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	AL11932571	02/26/2018
NAME OF PROVIDER OR SUPPLIER **FEEL AT HOME, INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **129 WEST 131ST AVENUE** **TAMPA, FL 33612**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

Assisted Living Facility

A complaint investigation (CCR#: 2018000665 & 2018001370) was conducted on [redacted] at Feel at Home Assisted Living Facility. Deficient practice was identified at the time of survey.

(License#: 4653)

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review and interview, the facility failed to ensure that four of ten sampled residents (#1, #8, #9 and #18) met minimum criteria for admission to the facility.

Findings included:

A focused record review for Resident #1 conducted on [redacted] revealed that the most current Agency for Healthcare Form 1823 (AHCA 1823) dated [redacted] stated that Resident #1 requires 24-hour nursing or [redacted] care. Resident #1 was admitted to the facility on [redacted].

A focused record review for Resident #8 conducted on [redacted] revealed the most current AHCA 1823 stated that Resident #8's needs cannot be met in an Assisted Living Facility (ALF), Resident #8 requires administration of medications, and requires 24-hour nursing or [redacted] care. Resident #8 was admitted to the facility [redacted]. There are no nurses employed with the facility to administer medication. No documentation was provided to indicate that third party services were contracted to provide Resident #8 with medication administration.

A focused record review for Resident #9 conducted on [redacted] revealed the most current AHCA 1823 dated [redacted] stated that Resident #9 requires medication administration and the assessment further indicated that Resident #9's needs could not be met in an assisted living facility. Resident #9 was admitted to the facility [redacted]. There are no nurses employed with the facility to administer medication. No documentation was provided to indicate that third party services were contracted to provide Resident #9 with medication administration.

A focused record review for Resident #18 conducted on [redacted] revealed the most current AHCA 1823 dated [redacted] stated that Resident #18's needs cannot be met in an assisted living facility. Resident #18 was admitted to the facility [redacted].

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In an interview with the Administrator conducted on at 5:00 PM, the Administrator acknowledged and confirmed the AHCA 1823s for Residents #1, #8, #9, and #18 indicated that these residents were not appropriate for admission. The Administrator stated that, "these are the only 1823s for them (referring to Residents #1, #8, #9, and #18)."

Class III

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure that documentation of a face-to-face health assessment on Agency for Healthcare Administration Form 1823 (AHCA 1823) was complete and included all required information to assist in determining the appropriateness of residents admitted to the facility for eight Residents (#1, #3, #7, #8, #9, #11, #14, and #18) of ten sampled residents.

Findings Included:

A record review conducted on of Resident #1's AHCA 1823 dated revealed that Resident #1 needs 24-hour nursing or care. No medications were listed or attached to Resident #1's AHCA 1823. Resident #1 was admitted to the facility .

A record review conducted on of Resident #3's AHCA 1823 dated revealed no medications listed or attached. Resident #3 was admitted to the facility .

A record review of Resident #7's AHCA 1823 conducted on revealed no date of examination. Resident #7 was admitted to the facility .

A record review of Resident #8's AHCA 1823 conducted on revealed no date of examination and needs cannot be met in an Assisted Living Facility (ALF). Resident #8 was admitted to the facility .

A record review conducted on of Resident #9's AHCA 1823 dated revealed that Resident #9 needs medication administration and no medications were listed or attached. The AHCA 1823 does not indicate if needs can be met in an ALF. Resident #9 was admitted to the facility .

A record review conducted on of Resident #11's AHCA 1823 dated revealed that

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Resident #11 is free from communicable . No new 1823 was obtained when Resident #11 started a medication regimen for on . There was no documentation indicating that Resident #11 is now free from communicable . Resident #11 was admitted to the facility .

A record review of Resident #14's AHCA 1823 conducted on revealed no date of examination, no type of assistance needed with medications indicated, and does not indicate name and date of birth on all pages. Resident #14 was admitted to the facility .

A record review of Resident #18's AHCA 1823 dated conducted on revealed that needs cannot be met in an ALF and medication was not listed or attached. Resident #18 was admitted to the facility .

During an interview with the Administrator conducted on at 03:00pm, teh Administrator stated that medication lists for residents in the facility are not kept on the premises. The Administrator stated that the resident's medication lists are "in the other house; the doctor's office send them to me there; [and,] I go get them right now."

