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
	AL11953555	A. BUILDING: _____ B. WING _____	03/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH FLORIDA HOME SERVICES IN	140 NW 9 AVENUE MIAMI, FL 33128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number 2020001262) was conducted at South Florida Home Services, Inc. on , and concluded . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel	A 025		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain general awareness of the resident's whereabouts for two out of ten sampled residents (Resident # 1 and # 2). The facility also failed to contact their case manager and health care provider after Resident # 1 and # 2 had a significant change. Resident # 1 was found in a Crisis Stabilization Unit (CSU) 3 days after he had eloped from the facility. Additionally, Resident # 2 went missing twice before he was found as a John Doe on the streets after leaving the facility and suffered a . There was no evidence the facility had contacted their doctor or legal guardian after the residents were found to have been missing for more than 24 hours. Finding Included: 1) On at 9:05 am in # , during the tour of the facility, Staff B stated "This is where [Resident # 2] sleeps, the one that is still	A 025		

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A 025	Continued From page 2 missing. He comes in and out, but he comes every time. He told me that he was going to buy cigarettes at the bodega close by. He never came ". A review of Resident # 2's records showed he was admitted to the facility on and a health assessment completed on . Resident # 2 was diagnosed with , D Deficiency, Prostatic Hyperplasia, , and ( ). He was also diagnosed with Mild , and was independent in all his activities of daily living (ADL's). An additional review of Resident # 2's progress notes showed a note dated stating "The resident left the facility about 7:27am on the day 17 of , and didn't return at this time. The administrator made a missing report person about 11:27 am on the day 18 of ,". On at 11:56 am, the Administrator stated "The first time was on . He told [Staff B] he was going to the bodega and he never returned. This happened at like 8 am and [Staff B] called me at 11 am. I contacted the police at 11:22 am the next day. The police tell me that I have to wait 24 hours to file a missing person report. He came from [hospital] on . The police officer contacted his social worker and notified her that he was . I don't have the information on why he went to [hospital]. He went to jail then the hospital then came here". A second progress note dated stated "The [program] called the ALF to inform that the	A 025		

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A 025	Continued From page 3	A 025		

resident was found in jail, but don't have more details about the ". There was no further documentation showing the facility had attempted to contact Resident # 2's legal guardian or case manager to notify of his disappearance.

Furthermore, the Administrator stated "[Resident # 2] left on at around 10am - 11am. He signed out. Sometimes he leaves and comes at night at around midnight. He notified [Staff B] he was going to leave. [Staff B] unlocked the gate for him. [Staff B] told me like at mid day that he hasn't returned for lunch. Since he comes at night, I didn't do anything. Then the next day I called the police at 10:50 am and told them he left the day before and never came . The police came at around 11:30 am and did a missing person report. The police contacted the owner on Thursday and notified that the resident was at [hospital]".

There was no documentation showing the administrator nor the owner contacted Resident # 2's legal guardian caseworker to report Resident # 2 had been found at the hospital. There was also no evidence of Resident # 2 ever having signed out of the facility. There was also no documentation that showed Resident # 2 was re-assessed by a healthcare provider after being released from jail and the hospital.

On at 11:45am, Resident # 2's Case Manager from Dade county guardianship stated "We got an alert from the hospital requesting authorization and that's how we knew he was at [hospital]. How he got to [hospital], I don't know. I just know that he went to jail and we got notified from [hospital] ...The second time we found out through the ALF, but a week later. [Administrator] emailed me saying that he went missing from

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A 025	Continued From page 4 . . . . . and was trying to call me, but hasn't been able to do so. I got notified on the 3rd of . I didn't have any missed messages". A review of hospital records showed Resident # 2 was found by Emergency Medical Services (. .) on . . at 11:02 pm and listed Resident # 2 as "John Doe" and documented he was homeless. The . . records showed the primary chief of complaint was " ". Further review of Resident # 2's hospital records showed the following 'Narrative Note': " is a Hispanic male who appears to be in his 60's, who was brought to the ER via City of Miami Rescue under ; he was intubated by prior to arrival. According to Rescue, , was found unresponsive on the streets, in , distress, at reported location . . .; he had no ID and other form of identification with him, said to be homeless. 2) A review of Resident # 1's records revealed a progress note dated . . . . stating "The resident left the facility about 5:21 am and at end the day (the word didn't was white out) return. The missing report person was made. A second progress note dated . . . showed documentation that the resident was found in a crisis facility and would be discharged on . On at 10:23 am, Staff B stated "A couple of months ago, 5 or 6, the gate was without lock and key and [Resident # 1] went outside looking for a cigarette on the floor and he never came . The administrator contacted the cops. I wasn't working that day. [Staff D] told me that [Resident # 1] wasn't yet".	A 025		

