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
	AL11966425	A. BUILDING: _____ B. WING _____	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT ASTON GARDENS AT PELICAN POINTE (THE)	9000 IBIS WAY VENICE, FL 34292

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A 000	Initial Comments An unannounced complaint survey for #2023005553 was conducted on . . . . through at The Inn at Aston Gardens at Pelican Pointe, an assisted living facility in Venice, Florida. Complaint #2022002294 was substantiated at A0030, A0077, and A0083 at Class I Level, and A0081 at Class II Level. The following is a description of the deficiencies.	A 000		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . Rights Florida,	A 030		

AHCA Form 3020-0001

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

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A 030	Continued From page 1 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d),	A 030		

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A 030	Continued From page 2 F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from [redacted] and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence,	A 030		

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A 030	Continued From page 3	A 030		

autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , , , , , , , , , for health care services, the provision of or arrangement of transportation to health care , , , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency

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A 030	Continued From page 4 relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names	A 030		

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A 030	Continued From page 5	A 030		

and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident.

This Statute or Rule is not met as evidenced by:
Based on record review, review of facility policies and procedures, and interview the facility failed to implement their policy to perform , ( ) for

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A 030	Continued From page 6 residents without a . . . . . ( ) and honor the resident's rights to have . . . . . performed for 1 (Resident # 1) of 2 resident reviewed for care at the end of life. The findings Include: Review of the Facility Emergency Situations Policy Revised . . . . . Policy: All 911 emergencies are responded to in the appropriate manner maintaining the well-being of each resident. 2. If a . . . . . does not exist, begin . . as indicated. NOTE: the team member beginning must be certified. 3. Once . is initiated, it must not stop until Emergency Medical Personnel are present. Review of the Facility Policies and Procedures, Advance Directives Policy: It is the policy of the facility to advise all new residents of the importance of Advance Directives upon admission. Generally, advance Directives are the instructions by or desires of the principal concerning any aspect of the principal's healthcare, including, the designation of a health care surrogate, a living will or an anatomical gift. 6. Facility staff will honor the resident's Advance Directives to the best extent possible within the limits of the state law. Record review of Resident #1's record revealed she was admitted to the facility on , with a diagnosis of . . . . . , gait disturbance, ... (. . . . .), ... , Iron deficiency . . . . . , and of right . A valid Durable Health Care Power of Attorney (POA) was executed on appointing Resident	A 030		

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A	Continued From page 7 #1's son as the health care agent. Documentation of Health Care Treatment Instructions In The Event Of [illegible] Medical Condition Or Permanent [illegible] signed indicated Resident #1 wanted [illegible] ( ). Review of facility incident report date revealed at approximately 6:10 a.m. Staff A (caregiver) was making rounds and entered Resident #1's room when there was no answer to her knocking, and found Resident #1 lying in the bed, her [illegible] hung over the side of the bed, and unresponsive. Staff A did not immediately initiate [illegible]. Staff A called Staff B (caregiver) and they both entered the room at 6:20 a.m. Staff B entered the room observed Resident #1 and rubbed her [illegible] which was [illegible]. Staff B called Staff C (caregiver). Staff B did not initiate [illegible]. Staff C entered the room and instructed Staff B to call the administrator. Staff C did not initiate [illegible]. Staff B called the administrator at 6:25 a.m. and was instructed to call 911. On [illegible] at 9:59 a.m., in an interview, Staff B said Staff A came and got her to come to Resident #1's room as she was making rounds and found the resident in her room unresponsive. Staff B said she entered the room, called Resident #1's name with no answer, rubbed her [illegible] which was [illegible] and her skin was pale. Staff B said she called Staff C into the room and was instructed by Staff C to call the Administrator. Staff B stated she called the administrator at 6:25 a.m. and notified her Resident #1 was found unresponsive. She said the Administrator instructed her to call 911. Staff B stated the Administrator did not instruct her to initiate [illegible]. Staff B said she saw no [illegible] in Resident #1's room and did not check	A 030		

