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
	AL11911702	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA'S RETIREMENT HOME	2233 NW 56TH AVENUE LAUDERHILL, FL 33313

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A 000	Initial Comments Unannounced licensure complaint surveys (#2020015149 and 2021013986), Relicensure with Limited Mental Health and Generator Monitoring surveys were conducted from to at Victoria's Retirement Home. The facility had deficiencies identified relating to the complaint (#2021013986) and the Relicensure with Limited Mental Health at the time of these surveys.	A 000		
A 025	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 and must assist in making 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 Resident Care Standards. An assisted living facility must provide care and	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 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 changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide appropriate personal supervision of care to 1 out of 24 sampled residents (Resident #1) which resulted in this resident to leave the facility unsupervised on for 4 days until the suspected resident was found by the police, in a parked vehicle located in the facility's parking lot.	A 025		

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A 025	Continued From page 2 The findings include: Review of the facility's policy and procedures titled "Responding to an Elopement" which were undated, revealed the following: Policy To establish an organized approach to search for a resident who is potentially missing and to ensure that if a resident is found to be missing that the appropriate authorities are notified. Procedure Time is of the essence when it is suspected that a resident is missing. When a staff member suspects that a resident may be missing the Administrator and Assistant Administrator must be notified immediately. Procedure for Responding to an Elopement; 1. Any staff member observing a . . . . or a previously identified ⌄ resident attempting to leave the premises shall attempt to prevent such departure. Should the attempt fail, the staff member shall obtain the assistance of other staff in the immediate vicinity. If none are available, the staff member shall immediately notify the Administration that the resident has left the premises, and then return quickly to the resident, continuing an attempt to redirect the resident safely . . into the building. Staff members are not to leave the resident for any reason if the resident's safety is at risk. 2. Upon notification that a resident is missing, the designee shall be responsible for initiating a thorough search of the facility and the premises. a. Give specific instructions to staff on duty for the search. Check all rooms, bathrooms, closets, etc. Check all common areas, dining room, laundry room, etc. Search outside perimeter of facility and surrounding areas (including corner store).	A 025		

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A 025	Continued From page 3 3. Should the search prove unsuccessful, the person in charge shall carry out the following steps: Notify the Administrator and Assistant Administrator; Notify the Police Department, i.e., 911; Notify the resident's responsible party; Notify the resident's physician; and Notify any other regulatory agencies required by law. Further review of the facility's records indicated that the facility did not have any other policies and procedures which related to resident change in health conditions, resident assessment after hospitalization, limited mental health resident requirements, resident sign-out or resident supervision of care. Review of the facility's adverse incident report dated revealed the following: On at 7:52 AM, Staff A (direct care staff member) contacted the Administrator to inform that Resident #1 wanted to leave the facility and the Administrator called the resident's family member at 7:55 AM to inform her of this. Further review of the adverse incident report revealed that on at 8:15 AM, Staff A reported that Resident #1 left the facility without signing out and at 9:09 AM, Staff A searched for Resident #1 and the resident was not in the facility. The adverse incident report revealed that on at 11:43 AM, the Administrator confirmed from Staff A that the resident did not return to the facility and the Administrator asked Staff A to call the police to report this missing resident since the resident was . The adverse incident report revealed that on at 12:05 PM, the police arrived at the facility to take this missing resident's report and at 1:00 PM, the facility called all local area hospitals to search for the resident in case the resident was hospitalized that day, but the resident was not found. The adverse incident	A 025		

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A 025	Continued From page 4 report revealed that on , Staff A reported to the Administrator that the car mechanic who was in the facility's parking lot, reported to her that there was a vehicle in the facility's parking lot which had a foul odor and there was a body in this vehicle's seat and Staff A called 911 to report this. Further review of the adverse incident report revealed that the police arrived at the facility to investigate the finding of this body and the police detective told the facility staff members that although the body may be that of Resident #1, the final identification of the body will be done by the medical examiner's office. Further review of the facility records indicated that the facility did not develop an internal incident report for the event on involving Resident #1. Review of a news article from www.55seniorcommunitysandiego.com, dated on revealed the following: A body of an elderly woman who was missing from the facility, was found in a parked car near the facility. Review of this news article revealed that the body was discovered on Wednesday ( ) shortly before 11:00 AM and the woman was pronounced at the scene. Review of this news article revealed that the investigators were able to determine that the woman was a resident at the facility, the identity of this individual had not been released and the incident remained under investigation. In an observation of the facility parking lot on at 4:00pm, it was noted that there were 12 parking spaces total, along the east side of the facility's property. The facility parking space located at the edge of the property to its north, had a grassy swath approximately 8 wide	A 025		

