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
	AL11910711	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

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A 000	Initial Comments An unannounced Relicensure with Limited Mental Health (LMH), Complaint (#2024007017, #2024010522, #2024012709), Generator Monitoring survey was conducted on - at Midtown Assisted Living Residence. The facility had deficiencies related to the Relicensure and Complaint (#2024012709 and 2024007017) at the time of the survey.	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 services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal	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 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, record review and interview, it was determined that the facility failed to provide appropriate supervision to all residents (census of 101) residing at the facility to ensure daily knowledge of their whereabouts. It was also determined that the facility failed to provide appropriate supervision to a resident that had a history of elopements and to have knowledge of the resident's whereabouts daily, for 1 of 1 resident (Resident #13).	A 025		

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A 025	Continued From page 2 The Findings Include: A review of the facility's undated Policy and Procedures for Resident Supervision documented the following: Supervision of Residents: All residents are under the direct supervision of facility staff. CNA/HHA supervise residents with ADL's. MedTech's supervise residents with medication Assistance. The Dietary Department supervise all meals. Housekeeping Department supervises laundry and keeping facility clean. Administration supervises with finances, rules and regulations and any other duties that require assistance. Additionally, the policy documented there has been a policy implemented that CNA/HHA are to make rounds to every room at least every 2 hours. Also, there will be weekly room checks to ensure residents are living in habitable dwellings free of hazards and debris. (Copy obtained). A review of the facility's Elopement Policy documented the following: It is the policy of Midtown to take all reasonable measures to prevent the elopement of residents, , those at-risk due to such as . This policy outlines procedures for assessing risk, monitoring residents, and responding effectively to any elopement incidents. Risk Assessment: -All residents will undergo a comprehensive risk assessment upon admission and regularly thereafter to determine their potential for elopement. -Risk factors may include a history of , , or a desire to return to a previous home.	A 025		

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A 025	Continued From page 3 -Residents identified as at-risk will have an individualized care plan that includes specific interventions to prevent elopement. (copy obtained). A review of the facility census provided to the surveyors on documented they have 101 residents. An additional review of the facility's file and documents documented thirty - one (31) of the 101 residents were identified as Limited Mental Health (LMH) Residents. The facility holds a Standard and Limited Mental Health (LMH) license. All the residents of the facility require supervision and/or assistance with Activities of Daily living. On at 9:17 AM, the survey team met with the Local Police Department to discuss their concerns regarding the supervision of residents of the facility. During the meeting, it was revealed that local law enforcement continues to have residents of the facility walking around the city, digging in garbage cans, being found by their department, and having to be returned to the facility. At this time, it was stated that to the current administrator's credit, he is doing a great job, and things are much better. However, the problem of residents leaving the facility persists. In a follow-up interview on at 9:37 AM with the Local Police Department, they stated the facility has had 14 Residents this year, and 2 missing persons incidents in the last 2 days (Resident #13 for both incidents). In an interview with the Executive Director (Administrator) on at 9:51 AM, he informed this surveyor that they had an elopement yesterday with Resident #13, but he had not submitted notification to the Agency yet	A 025		

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A 025	Continued From page 4 as he just got into the office. The Administrator further stated in the interview that he is not aware of additional Resident's living the facility, which could be considered an elopement, as they are free to leave the facility. The facility was unable to provide any documentation regarding additional ˳/missing residents and/or regarding law enforcement involvement with respect to multiple residents ˳ the community(due to lack of supervision) and having to be returned by local law enforcement. A review of Resident #13's facility file and documents revealed he was admitted to the facility on . A review of Resident 13's Heath Assessment (AHCA Form 1823) dated documented his diagnosis as , , T2DM (Type 2) controlled, (ˏ, - High). His ˳ status is documented as alert and oriented. The resident's physical limitations were documented as hearing ˏ . Resident#13 was not documented as an elopement risk. In an interview on at 10:12 AM with local law enforcement, they confirmed that they have had several missing person/elopements this year, including multiple ˳ residents. However, in the interview with the Administrator on , he stated Resident #13 was the only elopement this year. However, the facility had no documented intervention after the 1st incident, therefore, resulting in the resident leaving the grounds unsupervised again. In an interview with the Administrator on 11/2024 at 10:11 AM, he stated he spoke with Resident #13 who eloped the previous evening and was at the facility. He stated the Resident	A 025		