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A 030	Continued From page 8 her chart to verify if there was one. Staff B confirmed she did not initiate or use the facility Automated External Defibrillator ( ) machine, and stated she never received training on using the machine. On at 10:30 a. m., in an interview, the Administrator said she received a telephone call on at 6:25 a.m. from Staff B informing her that Resident #1 was found unresponsive and her were . The Administrator said she instructed Staff B to call 911. Administrator stated she did not instruct Staff B to initiate , and confirmed Staff A, B, and C should have initiated . On at 11:00 a.m., in an interview, Staff C stated she was called to Resident #1's room by Staff B informing her the resident was unresponsive and her was cool to touch. Staff C stated while in the room she observed that Resident #1 was not breathing and her was open. Staff C said she instructed Staff B to call the Administrator. Staff C said the facility policy requires staff to initiate if a resident is found unresponsive and does not have a and Resident #1 did not have a . Staff C confirmed she did not initiate or use the facility machine. On at 11:30 a.m., in an interview, Staff A said her certification had expired prior to her start of employment at the facility. Staff A stated on the morning of about 6:10 a.m. while making rounds she arrived at Resident #1's room and knocked with no answer, she entered the room and called to Resident #1 with still no answer. Staff A said she observed Resident #1's hanging off the bed and the resident was unresponsive. Staff A stated she	A 030		

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A 030	Continued From page 9 then called Staff B who came to the room, called to Resident #1 with no answer, rubbed her with no response and called for Staff C. Staff A said Staff C came to the room, looked at Resident #1, and told Staff B to call the Administrator. Staff A confirmed she did not initiate when she found Resident #1. She said, "I was so nervous and was still new to the facility that's why I called the other caregiver." Staff A said she did not know if Resident #1 had a and she did not have training on the facility until yesterday . Staff A stated no one instructed her to initiate or use the facility machine when she found Resident #1. On at 11:47 a.m., in an interview, Staff D (caregiver/medication technician) stated Resident #1 did not have a , therefore, was a full code and staff should have initiated when they found Resident #1 unresponsive. Review of personnel records for Staff A revealed a hire date of . There was no documentation of certification on file for Staff A. Record review for Staff B revealed a hire date of . Staff B's file contained documentation of certification completed on with an expiration date of . Record review for Staff C revealed a hire date of . Staff C's file contained documentation of certification completed on with an expiration date of . On at 3:44 p.m., the Administrator stated that on Staff F (caregiver) was on duty and had certification in . The Administrator confirmed none of the employees who were involved when Resident #1 was found unresponsive had a valid card and could	A 030		

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A 030	Continued From page 10 give no explanation as to why they did not notify Staff F as he was the staff member on duty that had certification. On at 4:34 p.m., in an interview, Resident #1's son (POA for healthcare) stated his mom had a Living Will and it documented wanting as her wish. His expectations would be for the facility to perform when needed. On at 8:38 a.m., in an interview, Staff F stated he is certified, and only works in the memory care unit of the facility. Staff F said he worked on the night of and left on the morning of at about 6:45 a.m. He said while on duty he received no call from facility staff about Resident #1 being found unresponsive. Staff F stated if he finds a resident unresponsive he is not sure what to do. He said he would contact the supervisor. He said he has not received training on the facility policies and procedures on what to do if he finds a resident unresponsive. He said he has not received training on the facility machine and has never been shown where the machine is located. He said he does not know which residents have and which residents are full code. Staff F did not recognize the term and said he does not know which of his coworkers are certified in . A review of the Staffing Schedule for to revealed that on , , and no designated staff with were on duty for 6:00 a.m. - 2:30 p.m. and 10:00 p.m. - 6:30 a.m. shifts. On no designated staff with were on duty for the 2:00 p.m. - 10:30 p.m. and 10:00 p.m. - 6:30 a.m. shifts. On no designated staff with were on duty for 10:00 p.m. - 6:30 a.m. shift. Further review found only 5	A 030		

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A 030	Continued From page 11	A 030		

of 21 current "Care Team" staff have valid documentation on file. On and , night shift (10:00 p.m. to 6:30 a.m.) the only certified staff member in the facility was Staff F. Review of the employee records for Staff D, F, and K revealed certification documentation from National Foundation which did not meet regulation requirements as it was not done by American Red Cross Association, leaving only 3 of 21 current care team staff with valid certification on file.

On at 9:19 a.m., in an interview, Staff G (caregiver) said she did not receive training on the facility machine and does not know and has not received any training for what to do if she finds a resident unresponsive. Staff G said she does not know which residents in the facility are full code or have and she does not know which of the caregivers on her shift are certified in . Staff G said she would not know who to call if she found someone unresponsive. She stated the staff schedule is posted in the wellness center for the Assisted Living and in the Memory Care unit at the nurses' station and does not indicate which staff have certification.