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A 025	Continued From page 5 which separated the facility property to the adjacent property to its north. The adjacent property to the north of the facility was a quadplex residential unit with 6 parking spaces along its east side of its property. (Photographic evidence was obtained.) Review of Resident #1's record revealed that the resident was admitted to the facility on , as a limited mental health resident. Review of the resident's admission Health Assessment Form 1823 dated on revealed that the resident had diagnoses including: , and , was independent with all of her activities of daily living (ADLs) and needed assistance with self-administration of medications. Review of the resident's most current Health assessment 1823 dated on revealed that the resident had diagnoses including: Type 2 , , Unsteady Gait, , and Communication . Review of this assessment revealed that the resident required precautions. , and , and also required supervision with ambulation and bathing ADLs. Review of the .com website (described as an evidence-based website designed to make the Speech Language Pathologists life easier) on , it revealed that -communication are problems with communication that have an underlying cause in a rather than a primary language or speech . A person with a -communication may have difficulty paying attention to a conversation, staying on topic, remembering information, responding accurately, understanding jokes or metaphors, or following directions.	A 025		

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A 025	Continued From page 6 Review of Resident #1's observation notes revealed the following: On . . . . the resident exhibited COVID symptoms and was transferred to the hospital and the resident tested positive for COVID. On , the resident was transferred to a nursing home and on . . . . the resident was transferred to the hospital from the nursing home. On . . . . at 10:35 PM, the resident returned to the facility and on , the resident was receiving home health services for daily and administration. Further review of the resident's record revealed that there were no copies of the resident's mental health Community Living Support Plan (CLSP) to address her severe or persistent mental health condition. Review of Resident #1's record revealed that there were no assessments performed of the resident upon her return to the facility from the hospital on so to reflect the resident's updated physical and mental condition. Further review of the resident's record revealed that there were no other assessments in her record to reflect the resident's physical and mental condition when she was admitted to the nursing home on and when she was hospitalized on . . . . and on . . . . . During an interview with the Administrator on . . at 1:45 PM, she stated that Resident #1 told Staff A (direct care staff) that she was leaving the facility on at approximately 8:00 AM. She stated that Staff A attempted to tell the resident to stay in the facility, but the resident did not listen. She stated that Staff A notified her by telephone of this at approximately 8:30 AM and she told Staff A to continue to encourage the resident to stay, with no detail on how to	A 025		

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accomplish this. She stated that Staff A told her that the resident left the facility, and she then called the resident's family member, but the family member was not able to assist the facility at that time since she was in process of catching a flight. She stated that Staff A reported on at approximately 10:30 AM that Resident #1 did not return to the facility and at approximately 11:45 AM, she told Staff A to call 911 to report the resident missing because she was and . She stated that the police responded to the facility on at approximately 12:00 PM, the police officer asked about the resident's condition and diagnoses, and the police then initiated a missing person report. She stated that for the remainder of the day on , she called about 5 local hospitals to attempt to locate the resident, but was unsuccessful. She stated that on she notified the resident's physician that she was missing, and she continued calling local hospitals to locate the resident, but there was no positive identification of the resident. She stated that from to , there were no developments in finding the resident. However, on at approximately 11:00 AM, Staff A notified her that a car mechanic who was in the facility parking lot, reported to her that there was a vehicle in the facility parking lot, which had a foul odor and there was a body in this vehicle's seat. She stated that Staff A called 911 to report this and on at approximately 12:00 PM, the police arrived at the facility to investigate the finding of the body inside the parked vehicle. She stated that the police detective told her that although the body may be that of Resident #1, the final identification of the body will be done by the medical examiner's office. She stated that she was not aware that this undefined vehicle was parked in the facility's parking lot on the north end

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A 025	Continued From page 8	A 025		

of the lot. She stated that she didn't know who this vehicle belonged to, but the police told her that it belonged to an unnamed male who lived next door to the facility's property, and it was found to be unlocked. She stated that on at approximately 4:00 PM, she called Resident #1's family member to notify her of the recent developments involving the body that was found and the police investigation to identify the body and manner of .

