STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105443	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Venice	1026 Albee Farm Rd Venice, FL 34285

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37256 Based on observation, record review, resident and staff interviews, the facility failed to ensure adequate supervision to prevent the elopement of 1 (Resident #2) of 1 sampled resident who left the facility without staff knowledge. The findings included: Facility policy Elopement/Wandering Risk Guidelines Document Name N-1031, Revision date 8/1/2020 indicated: Patient/Residents to be evaluated on admission, re-admission, 7 days post admission, quarterly, with a significant change in condition, and elopement event using the risk tool. Review of the clinical record for Resident #2 revealed a re-admitted [DATE] post hospitalization . Diagnoses included alcohol withdrawal and delirium. The Admission Minimum Data Set (MDS) Assessment with a target date of 10/7/24 noted the resident's cognition was moderately impaired with a Brief Interview for Mental Status score of 10. The care plan initiated on 9/20/24 noted the resident was an elopement risk/wanderer related to disorientation to place, history of attempts to leave the facility unattended, and impaired safety awareness. The care plan noted Resident #2 wandered aimlessly and attempted to exit the front door and attempted to remove the wander alert device (alerts staff when a resident attempts to leave a designated safe area). Review of facility notes revealed a note from the Speech Therapist which read: Last encounter with patient on 10/24/24. Brief Cognitive Assessment Tool (BCAT) completed with score 47/50. Errors in orientation/day of week: alternating /divided attention. Significant improvement with confusion. According to BCAT scoring, pt (patient) presents without functional deficits and potential independent living. Patient anticipated going home so he could return to work and pay the bills. Improvement of cognitive skills was discussed with rehab manager. A score of 47 on the Brief Cognitive Assessment Tool (BCAT) indicates normal cognitive functioning. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Worker documented in a progress note for 10/24/24 an Interdisciplinary Team meeting was held. Resident #2 reported he was doing well but wanted to be discharged . She discussed that she would need to verify where he was going first due to initial confusion when he was admitted to the facility. The Social Worker documented in a progress note for 10/25/24 Resident #2 was at the Administrator's office discussing discharge. On 10/26/24 at 2:04 p.m., a nursing progress note documented Resident #2 was missing. He left the premises without authorization. Resident #2 was last seen around 11:30 a.m. when the nurse was passing medication. The nurse noted the resident had a wander alert device to the right leg and was at risk for elopement. The facility was locked in for head count. The manager on duty and Administrator were aware. Review of the facility investigation revealed on 10/26/24 between 8:00 a.m., to 9:30 a.m., Resident #2 asked a staff member to remove his wander alert bracelet. He was redirected to talk to the nurse. On 10/26/24 around 9:30 a.m., or 10:00 a.m., Resident #2 was seen on the facility phone making calls with his credit card in hand. Resident #2 was later seen walking in the hallways around 11:30 a.m. When staff went in to retrieve his tray after lunch he was noted to be missing. The sign-out log indicated Resident #2 had not signed out of the building. Search ensued including notifying the police but Resident #2 was not found. On Sunday 10/28/24 the Social Worker (SW) was able to contact a friend of Resident #2 who explained he had spoken to Resident #2 on Friday. Resident #2 told him he was being discharged on Saturday. On 10/28/24 Resident #2's emergency contact called the Social Worker and told her Resident #2 had a storage unit where he stores a Recreational Vehicle (RV). On 10/31/24 Resident #2 called the Social Worker and told her he was under the impression that he was discharged per his conversation with the Administrator on 10/28/24. He reported he was picking up a friend from the airport, getting his RV and driving to Virginia. On 11/5/24 at 11:30 a.m., in a telephone interview Resident #2 said he was fine, he was safe and was in Virginia where he lives. He said he thought he was discharged and wasn't sure if the miscommunication was on his part or the facility. He said he had no complaints against the facility, and they had been absolutely wonderful. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/5/24 at 11:45 a.m., in an interview the Social Worker said Resident #2 came to her several times wanting to be discharged . She explained on initial admission he was confused and couldn't give information on his family but they were able to look through his phone and found family in Virginia. She said at the time he was confused and thought he was in Virginia and was not ok to discharge at that time. She said the Friday before he left, he again asked about discharge, he was calm, stable, and his overall confusion level was significantly improved. He wasn't making confusing statements. She said she came in on Sunday, the day after he left, and was trying to contact family/friends to verify where he was. When she did finally speak with him, he told her he was picking up a friend from the airport, then going to get his RV and driving to Virginia. She said a family member did call to confirm that he did have an RV in a public storage facility and all the things he had told her was accurate. The Social Worker said they found the wander alert bracelet; Resident #2 had taken it off. He told her he had been waiting outside her door on Saturday to tell her he was leaving, but she didn't come in and he left. On 11/5/24 2:00 p.m., in an interview the receptionist