On at 9:24 a.m., in an interview, Staff H (caregiver) stated she is not trained in and has not received training on the facility machine. Staff H asked, "what is an machine?" Staff H states she did not receive training on or what to do if she finds a resident unresponsive. She said she does not know which staff on her shift have . Staff H said the staff schedule is in the nurses' station but does not indicate who has .

On at 9:31 a.m., Staff B stated when Resident #1 was found unresponsive and she

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A 030	Continued From page 12 called the Administrator, the Administrator never instructed her to initiate or check for for Resident #1. Staff B stated she does not know what team members have and did not know Staff F, who was in the Memory Care unit, had and/or to call him, she just called Staff C and then the administrator. Staff B stated the employee schedule is posted in the wellness center and does not indicate which team member has and she does not know who has on her shift. On at 9:54 a.m., the Administrator reviewed the employee schedule and confirmed there were no staff on the schedule for , for 6:00 a.m. - 2:30 p.m. and 10:00 p.m. - 6:30 a.m. shifts, on for 2:00 p.m. - 10:30 p.m., 10:00 p.m. - 6:30 a.m. shifts and on for 10:00 p.m. - 6:30 a.m. shift with valid certification. The Administrator confirmed with Staff F in the Gardens (memory care) there would have been no staff on duty in the Assisted Living with valid certification. On at 12:40 p.m., the Administrator confirmed the staff schedule does not indicate which staff has certification so staff would not know who to call if a resident is found unresponsive or having sudden to perform . The Administrator stated she was not aware the certificates provided for certification completed on for Staff C and Staff L was done online and confirmed they would not meet regulation requirements, and that Staff C and Staff L currently do not have valid certification. On at 11:20 a.m., the Administrator stated she knows staff need to have certification from the American Red Cross Association as it is	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966425	A. BUILDING: _____ B. WING _____	04/06/2023

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INN AT ASTON GARDENS AT PELICAN POINTE (THE)	9000 IBIS WAY VENICE, FL 34292

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A 030	Continued From page 13 an accredited association for training staff of assisted living facilities (ALF), She confirmed the certification for Staff D, F, and K was not from American Red Cross Association and was not valid for ALFs and did not meet regulations. Class I	A 030		
A 077 SS=J	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.	A 077		

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
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A 077	Continued From page 14 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [illegible] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not	A 077		

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A 077	Continued From page 15 to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator	A 077		

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A 077	Continued From page 16 form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review, and interviews, the facility's Administrator failed to perform her duties as required. The Administrator failed to ensure staff follow policy and procedures for residents with no ( ) and honor residents wishes to have performed for 1 (#1) of 2 residents reviewed. (Refer to A0030 Residents care- Rights and facility procedures). The Administrator failed to ensure a staff member who has completed a course in - ( ) and First Aid and holds a currently valid card is in the facility at all times for 7 (Administrator, Staff A, B, C, D, F, L,) of 10 employee records reviewed. The failure of the Administrator to ensure systems were in place and being followed to ensure staff follow policies and procedures and honor resident's rights for , created a likelihood of serious harm to the current residents at the facility. The findings included: Reviewed job description for Executive Director, signed and dated indicating having read and understand the contents of the position description, and understand the responsibilities, requirements and duties expected. Assisted Living (AL) Administrator Position Description Summary: Plans and directs all day-to-day functions of the Assisted Living Facility	A 077		

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A 077	Continued From page 17 in accordance with applicable company, federal, state, and local standards to promote that the highest degree of quality care is provided to its residents. Essential duties and Responsibilities: Plans, organizes, develops, and leads the overall operation of Assisted Living in accordance with federal, state, and local laws... Prior to move-in, coordinates the health care needs with the Director of Health and Wellness ... Interprets the Assisted Living facility's standards and guidelines to team. members, residents, family members, visitors, government agencies, etc. as required and ensures they are followed ... Ensures that an adequate number of appropriately trained professional and auxiliary personnel are on duty at all times to meet the needs of the residents ... Develops a through working knowledge of current and evolving state laws and regulations and procedures dictated for residents and ensures compliance. Review of the clinical record revealed Resident #1 was an [redacted] female admitted to the facility on [redacted], with diagnoses including [redacted], gait disturbance, [redacted], iron deficiency [redacted], and [redacted] of right [redacted]. A valid Durable Health Care Power of Attorney (POA) was executed on [redacted] appointing Resident #1's son as the health care agent. Documentation of Health Care Treatment Instructions In The Event Of End- Stage Medical Condition Or Permanent [redacted] signed [redacted] indicated Resident #1 wanted [redacted]. Review of facility incident report dated [redacted] revealed at approximately 6:10 a.m. Staff A	A 077		

