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	AL11968284	**09/14/2018**
NAME OF PROVIDER OR SUPPLIER **DANIELLA'S LIFE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1910 W FERN ST** **TAMPA, FL 33604**	

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Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on employee record review and interview, the facility failed to maintain the eligibility results of employee Level II Background screening and the signed Attestation for 1 (Staff A) of 2 employee records reviewed.

Findings Included:

Employee record review conducted on revealed there was no results of Staff A's Level II Background screening or signed Attestation.

Interview with Administrator was conducted on at 9:58am. The Administrator confirmed there was no evidence of the Level II
Background screening and the signed Attestation in the file for Staff A.

Unclassified

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

Based on employee record review and interview, the facility failed to maintain an up-to-date Background Screening (BGS) Roster.

Findings Included:

Record review conducted on revealed Staff A was not on the Background Screening Roster.

An interview with Administrator was conducted on at 9:58am. The Administrator confirmed she is responsible for updating the BGS Roster. The Administrator stated she had not updated the roaster since Staff A returned to the facility and could not provide a hire date for Staff A. The Administrator confirmed it had been longer than 10 days.

Unclassified

Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation, interview and record review, the facility failed comply with the licensed capacity of six assisted living residents. The Facility provided 24-hour medication and activity of daily living services

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to eight residents who resided in facility for 24 hours.

Findings included:

During interview with Staff A, on at 06:00 a.m., Staff A stated that the Facility had eight assisted living residents who lived at the Facility for at least one month. Facility tour beginning at 6:15 a.m., conducted with Staff A revealed that the Facility has a total of eight residents (#1, #2, #3, #4, #5, #6, #7 and #8) who slept at the Facility.

Observation and interview with Resident #6, on , at 06:15 a.m., revealed that Resident #6 used a loveseat/pullout bed, for sleeping.

Observation of medication storage, on at 06:21 a.m., with Staff A, revealed that the Facility stored medications for the identified eight residents (#1, #2, #3, #4, #5, #6, #7 and #8). Staff A confirmed that she assisted with medication for all eight residents.

During entrance conference with the Administrator, on at 06:43 a.m., the Administrator confirmed that the Facility had seven assisted living residents (#1, #2, #3, #4, #5, #6, an #7), and confirmed that Resident #8, who she identified an adult daycare client, resided at the Facility for more than 24 consecutive hours, while family was out of town. Administrator confirmed that all eight residents received assistance with medications by the Facility.

Record review on revealed that the Facility maintained a medication observation records for seven (#2, #3, #4, #5, #6, #7 and #8) of the eight residents who received assistance with medication by the Facility.

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0000 - Initial Comments

Assisted Living Facility

A complaint survey (CCR#2018011294) was conducted on . . . . . at Daniella's Life ALF (License #12212), an assisted living facility in Tampa, Florida. There were deficiencies identified at the time of visit.

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

Based on record review and interview, the facility failed to obtain complete documentation of a face-to-face health assessments (1823) for 3 residents (#3, #4, and #5) out of 6 records reviewed.

Findings included:

Record review conducted on revealed Resident #3's 1823 was missing pages 2, 3 and 4.

Record review conducted on revealed Resident #4 had no date on the 1823.

Record review conducted on revealed Resident #5's 1823 dated was missing if the resident needed assistance with medications and what type of assistance the resident needed.

Interview with the Administrator was conducted on . . . . . beginning at 8:38am. The Administrator confirmed Resident #3's 1823 was missing pages 2, 3 and 4, Resident #4 had no date on the 1823 and Resident #5's 1823 was missing an indication of if the resident needed assistance with medications and what type of assistance the resident needed.

(Photographic evidence obtained)

Class III

0009 - Admissions - Admission Package - 58A-5.0181(3) FAC; 400.0078(2)

Based on interview and record review, the facility failed to obtain facility resident contracts for 2 (#3, and #4) out of 6 resident records sampled.

Findings Included:

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Record review conducted on [redacted] revealed there was no facility resident contract for Resident #3 in the file.

Record review conducted on [redacted] revealed the facility resident contract on file was not signed by the resident or the Power of Attorney (POA).

Interview with the Administrator was conducted on [redacted] beginning at 8:38am. The Administrator confirmed there was not facility resident contracts for Resident #3 or Resident #4.

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on resident record review and interviews, the facility failed to obtain an interdisciplinary care plan between hospice and the facility for 1 (#4) of the 6 records reviewed.

Findings Included:

Record Review conducted on [redacted] revealed there was no interdisciplinary care plan between hospice and the facility for Resident #4.

Interview with the Administrator was conducted on [redacted] at 8:11am. The Administrator confirmed there was no interdisciplinary care plan between hospice and the facility for Resident #4.

Interview with the Hospice Nurse was conducted on [redacted] at 8:49am. The Hospice Nurse confirmed there no interdisciplinary care plan between hospice and the facility for Resident #4 and confirmed Resident #4 was a hospice patient. The Hospice Nurse also stated that Resident #4 was "bedbound" and required medication administration.

Observation throguhout the survey on [redacted] from 6:45-10:00 AM confirmed no licensed nurses were employed by the facility.

Class III

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

Based on record review and interview, the facility failed to provide an ongoing activity program with a

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minimum of twelve hours per week as required.