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A 025	Continued From page 5 On at 10:36 AM, the Administrator stated "[Resident # 1] is an elopement risk. [Resident # 1] doesn't know how to come . If you ask him, he knows his name, but doesn't know where he lives". A review of Resident # 1's records showed he was admitted on and the last health assessment conducted on showed Resident # 1 was diagnosed with , and High . The health assessment also revealed that he was alert, awake, and oriented times 2 and was not an elopement risk. On at 11:28 AM, the Administrator stated "[Resident # 1] signed out". She also stated "[Staff D] was the one that called me. She called me like at 11 am. I called his guardian at around 4 pm. I called the police to make the missing report. At first, I called to get a translator and they told me the translator wasn't there and wasn't available. I called again at 5 pm. The cops came like at 8 pm and made the missing report". A review of the facility's sign in/out sheets showed no evidence that Resident # 1 had signed out of the facility. On at 11:28 AM, the Administrator stated that she didn't have the sign in/out sheets from past months "because the other papers either get crumbled up or get thrown away". On at 11 AM, Resident # 1's Case Manager stated "I went on to the facility and he wasn't there. I was told that he stepped out and walked around the neighborhood. I went the 17th, and the same lady told me that he didn't come and the police was called, and they filed the missing report. He was	A 025		

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A 025	Continued From page 6 and taken to the Crisis Stabilization Unit. I found out he was missing when I had gone to the facility to do my monthly assessments". Further review of Resident # 1's records revealed no documentation that Resident # 1's Case Manager from Dade county guardianship was contacted after staff had realized Resident # 1 went missing. There was also no documentation that showed Resident # 1 was re-assessed by a healthcare provider after having eloped from the facility. Class I	A 025		
A 032 SS=G	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make,	A 032		

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A 032	Continued From page 7 at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and	A 032		

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A 032	Continued From page 8 429.41(1)(i), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow their policies and procedures on elopement when two out of ten sampled residents went missing from the facility (Resident # 1 and # 2). Resident # 1 eloped from the facility and law enforcement was contacted until 12 hours later. Resident # 2 went missing twice and ended up incarcerated the first time and ended up in a hospital as a John Doe the second time after suffering from a . Law enforcement was contacted 48 hours after the first incident Resident # 2 went missing and 24 hours after the second time Resident # 2 did not return to the facility. Findings Included: 1) A review of Resident # 1's progress notes revealed a note dated that had the following documentation: "The resident left the facility about 5:21am and at end the day (didn't) return. The missing report person was made ...". A second progress note dated revealed Resident # 1 was found in a crisis stabilization unit 3 days later he had left the facility. On at 10:23 am, Staff B stated "A couple of months ago, 5 or 6, the gate was without lock and key and [Resident # 1] went outside looking for a cigarette on the floor and he never came . The administrator contacted the cops. I wasn't working that day. [Staff D] told me that [Resident # 1] wasn't yet".	A 032		