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A 077	Continued From page 18 (caregiver) was making rounds and entered Resident #1's room when there was no answer to her knocking, and found the resident lying in the bed, her ⌄ hung over the side of the bed, and unresponsive. Staff A did not immediately initiate . Staff A called Staff B (caregiver) and they both entered the room at 6:20 a.m., Staff B entered the room and observed Resident #1 and rubbed her ⌄ which was . . . . Staff B called Staff C (caregiver). Staff B did not initiate . Staff C entered the room and instructed Staff B to call the administrator. Staff C did not initiate . Staff B called the administrator at 6:25 a.m. and was instructed to call 911. On at 9:59 a.m., in an interview, Staff B said Staff A came and got her to come to Resident #1's room as she was making rounds and found the resident in her room unresponsive. Staff B said she entered the room, called Resident #1's name with no answer, she rubbed her ⌄ which was , and her skin was pale. Staff B said she called Staff C into the room and was instructed by Staff C to call the Administrator. Staff B stated she called the administrator at 6:25 a.m. and notified her Resident #1 was found unresponsive, and the Administrator instructed her to call 911. Staff B stated the Administrator did not instruct her to initiate . . , and she saw no in Resident #1's room and did not check her chart to verify if there was one. Staff B confirmed she did not initiate or use the facility Automated External Defibrillator (. . . .) machine, and stated she never received training on using the . . . machine. On . . . . . at 10:30 a.m., in an interview, the Administrator stated she received a telephone call on . . . at 6:25 a.m. from Staff B informing her that Resident #1 was found unresponsive and	A 077		

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A 077	Continued From page 19 were . . . The Administrator said she instructed Staff B to call 911. The Administrator stated she did not instruct Staff B to initiate , and confirmed Staff A, B, and C should have initiated . On at 11:00 a.m., in an interview, Staff C stated she was called to Resident #1's room by Staff B informing her the resident was unresponsive and her was cool to touch. Staff C stated while in the room she observed that Resident #1 was not breathing and her was open, and she instructed Staff B to call the Administrator. Staff C stated the facility policy requires staff to initiate if a resident is found unresponsive and does not have ( ) and Resident #1 did not have a . Staff C confirmed she did not initiate or use the facility machine. On at 11:30 a.m., in an interview, Staff A stated her certification had expired prior to her start of employment at the facility. Staff A stated on the morning of about 6:10 a.m. while making rounds she arrived Resident #1's room and knocked with no answer, she entered the room and called to the resident, still no answer. Staff A observed Resident #1 hanging off the bed and she was unresponsive. Staff A stated she called Staff B who came to the room and called to Resident #1 with no answer and rubbed her with no response. Staff A said Staff B called for Staff C, who came to the room and looked at Resident #1 and told Staff B to call the Administrator. Staff A confirmed she did not initiate when she found Resident #1, she said "I was so nervous and was still new to the facility that's why I called the other caregiver." Staff A said she did not know if Resident #1 had a and she did not have training on the	A 077		

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A 077	Continued From page 20 facility . . . Staff A stated no one instructed her to initiate or use the facility machine when she found Resident #1. On at 11:47 a.m., in an interview, Staff D (caregiver) stated Resident #1 did not have a and was a full code and Staff should have initiated when they found Resident #1 unresponsive. Review of personnel records for Staff A revealed a hire date of . There was no documentation of certification on file for Staff A. Record review for Staff B revealed a hire date of . Staff B's file contained documentation of certification completed on with an expiration date of . Record review for Staff C revealed a hire date of . Staff C's file contained documentation of certification completed on with an expiration date of . Further review revealed documentation of completed online on which did not meet the regulations and is not valid for ALF. Record review for Staff D revealed a hire date of . Staff D's file contained certification completed on through National Foundation, indicating the course was administered in accordance with the 2020 ECC/ILCOR and AHA guidelines, which did not meet the regulations and is not valid for ALF. Record review for Staff F revealed a hire date of . Staff F's file contained certification completed on through National Foundation, indicating the course was administered in accordance with the 2020 ECC/ILCOR and AHA guidelines, which did not meet the regulations and is not valid for ALF. Record review for Staff K revealed a hire date of . Staff K's file contained certification completed on through National	A 077		

