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	AL11968865	**03/01/2018**
NAME OF PROVIDER OR SUPPLIER **ROBERTS ADULT CARE HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **1615 GLENDALE RD** **ORLANDO, FL 32808**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

The re-licensure survey was conducted on . Roberts Adult Care Home Assisted Living Facility, License 12813
had deficiencies at the time of the visit.

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

Based on record review and interview the facility did not obtain a complete and accurate updated Resident Health Assessment form (AHCA form 1823) for 1 of 2 sampled residents (#1).

Findings:

Record review for resident #1 revealed and updated resident health assessment form 1823 that was dated after a hospital admission. The section for the health care provider to document the type of assistance she required with medications was left blank.

On at 2 PM, the administrator confirmed the findings.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review, medication observation record review (MOR) and interview, the facility did document that the health care provider and family was contacted when 1 of 2 sampled resident had a and was transported to the hospital (#1), did not follow health care providers orders for medications for 1 of 2 sampled resident (#2), and did not contact the health care provider when the resident refused to take his medication and did not follow a health care providers order for a medication for 1 of 2 sampled residents (#2).

Findings:

1. On at 9:30 AM, caregiver B said resident #1 required assistance with bathing, that the resident was hard to deal with and would not follow her instructions while trying to help her in the shower. She said the resident had a in the shower because she could not prevent it sometime in 2017, which resulted in her having to call 911 to get the resident up and have her transported to the hospital. She said the resident was not injured and returned to the facility.

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On at 10 AM, resident #1 was lying in bed and said she required assistance with showers from the facility staff. She said had two in the shower in the presence of caregiver B. She said she felt that caregiver B intentionally let her because she did not like her. She said she did go to the hospital and did not sustain any injuries. Resident #1 said while in the hospital in , 2018, she was prescribed every eight hours but the staff would only give it to her once a day, and she wanted to take it more often because she was in pain without it. She said she needed the medication to control her pain. She felt her , was going up because of her pain.

On resident #1's health assessment form (1823), dated , the health care provider noted the resident required assistance with bathing, dressing, , transfers ambulation and toileting. Her diagnoses included ( ) and back pain. She required assistance with the self-administration of her medications. The medical record did not contain documentation to confirm that the resident in the shower, and that her family and health care provider were notified when she had a and was sent to the hospital.

Review of the , 2018 MOR revealed / , , (a) 1 daily as needed. This dosage started on , and was marked as given on at 8 PM, at 8 AM, and at 8 AM. Handwritten across the remaining spaces was "same new order see below" and had caregiver B's initials.

The , 2018 MOR noted (,) take 1 tablet every 8 hours as needed. Twenty pills were marked as given as follows on: at 7 PM, at 8 AM and 8 PM, at 9 AM and 7 PM, at 7 AM and 9 PM, at 8 AM and 7 PM, at 7 AM and 7 PM, at 8 AM and 4 PM, from through , the MOR noted the medication was given at 7 AM and 7 PM, and on at 7 AM. On the bottom of the , 2018 MOR was noted " / , take one daily as needed." This dosage started on and was marked as given on and .

Resident #1's record revealed the only order that was available was from the hospital discharge record. It noted on , was to be given every 8 hours as needed. There was no order to restart the 1 daily again.

On at 1 PM, caregiver B presented a bottle of with 5 tablets inside of the bottle with a prescription fill date of order dated . She said when the pills from the hospital ran out, they began to give the resident the medication out of that bottle that was ordered previously for 1 daily that she use to take. The administrator confirmed and said the hospital had only given the resident 20

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pills, and they gave the to her twice a day so that it would last longer. She said resident #1 agreed to this. She said when the resident would run out of the pain medication, she would go to the hospital instead of the health care provider to obtain more because the health care provider would only prescribe one pill a day. The administrator said after the hospital's dosage ran out, they started back to her old dosage. The administrator was asked if she had contacted the health care provider when resident #1 returned from the hospital with the new dosage to get clarification of the dosage that she should actually start back with the old dosage of 1 daily after the hospital dosage of 1 every eight hours was completed. The administrator, a registered nurse, said she did not contact the health care provider for clarification of the order, and thought the old order could resume after the hospitals dosage was complete. The administrator confirmed the resident did in the shower and was transported to the hospital. She said there was no documentation in her record regarding what had occurred and that the family and health are provider was contacted. She reviewed her telephone text, and said on , she sent her daughter a text notifying her that she was sent to the hospital.

