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
	AL11969307	A. BUILDING: _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARLING AT NOCATEE	999 CROSSWATER PARKWAY PONTE VEDRA, FL 32081

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A 000	Initial Comments A complaint investigation (complaint #2024014316) was conducted at Starling at Nocatee from 10/30/24-10/31/24. The facility had deficiencies identified at the time of the survey, including Class I findings related to the provision of CPR.	A 000		
A 030	59A-36.007(5) FAC; 429.28(1-2) 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; Disability Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Abuse Hotline, 1(800)96-ABUSE or 1(800)962-2873. The telephone numbers must be posted in close	A 030		

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A 030	Continued From page 1	A 030		

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. Alcohol and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident abuse, neglect, and exploitation;
6. Administrative and housekeeping schedules and requirements;
7. Infection 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 restraints.
(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), 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

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A 030	Continued From page 2 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 abuse 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, 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	A 030		

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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 appointments for health care services, the provision of or arrangement of transportation to health care appointments, 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 incapacitated, the guardian shall be given at least 45 days' notice of a nonemergency 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

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A 030	Continued From page 4 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 restraint, 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, obligations, 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 Abuse Hotline operated by the Department of Children and Families, and, if applicable, Disability 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 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	A 030		

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A 030	Continued From page 5 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 Abuse Hotline operated by the Department of Children and Families, and Disability 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 incompetent or incapacitated 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 and interviews, the facility failed to honor the right to adequate and appropriate healthcare when a resident without a Do Not Resuscitate Order (DNRO) was found unresponsive and staff failed to perform Cardiopulmonary Resuscitation (CPR). The facility's failure to honor code status choices placed all other residents at risk of not having their advanced directives honored.	A 030		

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A 030	Continued From page 6 The findings include: Records indicated that Resident #1 was admitted to the facility 02/10/21 and died at the facility on 9/27/24. Diagnoses included, but not limited to: Alzheimer's disease, unspecified abnormalities of gait and mobility, ataxic gait, needs for assistance with personal care, hydrocephalus, and cognitive communication deficit. Review of Resident #1's Health Assessment for Assisted Living Facilities (Form 1823) dated 10/29/21 indicated that Resident #1 was alert and oriented to person and place, but noted to have short term memory loss . He required assistance with ambulation, toileting, bathing, dressing, self-care eating and transferring. He used a two wheeled walker for ambulation with standby assistance. Resident #1 also required assistance with self-administration of medication and was at risk of falls. Photographic evidence obtained. A witness statement authored by Employee D, Activities Assistant, dated 10/7/24 noted that a little after 5:00 pm on 9/27/24, she went to Resident's #1 room and asked him if he wanted to eat. Resident #1, said, "yes." Employee D then helped him sit up on the edge of the bed and put his shoes and socks on. When she attempted to help him stand, Resident #1 seemed very weak and out of breath. She assisted him back to bed and removed his shoes and covered him up. She proceeded to the nurses' station and notified Employee C, an LPN, about the situation. A progress note authored by Employee C, Licensed Practical Nurse (LPN) on 10/2/24 at 10:32am, indicated she was made aware that Resident #1 did not want to go to the dining area	A 030		

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A 030	Continued From page 7 to eat dinner and he seemed to have shortness of breath. Upon entering his room, Resident #1 was laying down in his bed. Vital signs were completed, and the resident was asked if he was going to dinner, but he stated he wasn't hungry. Caregivers were informed to save his food as he may want it later. The date and time of the progress note was 9/27/24 at 5:30pm, but was not authored by Employee C until 10/02/24. The header of the note asked the code status, which was documented as "Resuscitate." Photographic evidence obtained. In an interview with Employee C on 10/30/24 at 2:07 pm, she stated she had been in the facility for about a year. She explained that as a nurse she was supposed to document any incidents as soon as they happened, and clarified that the nurses do not do bedside reports, but they should report any incidents and occurrences for the day. When asked what she would do if notified that a resident was unresponsive, she stated that she would assess resident, identifying the code status. DNR forms are behind resident doors. If no DNR was located, she would initiate CPR and call for additional help. She was then asked if she would delegate CPR task, she said, "I would at least start the CPR as I find who else has the certification" and ask someone to call 911. When asked about Resident #1's functional status, she explained he was, "alert x1 and ambulated with a walker. He always complained of tiredness and preferred to stay at the couch in the living area watching TV with his leg elevated." On 9/27/24, she was called to the resident's room because he was weak. She went and assessed the resident; vital signs were normal, and the resident stated he wanted to wait for the wife so they could have dinner together. She said that she did not document the incident because there was nothing	A 030		

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A 030	Continued From page 8	A 030		

out of the ordinary for the resident. She mentioned that she was called later that night because the resident had expired and asked to write a report.