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A 077	Continued From page 21 Foundation, indicating the course was administered in accordance with the 2020 ECC/ILCOR and AHA guidelines, which did not meet the regulations and is not valid for ALF. Review of the Administrators file revealed a hire date of . The Administrators file contained no evidence of documented completion of . Record review for Staff L revealed a hire date of , Staff L's file contained documentation of certification completed on with an expiration date of . Further review revealed documentation of completed online on which did not meet the regulations and is not valid for ALF. On at 3:44 p.m., the Administrator stated on Staff F was on duty and had certification in . The Administrator confirmed that none of the employees who were involved when Resident #1 was found unresponsive had a valid card and can give no explanation as to why they did not notify Staff F as he was the staff member on duty that had certification. On at 4:34 p.m., in an interview, Resident #1's son (POA for healthcare) stated his mom had a Living Will and it documented wanting as her wish. His expectations would be for the facility to perform when needed. On at 8:38 a.m., in an interview, Staff F stated he is certified, and only works in the memory care unit of the facility. Staff F said he worked on the night of and left on the morning of at about 6:45 a.m. He said while on duty he received no call from facility staff about Resident #1 being found unresponsive. Staff F stated if he finds a resident unresponsive he is not sure what to do. He said he would contact the supervisor. He said he has not	A 077		

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A 077	Continued From page 22	A 077		

received training on the facility policies and procedures on what to do if he finds a resident unresponsive. He said he has not received training on the facility machine and has never been shown where the machine is located. He said he does not know which residents have and which residents are full code. Staff F did not recognize the term and said he does not know which of his coworkers are certified in .

A review of the Staffing Schedule for to revealed that on , , and no designated staff with were on duty for 6:00 a.m. - 2:30 p.m. and 10:00 p.m. - 6:30 a.m. shifts. On no designated staff with were on duty for the 2:00 p.m. - 10:30 p.m. and 10:00 p.m. - 6:30 a.m. shifts. On no designated staff with were on duty for 10:00 p.m. - 6:30 a.m. shift. Further review found only 5 of 21 current "Care Team" staff have valid documentation on file. On and , night shift (10:00 p.m. to 6:30 a.m.) the only certified staff member in the facility was Staff F. Review of the employee records for Staff D, F, and K revealed certification documentation from National Foundation which did not meet regulation requirements as it was not done by American Red Cross Association, leaving only 3 of 21 current care team staff with valid certification on file.

On at 9:19 a.m., in an interview, Staff G (caregiver) said she did not receive training on the facility machine and does not know and has not received any training for what to do if she finds a resident unresponsive. Staff G said she does not know which residents in the facility are full code or have and she does not know which of the caregivers on her shift are certified in

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A 077	Continued From page 23 . and would not know who to call if she found someone unresponsive. She stated the staff schedule is posted in the wellness center for the Assisted Living and in the Memory Care unit at the nurses' station and does not indicate which staff have certification. On at 9:24 a.m., in an interview, Staff H (caregiver) stated she is not trained in . and has not received training on the facility machine. Staff H asked, "what is an . . . machine?" Staff H states she did not receive training on . . or what to do if she finds a resident unresponsive. She said she does not know which staff on her shift have . . . Staff H said the staff schedule is in the nurses' station but does not indicate who has . . On . . . at 9:31 a.m., Staff B stated when Resident #1 was found unresponsive and she called the Administrator, the Administrator never instructed her to initiate or check for for Resident #1. Staff B stated she does not know which team members have and did not know Staff F, who was in the Memory Care unit, had and/or to call him, she just called Staff C and then the administrator. Staff B stated the employee schedule is posted in the wellness center and does not indicate which team member has and she does not know who has on her shift. On . . . . at 9:54 a.m., Administrator reviewed employee schedule and confirmed no staff members scheduled for . . . . . , ... , ... for 6:00 a.m. - 2:30 p.m. and 10: 00 p.m. - 6:30 a.m. shifts, on . . . . . for 2:00 p.m. - 10:30 p.m., 10:00 p.m. - 6:30 a.m. shifts and on for 10:00 p.m. - 6:30 a.m. shift with valid certification. The Administrator confirmed with Staff F in the	A 077		