In an interview with the police detective on at 3:20 PM, he stated that the investigation relating to the body found inside the car outside of the facility on was still under investigation. He stated that he could not confirm the identity of the body, and this was a reason why the body is under the custody of the medical examiner's office.

In an interview with Resident #1's physician on at 10:10 AM, she stated that she was informed by the facility that the resident left the facility on and that the resident did not exhibit any risk for elopement before and when she last saw the resident on .

In an interview with the Maintenance Director on at 10:15 AM, he stated that he knew Resident #1 and she liked to spend time outdoors and to walk and smoke cigarettes outside the facility. He stated that he hired a mechanic to come and change his power steering rack in his truck and he arranged for the mechanic to meet him at the facility the morning of , to make the repair in the parking lot. He stated that when he arrived for work at the facility on at approximately 8:30 AM, he parked his truck about 5 parking spaces south of the northern facility property line, which was approximately

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parking spaces from where an undefined gray Honda CRV was parked. He stated that he left the facility to go to the other facility (Victoria Gardens) in another vehicle at approximately 10:00 AM. He stated that on [redacted] at approximately 11:00 AM, his mechanic informed him that he didn't have the keys to his truck to begin working on it and he told the mechanic that he will arrive to the facility soon to give him the truck keys. He stated that when he returned to the facility on [redacted] at approximately 11:15 AM, his mechanic told him that while he was waiting in the parking lot for him, he noticed a foul odor which came from the undefined gray Honda CRV parked in the facility parking lot. He stated that the mechanic told him that a [redacted] body was found inside the undefined gray Honda CRV. He stated that the police and fire rescue arrived at the facility immediately after he arrived there. He stated that this undefined vehicle was parked about 2 spaces next to the edge of the property to the north of the facility and he learned that this undefined vehicle belonged to an individual who lived in the quadplex property, immediately to the north of the facility. He stated that he didn't know this undefined vehicle's owner.

In an interview with Resident #1's Case Manager on [redacted] at 9:25 AM, he stated that he followed this resident's case since she moved in the facility in [redacted], of 2019. He stated that the facility notified him of the resident's departure from the facility on [redacted] and that the resident did not exhibit any exit-seeking behaviors before or when he last saw her on or about [redacted]. He stated that he had not seen her recently and he did not describe any specific mental health interventions needed for this resident.

During an interview with Staff A (direct care staff)

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on . . . . at 9:35 AM, she stated that on . . . . at approximately 7:30 AM, she saw Resident #1 in the parking lot as she arrived at the facility for her (7:00 AM to 4:00 PM) shift. She stated that the resident told her that she was going out at this time, and she asked the resident to come inside so she could give the resident her morning medications. The resident then followed her inside the facility. She stated that after she assisted the resident with her medications on . . . . at approximately 8:00 AM, the resident stated once again that she was going out and she offered the resident coffee, but the resident declined. She stated that shortly after that, she saw the resident go out the facility's front gate, into the parking lot and she asked the resident to stay and not leave, but the resident declined and told her that she was going out. She stated that she did not attempt any other redirection interventions for the resident, and she did not stay with the resident while she was outside in the parking lot. She stated that she went inside the facility and called the Administrator to notify her that the resident was leaving the facility and the Administrator told her that she was going to call the resident's family member to assist in this situation. She stated that on . . . . at approximately 8:30 AM, her and Staff C (direct care staff) began searching in and around the facility for the resident, but the resident was not found. She stated that she did notice an undefined Honda CRV vehicle parked in the north end of the facility's parking lot. She saw through the windshield that the front seats were empty but could not see the rear seats because it had tinted windows. She stated that she didn't think much of this vehicle, and she didn't know who it belonged to. She stated that she remembered this undefined vehicle being parked in the same spot since she started working in the facility in