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A 025	Continued From page 5 informed him that he left through a first-floor window in the West Wing of the facility (no time provided). Observation of the facility by this survey on revealed it is a four-story building comprised of two four-story buildings (East Wing and West Wing). The two wings are separated by a long single-story hallway which contains the dining room and kitchen (on the West side of the hallway), and two bathrooms which are located on the South side of the hallway, and an elevator on the South side of the hallway. There is a stairwell door and entry/exit door adjacent to each other on the Northwest side of the hallway. In addition, this surveyor observed the window located at the end of the West Wing's first-floor North/South hallway where Resident #13 is said to have eloped from. Observation revealed the window did not have any mechanism preventing it from being opened. However, a camera was observed in the ceiling by the window (photo obtained). No video, only still photos were available during the survey. The Administrator further stated in the interview on beginning at 10:11 AM, that Resident #13 informed him that he left because he didn't like his roommate, so he walked to (adjacent city) and caught a bus to his brother's house in (another city). The Administrator stated Resident #13 has no family or guardian, and that a Local Behavioral Health entity intervened and granted approval of Resident #13 being transferred to a sister facility who has a Memory Care unit (MCU). On at 10:19 AM this surveyor attempted to interview the resident, but he was	A 025		

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A 025	Continued From page 6	A 025		

asleep in the chair in front of the Administrator's desk, and did not respond to any of this surveyor's questions. The Administrator, who was present at the time, informed this surveyor that the Resident is always like that, but he walks and talks. As such, he requires ongoing observation/supervision.

A review of the facility's Staffing Schedule for provided to the surveyors revealed the following staffing levels for staff providing direct care/supervision for residents:

Certified Nursing Assistants (CNA):

7:00 AM - 3:00 PM: Three (3)
3:00 PM - 11:00 PM - Two (2)
11:00 PM - 7:00 AM - Two (2)

Medical Technician (MedTech):

7:00 AM - 3:00 - Two (2)
3:00 PM - 11:00 PM - Two (2)
11:00 PM - 7:00 PM - None (0)

During an interview with the Administrator on at 2:50 PM he provided the Staffing Schedules referenced and confirmed that they are reflective of the staffing hours provided by the facility's staff. As such, the facility has two (2) direct care staff working during the 11:00 PM - 7:00 AM shift to supervise one hundred and one (101) residents, of which thirty-one (31) are documented as LMH Residents. As such, the facility has a ratio of 1 staff member for each 50.5 Residents during the 11:00 PM - 7:00 AM shift who must be supervised and checked on every two (2) hours. The staffing ratio for the 7:00 AM to 3:00 PM shift, 1 staff member for each 33.66. Due to the facility's staffing ratio and the layout of

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A 025	Continued From page 7	A 025		

the facility, it is extremely difficult for staff to monitor the residents(including their behaviors due to the LMH census), provide assistance/supervision with ADLs (Activities of Daily Living) and supervise accordingly with the minimum staffing hours represented within the facility. Residents are capable of leaving the grounds without the knowledge of staff.

In an interview with the Administrator on at 5:27 PM, a request was made for the facility's documentation reflecting the dates/times facility residents were checked on by staff. He stated they do not document each time a resident is checked on, but that they do document in their Progress Notes any changes observed during the checks. This surveyor requested the documentation for the observations that were made for Resident #13, specifically the day he was missing from the facility. No documentation was provided during the survey that indicated Resident #13 was checked on during the time of his absence. A review of the facility's Sign-In/Sign-Out log revealed Resident #13 did not sign out that he was leaving the facility. As such, it could not be determined what time on Resident #13 left the facility without Staff's knowledge. The facility was also unable to provide documentation indicating staff were monitoring the whereabouts of residents that signed- out or residents that had left the facility.

