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
	AL11968413	A. BUILDING: _____ B. WING _____	03/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSE GARDEN OF ORLANDO	9309 S ORANGE BLOSSOM TRAIL ORLANDO, FL 32837

(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 Relicensure survey, Complaint Investigation #2021002308, ... Control Assessment, and a Generator Monitoring were conducted on . . . . The Rose Garden of Orlando had deficiencies at the time of the visit.	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner ' s form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident ' s admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner ' s direct observation of the patient at the time of examination and must include the patient ' s medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident ' s admission to or continued residency in the facility. The medical examination form, reflecting the resident ' s condition on the date the examination is performed, becomes a permanent part of the facility ' s record of the resident and must be	A 008		

AHCA Form 3020-0001

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

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A 008	Continued From page 1 made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or [illegible] nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel	A 008		

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A 008	Continued From page 2 shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of [illegible] require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a [illegible]-to-[illegible] medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or [illegible] services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of [illegible] or any other communicable [illegible], which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an	A 008		

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A 008	Continued From page 3 assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S. (b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, [illegible], which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed. 1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider. 2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided. 3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823. (c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30	A 008		

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A 008	Continued From page 4 days after admission. (d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule. (f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or (g) 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 the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission.	A 008		

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A 008	Continued From page 5 This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to obtain the correct version the Agency for Health Care Adminsitration (AHCA) Form 1823 Health Assessment, dated , from the healthcare provider for 1 of 8 sampled residents (#12). Findings: Resident #12's record revealed admission date . The 1823 Health Assessment dated was using an obsolete version from . On page one, the healthcare provider listed medical codes for diagnosis instead of the name of health conditions. Photographic evidence obtained. On at 3:30 PM, the Director of Nursing (DON) confirmed the findings. Class III	A 008		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall 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 must notify the resident ' s representative or designee of the need for health care services	A 025		

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A 025	Continued From page 6 and must assist in making [illegible] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for 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 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	A 025		

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A 025	Continued From page 7 changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, records review and interview, the facility failed to provide care and services appropriate to the needs of 1 of 8 sampled residents and did not ensure medication was given as ordered (#2), and the facility directly threatened the physical safety and security of 2 of 3 Memory Care residents (#4 & 13) by failing to follow the facility policy regarding elopement evaluation and follow-up plan of care. Findings: 1. During an interview on at 10:30 AM resident #2 said that his doctor changed , from 1 milligram (mg.) to 2 mg. daily. He said "One Wednesday of last week, I did not get it (,). The nurse said she was waiting for 2 milligrams of ....I know it does not come in 2 milligrams. She needed to give me 2 tablets to make the 2 milligrams." He said he told the nurse supervisor about the issue, and the nurse supervisor told him to tell the staff to give him 2 tablets. Resident #2's record revealed a health assessment report dated that listed diagnoses of , and post distress . His record reflected that he needed assistance with self-administration of medications. An order dated indicated , 1 mg. 3 times a day for x 3 days. An order dated indicated 2 mg. one at bedtime and continue 1 mg. twice daily at 8 AM and 2 PM.	A 025		

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A 025	Continued From page 8 The . . . . . Medication Observation Record (MOR) listed , 1 mg. twice daily. The medication was given on . . . . . at 8 AM and 12 PM. There was a handwritten note that indicated to discontinue the medication. Another page of the MOR indicated , 1 mg. twice daily at 8 and 12 PM. Another entry indicated , 2 mg. at bedtime and was given on . . . . . and . . . . . . There was no evidence he was given the 2 mg. of . . . . . , as ordered on . . . . . at bedtime. The . . . . . MOR listed . . . . . , give 1 tablet twice daily at 8 AM and 12 PM, and 2 tabs at bedtime. On 3/012021 for 8 AM and 12 PM there was an arrow in the signature . On . . . . . and . . . . . , there were circled staff initials. The page of the MOR indicated that on . . . . . , the medication was not given: "waiting on pharmacy to deliver , 2 mg." Observations of the resident's medication supply noted 2 packs dated that indicated . . . . . , 1 mg.; 10 pills were available. There were 2 packs of . . . . . , 1 mg. dated . . . . . ; 60 were dispensed and 58 were available. On at 2 PM, the Director of Nursing confirmed the findings and added the staff should have given 2 tablets of 1 mg. each. 2. Review of the facility operating procedure regarding Memory Care elopements reflected that within 30 days of admission, the failiy is to conduct an elopement evaluation on all Memory Care residents who are not wheelchair or bed bound. The facility operating procedure reflected a follow-up elopement evaluation is to be	A 025		