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A 077	Continued From page 24 Gardens (memory care) there would have been no staff on duty in the Assisted Living with valid certification. On at 1:00 p.m., Administrator confirmed the Staff Schedule does not indicate which staff have certification, so staff would not know who to call if a resident is found unresponsive or having sudden to perform . The Administrator stated she was not aware the certificates provided for certification completed on for Staff C and Staff L was done online, and confirmed they would not meet regulation requirements and Staff C and Staff L currently still has no certification. On 11:20 a.m., Administrator stated she knows staff need to have certification from the American Red Cross Association as it is an accredited association used for assisted living facilities (ALF), She confirmed the certification for Staff D, F and K was not from American Red Cross Association and was not valid for ALFs and did not meet regulations. Class I	A 077		
A 081 SS=G	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the	A 081		

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(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 081	Continued From page 25	A 081		

needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record.

(7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.

59A-36.011
(2) STAFF PRESERVICE ORIENTATION.
(a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1).
(b) New staff must complete the preservice orientation prior to interacting with residents.
(c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record.
(d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:
1. Resident's rights; and,
2. The facility's license type and services offered by the facility.
(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or

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
	AL11966425	A. BUILDING: _____ B. WING _____	04/06/2023

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INN AT ASTON GARDENS AT PELICAN POINTE (THE)	9000 IBIS WAY VENICE, FL 34292

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A 081	Continued From page 26 arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [illegible] borne [illegible], may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident [illegible], neglect, and [illegible]. The facility must use its [illegible] prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the	A 081		

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A 081	Continued From page 27 following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure staff receive and attend 2-hour preservice orientation training that covers topics including resident rights to help provide responsible care and help provide for the needs and wishes of the residents for 8 (Staff, A, B, F, G, H, I, J, K) of 10 records reviewed. The findings included: Review of the Facility Policies and Procedures Advance Directives Policy: It is the policy of the facility to advise all new residents of the importance of Advance Directives upon admission. Generally, advance Directives are the	A 081		

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A 081	Continued From page 28 instructions by or desires of the principal concerning any aspect of the principal's healthcare, including, the designation of a health care surrogate, a living will or an anatomical gift. 6. Facility staff will honor the resident's Advance Directives to the best extent possible within the limits of the state law. A valid Durable Health Care Power of Attorney (POA) was executed on appointing Resident #1's son as the health care agent. Documentation of Health Care Treatment Instructions In The Event Of Medical Condition Or Permanent signed indicated Resident #1 wanted ( ). Review of facility incident report dated revealed at approximately 6:10 a.m. Staff A (caregiver) was making rounds and entered Resident #1 room when there was no answer to her knocking, and found Resident #1 lying in the bed, her hung over the side of the bed, and unresponsive. Staff A did not immediately initiate . Staff A called Staff B (caregiver) and they both entered the room at 6:20 a.m., Staff B entered the room and observed Resident #1 and rubbed her which was . Staff B called Staff C (caregiver). Staff B did not initiate . Staff C entered the room and instructed Staff B to call the administrator. Staff C did not initiate . Staff B called the administrator at 6:25 a.m. and was instructed by the Administrator to call 911. The Administrator did not instruct Staff B to initiate and/or use the Automated External Defibrillator ( ) machine. Staff A, B, and C did not initiate or use the Machine. Review of personnel records for Staff A (caregiver) revealed a hire date . Staff A's	A 081		

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A 081	Continued From page 29 file contained a certificate with an agenda for 2-hour preservice orientation completed on .. .... the agenda did not include the topic of resident rights. Record review for Staff B (caregiver/med tech) revealed a hire date of .. .. Staff B's file contained a certificate of completion for 2-hour preservice orientation completed online on , the agenda did not include the topic of resident rights. Record review for Staff F (caregiver/med tech) revealed a hire date of . Staff F's file contained a certificate of completion for the 2-hour preservice orientation completed online on , the agenda did not include the topic of resident rights. Record review for Staff G (caregiver) revealed a hire date of .. .. Staff G's file contained a certificate of completion for 2-hour preservice orientation completed online on .. ...., the agenda did not include the topic of resident rights. Record review for Staff H (caregiver) revealed a hire date of .. .. Staff H's file contained no evidence of preservice orientation on file. Record review for Staff I (caregiver/med tech) revealed a hire date of .. .. Staff I's file contained no evidence of preservice orientation on file. Record review for Staff J (caregiver) revealed a hire date of . Staff J's file contained a certificate of completion for 2-hour preservice orientation completed online on , the agenda did not include the topic of resident rights.	A 081		