A review of Resident #13's Progress Notes revealed an entry dated at 7:31 PM documenting the Executive Director (ED) received a text approximately 1:23 PM informing him that resident has not gotten his meds today ( ). The ED told staff to find the resident. Observation of the same Progress Note revealed documentation that on at

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A 025	Continued From page 8 10:30 PM the ED received a call from an officer at the Local Police department stating they found Resident #13 in an adjacent city and was being transported to the facility. During various confidential interviews with facility staff during the survey (-), each stated they were trained on the facility's policies and procedures, which included elopement and supervision of residents. However, no documentation was provided relative to staff conducting resident checks every two hours. Staff were unable to demonstrate how they monitor the daily whereabouts of each resident neither were staff able to demonstrate appropriate supervision for the 101 residents residing at the facility. As evidenced of local law enforcement involvement in returning multiple residents to the facility that had left the grounds for unknown periods of time without the knowledge of staff. Class III	A 025		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly	A 052		

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A 052	Continued From page 9 labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or , medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route.	A 052		

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A 052	Continued From page 10 (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section	A 052		

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A 052	Continued From page 11 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.	A 052		

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A 052	Continued From page 12 (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that prescribed medications were provided to residents as ordered by the physician, for 3 of 3 residents reviewed (Residents #18, #19, #20). It was also revealed that the facility failed to accurately document each Medication Observation Record accordingly after assistance was offered or medications not given with explanation . The Findings Include: A) Record review of Resident #18 Medication Observation Record dated and revealed the following medications were not given(assisted) to resident for the following reasons and the MORs documented accurately (as documented on the of the MORs): Other, Cart#a, Med not available-backordered or no reason noted . 1) : , Tab 5 MG - 1 x daily by . 2) , 2, 3, 4, 23: , Tab 50 MG- 1x daily by .	A 052		

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A 052	Continued From page 13 3) , 27: Tab 10 MG- Tab 2 x daily by . 4) , 4, 9: , , Tab 150 MG -1 Tab by every morning along with 300 MG to = 450 MG 5) : , , Tab 300 MG - 1 Tab by every morning along with 150 MG to = 450 MG 6) , 6, 7, 8, 9, 10, 11, 25, 26, 27: , Tab 100 MG - 1 Tab at bedtime by . 7) , 7: Tab 10 MG - Tab 2 x daily by 8) : Tab 50 MG - 1 x daily by 9) : , Tab 300 MG - 1 Tab by every morning along with 150 MG to = 450 MG 10) : Tab 20 MG - 1 Tab at bedtime by . B) A Record review of Resident #19's Medication Observation Record dated and revealed the following medications were not given(assisted) to resident for the following reasons (as documented on the of the MOR): Other, Cart#a, Med not available-backordered or no reason noted. 1) : , Tab .5 MG - 2 x daily by 2) , 5: Cap 24 MCG - 2 x daily by 3) , 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12: Tab 10 MG - 2 Tab by at bedtime 4) , 2, 3, 4, 5,15, 16,17: , Tab 30 MG - 1 Tab by at bedtime 5) , 4, 5: Tab 40 MG 1 Tab by at bedtime	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910711	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDTOWN ASSISTED LIVING RESIDENCE	2001 POLK STREET HOLLYWOOD, FL 33020