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A 025	Continued From page 11 During an interview with Staff A (direct care staff) on at 9:45 AM, she stated that she notified the Administrator that the resident was not in the facility on at approximately 9:00 AM and the Administrator told her at approximately 11:30 AM to call 911 since the resident was and She stated that the police arrived on sometime around 12:00 PM and they took the missing resident report. She stated that on at approximately 11:00 AM, the mechanic who was hired by the maintenance director, found the body of Resident #1 in the undefined vehicle parked in the facility parking lot and she immediately called the police. She stated that the police arrived onsite shortly thereafter and that the police said that the body found in the vehicle may be the resident's body, but final identification of the body will be done by the medical examiner's office. In an interview with Staff B (direct care staff) on at 10:10 AM, she stated that she was the caregiver who worked on Friday night of She stated that she saw Resident #1 on after dinner. The resident was smoking a cigarette in the courtyard and she gave the resident some iced tea at around 11:00 PM. She stated that she saw the resident go into her bedroom and she then saw the resident on eating breakfast in her room. She stated that she didn't notice anything unusual with the resident. In an interview with Staff C (direct care staff) on at 10:25 AM, she stated that she came to work at the facility on at around 8:00 AM and she didn't see Resident #1 that day. She	A 025		

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stated that Staff A notified her on at approximately 8:15 AM that the resident left the facility unsupervised. She stated that she helped Staff A look for the resident on inside the facility and in the courtyard, but they did not find the resident. Staff A then called the Administrator to notify her of the incident. She stated that her duties were primarily to assist the residents with their activities when she arrived for her shift at the facility and throughout the day.

Review of the police report, dated at 12:15 PM, revealed that Staff A identified Resident #1 leaving the facility on between approximately 7:00 AM and 8:00 AM and the resident did not return. Review of this report revealed that the resident had gone missing before and was diagnosed with , , , and . This report did not provide more detail on the resident's condition. Further review of this report revealed that the resident usually went to the store and took public transit, but Staff A didn't know where the resident went.

In an interview with the Administrator on at 1:45 PM, she stated that Resident #1 was classified and admitted to the facility as a limited mental health resident and the resident had a severe or persistent mental condition. She stated that the facility never developed or implemented a , Agreement and Community Living Support Plan (CLSP) for the resident, so it was difficult to ascertain the resident's care and service needs based on her , and communication diagnoses.

In an interview with the Administrator on at 2:35 PM, she stated that she documented in the facility's adverse incident report the corrective

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A 025	Continued From page 13 actions to prevent what happened to Resident #1, were to train the staff about elopement and _; implement a room/check count program during every staff shift change and at meal times; and to have the psychiatrist review every resident's health assessment to make necessary changes in the residents care and services, based on their medical health needs. She stated that the only aforementioned corrective action the facility fulfilled was to provide a staff inservice and elopement drill on and that the other additional corrective measures were not presently implemented or completed. Review of the facility resident supervision logs revealed that the facility direct care staff did not document any resident room/checks and counts at every shift change and at meal times and there was no documentation of a physician or psychiatrist that reviewed every resident's health assessment to make necessary changes in the residents' care and services based on their medical health needs. In an interview with the Administrator on at 11:05 AM, she stated that Resident #1 was not properly assessed after being re-admitted to the facility on , after being hospitalized 2 times and being in a nursing home in the prior month. She stated that due to the resident's recent hospitalizations and change in condition, the resident needed to be supervised and not be left alone outside of the facility. She stated that had the facility developed and implemented a CSLP for the resident, this CSLP would have reflected her individual needs and to properly enable the residents to live in the facility and the community. This CSLP would have also provided the facility direction from the resident's mental health care provider to help meet the residents	A 025		

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	AL11911702	A. BUILDING: _____ B. WING _____	10/13/2021

