

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969460	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/17/2019
NAME OF PROVIDER OR SUPPLIER THE BLAKE AT PENSACOLA OPERATING COMPANY		STREET ADDRESS, CITY, STATE, ZIP CODE 428 AIRPORT BLVD PENSACOLA, FL 32503		
(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 An unannounced complaint survey was conducted at The Blake at Pensacola Operating Company assisted living facility on 7/17/19 to review the allegation within complaint #2019008762. An initial Extended Congregate Care survey was also conducted on 7/17/19. Deficient practice was identified at the time of the survey. A class I deficiency was identified on 7/17/19 at A0025 for concerns related to adequate supervision and failure to conduct minimum 2 hour checks during the night shift. A resident experienced a ... during the night shift which resulted in the resident's ... The resident was a ... and would have required ... (...). The staff did not discover the resident until the morning hours, and by that time, the resident was ... and ... The Administrator and Director of Wellness were notified of the class I deficiency on 7/17/19 at 4:25 PM. At the time of the survey, the facility census was 107, and there were 79 residents in the facility with ... status.	A 000		
A 025 SS-J	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. 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 shall arrange, with the appropriate health	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969460	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/17/2019
NAME OF PROVIDER OR SUPPLIER THE BLAKE AT PENSACOLA OPERATING COMPANY			STREET ADDRESS, CITY, STATE, ZIP CODE 428 AIRPORT BLVD PENSACOLA, FL 32503		
(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 025	Continued From page 1 care provider, the necessary care and services to treat the condition. 58A-5.0182 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 58A-5.020, 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, staff interviews, and policy review, the facility failed to provide adequate supervision for 1 of 3 sampled residents to ensure awareness of the general	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969460	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/17/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE BLAKE AT PENSACOLA OPERATING COMPANY

**428 AIRPORT BLVD
PENSACOLA, FL 32503**

(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 025	Continued From page 2 health, safety, and physical well-being. On _____, the facility staff failed to conduct minimum 2 hour resident checks during the night shift. Resident #1 experienced a _____ during the night which resulted in the resident's _____. The findings include: A record review for Resident #1 found that the resident had been residing in a _____ unit and had a diagnosis of _____'s _____. Resident #1 was ambulatory (able to walk) and was independent in performing her own activities of daily living. On _____ at 5:40 AM, a nurse entered the room to find resident #1 _____. Review of a statement dated _____ signed by employee A (licensed practical nurse night shift) revealed on _____ at 5:40 AM the nurse entered resident #1's room and found the resident lying with her _____ between the night stand and the bed with _____ coming from her _____ and _____. The residents _____ were fixed and open and her skin was _____ and dry to touch. The resident was _____ to name being called and _____ No _____ or _____ detected. Emergency medical services activated at 5:41 AM. Employee A documented that she asked employee B if she had seen resident #1 coming and going out of her room during the night, and she stated, "no." Employee A wrote that resident #1 toilets herself independently, and staff checks in on resident at the end of shift for _____ episodes and room cleanliness. A statement from employee D dated _____ indicated employee D last observed the resident in her room on _____ at 10:10 PM. She was sitting up in bed and then laid back down.	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969460	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/17/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE BLAKE AT PENSACOLA OPERATING COMPANY

**428 AIRPORT BLVD
PENSACOLA, FL 32503**

(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 025	Continued From page 3 Review of resident #1's record revealed a statement indicating the _____ ruled the resident's _____ to be _____. A telephone interview was conducted with employee A on 7/17/19 at 10:30 AM. The nurse stated she went to the resident's room to give her medications. The resident was _____ and not _____. She went to get the personal assistant and phone to call 911 and check to see if resident was a _____. She does not recall if the resident was a _____ and did not attempt to perform _____ because the resident was _____ and was _____. The resident's _____ were fixed, she had been _____ for a while. She stated Resident #1 was very independent and did everything for herself. Employee A stated that this was the first time she saw the resident on her night shift and that the personal assistants are required to check the residents at the beginning of the shift. A telephone interview was conducted with employee B (personal assistant) on 7/19/19 at 10:45 AM. She stated she worked 11 PM - 7 AM shift and was working at the time of the incident. The personal assistants typically laid eyes on all residents at the beginning and end of each shift. She confirmed she did not observe resident #1 on _____ during her shift until they found the resident _____. An interview was conducted with the Director of Wellness (DOW) on 7/17/19 at 11:08 AM. He stated through other instances they had identified that staff were not checking all residents every 2 hours, they were under the impression that they were not to bother some residents at night. He stated upon completion of the facility investigation	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969460	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/17/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE BLAKE AT PENSACOLA OPERATING COMPANY

**428 AIRPORT BLVD
PENSACOLA, FL 32503**

(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 025	Continued From page 4 the facility had no concerns with the resident's The facility policy for Delivery of resident care and services (1.12) reveals rounding the building for security and safety- the night shift must check all doors to ensure that the building is secure. Interior stairwells must be checked at the beginning of the shift, mid shift and end of shift. The nurse call system may be utilized to schedule routine pages to ensure that specific doors and areas of the building are monitored within specific time frames. All doors must be locked and unlocked according to the community operation rules. The wellness staff must conduct a minimum of 2 hour rounds and resident checks during the afternoon, evening and night shifts. The Director of Wellness may request that specific residents be checked more frequently according to their level of acuity and needs. Class I	A 025		