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A 052	Continued From page 14 6) : , Tab 1MG - 1 Tab by at bedtime 7) : , /Levo 25-100 MG 1 Tab 2 x daily by 8) : , Tab 500 MG - 1 Tab 3 x daily by 9) : Tab 20 MG - 1 Tab 2 x daily by 10) , 4, 5, 8: Ingrezza Cap 40 MG - 1 Cap daily by 11) , 9: , Tab 100 MG - 1 Tab daily by 12) , : Cap .4 MG - 1 Cap daily by 13) , , 13: Cap 24 MCG 2 x daily by 14) , , 13: Tab 10 MG - 2 Tab s by at bedtime 15) , , 11, 12, 13, 14: , Tab 1 MG - 1 Tab by at bedtime 16) , 5, 9: , /Levo 25-100 MG - 1 Tab 2 x daily by 17) : , Tab 500 MG - 1 Tab 3 x daily by 18) : Tab 20 MG - 1 Tab 2 x daily by 19) : Ingrezza Cap 40 MG - 1 Cap daily by 20) : , Tab 100 MG - 1 Tab daily by 21) : Cap .4 MG - 1 Cap daily by C) A Record review of Resident #20's Medication Observation Record dated and revealed the following medications were not given(assisted) to resident for the following reasons: Other, Cart#a, Med not available-backordered or no reason noted.	A 052		

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A 052	Continued From page 15 1) : , low dose 81 MG - 1 x daily by 2) , 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 23: Tab 40 MG - 1 x daily by 3) , 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23: 300 MG Cap - 1 Tab by 2 x daily 4) , 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31: Gel 3% - apply 1 application , , to affected area 2 x daily 5) , 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15: Tab 20 MG - 1 x daily by 6) : , Tab 25 MG - 1 Tab by 3 x daily 7) : , 25 MG Tab - 1 Tab 2 x daily by with food 8) , 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 23: , ER Tab 900 MG - 1 Tab by daily 9) : , ER 50 MG TB24 - 1 Tab by daily 10) , 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30: - , 400-80 MG Tab - 1 Tab by daily 11) , 4, 5, 6, 7, 8, 9, 10: , , Tab 2 MG - 1 Tab by at bedtime 12) , 2, 3: , low dose 81 MG - 1 x daily by 13) , 3, 4: Tab 40 MG 1 x daily by 14) , 3, 4, 5, 6, 7: Tab 20 MG - 1 x daily by 15) , ,14,15,16, 17: , 25 MG Tab - 1 Tab 2 x daily by with food 16) , 3, 4, 5, 6: , , ER Tab 900 MG - 1 Tab by daily	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 052	Continued From page 16 17) , 12, 13, 14, 15, 16, 17: , ER 50 MG TB24 - 1 Tab by daily 19) , 2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17: - , 400-80 MG Tab- 1 Tab by daily No additional information was provided during the survey. The facility was unable to provide any documentation indicating notification to the physican regarding multiple missed dosage and/or pharmacy delays. On at 11:45 AM during an interview with Resident #18 she stated about a week ago that the facility did not give her the evening medications and she also stated that at another time (unspecified date and time) the Medication Technician (Med Tech) told her that the facility ran out of her medication (not able to provide name of medication). Class III	A 052		
A 152	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	A 152		

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A 152	Continued From page 17 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. (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, record review and interview, it was determined the facility failed to ensure the living environment was maintained in a safe manner and free from hazards, for 101 of 101 Residents (Residents 1-101) residing in the facility. It was also determined that the facility failed to make mandatory repairs as order by the local fire department to ensure satisfactory compliance. The Findings Include:	A 152		

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A 152	Continued From page 18 Interview on at 9:55 AM with Resident #6, she stated her room (#318W) has roaches and that the facility has roaches in the common areas on the first floor. She stated, she had complained to Administration regarding this matter with no resolution. Interview on at 3:15 PM with Resident #23, she stated her room has roaches and in other areas of the facility including the dining room. Record review on revealed the facility's most recent Fire Inspection reports dated . A review of the report revealed the findings identified in their investigation during the , investigation with AHCA on - had not been cleared. Specifically: Emergency Generator, Fire Alarms, Fire Protection, Sprinklers & Standpipes and General Compliance (Seal Openings in Firewall) (Photographic evidence obtained). During a tour of the facility on thru between 9:30 AM and 4 PM, the following concerns were identified: 1. observation of , revealed three (3) beds, and two (2) bathrooms. Observation of the bathroom located to West was observed dirty with various stains, dirt and debri. The bathroom tile noted to be broken in various locations. The bathroom located to the left (North) was observed to have a 1-gallon bottle of cleaning solution (unsecured), and a mop bucket with a mop inside it (Photographic evidence obtained). 2. observation was made of the bathroom located on the first floor in the TV/Dining room area, just west of the west wing's elevator. Observation revealed it had no toilet paper, towels, soap, dirty and evidence of roach activity	A 152		