Class III

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on observation, record review, and interview, the facility failed to provide a diverse and ongoing activities program to meet the needs, abilities, and interests of 15 of 15residents residing in the facility.

Findings Included:

An observation during a survey conducted on revealed that no activities were observed throughout the day of the survey.

A review of the posted activity calendar conducted on revealed that the activity calendar was dated , 2018 and listed 11.5-hours of scheduled activities per week (See Photographic Evidence6). No activity calendar was posted dated , 2018.

During a staff interview with the Administrator conducted on at 05:30pm, the Administrator stated that, "I didn't make one for ."

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Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on record review and interview, the facility failed to:
1. Have a written Elopement Policy and Procedure (EP&P) addressing an immediate search of the facility and premises and identify staff responsible for implementing each part of the elopement response with their specific duties and responsibilities; and,
2. Conduct and document resident elopement drills pursuant to Sections 429.41(1) (a)3. and 429.41(1) (l), F.S.

Findings Included:

A review of the facility's EP&P conducted on , revealed that the facility's EP&P does not address an immediate search of the facility and premises. The EP&P stated that, "(1) If a resident is missing for more that 24-hours, check on the sign out sheet for resident's whereabouts; [and,] (2) Call the Sherriff to report for missing resident ..." The facility's EP&P does not identify staff responsible for implementing each part of the elopement response with their specific duties and responsibilities.

Continued review of the facility's EP&P conducted on , revealed that the facility failed to follow the Elopement P&P by notifying the Sherriff within 24-hours of an incident where Resident #18 was missing and reporting the elopements of Resident #1 and Resident #18 "to the AHCA in Tallahassee."

A review of the facility's documented Elopement Drills conducted on revealed that the last documented Elopement Drill is dated on .

During a staff interview with the Assistant Administrator conducted on at 03:30, the Assistant Administrator stated that no other documented Elopement Drills for the facility.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, record review and interview, the facility failed to give meds as prescribed during a med pass observation for nine Residents (#1, #2, #3, #4, #7, #10, #11, #13, and #14) of nine sampled residents, who need assistance with self-administration of meds or med administration and also failed to compare medication (med) labels to Medication Observation Record (MORs) for verification. In addition,

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facility staff failed to ensure residents receiving medications had their rights respected by following universal precautions for control while passing medications.

Findings Included:

During an observation of the Administrator conducted on at 07:15am, the Administrator put on gloves. The Administrator touched own face three times with gloved hands and proceeded to takethe medication (med) cart from the office area to the dining med pass.

During a med pass observation for Resident #4 conducted on at 07:30am, the Administrator took med pill cards to Resident #4 and handed the pill cards to resident. The Administrator did not have MORs present for comparison of med labels. The Administrator returned the med cards to the med cart. The Administrator did not change gloves or sanitize hands before beginning med pass or between residents.

During a med pass observation for Resident #3 conducted on at 07:35am, the Administrator took two med pill cards to Resident #3 and handed the pill cards to resident. The Administrator did not have MORs present for comparison of med labels. The Administrator returned the med cards to the med cart. The Administrator did not change gloves or sanitize hands between residents. The Assistant Administrator brought the book of MORs to the Administrator. The Administrator documented meds as given. Resident #3 received two meds (, 50mg and 20mg). Resident #3's MORs indicated two additional meds (40mg and , 5mg) due at this time. Resident #3 did not receive these two meds.

During a med pass observation for Resident #2 conducted on at 07:40am, the Administrator took two med pill cards (40mg and Beztropine , 2mg) to Resident #2 and handed the pill cards to resident. The Administrator did not compare med label to MORs. The Administrator returned the med cards to the med cart. The Administrator did not change gloves or sanitize hands between residents. The Administrator documented meds as given.

During a med pass observation for Resident #11 conducted on at 07:45am, the Administrator took two med pill cards (, 300mg and , 20mg) to Resident #11 and handed the pill cards to resident. The Administrator did not compare med label to MORs. The Administrator returned the med cards to the med cart. The Administrator did not change gloves or sanitize hands between residents. The Administrator documented meds as given. A review of the MOR indicated that one additional med was due at this time (, 800mg). Resident #11 did not get this med. When questioned at 7:47 AM, the Administrator stated that the med "ended yesterday" and

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proceeded to draw an arrow ending the med on Resident #11's MORs.