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A 032	Continued From page 9 On . . . . . at 10:36 am, the Administrator stated, "[Resident # 1] is an elopement risk. The rest leaves and know how to come . . . . [Resident # 1] doesn't know how to come . If you ask him, he knows his name, but doesn't know where he lives". A review of Resident # 1's records showed he was admitted on . . . . and the last health assessment conducted on showed Resident # 1 was diagnosed with . . . . , . . and High . The health assessment also revealed that he was alert, awake, and oriented times 2 and was not an elopement risk. On at 11:28am, the Administrator also stated, "[Resident # 1] signed out ...[Staff D] was the one that called me. She called me like at 11 am. I called his guardian and at around 4 pm, I called the police to make the missing report. At first, I called to get a translator and they told me the translator wasn't there and wasn't available. I called again at 5 pm. The cops came like at 8pm and made the missing person report". On at 1:27 pm, Staff D stated "I don't work there anymore. I don't remember anytime he left and didn't come ". A review of the facility's sign in/out sheets showed no evidence that Resident # 1 had signed out of the facility. A review of the facility's elopement policies and procedures showed "What to do in case a resident does elope: A) Identify Resident B) Search Immediate Area C) Advise Police 911 D) Inform facility administrator or person in charge E) Inform family F) Inform health care providers G)Search a larger area	A 032		

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A 032	Continued From page 10 There was no documentation that the facility attempted to searched immediate area, informed family members, informed health care providers, or searched a larger area. A review of the facility's elopement policy and resident evaluation revealed the following statement "All residents assessed at risk for elopement or with a history of elopement shall be identified so staff can be alerted to their needs for support and supervision. There was no evidence that revealed Resident # 1 was assessed for elopement risk by the facility. There was also no documentation that showed Resident # 1 was re-assessed by a healthcare provider after having eloped from the facility. On . . . . . at 10:36 am, the Administrator stated "I assess the residents for elopement risk based on their doctor's assessment and their case manager or social worker". On at 11:28 am, the Administrator stated "The only thing I did differently after [Resident # 1]'s incident was give everyone a bracelet and put a lock on the front gate. The residents now have to ask permission to one of the employees to leave and they have to sign the book". She also stated "The majority of them took them off. Because they didn't like them". 2) On . . . . . at 9:05 am in . . # . , during the tour of the facility, Staff B stated "This is where [Resident # 2] sleeps, the one that is still missing. He comes in and out, but he comes . . every time. He told me that he was going to buy cigarettes at the bodega close by. He never	A 032		

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A 032	Continued From page 11 came ". A review of Resident # 2's records showed he was admitted to the facility on and a health assessment completed on . Resident # 2 was diagnosed with , D Deficiency, Prostatic Hyperplasia, , , , , and ( ). He was also diagnosed with Mild , and was independent in all his activities of daily living (ADL's). Further review of Resident # 2's records revealed a Complaint/ Affidavit dated . The affidavit revealed Resident # 2 was on at 12:45 pm and charged with possession, drug paraphernalia with intent to use, and drinking in public. The affidavit stated "While on routine patrol, I observed [defendant] drinking out of a 16 oz. can of Marina beer in plain view of motorists and pedestrians. [Defendant] . Search incident to revealed defendant to have 1 metal pipe containing suspected residue inside the front left pocket of his pants". An additional review of Resident # 2's progress notes showed a note dated (two days after Resident # 2 was) stating "The resident left the facility about 7:27am on the day 17 of , and didn't return at this time. The administrator made a missing report person about 11:27 am on the day 18 of ,". On at 11:56 am, the Administrator stated "The first time was on . He told [Staff B] he was going to the bodega and he never returned. This happened at like 8 am and [Staff B] called me at 11 am. I contacted the	A 032		

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A 032	Continued From page 12	A 032		

police at 11:22 am the next day. The police tell me that I have to wait 24 hours to file a missing person report. He came . . . from [hospital] on . The police officer contacted his social worker and notified her that he was . . . . . I don't have the information on why he went to [hospital]. He went to jail then the hospital then came here".

There was no documentation that the facility attempted to searched immediate area, informed family members, informed health care providers, or searched a larger area when Resident # 2 was found to be missing.

A second progress note dated stated "The [program] called the ALF to inform that the resident was found in jail, but don't have more details about the . . . ". There was no further documentation showing the facility had attempted to contact Resident # 2's legal guardian or case manager on to notify of his disappearance.

Furthermore, the Administrator stated "[Resident # 2] left on at around 10am - 11am. He signed out. Sometimes he leaves and comes at night at around midnight. He notified [Staff B] he was going to leave. [Staff B] unlocked the gate for him. [Staff B] told me like at mid day that he hasn't returned for lunch. Since he comes at night, I didn't do anything. Then the next day I called the police at 10:50 am and told them he left the day before and never came . The police came at around 11:30 am and did a missing person report. The police contacted the owner on Thursday and notified that the resident was at [hospital]".