2. Observation On at 12 PM revealed resident #2 at the dining table with another resident eating lunch. Caregiver B yelled out resident #2's name and said "Are you going to take your for your ?" The resident did not answer and she yelled it again. She place the medication in a small white paper cup and placed it on the table next to the resident. At 12:15 PM, the resident left the table with the medication inside of his hand and went to his . At 12:20 PM, the resident was asked if he had taken his medication, resident #2 said he had not taken the medication because he did not believe it was his medication because it was a different color, and it was making him . He wanted to wait until he visited the doctor. He was asked where the medication was. Resident #2 pulled out his drawer. He had placed the small cup with the medication inside of it in the drawer.

Review of the MOR for and noted ( ) 100 milligrams (mg.) one capsule 3 times daily. The MOR had an "r" in the spaces as follows:
at 8 AM on , , , , , , , , , , , , , , , ,
, at noon on , , , , 2/6, 2/7, , , , , , , , ,
at 8 PM on , , , , , , , , , , , , and .
10 mg. take one tablet 1 daily - "Hold if is less than 95" was hand written and there was an "r" in the spaces at 8 AM on , through , , and .

Review of the hand written "r" meant "refused/chose not to take."

Resident #2's resident health assessment form 1823, dated , reflected that the health care provider noted he required assistance with the self-administration of his medications, and his diagnoses included uncontrolled , , , , and .

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Resident #2's record did not contain documentation to confirm that the resident's health care provider was contacted to notify him that he was refusing to take his and high , medications.

The , 21018 MOR noted , , 10 mg. 1 table every day for , , hold if , is less than 95. An "h" was written in the spaces on , and . The , 2018 MOR had an "h" in the spaces on and . The hand written "H" meant hold. Review of the , monitoring log revealed the results were as follows: - , - , - , - , and - . The , results (the top number) were not less than 95 on they days that the medication was held. The medication was held in error.

On at 1 PM, caregiver B said when she held the medication, she was thinking the was the bottom number of the results, and she held the medication when the bottom number was less than 85. She said she later found out she should have not held the medication.

Class II

0028 - Resident Care - Activities of Daily Living - 58A-5.0182(4) FAC

Based on record review and interview, the facility failed to provide assistance with showers as needed for 1 of 2 sampled residents (#1).

Findings:

On at 9:30 AM, staff B, a caregiver said resident #1 required assistance with bathing, she said the resident was hard to deal with and would not follow her instructions while trying to help her in the shower. She said the resident had a in the shower because she could not prevent it sometime in , which resulted in her having to call 911 to get the resident up and have her transported to the hospital. She said the resident was not injured and was returned back to the facility. She said she could not give the resident a shower alone, she said the other staff was elderly and could not assist her with the shower and would only bathe her while she was in bed.

On at 10 AM, resident #1 who was lying in bed said she required assistance with showers from the facility staff. She said had two in the shower in the presence of staff B. She said she felt that

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staff B intentionally let her because she did not like her. She said she did go to the hospital and did not sustain any injuries. She said she would love to have showers instead of being bathed in the bed. She said her family would come when they could to help her get a shower.

Record review for resident #1 revealed a resident health assessment form dated ; the health care provider noted resident #1 required assistance with bathing, dressing, , transfers ambulation and toileting. She had diagnosis that included and back pain. She required assistance with the self-administration of her medications.

On at 1 PM, the administrator confirmed the resident was not getting showers because she had a with the staff B. She said the resident would shake while in the shower and it was hard to give her a shower alone. The administrator was asked at the time if she assisted with showers or had any other alternatives to ensure the resident received a shower as needed and she said she did not.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record review and interviews, the facility failed to ensure that each resident was treated with consideration and respect and with due recognition of personal dignity and allowed a staff to continue to work at the facility after reports of alleged for 1 of 2 sampled residents (#1).

Findings:

On at 10 AM, resident #1 who was lying in bed said she required assistance with showers from the facility staff. She said had two in the shower in the presence of staff B. She said she felt that staff B intentionally let her because she did not like her. Resident #1 said staff B was rude to her and would yell at her. She said she required assistance with changing her briefs. She said there were times when she would have a bowel movement, staff B would enter her loudly say, "It stinks in here." She said the other residents could hear her saying this and this would make her feel belittled. She said staff B would become angry and would slam doors. She said staff B told her she did not belong at the Assisted Living Facility She said she did not want to ask staff B for anything because she would always want to start and argument. She said she reported this to the administrator and the administrator told her she was trying to hire another staff to replace staff B.

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On at 11 AM, resident #2 said he had overheard staff B yelling at resident #1 and she would yell at him, he said she was argumentative and confrontational. Because of the way she made him feel, he would just go outside to smoke and remain in his avoid her. He did not like asking her for anything because she would just yell at him. He said the administrator told him she was searching for a new employee to replace her.