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A 081	Continued From page 30 Record review for Staff K (caregiver) revealed a hire date of . Staff K's file contained a certificate of completion for 2-hour preservice orientation completed online on , the agenda did not include the topic of resident rights. On at 4:34 p.m., in an interview, Resident #1's son (POA for healthcare) stated his mom had a living will which documented wanting as her wish. His expectations would be for the facility to perform when needed as she wished. On at 12:40 p.m., the Administrator stated for new hires the preservice orientation training is completed online through myalf.com. The Administrator stated the staff follow the training that is given online, which consists of videos, and quizzes after the training modules. The administrator said she does not know if the online training teaches about the right for if the resident wishes to have it. The Administrator confirmed the 2-hour preservice orientation is completed online and she does not know if the preservice training includes resident's rights, and confirmed the training provided online is not specific to her facility. On at 12:55 p.m., the Administrator stated most of the training for the staff is done online through myalf.com. She reviewed the preservice certificates and confirmed it does not list on the agenda resident rights as being discussed or taught during the online training. Class II	A 081		
A 083 SS=G	59A-36.011(5) FAC Training - First Aid and	A 083		

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A 083	Continued From page 31 (5) FIRST AID AND . . . . . ( ). A staff member who has completed courses in First Aid and . and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American . . Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a staff member who has completed a course in - , ... (.) and First Aid and holds a currently valid card is in the facility at all times. There was not a staff member . certified on duty for 9 of 18 shifts reviewed for the six days of . . . . through . . . . . Of the 10 employee records reviewed only 3 staff members had valid . training. The findings included: Emergency Situations Policy Revised . Policy: All 911 emergencies are responded to in	A 083		

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A 083	Continued From page 32 the appropriate manner maintaining the well-being of each resident. 2. If a [illegible] does not exist, begin [illegible] as indicated. NOTE: the team member beginning [illegible] must be certified. 3. Once [illegible] is initiated, it must not stop until Emergency Medical Personnel are present. Review of the Facility Policies and Procedures Advance Directives Policy: It is the policy of the facility to advise all new residents of the importance of Advance Directives upon admission. Generally, advance Directives are the instructions by or desires of the principal concerning any aspect of the principal's healthcare, including, the designation of a health care surrogate, a living will or an anatomical gift. 6. Facility staff will honor the resident's Advance Directives to the best extent possible within the limits of the state law. A valid Durable Health Care Power of Attorney (POA) was executed on [illegible] appointing Resident #1's son as the health care agent. Documentation of Health Care Treatment Instructions In The Event Of [illegible] Medical Condition Or Permanent [illegible] signed [illegible] indicated Resident #1 wanted [illegible] ([illegible]). Review of facility incident report dated [illegible] revealed at approximately 6:10 a.m., Staff A (caregiver) was making rounds and entered Resident #1 room when there was no answer to her knocking, and found the resident lying in the bed, her [illegible] hung over the side of the bed, and unresponsive. Staff A did not immediately initiate [illegible]. Staff A called Staff B (caregiver) and they both entered the room at 6:20 a.m. Staff B entered the room and observed Resident #1 and	A 083		

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A 083	Continued From page 33	A 083		

rubbed her , which was . Staff B called Staff C (caregiver). Staff B did not initiate . Staff C entered the room and instructed Staff B to call the administrator. Staff C did not initiate . Staff B called the administrator at 6:25 a.m. and was instructed by the Administrator to call 911. Administrator did not instruct Staff B to initiate and/or used the Automated External Defibrillator ( ) machine, Staff A, B, and C did not initiate or use the Machine.

Review of personnel records for Staff A revealed a hire date of . There was no documentation of certification on file for Staff A.

Record review for Staff B revealed a hire date of . Staff B's file contained documentation of certification completed on with an expiration date of .

Record review for Staff C revealed a hire date of . Staff C's file contained documentation of certification completed on with an expiration date of . Further review revealed documentation of completed online on which did not meet the regulations and is not valid for Assisted Living Facilities (ALF).

Record review for Staff D revealed a hire date of . Staff D's file contained certification completed on through National Foundation, indicating the course was administered in accordance with the 2020 ECC/ILCOR and AHA guidelines, which did not meet the regulations and is not valid for ALF.