on duty on 10/26/24 said Resident #2 came to her that day around 10:00 a.m., to 10:30 a.m. He asked who he may see to remove the wander alert bracelet. She advised him to talk to a nurse. She said he walked away and came back up front about 20-30 minutes later and asked for the Director of Nursing (DON), but she wasn't working. He said he was told it was the DON that was who removes it, and he went back into the facility. The Receptionist said she never saw him leave out the front door and she would have had to buzz him out. She said she would have recognized him as a resident as he had been up to the desk twice that morning. She said she was aware of the elopement book kept at the front desk. On 11/5/24 at 11:40 a.m., in an interview the Administrator said Resident #2 was very close to being discharged from the facility but had his own plan and followed his own plan. The Administrator said Resident #2 was his own person and did not lack capacity. He had an order for leave of absence with responsible party and he was his own responsible party. The only thing he did wrong was not signing out. The Administrator said he cut off the wander alert bracelet. He said the facility doors are alarmed. During the day the receptionist hits a button to let a person out. He said they did not know but maybe the receptionist let him out. Resident #2 was younger than most of the residents and looked like a regular person. He said it was possible the resident tailgated another person out of the facility.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 37256 Based on observation, resident and staff interviews, the facility failed to sufficient nursing staffing to ensure timely response to request for assistance for 3 (Residents #5, #6 and #7) of 3 sampled residents. The findings included: On 11/6/24 at 10:54 a.m., in an interview Certified Nursing Assistant (CNA) Staff A said the facility is often short staffed and Residents complain about call lights not being answered. On 11/6/24 at 12:45 p.m., Registered Nurse (RN) Staff B said she didn't think residents were getting the care they need. She said she felt the CNAs just didn't care. On 11/6/24 at 12:30 p.m., in an interview RN Staff C said the facility could always use more staff. She said she gave Administration credit as they are trying to hire, but the people stay two weeks and they leave. On 11/6/24 at 1:15 p.m., in an interview Resident #5 said when he presses his call bell there had been times no one comes and he's had to scream out in order to get someone to come. He said it had happened just within the last few days. He said it can be over an hour, if they come at all. On 11/6/24 at 12:15 p.m., Resident #6 and her husband were in her room. Both said even though Resident #6 had only been there a short time, it could take quite a bit of time for someone to answer the call light. On 11/6/24 at 2:50 p.m., Resident #7's daughter came out of the room requesting assistance for her father. She was redirected to a staff member near the nurse's station whom she was observed speaking with. On 11/6/24 at 2:55 p.m., in an interview Resident #7's daughter said her mother and father shared a room at the facility. She said her father was receiving hospice services and needed to be repositioned every two hours. A friend had been with them since 8:00 a.m., and no one came in to change her father until 1:00 p.m. The daughter also complained her mother's call light was not working and the light did not turn on when pressed. She said her mother suffered from dementia. A month she fell and had to crawl on the floor to get help. The daughter said the staff were overwhelmed and it can take up to 1.5 hours for someone to come and assist. The daughter said she was still waiting for someone to come and assist her father. On 11/6/24 at 3:02 p.m., four staff members wearing scrubs were observed speaking to each other in the hallway. The staff members walked away and did not enter Resident #7's room to provide the assistance requested. On 11/6/24 at 3:07 a staff member dressed in scrubs was observed coming down hall to retrieve supply cart near Resident #7's room. The staff member did not enter the resident's room. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/6/24 at 3:10 p.m., Registered Nurse (RN) Staff C was observed pushing her medication cart down the hall, past Resident #7's room. She placed the cart one door away from Resident #7's room and began passing medications. On 11/6/24 at 3:11 p.m., an aide walked slowly down hall past Resident #7's room and conversed with Staff C, then returned down hallway past Resident #7's room again. On 11/6/24 at 3:24 p.m., The Director of Nursing (DON) was observed entering the hallway. She spoke with Staff C. When the DON walked past Resident #7's room, the resident's daughter called her in the room. When the DON exited room, she was heard saying, I have to find (Maintenance Director's name) On 11/6/24 at 3:27 p.m., the Activity Director was observed entering and exiting Resident #7's room. The DON, Activity Director and Maintenance Director were observed in the hallway having a short discussion then leave. On 11/6/24 at 3:33 p.m., a Certified Nursing Assistant was observed going into Resident #7's room and provided the requested assistance. On 11/6/24 at 4:00 p.m., the DON said she had been employed at the facility about two weeks. She said she felt a good response time for call lights would be within five minutes. She said waiting 43 minutes for assistance was excessive. She said when she went in the room, the daughter told her the call light wasn't working and she contacted maintenance. She explained when pressed it would go off at the desk but the light outside the room was not working. She agreed then that when the daughter pressed the call light button it alerted at the nurses station, and no one responded. She said she would begin doing call light response audits.