On at 12:45 AM, a telephone interview was conducted with the family member of resident#1, who stated resident #1 did let her know how she was being treated by staff B. She spoke with the administrator about it, and was informed that she was trying to hire another staff. She said when she would come to visit Resident #1 staff B would not speak or say anything to her the entire time she was at the facility. She said staff B was rude.

On at 2 PM, the administrator said she did receive report of staff B's behavior, she said she did not have a staff to replace her and was awaiting background screening results from a person she wanted to hire and then she was going to terminate staff B. She said she had terminated another staff because resident #1 did not get along with her, she said staff B would always tell her what resident #1 would tell her was not true so she allowed her to continue to work.

The administrator was informed at the time, that there was more than one resident complaining about how staff B treated them and she allowed the staff to remain at the facility.

On at 8:45 AM, a visit was made to the facility, resident #1 said staff B was no longer at the facility, she said she could sleep in peace. She said usually staff B would be around slamming doors and she could not rest and arguing. She said that staff B was no longer in the facility and she felt much better. She said staff C took good care of the residents and was nice to everyone.

Class III

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

Based on observations and interview, the facility failed to ensure when unlicensed staff provided assistance with the self-administration of medications, the staff followed the appropriate procedure at all times.

Findings:

Observation on at 12 PM revealed resident #2 was at the dining table with another resident eating

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lunch, staff B yelled Resident #2's name and said, "Are you going to take your for your ", the resident did not answer and she yelled it again. She placed the medication in a small white paper cup, on the table next to the resident, and walked away.
At 12:15 PM, the resident left the table with the medication inside of his hand and went to his .

At 12:20 PM, the resident was asked if he had taken his medication, resident #2 said he had not taken the medication because he did not believe it was his medication because it was a different color and it was making him . He wanted to wait until he visited the doctor. He was asked at the time where the medication was. Resident #2 pulled out his drawer and he had placed the small cup with the medication inside of it in the drawer.

Observation on at 12:15 PM-staff B caregiver (non-nurse) said resident #5's name and said this is your Voltaren gel for your knee; staff b squeezed some of the gel in a small cup and placed it on the table next to resident #5 while she ate her lunch and walked away. Further observation revealed there was a dosing card that was to be used to measure the proper amount of the Voltaren gel in the bag that had another tube of Voltaren gel inside. Staff B did not use it. Staff B said at the time she would just squeeze some in the cup and give it to her because there was no amount on label. She said she was aware there was dosing card in the bag. The Voltaren gel remained on the table the entire time the resident had lunch and the staff left it there.

Staff B did not follow the proper steps when she assisted with the residents medications, she did not in the presence of the resident, read the label, open the container, remove the prescribed amount of medication from the container and observe the residents take their medications.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on medication observation record (MOR) review, medication review, observations and interview, the facility did not ensure that the unlicensed staff who assisted with the Voltaren 1% gel for 1 of 2 sampled residents (#5) was aware of the dosage amount to ensure the effectiveness of the medication.

Findings:

Observation on at 12:15 PM-staff B, a caregiver (non-nurse) said resident #5's name and said this is your Voltaren gel for your knee. Squeezed some of the gel in a small cup, placed it on the table next to her while she ate her lunch, and walked away. Further observation revealed there was a dosing

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card in the bag that was to be used to measure Voltaren gel. Staff B did not use it. Staff B said at the time she would just squeeze some in the cup and give it to her because there was no amount on label. She said she was aware there was dosing card in the bag.

Observations revealed the Voltaren gel was in a plastic bag the label noted Voltaren 1% Gel apply to right knee 3 times daily. There was no amount on the label and there was no way for the facility staff to determine the amount to give to the resident to apply.
Review of the instruction on back of the tube for dosage noted: Apply to skin over the affected area four times daily. Use the dosing card provided to measure the amount of Voltaren gel to be applied. See accompanying prescribing information. Staff B was asked if there was any prescribing information available for review and she said there was not.

Review of the MOR for and revealed there was no amount listed and the unlicensed staff had initialed the MOR as applying the medication for the resident.

On at 1 PM, the administrator a nurse confirmed that there was no amount listed on the prescription label, she was not aware there was a measuring card in the bag; she said she had not called the health care provider or pharmacy to obtain the dosage amount.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on personnel record review, medication observation record (MOR) review, record review interview the facility allow unlicensed staff to perform duties that were not consistent with their level of education, training, preparation, and experience, the unlicensed staff took 1 of 2 sampled resident's (#2) and exercise judgment as to whether or not the medications were needed and 1 of 3 sampled staff (A,) did not have evidence of Freedom from ( ) annually and 1 of 1 newly hired staff (B) did not have a statement form a health care provider documenting freedom from communicable conducted no earlier than 6 months before submission of the statement.