Record review for Staff F revealed a hire date of . Staff F's file contained certification completed on through National

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A 083	Continued From page 34 Foundation, indicating the course was administered in accordance with the 2020 ECC/ILCOR and AHA guidelines, which did not meet the regulations and is not valid for ALF. Record review for Staff K revealed a hire date of . . . . . Staff K's file contained . certification completed on through National Foundation, indicating the course was administered in accordance with the 2020 ECC/ILCOR and AHA guidelines, which did not meet the regulations and is not valid for ALF. Review of the Administrators file revealed a hire date of . . . . . The Administrators file contained no evidence of documented completion of . Record review for Staff L revealed a hire date of . . . . , Staff L's file contained documentation of certification completed on with an expiration date of . . . . . Further review revealed documentation of completed online on . . . . . which did not meet the regulations and is not valid for ALF. On at 3:44 p.m., Administrator confirmed on . . . . . staff A, B, C, and F were on duty and had no valid certification in at the time Resident #1 was found unresponsive and did not use the machine. On at 4:34 p.m., in an interview, Resident #1's son (POA for healthcare) stated his mom had a living will which documented wanting as her wish. His expectations would be for the facility to perform . when needed. On at 8:38 a.m., in an interview, Staff F stated if he finds a resident unresponsive he is not sure what to do but would contact the	A 083		

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A 083	Continued From page 35 supervisor, has not received training on the facility machine, and has never been shown where the machine is located. He said he does not know which residents have and which residents are full code. Staff F asked, "what is a ?" and said he does not know which of his coworkers are certified in . A review of the Staffing Schedule for to revealed that on , , and no designated staff with were on duty for 6:00 a.m. - 2:30 p.m. and 10:00 p.m. - 6:30 a.m. shifts. On no designated staff with were on duty for the 2:00 p.m. - 10:30 p.m. and 10:00 p.m. - 6:30 a.m. shifts. On no designated staff with were on duty for 10:00 p.m. - 6:30 a.m. shift. Further review found only 5 of 21 current "Care Team" staff have valid documentation on file. On and , night shift (10:00 p.m. to 6:30 a.m.) the only certified staff member in the facility was Staff F. Review of the employee records for Staff D, F, and K revealed certification documentation from National Foundation which did not meet regulation requirements as it was not done by American Red Cross Association, leaving only 3 of 21 current care team staff with valid certification on file. On at 9:19 a.m., in an interview, Staff G (caregiver) said she did not receive training on the facility machine. She said she has not received any training on what to do if she finds a resident unresponsive. Staff G stated she does not know which residents in the facility are full code or have , does not know which of the caregivers on her shift are certified in and would not know who to call if she found someone unresponsive. She stated the staff schedule is posted in the wellness center for the	A 083		

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A 083	Continued From page 36 Assisted Living and in the Memory Care unit at the nurses' station and does not indicate which staff have certification. On at 9:24 a.m., in an interview, Staff H (caregiver/med tech) stated she is not trained in and has not received training on the facility machine, Staff H asked, "what is an machine?" Staff H stated she did not receive training on , or what to do if she finds a resident unresponsive. She said she does not know which staff on her shift have certification. Staff H said the staff schedule is in the nurses' station but does not indicate who has certification. On at 9:31 a.m., Staff B stated she does not know what team members have and stated the employee schedule is posted in the wellness center and does not indicate which team member has and she does not know who on her shift has . On at 9:54 a.m., the Administrator reviewed employee schedule and confirmed no staff members scheduled for , , for 6:00 a.m. - 2:30 p.m. and 10: 00 p.m. - 6:30 a.m. shifts, on for 2:00 p.m. - 10:30 p.m., 10:00 p.m. - 6:30 a.m. shifts and on for 10:00 p.m. - 6:30 a.m. shift with valid certification. The Administrator confirmed with Staff F in the Gardens (memory care) there would have been the staff member on duty in the Assisted Living with valid certification. On at 1:00 p.m., the Administrator confirmed the staff schedule does not indicate which staff members have certification, so staff would not know who to call if a resident is found unresponsive or having sudden	A 083		

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A 083	Continued From page 37 . . . . to perform . . . The Administrator stated she was not aware the certificates provided for . certification completed on . . . . for Staff C and Staff L was done online, and confirmed they would not meet regulation requirements and Staff C and Staff L still don't have valid certification. On . . . . . 11:20 a.m., the Administrator stated she knows staff need to have certification from the American Red Cross Association as it is an accredited association used for assisted living facilities (ALF). She confirmed the . certification for Staff D, F and K was not from American Red Cross Association and was not valid for ALFs and did not meet regulations. Class II	A 083		