On at 11:45am, Resident # 2's Case

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A 032	Continued From page 13 Manager stated "We got an alert from the hospital requesting authorization and that's how we knew he was at [hospital]. How he got to [hospital], I don't know. I just know that he went to jail and we got notified from [hospital] ...The second time we found out through the ALF, but a week later. [Administrator] emailed me saying that he went missing from and was trying to call me, but hasn't been able to do so. I got notified on the 3rd of . I didn't have any missed messages". Class II	A 032		
A 057 SS=D	59A-36.008(8) FAC Medication - Over The Counter (OTC) Products (8) OVER THE COUNTER (OTC) PRODUCTS. For purposes of this subsection, the term over the counter includes, but is not limited to, over the counter medications, , nutritional supplements and nutraceuticals, hereafter referred to as OTC products, that can be sold without a prescription. (a) A facility may keep a stock supply of OTC products for multiple resident use. When providing any OTC product that is kept by the facility as a stock supply to a resident, the staff member providing the medication must record the name and amount of the OTC product provided in the resident's medication observation record. All OTC products kept as a stock supply must be stored in a locked container or secure room in a central location within the facility and must be labeled with the medication's name, the date of purchase, and with a notice that the medication is part of the facility's stock supply. (b) OTC products, including those prescribed by a health care provider but excluding those kept	A 057		

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	AL11953555	A. BUILDING: _____ B. WING _____	03/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 057	Continued From page 14 as a stock supply by the facility, must be labeled with the resident's name and the manufacturer's label with directions for use, or the health care provider's directions for use. No other labeling requirements are required. (c) Residents or their representatives may purchase OTC products from an establishment of their choice. (d) A health care provider's order is required when a nurse provides assistance with self-administration or administration of OTC products. When an order for an OTC product exists, the order must meet the requirements of paragraphs (b) and (c) of this subsection. A health care provider's order for OTC products is not required when a resident self-administers his or her medications, or when unlicensed staff provides assistance with self-administration of medications. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to keep all Over The Counter (OTC) in a locked container or secure room in a central location. The facility also failed to label all OTC products with the resident's name, manufacturer's label with directions for use, or the health care provider's directions for use. Findings Include: On at 8:59 am, observed a small tube labeled as 'Triple ' in # . At 9:09 am, observed a Severe & bottle on top of a dresser in # . Both OTC products showed no evidence of a resident's name, manufacturer's label with directions for use, or the healthcare provider's directions for use on each OTC product.	A 057		

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A 057	Continued From page 15 On . . . . . at 9:10 am, Staff B stated that she did not know who the OTC products belonged to or the reason why they were being used. Class III	A 057		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable . . . . to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency.	A 152		

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A 152	Continued From page 16 (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all existing architectural, mechanical, electrical, and structural systems and appurtenances maintained in good working order. Finding include: Observation on at 8:59 AM showed a large crack on the wall in # . Observation on at 9:03 AM showed that # closet door was missing. Observation on at 9:09 AM showed a broken closet door in # . Observation on at 9:10 AM showed a clogged toilet filled with brown colored fluid substance. Observation on at 9:12 AM showed handrails on stairs leading upstairs and the first-floor bathroom wall had peeling paint. Interviewed on at 2:04 PM, the Administrator stated all the items had been fixed. Class III	A 152		

Agency for Health Care Administration

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A 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the	A 160		

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A 160	Continued From page 18 county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with [illegible]'s [illegible] or related [illegible], a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the	A 160		

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A 160	Continued From page 19 last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to keep an up-to-date admission and discharge log. Findings Include: A review of the facility's admission and discharge log showed Resident # 9 was admitted to the facility on . . . . and discharged on .. .. There was no documentation for the reason for discharge. Further review of the admission and discharge log showed Resident # 10 was admitted to the facility on ..... . There was no documentation indicating the place Resident # 10 was admitted from. On ..... at 2:25 pm, the Administrator confirmed the admission and discharge log was incomplete and stated that she would update it. Class III	A 160		