Findings:

Review of the MOR revealed it noted 10 mg 1 table every day for hold if is less than 95. There was an "h" in the spaces on and

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Review of the MOR revealed there was an "h" in the spaces on 2/1 and 2/3.
Hand written on the MOR was "H=Held"
Review of the monitoring log revealed the results were as follows:
On , on , on , on 2/1- and 2/2- .
The results (the top number) were not less than 95 on the days that the medication was held, the medication was held in error.

On at 1 PM, staff B an unlicensed caregiver said when she held the medication she was thinking the was the bottom number of the results and she held the medication when the bottom number was less than 85. She said she later found out she should have not held the medication.

Record review for resident #2 revealed a resident health assessment form 1823 that was dated , the health care provider noted he required assistance with the self-administration of his medications and his diagnosis included uncontrolled .

On at 1:30 PM, the administrator, a nurse said she was not aware the unlicensed staff could not take vitals and make judgment as to hold or give a medication.

Personnel record review for Staff A, the administrator revealed the last documentation to confirm she was free from was dated .

Personnel record review for Staff B hired had a freedom from communicable statement that was dated (more than 6 months).

On at 4 PM, the administrator confirmed the findings.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on staff schedule review and interview, the facility did not maintain a staff schedule that accurately reflected its 24-hour staffing pattern for a given time period.

Findings:

Review of the staff schedule provided for , revealed it listed only names on some days, on other days a 24 would be written next to the staff's name and on some days a 4 would be written next to

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the administrators name. There was no way to determine the actual time a staff worked.

There was no schedule available for through .

On at 4 PM, the administrator confirmed the findings.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on personnel record reviews and interview, the facility failed to ensure that 2 of 3 sampled staff (B and C) received the required in-service training within 30 days of hire.

Findings:
Personnel record review for staff b a caregiver, hired revealed there was no documentation to confirm she had received in-service training's regarding facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation and the facility's resident elopement response policies and procedures.

Personnel record review for staff c a caregiver, hired revealed there was no documentation to confirm she had received in-service training regarding the facility's resident elopement response policies and procedures. The elopement procedure training located in her record was received at another facility.

On at 4 PM, the administrator confirmed the findings.

Class III

0082 - Training - / - 58A-5.0191(3) FAC

Based on personnel record review and interview, the facility failed to ensure that 1 of 3 sampled staff (B) had obtained the one-time education course on and within 30 days of employment.

Findings:

Personnel Record review for staff B, a caregiver hired revealed there was no documentation to confirm she had obtained a one-time education and including the topics prescribed in the Section 381.0035, F.S. within 30 days of employment.

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On ... at 4 PM, the administrator confirmed the findings.

Class III

0083 - Training - First Aid and ... - 58A-5.0191(4) FAC

Based on personnel record review and interview, the facility failed to ensure that a staff member who held a currently valid card that documented the completion courses in First Aid and ... was in the facility at all times.

Findings:

Observations on at 8:45 AM, revealed staff B a caregiver, was working alone with the residents. Personnel record for staff B revealed her first aid and ... cards expired on ....

On ... at 4 PM, the administrator confirmed the cards had expired.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on observations, personnel record review and interview, the facility failed to ensure that 1 of 3 sampled unlicensed staff (B), who provided assistance with the resident's medications received the initial 4 hours training in providing assistance with self-administered medications and safe medication practices in an Assisted Living Facility (ALF) and 1 of 3 sampled unlicensed staff (C) who provided assistance with the residents medication did not receive annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility provided by a licensed registered nurse, or a licensed pharmacist.

Findings:

On at 9 AM staff B said she provided assistance with the self-administration of the resident's medication.
Personnel record review for staff B revealed there was no documentation to confirm she had obtained the initial 4 hours training in providing assistance with self-administered medications and safe medication practices in an ALF.

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Personnel record review for staff C revealed the last 2-hour continuing education was on .

During an interview with the administrator on at 4 PM, revealed staff B and C both assisted the residents with their medications. The administrator confirmed the findings.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on personnel record review and interview the facility failed to have evidence that 2 of 3 sampled staff (B and C) had at least one hour of training in the facility's policies and procedures regarding ('s) that included information in Rule 58A-5.0186, F.A.C. within 30 days after employment.

Findings:

Personnel record review for staff B a caregiver hired and staff C a caregiver hired , revealed there was no documentation to confirm they had obtained a 1-hour in-service training within 30 days of hire regarding the facility's policies and procedures regarding ('s) that included information in rule 58A-5.0186, F.A.C.