During a med pass observation for Resident #10 conducted on at 07:50am, the Administrator took one med pill card (, , 2mg) to Resident #10 and handed the pill card to resident. The Administrator did not compare med label to MORs. The Administrator returned the med card to the med cart. The Administrator did not change gloves or sanitize hands between residents. The Administrator documented med as given.

During a med pass observation for Resident #13 conducted on at 07:55am, the Administrator took Resident #13's med pill packs from the top of the med cart. The Administrator stated that Resident #13, "is not here" and placed the med pill packs back in the med cart. The Administrator stated that she would give Resident #13 his meds when he returns to the facility "around noon."

During a med pass observation for Resident #1 conducted on at 08:00am, the Administrator took Resident #1's med pill packs (, DR 250mg, , 8mg, , 0.5mg, and , 2mg) to Resident #1 and handed the pill cards to resident. The Administrator did not compare med label to MORs. The Administrator did not change gloves or sanitize hands between residents. The Administrator returned med pill cards to med cart and documented meds as given.

During a med pass observation for Resident #14 conducted on at 08:05am, the Administrator took Resident #14's med pill packs (, 1mg, , 800mg, , 500mg, and B-3) to Resident #14 and handed the pill cards to resident. The Administrator did not compare the med label to MORs. The Administrator did not change gloves or sanitize hands between residents. The Administrator returned the med pill cards to med cart and documented meds as given.

During a med pass observation for Resident #7 conducted on at 08:08am, the Administrator handed Resident #7 med pill packs (, 25mg, , 145mg, and , 1mg) one at a time as he was standing in front of the med cart. Resident #7 dropped the med on the floor. The Administrator did not intervene and Resident #7 took the meds, including the pill from the floor. The Administrator did not compare the med label to MORs. The Administrator did not change gloves or sanitize hands between residents. The Administrator returned the med pill cards to med cart and documented meds as given.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

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Based on observation, record review, and interview, the facility failed to (1) maintain an up-to-date daily medication observation records (MORs) for each resident who receives assistance with self-administration of medication or medication administration; and, (2) document MORs immediately each time medication is offered or refused.

Findings Included:

During a medication (med) pass observation for Resident #4 conducted on at 07:30am, it was observed that the facility does not immediately update MORs when a med is offered to a resident. The Administrator took the med cart into the dining multiple meds for multiple residents on top of the med cart and began med pass. No MOR was visible. The Administrator took med packs from the pile on top of the med cart and walked over to Resident #4. No MORs was present for comparison of meds being offered. The Administrator did not document meds offered to Resident #4. After offering Resident #4 meds, the Administrator returned to med cart and continued with the next resident.

During a med pass observation for Resident #3 conducted on at 07:35am, the Administrator pulled two med packs (, 40mg and 20mg) from the pile of meds on top of the med cart and took the med packs to Resident #3. After the Administrator gave Resident #3 these two meds, the Assistant Administrator brought the MORs to the Administrator. The Administrator opened the MOR book to Resident #3's MORs and documented that she had given the two aforementioned meds. The Administrator also documented that she had given Resident #3 40mg and , 5mg and she had not been observed giving these medications.

During a med pass, observation for Resident #11 conducted on at 07:45am, the Administrator took two med packs (, 300mg and , 20mg) to Resident #11. The MORs indicated that , 800mg was due at this time. This med was not given and was not available on med cart. The Administrator stated that the , ended yesterday and drew an arrow to end this med on the MOR.

A record review conducted for Resident #3 conducted on , revealed that Resident #3 had an to . Resident #3's MORs listed "NKA" (No Known) for .

A record review conducted for Resident #11 conducted on , revealed that Resident #11 had an to . Resident #11's MORs listed "NKA" (No Known) for .

During an interview with the Administrator conducted on at 11:35am, the Administrator stated she handwrites the MORs for all residents in the facility based on the label on the med packs that

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pharmacy sends. In a further interview at 03:00pm, the Administrator stated that residents' med lists and physician orders are kept "in the other house [and] the doctor's office send them to me there."

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to keep centrally stored medications (meds) in a locked cabinet, locked cart, or other locked storage receptacle at all times.

