stating he did not . He was organizing the items on the floor for the animals outside. Nurse attempted to roll resident on . He stated there was , in his left , . Resident was transported to Horizon West Hospital via .

A facility incident report on at 8:45 AM read, incident type , , his left , , call 911, , , -left, transferred to ER.

A facility note on at 6:42 PM read, Fox collab care meeting today. Resident continues to have good balance and standing tolerance. Resident not always compliant however with participation.

A facility note on at 6:04 PM read, FOX collaborative care meeting on . Resident is receiving / . Noted progression with balance and endurance.

On at 1:54 PM, the director of wellness stated resident #1 was falling in assisted living (AL) and declining we moved him to memory care. After moving to memory care, we put frequent checks in place, lowered his bed, and a mattress. We were having talks with his family to have a sitter in place, but we didn't get to that point.

On at 2:03 PM, nurse C stated resident #1 lived int he assisted living part of the facility before moving to memory care because he was falling. I know he had several in memory care. One thing with resident #1, he loved his room which is where his were happening.

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A 025	Continued From page 17 We knew that was the reason for the when he was unsupervised, but his family still wanted him to be able to get into his room. We were keeping him out. I don't know if staff E was telling the family, but we completed incident reports every time he . The family was upset when I called about the because resident #1 was always falling. On the 2nd he was complaining of side , . We were trying to get the doctor to order for the , he was having. Due to the delay in the process resident #1 was sent out to the hospital. On at 3:03 PM caregiver D stated resident #1 had a lot of . He would forget his walker. He usually likes to go to his room after his meals. I was told that we were not allowed to keep him out of his room and his door was to remain unlocked. We would try to keep him busy when he was out of his room, but he didn't like that. So, we would take him to his room and do 2-hour checks on him. That day, or , I went to get him out of his room for his meal and his arm was . That was the time I found him. I believe they tried to put something on his bed, like an alarm, but whatever it was it didn't work because he kept falling. On at 3:44 PM, the POA stated resident #1 in the bathroom at the facility and broke 4 . He was transported to Horizon West and then transported to ORMC. He was sent to rehab from ORMC where he then , . The POA added, in a perfect world, the facility could have had a little bit more staff in memory care. Resident #1 was disoriented and all over the place. The facility could have done a little bit more monitoring. Towards the end they told me they didn't want to keep him in his room and tried to keep him in the TV room. We did consider a	A 025		

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A 025	Continued From page 18	A 025		

sitter, but memory care is not cheap and having to have someone 24 hours. The facility's responsibility was to check on resident #1 every 2 hours.

The administrator was asked what interventions were put in place to prevent resident #1's excessive .

On at 4:28 PM, the administrator stated we tried the pool noodle, 2-hour checks and repositioned his bed. Resident #1's family said to move the bed . The last in we were trying to get the POA to put a sitter in place. The administrator was asked why it took resident #1 falling 13 - 14 times before the option of putting a sitter in place. She added, we were trying to assist with aging in place. The resident has a right to . As they age it's an inherited risk. The administrator was asked if the facility could have assisted by having staff to monitor resident #1 more closely. She stated we have 24-hour nurses and 24-hour staff in memory care. We spoke with the POA, and they were waiting to hear from a family member who handles the finances, but resident #1 never returned. In the residents' contract there was a disclosure stating that resident has a right to . Therefore, if it goes to arbitration, it cannot be used as lawsuit. family had a camera in the room and were grateful for what we were doing. We were at that last stage at the last resident # , no longer be appropriate and looking at long term care.

On at 4:59 PM nurse F stated I was not at work when resident #1. I sent him out on to the hospital. A lot of his were not on my shift. I believe most of his happened at night. In the reports it stated he was found wet

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A 025	Continued From page 19 and had . We were told he has right to be in his room. So, we were not to keep him out and to keep his door unlocked. Resident #1 wanted his independence like most people, and he felt like he could still do certain things. During my shifts, my staff and I would check on him every 30 - 45 minutes or so. During those rounds we would make sure resident #1 had everything he needed before leaving this room to prevent him from needing to get up. The facility failed to follow their Prevention & Interventions Policy by implementing prevention strategies to reduce the risk of resident #1's excessive with increased attention and supervision. On at 4:00 PM, the administrator confirmed the findings. (photographic evidence obtained) Class II	A 025		