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A 152	Continued From page 19 (Photographic evidence obtained). 3. observation was made of the hallway between the east wing and the west wing, where the double entrance/exit doors to the outside courtyard, and the dining room/kitchen is located. Observation revealed the ceiling tile was dirty, the vents were dusty/dirty. 4. observation of the elevator in the east wing revealed it was not working. This surveyor pushed the button to call the elevator to the third floor and it did not operate, and no sound was heard. 5. observation of the east wing third floor hallway ceiling tiles revealed tiles by had moldlike substance (Photographic evidence obtained). 6. observation was made of the resident common dayroom to have broken window blinds. (Photographic evidence obtained). 7. observation revealed the outdoor patio area to have cigarette butts throughout area used for Resident. (Photographic evidence obtained) 8. observation revealed the door frames and floor molding damaged and requiring repair and painting throughout 1st floor, 2nd floor and 3rd floor common corridors. (Photographic evidence obtained). 9. observation was made of the resident common dayroom to have broken and ripped and damaged chairs for Resident use. (Photographic evidence obtained). 10. observation revealed the resident dining area to have broken tile on countertop, floors are stained and dirty, chairs (45 of 45 chairs observed) utilized for Resident dining are stained and ripped. (Photographic evidence obtained). 11. observation revealed the facility kitchen located on first floor to have stained and dirty floors, equipment covered in grease, food storage area dirt with unknown spilled substance on floor.	A 152		

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A 152	Continued From page 20 Ceiling vent , , kitchen stove for cooking and heating resident food to be not working, active roach activity observed in kitchen area. Bathroom located next to kitchen designated for staff is dirty and had no towels. (Photographic evidence obtained). 12. Observation revealed two exhaust fans in the kitchen wall to take heat and fumes to the outside. However, neither of the two was observed working during the observation. (Photographic evidence obtained). 13. observation revealed resident # to have wall damage requiring repair and painting, damaged floor molding. (Photographic evidence obtained) 15. observation revealed Resident # to have dirty damaged walls needing repair and paint, missing closet door, pictures on wall were removed and never replace and bathroom has no soap. (Photographic evidence obtained) 16. observation revealed resident # to be occupied by two Residents with only 1 dresser, dirty ceiling air vent, window shades stained, and broken. Resident's bed sheets stained with fesses and , shower leaking water into bucket, damage to bathroom doorframe, bathroom has no soap. (Photographic evidence obtained). 17. observation revealed resident # to have dirty broken window shades, missing closet door, bathroom floor dirty and bathroom has no towels or soap. (Photographic evidence obtained) 18. observation revealed resident # to have damaged window frame, damaged ceiling tile, broken floor tiles, bathroom has no toilet paper or soap. (Photographic evidence obtained) 19. observation revealed resident 's	A 152		

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A 152	Continued From page 21 doorknob was broken. {Photographic evidence obtained) 20. observation revealed resident to have dirty broken window shades, shower drain not draining. (Photographic evidence obtained) 21. observation revealed elevator 1 and elevator 2 for Resident use to be dirty and both elevators have expired county inspection certificates dated . (Photographic evidence obtained) 22. observation revealed garbage and debris piled along fence in rear of facility, air conditioner units have exposed wiring, side of facility broken concrete revealing a hole into side of building, (Photographic evidence obtained) In an interview with the Administrator on at 4:58 PM he stated he recognizes and understands the facility needs repair. Stated he will address with his corporate office. Class III	A 152		