Findings Included:

Entrance into the facility conducted on . . . . . at 07:15am revealed the following:
When the Assistant Administrator opened the front door (which opens up to an office area), the med cart had several piles of resident's meds stacked on top (See Photographic Evidence1). Both the Administrator and the Assistant Administrator walked in and out of office area eight times (for one to two minutes each time) leaving the office door open and meds unattended and unsecured with two Agency staff in the .

During a med pass observation, in the dining , conducted on from 07:20am through 08:06am, the stacks of resident's meds remained on top of the med cart. Each time the Administrator went to offer meds to each resident, her back was toward the med cart and out of her line of vision. The Assistant Administrator and Staff A were in and out of the dining area.

During a facility tour conducted on . . . . . at 07:20am several med bottles with a towel half covering them were observed on a table off the kitchen area (See Photographic Evidence2).

During a staff interview with the Administrator conducted on at 07:26am, she stated that it is usual practice to leave meds unsecured within the facility. The Administrator stated that the Assistant Administrator "does this (referring to the several piles of meds on top of the med cart)." The Administrator stated that, "these are mine and [the Assistant Administrator's] meds (referring to the several med bottles with a towel half covering them on a table off the kitchen)."

During an observation conducted on at 08:40am, for Resident #6 and Resident #9 was observed kept in the kitchen refrigerator in an unlocked box. Both Administrator and Assistant Administrator attempted to find the key to the lock on the box but were unable to find a key by end of survey.

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Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observation, record review, and interview, the facility administrator failed to supervise the operation and maintenance of the facility, including the management of staff and the provision of sufficient care and oversight of all residents as required.

Findings Included:

During a survey of the facility conducted on , deficient practice at the facility included the following:
Resident #1's most current Agency for Healthcare Form 1823 (AHCA 1823) stated "Needs 24-hour nursing or care." Resident #8's most current AHCA 1823 stated, "Needs cannot be met in an Assisted Living Facility (ALF), requires administration of medications, and requires 24-hour nursing or care." Resident #9 most current AHCA 1823 stated, "Requires medication administration" and there was no indication that needs could be met in an ALF. Resident 18's most current AHCA 1823 stated, "Needs cannot be met in an ALF." The facility does not employ nurses. The facility did not contract with third party services to meet the needs of Resident #1, Resident #8, Resident #9, and Resident #18.

There was not a current activity calendar posted on the day of survey. There were no activities observed on the day of survey.

Review of facility records on revealed he facility does not have an Elopement Policy and Procedure in place that contains all required elements. The facility does not conduct Elopement Drills pursuant to Sections 429.41(1) (a)3. and 429.41(1)(l), F.S. The last documented Elopement Drill was conducted on . Resident #1 eloped from the facility on and Resident #18 eloped from the facility on .

Observation of medication pass at the facility conducted on beginning at 7:00 AM revealed that the facility does not use Universal Precautions to decrease the risk of transmitting during medication pass. The facility does not compare medication labels with the Medication Observation Record (MORs) ensuring the delivery of the correct medication to the correct resident. The facility does not maintain up-to-date resident's MORs. Resident #3 and Resident # 11's MORs did not list their . The facility does not keep centrally stored medication and personal (staff) medication

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secured in a locked cabinet, locked cart, or other locked storage receptacle at all times (See Photographic Evidence1 & Evidence2).

Record review revealed the last Department of Health inspection was dated on . The last Fire Inspection was dated on . The resident admission and discharge log was not up-to-date and it was difficult to determine all residents residing in the facility.
The Administrator did not know the last name of Resident #12. The Administrator stated during a medication observation at 07:55am that Resident #13 "left with his friend at 0500am" and at 03:41pm stated that he was discharged.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation, record review, and interview the facility failed to maintain a safe and hazard-free living environment.

Findings Included:

Entrance into the facility conducted on at 07:10am revealed a large pile of bagels and larger pile of decaying boards with nails in the front yard.

During a facility tour conducted on at 07:20am, a thermostat was observed on the wall taped shut with accumulated dust on cover and inside the box. The lever to change temperature was taped so that the temperature could not be changed. The label across the outer box inhibited seeing the current temperature.

During a facility, tour conducted on at 07:28am, it was observed that the last satisfactory annual Health inspection was dated . The last satisfactory annual fire inspection was dated . The Administrator stated that, "I need to call them," referring to the inspection agencies.