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A 025	Continued From page 9 conducted along with a "plan of care" meeting for any resident who elopes. Resident #4's record reflected that the resident is a Memory Care resident and was admitted to the facility on . Resident #4's Agency for Health Care Administration (AHCA) 1823 Health Assessment did not indicate resident #4 as a wheelchair or bedbound resident. Resident #4's record did not contain documentation of the required elopement evaluation per facility policy. 3. Review of an AHCA Adverse Incident Report reflected that resident #13 eloped from the Memory Care unit at 1:06 AM on . Resident #13 was returned to the facility by law enforcement at 3:06 PM on . On at 10:30 AM, in an interview with staff H and staff I, staff H stated the facility considers all Memory Care residents, unless in a wheelchair, an elopement risk. Staff H and staff I stated all Memory Care residents are given an elopement risk evaluation when they are admitted to the facility. Staff H and staff I stated the details of the elopement by resident #13, outlined in the Adverse Incident Report, were correct. Staff H stated the staff working the overnight shift in Memory Care noticed that on the night of , resident #13 the hallways. Staff I stated they reviewed the video and it showed the laundry door alarm going off and staff going to the control box to determine which door was opened. Staff I stated staff working in the Memory Care unit realized resident #13 was missing and started a search. Staff H stated resident #13 had two additional elopements since the elopement. Staff H and staff I could not say if they had documented resident #1's two additional elopements. Staff I stated they did have	A 025		

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A 025	Continued From page 10 a Plan of Care meeting with the family and primary care physician. On at 4:33 PM, resident #13's family member stated the information in the Adverse Incident Report sounded correct. The family member stated that resident #13 was able to provide his name and law enforcement tracked the family member down. The family member stated they provided law enforcement with address of the facility. The family member stated they called the facility to let them know resident #13 had been found and was returning to the facility. The family member stated they were not contacted about the elopement by the facility. Since the elopement, the family member stated the facility told them resident #13 had eloped two additional times. Resident #13's record reflected an admission of . . . . . Resident #13's 1823 assessment form reflected that the resident was considered an elopement risk. Resident #13's record did not include an elopement evaluation when the resident was admitted, as per the facility's policy. The resident's record did not include the facility's Memory Care operating procedure documentation of an updated at-risk elopement evaluation based on the three elopements. Resident #13's record did not contain the required facility's operating procedure documentation of a Plan of Care meeting with the family and primary care physician. Resident #13's record did not contain documentation of the two additional elopements. Review of the Memory Care Incident Log contained an MD (physician) notification form dated , with resident #13's name on it. It read, "Resident did [elope]." The signature of	A 025		

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A 025	Continued From page 11 who wrote the form was not legible. On . . . . . at 11:20 AM, resident #13's family member stated the facility did not include them in a "Plan of Care" meeting. Class II	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, 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.	A 032		

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A 032	Continued From page 12 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 429.41(1)(i), F.S. This Statute or Rule is not met as evidenced by: Based on record review, observations and interviews, the facility directly threatened the physical safety and security of all 35 Memory Care residents by failing to follow the facility policy regarding elopement evaluation and	A 032		

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A 032	Continued From page 13 follow-up plan of care. Findings: Review of the facility operating procedure regarding Memory Care elopements reflected that within 30 days of admission, staff will conduct an elopement evaluation on all Memory Care residents who are not wheelchair or bed bound. The facility operating procedure reflected that any resident who elopes, a follow-up elopement evaluation is to be conducted along with a "plan of care" meeting. The elopement policy did not list who is responsible for each of the duties, how the facility is searched, who supervises the remaining population, and who contacts law enforcement. On at 11:40 AM, a tour of the facility noted the building layout has two separate campuses. The Memory Care Unit is located to the west of the main Assisted Living Building. The Memory Care Unit is secured, and all the doors have alarms. The Memory Care Unit has its own kitchen and dining area. Review of an Agency for Health Care Administration Adverse Incident Report reflected that resident #13 eloped from the Memory Care unit at 1:06 AM on , and was returned to the facility by law enforcement at 3:06 PM. The Adverse Incident Report reflected that resident #13 pressed the locked door handle for 30 seconds and it released to allow him to get out of the secured building. On at 10:30 AM, in a interview with staff H and staff I, staff H stated the facility considers all Memory Care Residents, unless in a wheelchair, an elopement risk. Staff H and staff I stated all Memory Care residents are given an	A 032		