Employee B, LPN, authored a progress note on 10/02/24 at 8:49 pm. It indicated she was called to Resident's #1's room for an emergency 9/27/24. Upon entry to the room, she observed Resident #1 on the floor beside his bed, legs raised, and arms clenched at his chest. Resident #1 was, "unresponsive to touch and did not appear to be breathing." Employee B called 911 and Emergency Medical Services (EMS) staff arrived within 5 minutes and pronounced resident dead on arrival. Nothing was documented about initiating CPR. The header of the note also asked the code status, which was documented as "Resuscitate." Photographic evidence obtained.

In an interview on 10/30/24 at 2:26 pm, the Administrator stated that she received a phone call from Employee B around 7:00 pm on 9/27/24 stating that Resident's #1's family had found the resident on the floor around 6:45 pm. The Administrator then went to the facility around 7:30pm and initiated investigation. She explained that Employee A was the unlicensed caregiver assigned to the resident and was the first staff to see the resident on the floor. Employee A contacted Employee B, the nurse on duty, who went immediately to the room. Employee B asked Employee A to conduct CPR as she went to contact 911. Employee A did not perform CPR as instructed. EMS arrived at approximately 7:15 pm and they did not initiate CPR, and Resident #1 was pronounced dead. She confirmed that both Employees A and B did not perform CPR.

When was asked for the facility's actions after the

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A 030	Continued From page 9 incident, she outlined the following: Employee A failed to conduct rounds during the change of shift per facility policy, and failed to perform CPR. She was suspended, then terminated on 10/6/24. Staff who worked on the memory care unit were inserviced on the facility's expectation and policies related to CPR. Advanced Directives, and abuse/ neglect were reviewed. The Administrator was again asked about Employee B, and she said, "she did not do anything wrong. She went to call 911 and delegated the CPR to the unlicensed caregiver who had a current CPR certification." She added, "she just made a bad judgement call." She also confirmed that she had not reported staff's neglect of their duties to the Department of Children and Families (DCF). Review of the policy and procedure titles Abuse, Neglect and Exploitation, Policy Number: A0150, Effective Date: 08/01/2019, showed the facility defined neglect as, "not receiving help needed to keep physically or mentally healthy; is at risk of harm or decreased function or health. Not administering treatment or medications, etc." The policy further stated allegations were to be reported to DCF and as needed. to the Department of Health's Licensing Authority (i.e board of nursing , board of physicians etc). Photographic evidence obtained. Review of the staff's in-service dated 10/2/24 revealed that only seven (7) staff signed in as having received the education. Employee B had not yet received any of the post-incident inservice training as of the time of the survey. Review of the schedule showed that on 10/02/24, the facility had 9 staff working. In October 2024, 31 direct care staff were scheduled to work. Photographic evidence obtained.	A 030		

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A 030	Continued From page 10 The facility's Resident Rights Policy, Number: A0028, Effective Date: 08/01/2019 revealed the facility, "Shall maintain Resident Care Standards in a manner consistent and in compliance with the minimum standards required by current statute and rule." The policy included information that residents were to, "Live in a safe and decent environment, free from abuse and neglect" and have "Access to adequate and appropriate health care consistent with established and recognized standards within the community." Photographic evidence obtained. Class I	A 030		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable disease. The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative tuberculosis examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of tuberculosis testing materials satisfies the annual tuberculosis examination requirement. An individual with a positive tuberculosis test must	A 078		

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A 078	Continued From page 11 submit a health care provider's statement that the individual does not constitute a risk of communicating tuberculosis. 2. If any staff member has, or is suspected of having, a communicable disease, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable disease. (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility contracting to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be	A 078		

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A 078	Continued From page 12 conducted for staff, including staff contracted by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure there was at least one staff member present at all times who had completed the approved course in Cardiopulmonary Resuscitation (CPR). As of 10/30/24, 51 of 95 total residents were full code. The facility's failure to ensure staff carried through with their duties put other residents who were full code at risk for serious harm and/or death should there be a need to initiate life-saving procedures. The findings include: Review of the facility's policy number A0075 titled "First Aid and CPR", Effective 08/01/19, revealed "the facility would maintain staffing standards in a manner consistent and in compliance with the minimum standards required by current statute and rule." Procedures included having "a staff member who has completed courses in First Aid and CPR and hold a currently valid card documenting completion of such courses must be in the facility at all times." The policy mandated that staff needed CPR certification that required the student to "demonstrate, in person, that he or she is able to perform CPR." The instructor of the program was to have been approved to provide CPR training by "the American Red Cross, the American Heart 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."	A 078		