During an observation conducted with the Assistant Administrator on at 04:30pm, the backyard was noted to have a pile of broken dresser drawers and dresser and two old mattresses stacked against the fence, which have the appearance of exposure to the elements for a long time. Along the left side yard of the facility were two piles of old decaying boards/wood (one pile near fence and one pile near facility outer wall). A double sink with countertop was leaning against facility. In the front yard there was a washing machine. The Assistant Administrator stated that the machine was

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broken. Also in the front yard was a large pile of decaying boards with several large rusting nails poking out. Under the tree in the front yard, a large pile of old bagels/food (See Photographic Evidence4 & Evidence5).

During a staff interview with the Assistant Administrator conducted on at 04:35pm, the Assistant Administrator acknowledged and confirmed that all items observed have been sitting in the facility's yard for a long time. The Assistant Administrator stated that, "I know, there's so much work that needs to be done. I get to it."

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on observation, record review, and interview, the facility failed to maintain (1) an up-to-date admission and discharge log; (2) a log listing names of all temporary emergency placement residents; (3) annual satisfactory fire safety and sanitation inspection reports; and, (4) documented elopement response drills.

Findings Included:

A request for resident census from the Administrator conducted on . . . . . at 07:20am revealed that current facility census was fifteen residents in-house.

A review of the admission and discharge log conducted on revealed that current resident census per the log was sixteen residents in-house.

A record review for Resident #15 conducted on . . . . . revealed that Resident #15 no longer resided in the facility. Resident #15 on . . . . . .

A facility tour and record reviewconducted on . . . . . at 07:28am revealed that the last satisfactory annual county health inspection was dated . . . . . . The last satisfactory annual fire inspection dated . . . . . . The Administrator stated that, "I need to call them."

During a medication, observation for Resident #13 conducted on at 07:55am the Administrator stated that Resident #13 "left with his friend at 05:00am" as she placed Resident #13's medication back in medication cart. At 03:41pm, the Administrator stated that Resident #13 had been discharged from the facility. A record review of the admission discharge log confirmed that Resident

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#13's discharge was not documented on the log.

A record review for Resident #18 conducted on revealed that Resident #18 was from the facility on .

An observation of all in-house residents and follow-up interview with the Adminsitrator conducted on at 03:41pm revealed that the Administrator could not provide a last name or any information for Resident #12 and stated a local Mental Health placed Resident #12. The Administrator stated that:
(1) Resident #1 was currently at a day program
(2) Resident #13 was discharged from the facility
(3) Resident #14 was discharged from the facility
(4) Resident #16 was discharged after given a forty-five day notice

A second review of the admission and discharge log (See Photographic Evidence3) conducted on revealed that:
(1) Residents #12 not listed as a current in-house resident
(2) Resident #13 not listed as a current or former resident
(3) Resident #14 not listed as a current or former resident
(4) Resident #15 listed as current resident with no discharge information noted
(5) Resident #16 listed as current resident with no discharge information noted
(6) Resident #18 listed as current resident with no discharge information noted

A record review of the facility's elopement drills conducted on revealed that the last documented elopement drill was conducted on .

During a staff interview with the Administrator conducted on at 03:41pm, the Administrator acknowledged and confirmed that the admission and discharge log was not up-to-date.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview the facility failed to maintain complete resident records for six Residents (#1, #3, #9, #11, #12, and #18) of ten sampled residents.

Finding included:

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A record review for Resident #1 conducted on revealed that no medication list or physician orders were maintained in Resident #'s1 record. Resident #1 was admitted to the facility .

A record review for Resident #3 conducted on revealed that no medication list or physician orders were maintained in Resident #3's record. Resident #3 was admitted to the facility .

A record review for Resident #9 conducted on revealed that no medication list or physician orders were maintained in Resident #9's record. Resident #9 was admitted to the facility .

A record review for Resident #11 conducted on revealed that no medication list or physician orders were maintained in Resident #11's record. Resident #11 was admitted to the facility .

A record review for Resident #18 conducted on revealed no medications list or physician orders were maintained in Resident #18's record. Resident #18 was admitted to the facility .

During a staff interview with the Administrator conducted on at 03:00pm, the Administrator stated that medication lists and physician orders for residents are kept "in the other house; the doctor's office send them to me there; [and,] I go get them right now."