On at 4 PM, the administrator confirmed the findings.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on personnel record review and interview the facility failed to ensure staff had certificates that included the required information for 2 of 3 sampled staff (b and C).

Findings:

1. Personnel record review for staff B, a caregiver, hired revealed there was a certificate that listed multiple training's that included:
1. control
2. Resident needs Behavior and ADL's
3. Incidents
4. Resident rights

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Further review of the certificate revealed it was dated , 2017, the total contact hours of the certificate noted 2 hours.

2. Personnel record review for staff C, a caregiver hired , there was certificate that had multiple training's that included:
1. Emergency procedure
2. Resident rights
3. Incidents

Further review of the certificate revealed it was dated , 2017, the total contact hours of the certificate noted 2 hours.

There was no way to determine if the staff had obtained the required amount of training time because the hours of training's of each was not identified only the total amount of all of the training's.

On at 4 PM, the administrator confirmed the findings.

Class

0092 - Food Service - General Responsibilities - 58A-5.020(1) FAC

Based on facility record review and interview, the facility who provided food service, failed to ensure that there was a person designated in writing to be responsible for total food services and the day to day supervision of food services staff.

Findings:

Review of the facility's documentation revealed there was no documentation found to determine who was responsible for total food services and the day to day supervision of food services staff.

On at 2 PM the administrator said staff C was responsible for the total food services and day to day supervision of the food service staff and she did designate her in writing.

Class

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

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

Based on the menu log review and interview the facility did not maintain the menus for 6 months and did not follow the menu to serve or offer soup or a substitute.

Findings:

Review of the menu for the day revealed it noted hot dogs, chips, fruit cocktail and tomato soup and cracks
Observations during lunch on at 11:45 AM revealed the residents were not served soup.

On at 1 PM, staff B said she did not serve the tomato soup because the residents did not like it, she was asked at the time if there was another soup the residents could have received instead, staff B said the facility did have other soups available,

Review of the log used for the dates that the facility used for the cycled menus revealed there was no dates of usage of the menus documented for , and nor were there menus available for those months.

On at 2 PM, the administrator confirmed the facility did not start using the cycled menu date log until .

Class

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on personnel record reviews and interview, the facility failed to ensure the staff record contained a copy of the Registered Nurse License for 1 of 3 sampled staff (A).

Findings:

Personnel record review for staff A the administrator, a registered nurse revealed there was not a copy of her license in the record.

On at 4 PM, the administrator confirmed the findings.

Class

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968865	**03/01/2018**
NAME OF PROVIDER OR SUPPLIER **ROBERTS ADULT CARE HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **1615 GLENDALE RD** **ORLANDO, FL 32808**	

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

Based on record review and interview, the facility did not inform 2 of 2 sampled residents (#1 and #2) whether or not a nurse would oversee the unlicensed staff who provided assistance with the self-administration of medication.

Findings:

Record review for resident's #1 and #2 revealed there was no documentation to confirm that the facility had informed the residents or their family members if a nurse would oversee the unlicensed staff who provided assistance with the self-administration of medication.

On at 2 PM, the administrator confirmed the findings.

Class

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on interview, the facility did not have evidence that the comprehensive emergency management plan (CEMP) was submitted for review and approval to the local emergency management agency within 30 days after obtaining a license.

Findings:

On at 11 AM, the administrator was asked to provide the CEMP approval letter from the local emergency management agency.

On at 11:30 AM, the administrator said she was working on the plan and did not have an approval letter.

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on the staff schedule review, interview and the agency's background screening website, the facility did not initiate all Criminal history checks through the clearinghouse before employment.

Findings:

Review of the staff schedule revealed staff C was listed as working.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968865	**03/01/2018**
NAME OF PROVIDER OR SUPPLIER **ROBERTS ADULT CARE HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **1615 GLENDALE RD** **ORLANDO, FL 32808**	

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

Review of the agency's background screening website revealed she was not listed on the facility's background screening roster, further review of the roster revealed staff A, the administrator was not listed.

On . . . at 2 PM, the administrator confirmed the findings.

Unclassified

Z821 - Reporting Requirements; Electronic Submission - 59A-35.110 FAC

Based on record review and interview the facility failed to submit an adverse incident report when Law enforcement were called to conduct an investigation.

Findings:

Record review for resident #1 revealed a facility note dated . . . that noted:

Family member called police to report that resident #1 name listed, was not being taking care of. Officer observed no distress or mistreatment.

On . . at 3 PM, the administrator said she was not aware that an adverse incident was required for a police investigation

Unclassified