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	AL11968413	A. BUILDING: _____ B. WING _____	03/08/2021

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A 032	Continued From page 14	A 032		

elopement risk evaluation when they enter the facility. Staff H and staff I stated the details of the elopement by resident #13, outlined in the Adverse Incident Report, were correct. Staff H stated the staff working the overnight shift in Memory Care, noticed on the night of , resident #13 the hallways. Staff I stated they reviewed the video and it showed the laundry door alarm going off and the staff going to the control box to determine which door was opened. Staff I stated the staff working in Memory Care realized resident #13 was missing and started a search. Staff H stated resident #13 had two additional elopements since the elopement noted in the Adverse Incident Report. Staff H and staff I could not say if they had documented resident #13's two additional elopements. Staff I stated they did have a Plan of Care meeting with the family and primary care physician. Staff H and staff I stated all the outside exit doors have alarms. Staff I stated if you push the door for more than 30 seconds the door releases, but the alarm continues to sound. Staff I stated only a staff member would be able to reset the door and turn off the alarm. Staff H stated the staff started a search of the area which included looking in all the residents' rooms to see if resident #13 might have gotten and went into someone elses room. Staff H stated the staff called staff H and staff I so they could return to the building. Staff H stated it took her about 20 to 25 minutes to get to the facility. Staff I stated it took her about 30 minutes to get to the facility on . When asked, both staff H and staff I stated no one called law enforcement, that would be the administrator's job.

On at 4:33 PM, resident #13's family member stated the information in the Adverse Incident Report sounded correct. The family

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A 032	Continued From page 15 member stated resident #13 was able to provide his name and law enforcement tracked the family member. The family member stated they provided law enforcement with the address of the facility. The family member stated they called the facility to let them know resident #13 had been found and was returning to the facility. The family member stated they were not contacted about the elopement by the facility. Since the . . . . . elopement, the family member stated the facility told them resident #13 had eloped two additional times. Resident #13's record revealed an admission date of . . . . Resident #13's 1823 assessment form reflected that resident #13 was considered an elopement risk. Resident #13's record did not include an elopement evaluation when the resident was admitted. Resident #13's record did not include the facility's Memory Care operating procedure documentation of an updated at-risk elopement evaluation based on the three elopements. Resident #13's record did not include the required facility's operating procedure documentation of a Plan of Care meeting with the family and primary care physician. Resident #13's record did not contain any documentation of the two additional elopements. The Memory Care Incident Log contains an MD (physician) notification form dated , with resident #13's name on it. It read, "Resident did [elope]." The signature of who wrote the form was not legible. On . . . . . at 11:20 AM,resident #13's family member stated the facility did not include them in a "Plan of Care" meeting.	A 032		

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A 032	Continued From page 16 Review of the facility elopement drills held since revealed that 11 drills were conducted. Of the 11 drills, only three related to the Memory Care unit. The drills for the Memory Care unit were as follows: . . . . . at 9:20 AM, at 4 PM, and at 3:35 PM. On at 3:20 PM, the administrator concurred that the staff working the night of resident #13's elopement had not participated in an elopement drill and the facility failed to have an elopement drill with the overnight shift. On at 1:15 PM, staff J stated the door alarm codes are adjusted quarterly unless they have an incident which would require them to be adjusted. Staff J stated that would include an employee termination or a resident elopement. Staff J stated the door alarms have horns which sound at the door, so he is not sure why staff would need to go the control box; they should be able to hear the sound. Staff J stated they do not have the software that allows management to see which doors have had alarms pushed and how long the alarm was going off prior to being reset by staff. Staff J stated once the alarm goes off, it continues to sound until staff put in the code. Class II	A 032		
CZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall	CZ830		

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CZ830	Continued From page 17 submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license.	CZ830		

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CZ830	Continued From page 18 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) The agency may adopt rules relating to emergency management planning, communications, and operations. Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on daily Emergency Status System (ESS)	CZ830		

Agency for Health Care Administration

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CZ830	Continued From page 19 report review and interview, the facility failed to report the facility's daily census and COVID-19 status of residents and staff. Findings: Review of the ESS report for [redacted] revealed that the facility last reported their census, COVID-19, and [redacted] status on [redacted]. On [redacted] at 9:30 AM, the administrator confirmed the finding. Class III	CZ830		