During an observation of one hundred percent of facility residents conducted on at 03:41pm, revealed that Resident #12 was residing in the facility but no resident record was found for Resident #12. The Administrator could not provide the last name for Resident #12 and Resident #12 was not listed on the facility's admission and discharge log.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview the facility failed to:
1. Establish a risk management and quality assurance program to assess resident care practices for adverse incidents reports and develop a plan of action to correct and respond quickly to resident elopements;
2. Maintain adverse incident reports for elopement events in which the elopement events reported to law enforcement; and,
3. Report elopement events within one business day after the occurrence of an adverse incident report to the Agency for Healthcare Administration (AHCA) for three Residents (#1, #, and #18) of three

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932571	02/26/2018
NAME OF PROVIDER OR SUPPLIER **FEEL AT HOME, INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **129 WEST 131ST AVENUE** **TAMPA, FL 33612**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

sampled residents who eloped from the facility.

Findings Included:

During a record review for Resident #1 conducted on , revealed that on at 06:45pm and on at 10:15am, the facility was notified on both occasions that Resident #1 had been found away from the facility by law enforcement. "Sherriff

During a record review for Resident #18 conducted on , revealed that on at 03:00pm, Resident #18's Psychiatrist "wants to resident but he is not in the premises; he walk out; reason is he refuse taken his meds." On at 11:30am, the Assistant Administrator "report him [Resident #18] for a missing that he never came back." On at 01:30am, the Police "brought him [Resident #18] from somewhere."

A review of the facility's Elopement Policy and Procedure (P&P) conducted on , revealed that the facility failed to follow the Elopement P&P by notifying the Sherriff within 24-hours of Resident #18 being missing and reporting the elopements of Resident #1 and Resident #18 "to the AHCA in Tallahassee."

During a staff interview with the Assistant Administrator conducted on at 03:30pm, revealed that the facility did not report elopements for Resident #1 and Resident #18. The Assistant Administrator stated that Resident #1, "We haven't had any elopements."

Class III

L241 - LMH - Records - 429.075(3-4); 58A-5.029(2) FAC

Based on record review and interview, the facility failed to: (1) have an up-to-date admission and discharge log clearly identifying all mental health residents; and, (2) obtain an annual updated Community Living Support Plan for one Limited Mental Health (LMH) Resident (#) of one sampled LMH resident.

Findings Included:

A request for resident census from the Administrator conducted on at 07:20am revealed that current facility census was fifteen residents in-house.

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During a medication, observation for Resident #13 conducted on at 07:55am the Administrator stated that Resident #13 "left with his friend at 05:00am" as she placed Resident #13's medication back in medication cart.

A review of the admission and discharge log conducted on revealed that current resident census was sixteen residents in-house.

A record review for Resident #11 conducted on revealed that the last update to Resident #11's Community Support Plan was on .

During a record review for Resident #15 conducted on revealed that Resident #15 no longer resided in the facility. Resident #15 expired on .

During a record review for Resident #18 conducted on revealed that Resident #18 was from the facility on . The last Community Support Plan in Resident #18's record dated and stated that Resident #18 is a "high risk for elopement." Resident walked out of facility on . The facility reported Resident #18 as missing to police on . The police brought Resident #18 back to the facility on at 01:30pm and was from the facility the same day.

During an observation of all in-house residents conducted on at 03:41pm revealed that the Administrator could not provide a last name or any information for Resident #12 and referred surveyor to local Mental Health , who placed Resident #12. The Administrator stated that:
(1) Resident #1 was currently at a day program
(2) Resident #13 was discharged from the facility
(3) Resident #14 was discharged from the facility
(4) Resident #16 was discharged after given a forty-five day notice

A second review of the admission and discharge log (See Photographic Evidence3) conducted on revealed that:
(1) Residents #12 not listed as a current in-house resident
(2) Resident #13 not listed as a current or former resident
(3) Resident #14 not listed as a current or former resident
(4) Resident #15 continues listed as current resident with no discharge information noted
(5) Resident #16 continues listed as current resident with no discharge information noted
(6) Resident #18 continues listed as current resident with no discharge information noted

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During a staff interview with the Administrator conducted on at 03:41pm, the Administrator acknowledged and confirmed that the admission and discharge log was not up-to-date.
Class III