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A 025	Continued From page 14 needs and list the [illegible] of the facility to facilitate and assist the residents with related services and activities and to list the factors pertinent to the care, safety, and welfare of each mental health resident. Class I	A 025		
AL241	429.075( ); 59A-36.020(2) FAC LMH - Records 429.075 (3) A facility that has a limited mental health license must: (a) Have a copy of each mental health resident's community living support plan and the agreement with the mental health care services provider or provide written evidence that a request for the community living support plan and the agreement was sent to the Medicaid managed care plan or managing entity under contract with the Department of Children and Families within 72 hours after admission. The support plan and the agreement may be combined. (b) Have documentation provided by the department that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility that has a limited mental health license or provide written evidence that a request for documentation was sent to the department within 72 hours after admission. (c) Make the community living support plan available for inspection by the resident, the resident's legal guardian or health care surrogate, and other individuals who have a lawful basis for reviewing this document. (d) Assist the mental health resident in carrying out the activities identified in the resident's	AL241		

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AL241	Continued From page 15 community living support plan. (4) A facility that has a limited mental health license may enter into a [illegible] agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager. 59A-36.020 (2) RECORDS. (a) A facility with a limited mental health license must maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents. The admission and discharge log required in rule 59A-36.015, F.A.C., satisfies this condition provided that all mental health residents are clearly identified. (b) Staff records must contain documentation that designated staff have completed limited mental health training as required by rule 59A-36.011, F.A.C. (c) Resident records must include: 1. Documentation, provided by a mental health care provider within 30 days of the resident's admission to the facility, that the resident is a mental health resident as defined in section 394.4574, F.S., and that the resident is receiving social security [illegible], or supplemental security income and [illegible] as follows: a. An affirmative statement on the Alternate Care Certification for [illegible] ([illegible]) form, CF-ES 1006, [illegible], which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-03988, that the resident is receiving SSI or SSDI due to a mental [illegible],	AL241		

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AL241	Continued From page 16 b. Written verification provided by the Social Security Administration that the resident is receiving SSI or SSDI for a mental . . . . . Such verification may be acquired from the Social Security Administration upon obtaining a release from the resident permitting the Social Security Administration to provide such information, or c. A written statement from the resident's case manager or other mental health care provider that the resident is an adult with severe and persistent mental . . . . . The case manager or other mental health care provider must consider the following minimum criteria in making that determination: (I) The resident is eligible for, is receiving, or has received mental health services within the last 5 years, or (II) The resident has been diagnosed as having a severe or persistent mental . . . . . 2. An appropriate placement assessment provided by the resident's mental health care provider within 30 days of admission to the facility that the resident has been assessed and found appropriate for residence in an assisted living facility. Such assessment must be conducted by a psychiatrist, clinical psychologist, clinical social worker, ... nurse, or an individual supervised by one of these professionals. a. Any of the following documentation that contains the name of the resident and the name, signature, date, and license number, if applicable, of the person making the assessment, meets this requirement: (I) Completed Alternate Care Certification for . . . . . (. . .) form, CF-ES Form 1006, (II) Discharge Statement from a state mental hospital completed no more than 90 days before admission to the assisted living facility provided it	AL241		

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AL241	Continued From page 17 contains a statement that the individual is appropriate to live in an assisted living facility, or (III) Other signed statement that the resident has been assessed and found appropriate for residency in an assisted living facility. b. A mental health resident returning to a facility from treatment in a hospital or crisis stabilization unit will not be considered a new admission and will not require a new assessment. However, a break in a resident's residency that requires the facility to execute a new resident contract or admission agreement will be considered a new admission and the resident's mental health care provider must provide a new assessment. 3. A Community Living Support Plan. Each mental health resident and the resident's mental health case manager must, in consultation with the facility administrator, prepare a plan within 30 days of the resident's admission to the facility or within 30 days after receiving the appropriate placement assessment in paragraph (2)(c), whichever is later, that: a. Includes the specific needs of the resident that must be met in order to enable the resident to live in the assisted living facility and the community, b. Includes the clinical mental health services to be provided by the mental health care provider to help meet the resident's needs, and the frequency and duration of such services, c. Includes any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs, and the frequency and duration of such services and activities, d. Includes the [illegible] of the facility to facilitate and assist the resident in attending [illegible] and arranging transportation to [illegible] for the services and activities identified in the plan that have been provided or	AL241		