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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 078	Continued From page 13 Employee record review of Employee A, Unlicensed Caregiver, revealed she received CPR certification on 09/03/24. Employee G, LPN, had CPR certification on file dated 05/10/23. Both had received CPR Certification online through NationalCPRFoundation. Photographic evidence obtained. Review of the National CPR Foundation's website accessed 10/30/24 at 11:00 am read, "Our accredited courses are strictly designed to be the most efficient way to earn your certification from the comfort of your home or office, in as little as 20 minutes. *Our training is based on the cognitive component. Check with your employer if you require a hands-on or skills-check component." The Frequently Asked Questions section further clarified, stating, "Do you offer hands-on training/" with a response that read, "No, we do not offer hands-on training. If your employer has requested you to receive hands-on training or a skills check, please visit CPRnearMe.com." Photographic evidence obtained. Employee B, LPN, had CPR certification on file dated 04/26/24 from the Red Cross. The card read, "1-year Provisional Certification for Adult and Pediatric First Aid/CPR/AED. The skills portion must be taken within 1-year of completing the online course to receive a 2-year Red Cross certification." Photographic evidence obtained. There was no evidence in the file to show the skills portion was completed. The nursing summary note created on 10/02/24 at 8:49 pm and authored by Employee B indicated that staff called writer to Resident's #1 room for an emergency on 9/27/24. Upon entry to	A 078		

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	AL11969307	A. BUILDING: _____ B. WING _____	10/31/2024

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A 078	Continued From page 14 residents' room, resident observed was on the floor beside his bed, legs raised, and arms clenched at his chest. Resident #1 was unresponsive to touch and did not appear to be breathing. Writer placed call to 911. Emergency Medical Services (EMS) staff arrived within 5 minutes and pronounced resident dead-on arrival (DOA). Photographic evidence obtained. Facility records indicated that Resident #1 was admitted to the facility 2/10/21 and discharged 9/27/24 (date of death). Diagnoses included, but not limited to: Alzheimer's disease, unspecified abnormalities of gait and mobility, ataxic gait, needs for assistance with personal care, hydrocephalus, and cognitive communication deficit. Review of Resident #1's Health Assessment for Assisted Living Facilities (Form 1823) dated 10/29/21 indicated that Resident #1 was alert and oriented to person and place, but noted to have short term memory loss . He required assistance with ambulation, toileting, bathing, dressing, self-care eating and transferring. He used a two wheeled walker for ambulation with standby assistance. Resident #1 also required assistance with self-administration of medication and was at risk of falls. Photographic evidence obtained. In an interview on 10/30/24 at 1:30 pm, Employee E, Unlicensed Caregiver, stated that she had worked in the facility for a year. She explained that upon reporting to work, the off-going and incoming staff are required to conduct a bedside report (room to room). She added that she always worked in memory care (MC) and residents are supposed to be checked and changed every 2 hours. She stated that all memory care residents are encouraged to eat in the dining area, but if a	A 078		

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A 078	Continued From page 15 resident refuses, the nurse is notified. When asked how to identify resident's code status, she said that residents that had executed a Do Not Resuscitate Order (DNRO) had the yellow form hanging at the back of the resident's room door. She was then asked what she would do if she found resident unresponsive. She said, "I would stay with the resident then contact the nurse or the Medication Technician (Med Tech) via walkie talkie." She added that she would then wait for directions from the nurse or the med tech. If she found a resident unresponsive that did not have a DNRO, she again said that she would contact the nurse or Med Tech. She added, "Caregivers must wait for the nurse to assess the resident. We are not allowed touch the resident until the nurse completes the assessment and the nurse would give directions on what to do." She added, "Caregivers are not required to have cardiopulmonary Resuscitation (CPR) certification. I don't have CPR certification myself". During the interview on 10/30/24 at 1:53 pm, Employee F, Unlicensed Caregiver, stated that she has been in the facility for three months. She explained that at the beginning of each shift both the incoming and off-going staff are supposed to conduct reports from room to room. When asked how she would identify resident code status, she said, "those with a DNR have a yellow paper behind the door". When asked what she would do when a resident was unresponsive, she stated that she would check behind the door if there was yellow paper, call the nurse and initiate CPR. When asked if she had a CPR certification, she said she did. She said she got CPR certified in a different county. When	A 078		

