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 _____	09/30/2025

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 complaint investigation (#2025012898) and generator monitoring was conducted on at The Blake Assisted Living, Viera. A deficiency was found 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: Based on record reviews, observation and interviews, the facility failed to ensure 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 residents for 1 of 2 sampled resident (#1). Findings: In a review of resident#1's record and health assessment it confirmed an admission date of and a health assessment with a medical history of of the 's type with behavioral disturbances. Additionally, under	A 025		

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A 025	Continued From page 2 pr behavioral status: the health assessment listed poor short memory, disorientation to time, difficulty answering questions, disoriented in new places, sundowners, and believes she heard people in the attic and afraid of people coming after her and barricades the door. There were no recent behaviors. The resident was placed in assisted living and was not an elopement risk. There was no care plan available for review. In a review of resident#1's facility observation notes, it reported the following: resident observed with increased , Tract ordered On the resident was outside on bench and another resident backed up wheelchair and it ran over her right top of . Top of red. Able to move without , . order obtained for UA for increased resident observed with unsteady gait. Glazed state and very weak. Transported to hospital. Resident was admitted Resident discharged from hospital on residents observed with increased 0650 deputies on site requesting to speak to nursing staff. Deputies stated they found the resident alert and disoriented to place time and situation, on the street	A 025		

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A 025	Continued From page 3 approximately 2 miles from the facility. Law enforcement stated the resident was feeling weak at the time of the encounter, but resident safely returned to facility. Resident is and unable to explain what happened. Upon return resident was transferred to her room in a wheelchair with staff assistance. No open . Residents will be placed in memory care unit. at 10 am The resident's family came to the facility. The nurse was called to the residents' room to look at her that had on them. Full body check skin check and dressed resident's two big as they appeared to have skin scraped off them and some noted . at 2000 resident was heard banging on her door from the inside, Staff entered the room and found the resident alert but restless. No signs of distress. Resident noted with agitation. residents observed walking around bedroom. Residents did not sleep during the night. Noted significant but , with medications. Review of the facility's elopement policy revealed staff should recognize any unusual or exit seeking behaviors and report to management. Behaviors such as residents who normally sleep through the night wake at odd hours and enter hallways. Overnight staff and nurses to do regular rounds on all entry and exit doors. Immediate interventions for behavior are one on one supervision or placement in the secure memory care unit. Utilize techniques that redirect the resident from doors and windows.	A 025		

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A 025	Continued From page 4	A 025		

Interview on 10:00am with the Assistant Director of Nursing revealed resident#1 was found about 1 to miles away from the facility. She stated the resident had a about a month before the incident. She stated she did not show any signs of or exit seeking behaviors before the incident. She stated the last Tract check was negative. She stated the resident was found with 2 small scrapes on her big when she returned to the facility. She stated no other injuries were observed.

In an interview on at 11:00am with staff C, he stated that during the time of the incident, there were lightning storms every day and it was knocking out different exit doors and elevators intermittently. He stated the doors are checked daily and the exit door of the incident was checked that evening. He stated the alert for the door must have gone out in the middle of the night. He stated it was repaired immediately that morning after the incident.

In an interview on at 11:45am with staff A, stated resident#1 did not have or exit seeking behaviors before this incident. Stated she was not one of the residents we needed to do 2 hour checks on. Stated, she normally would go to the lobby and watch the movie at night and then a little in the halls and then sleep through the night. Stated she had a about a month before the elopement, but no exit seeking behavior was present.

In an interview on at 12:00 pm with staff C, she stated resident#1 never displayed exit seeking behaviors and was happy at the facility. She stated staff does checks on the residents 2 x per night or more frequently if they

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A 025	Continued From page 5 have behavioral issues. She stated resident#1 was not one of them. She stated she would go to see the movie downstairs and then go to her room and sleep during the night. She stated nothing like this ever happened before. In an interview on at 12:15am staff D, stated she saw resident#1 walking the halls that evening after she came up from downstairs from watching the movie. She then saw her walking around 2 am in the hallway and redirected to her room and put her to bed. She stated that it was the last time she saw her that evening. She stated the staff does checks 2 x per night on this shift and only do 2-hour checks if the resident has that on the care plan or displayed unusual behaviors. She stated resident#1 never had , or exit seeking behaviors before this incident, that she is aware of. Observation on at 11:15 am of the exit door in the dining area (where resident #1 eloped from). The door beeps when exciting and a signal is sent to staff and administration when door is opened. Interview on at 2:00pm with the administrator, she confirmed the above findings and stated the resident never showed signs of exit seeking behaviors. She stated the resident is very independent and she has been living here for 2 years and never had an issue. She stated after the incident she was placed in memory care for safety reasons, and she is very , , and needs more supervision. She stated the resident was found about a mile to 2 miles from the facility at a car dealership. She stated law enforcement found her and brought her to the facility. She explained there are 2 caregivers and a nurse on duty on the overnight shift. She	A 025		

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A 025	Continued From page 6 stated the resident was checked on about 2:30 am where she was walking through the halls and then went to her room. The caregiver thought she had gone to bed. She stated there is no policy for checking on the residents just best practice every 2 or 3 hours, if possible, on the assisted living side or if the resident's care plan has that in it to check more frequently. Photographic evidence obtained Class II	A 025		