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AL241	Continued From page 18 arranged for by the resident's mental health care provider or case manager, e. Includes a description of other services to be provided or arranged by the facility, f. Includes a list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms , to the resident that indicate the immediate need for professional mental health services, g. Is in writing and signed by the mental health resident, the resident's mental health case manager, and the assisted living facility administrator or manager and a copy placed in the resident's file. If the resident refuses to sign the plan, the resident's mental health case manager must add a statement that the resident was asked but refused to sign the plan, h. Is updated at least annually or if there is a significant change in the resident's behavioral health, i. , include the , Agreement described in subparagraph (2)(c)4. If included, the mental health care provider must also sign the plan; and, j. Must be available for inspection to those who have legal authority to review the document. 4. , Agreement. The mental health care provider for each mental health resident and the facility administrator or designee must prepare a written statement, within 30 days of the resident's admission to the facility or receipt of the resident's appropriate placement assessment, whichever is later. The statement: a. Provides procedures and directions for accessing emergency and after-hours care for the mental health resident. The provider must furnish the resident and the facility with the provider's 24-hour emergency crisis telephone	AL241		

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AL241	Continued From page 19 number; b. Must be signed by the administrator or designee and the mental health care provider, or by a designated representative of a Medicaid prepaid health plan if the resident is on a plan and the plan provides behavioral health services in section 409.912, F.S.; c. , cover all mental health residents of the facility who are clients of the same provider; and, d. , be included in the Community Living Support Plan described in subparagraph (2)(c)3. 5. Missing documentation will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the appropriate party. A documented request for such missing documentation made by the facility administrator within 72 hours of the resident's admission will be considered a good faith effort. The documented request must include the name, title, and phone number of the person to whom the request was made and must be kept in the resident's file. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain an updated community living support plan (CLSP) and , agreement with a mental health care services provider for 8 out of 19 sampled mental health residents (Residents #1, 4, 6, 9, 11, 12, 16 and 17). The findings include: In an interview with the Administrator on at 1:45 PM, she stated that Resident #1 was classified and admitted to the facility on as a limited mental health resident with severe or persistent mental condition. She stated that the facility never developed or implemented a	AL241		

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AL241	Continued From page 20 . . . . . Agreement and Community Living Support Plan (CLSP) for the resident, so it was difficult to ascertain the resident's care and service needs based on her , and . . . communication . . . . diagnoses. In an interview with Resident #1's Case Manager on at 9:25 AM, he stated that Resident #1 was a limited mental health resident with a mental health condition. In an interview with the Administrator on at 11:05 AM, she stated that the facility currently had a total of 20 limited mental health residents, and she provided a list of these residents for review. She stated that the facility did not develop and complete CLSPs for Resident #1, who was no longer in the facility, and Resident #16, who was presently a resident there. She stated that the facility did not update Resident # 4, 6, 9, 11, 12 and 17's CLSPs to reflect their individual needs and to properly enable the residents to live in the facility and the community. She stated that she was aware that every CLSP included the services provided by the mental health care provider to help meet the residents needs and listed the . . . . . of the facility to facilitate and assist the residents with related services and activities and to list the factors pertinent to the care, safety, and welfare of each mental health resident. Review of the facility's limited mental health resident list revealed that there were presently 18 limited mental health residents (Resident #2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 ,19 and 20) who live in the facility. Review of the facility admit/discharge log revealed that Resident #1 was admitted on as a limited mental health resident and was discharged from the	AL241		

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AL241	Continued From page 21 facility on . .. . . Review of Resident #4's record indicated that this resident's CLSP was dated on . Review of Resident #6's record indicated that this resident's CLSP was dated on . Review of Resident #9's record indicated that this resident's CLSP was dated on . Review of Resident #11's record indicated that this resident's CLSP was dated on . Review of Resident #12's record indicated that this resident's CLSP was dated on . Review of Resident #17's record indicated that this resident's CLSP was dated on . Review of Resident # 4, 6, 9, 11, 12 and 17's records revealed that their yearly CLSP update could not be located. Class III	AL241		