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A 078	Continued From page 16 provided with her trainings and asked to identify evidence of her CPR certification, she confirmed that it was not there. She was again asked if she would provide CPR, she said that she participated in the in-service at the facility a few weeks ago and staff were informed to initiate CPR. She confirmed that she was assigned to Resident #1 on 9/27/24. She explained that she saw the resident approximately 4:00 pm when he returned from a lunch outing with the son, and that was the last time she saw him. When asked if she provided report to the oncoming staff, she said, "yes, but we did not go room to room because I was running behind in completing my tasks." In an interview on 10/30/24 at 2:26 pm, the Administrator stated she received a phone call from Employee B around 7:00 pm on 9/27/24, stating that Resident's # 1's family had returned to the facility and found the resident on the floor around 6:45 pm. The Administrator went to the facility around 7:30pm and initiated investigation. She explained that Employee A was the Caregiver assigned to the resident and was the first staff to see the resident on the floor. Employee A contacted the on-duty nurse, Employee B, who went immediately to the room. Instead of initiating CPR herself, Employee B asked Employee A to, but Employee A did not perform CPR as instructed. EMS arrived approximately 7:15 pm and they did not initiate CPR, and Resident #1 was pronounced dead. When asked about the facility's policies, she stated one person per shift was required to be CPR certified. To ensure this requirement was achieved, she said the shift's nurse was required to have the CPR certification. The facility had a nurse scheduled around the clock, so it would	A 078		

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A 078	Continued From page 17	A 078		

ensure the requirement was met. When asked if the facility had any requirement as to where staff could obtain CPR certification, she said, "I would hope they get it from a reputable organization like American Heart Association (AHA) or Red Cross, however, the facility does not have any requirement or preference of a company as long as they have an active certification."

The Administrator was provided with the employment records for Employee A and B. She confirmed that CPR certification for both employees was obtained online, therefore, they did not meet the CPR skills requirement. She added that she would need to educate the business office manager on checking the CPR training credentials and contact the American Heart Association to conduct CPR class for staff.

Regarding documentation of incidents, she stated that all incidents should be documented as soon as the incident happens. She was asked about any documentation regarding Resident #1, she confirmed that it was done late. She said, "the employees were off and therefore documented on the next day that they were scheduled to work." The Administrator confirmed that she did not obtain a witness statement from Employee A.

Review of the facility's schedule and timesheets revealed that Employee B had worked 13 shifts after the incident on 9/27/24, and Employee G had worked 15 shifts. On the days they worked after the incident, these two nurses were the staff members on duty with CPR certification. Further review of the facility's November 2024 schedule revealed that Employee B and G were scheduled 14 and 15 shifts respectively. Employee G was scheduled to be the only nurse on her shifts. Employee B was scheduled to be the only nurse

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A 078	Continued From page 18 on all but two shifts (11/01 and 11/02). Photographic evidence obtained. Review of the job description for Employee A's Caregiver position, Revised September 2019, revealed the job entailed giving "hands on care, physical and emotional support to each resident while maintaining a safe and comfortable home like environment." The Essential Duties and Responsibilities listed on the job description included oversight of a "designated group of resident during shift" and maintaining knowledge of their whereabouts and performing physical checks. The Caregiver, "observes, reports and documents symptoms and conditions of the resident for changes in condition such as skin, behavior alertness, weight, dietary and participation in activities." Photographic evidence obtained. Review of the job description for Employee B's Wellness Nurse position revealed that essential duties and responsibilities of the nurse included but were not limited to, identifying what resident service needs were, and document any resident changes in condition. They were responsible for completing resident evaluations and were to communicate with families or responsible parties about changes in condition. The Wellness Nurse provides supervision to "Certified Nursing Assistants and other assigned to assure delivery of consistently high quality of care to residents" in accordance with the organization's policies and applicable laws. Photographic evidence obtained. Review of the Administrator's job description summarized the position as, "Responsible for the operation and management of the community in accordance with the standards and guidelines established by the Company, as well as	A 078		

Agency for Health Care Administration

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A 078	Continued From page 19 federal/state/local laws and regulations." Essential Duties and Responsibilities included Quality Assurance and Regulatory Compliance. The Administrator was to review incident reports and put timely corrective actions in place and ensure "ongoing training is delivered to team members." Photographic evidence obtained. Class I	A 078		