Findings included:

Facility tour, conducted on , at 06:00 a.m., revealed that the posted Facility activities schedule was for the month of , 2018.

On , at 07:33 a.m., the Administrator confirmed that the Activities schedule, posted on the living , was for the month of . When asked, the Administrator did not know if the facility staff followed, or paid attention to the Activities schedule. Administrator became upset, and stated that the Owner was supposed to keep up with the schedules.

During interview with Resident #6, on , at 07:37 a.m., resident indicated that the Facility did not do activities lately. Resident #6 stated, "We watch TV and sit outside. We have games, but we don't play them."

During interview with Resident #3, on , at 07:46 a.m., resident indicated that he did not know , when asked about activities provided by the Facility for the residents.

During interview with Resident #2, on , at 07:58 a.m., resident stated that the Facility sometimes celebrated resident birthdays, and indicated that Facility perhaps offered an activity once a week.

During interview with Resident #8, on , at 09:58 a.m., resident stated that the Facility did not do anything for fun with the residents.

During interview with Resident #5, on , at 10:00 a.m., resident stated that the Facility did not provide activities for the residents. Resident #5 stated, "All I do here is sit here and smoke my cigarettes. There is nothing else to do."

Class III

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

Based on observation, and interview, the facility failed to (1) ensure that resident was provided with privacy while receiving assistance with shower for one (Resident #5), and (2) failed to provide 45 days' notice of relocation from the Facility to another location operated by the Facility Owner, and then to

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another licensed assisted living facility (Gaining Facility).

Findings included:

(1)

On at 07:50 a.m. Staff A was observed assisting Resident #5 with bathing with the open, Resident #5 was nude and seated on a shower chair, viewable from the hallway.

On at 07:51 a.m., the Administrator was informed of the opened . Administrator confirmed that Staff A was providing Resident #5 assistance with shower while the was opened.

(2)

During interview with the Legal Representative for Resident #9, on at 04:51 p.m., he indicated that the Facility did not inform him that Resident #9 was moved from the Facility until , when the Administrator of the Gaining Facility contacted him about a contract on the day Resident #9 was admitted to the Gaining Facility.

On at 10:05 a.m., the Administrator stated that none of the records requested for discharged residents, to include Resident #9, were at the Facility. The Administrator only had an incomplete contract, which was not signed by Resident #9 or the Legal Representative for Resident #9. The Administrator stated that she did not remember speaking to Resident #9's Responsible Party about Resident #9's discharge. Administrator indicated that the date of discharge and location of discharge was listed on the Facility's admission discharge log.

Review of Admission discharge log, provided by the Facility on , indicated that Resident #9 went to another licensed assisted living facility (Gaining Facility), on .

During interview with the Administrator of the Gaining Facility, on at 02:30 p.m., the administrator confirmed that Resident #9's first day at the Gaining Facility was , and that the Administrator contacted the legal responsible party for Resident #9 to complete a contract for admission.

Interview with Case Manager for Resident #9, on , at 10:27 a.m., revealed that Resident #9 lived at the Facility as an assisted living resident until .

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Class III

0051 - Medication - Pill Organizers - 58A-5.0185(2) FAC

Based on observation and interview, the facility failed to ensure that a licensed staff removed medications from the primary packaging and into pill organizers for eight (#1, #2, #3, #4, #5, #6, #7 and #8) of eight residents who received assistance with self-administration of medication.

Findings included:

During Facility tour on [redacted], at 06:21 a.m., medications were observed were found removed from original packaging and placed in clear plastic containers, each container was labeled with residents' names for all eight residents that resided at the Facility (image taken).

Staff A, who was present for the Facility tour, stated that she removed the medications last night to get ready for the morning medications. Staff iA then changed her statement, and stated that she removed the medications from original packaging and into the containers on [redacted], around 05:30 a.m., Staff A confirmed that morning medications were scheduled for 08:00 a.m. When asked, Staff A was not able to identify any of the medications in the containers.

During interview with the Administrator, on [redacted], at 07:08 a.m., the Administrator observed and confirmed that medications were removed from original packaging, and placed in containers for all eight residents. Administrator stated that she does not know why Staff A did that.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on observation, interview, and record review, the facility failed to provide assistance with self-administered medications in accordance with procedures described in Section 429.256, F.S.; specifically, Staff A, unlicensed, removed medications from original packaging to store in plastic containers for eight residents (#1, #2, #3, #4, #5, #6, #7 and #8), Staff A failed to remove medication from primary packaging in the presence of the resident for eight residents (#1, #2, #3, #4, #5, #6, #7 and #8), failed to read medication labels aloud for two (#4, and #6) of two resident observed for assistance with medication self-administration, and Staff A, unlicensed, failed to provide medication dosage within one-hour of the prescribed time, and administered oral medication dosages for one (#4) of two resident observed for Assistance with medication self-administration.

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Findings included:

During Facility tour, on , beginning at 06:21 a.m., medications were observed removed from original packaging and placed in clear plastic containers, each container was labeled with residents' names for all eight residents that resided at the Facility (image taken).

Staff A, who was present for the Facility tour, stated at 6:25 AM that she removed the medications last night to get ready for the morning medications. Staff A then immediately changed her statement, and stated that she removed the medications from original packaging and into the containers on , around 05:30 a.m., Staff A confirmed that morning medications were scheduled for 08:00 a.m. When asked, Staff A was not able to identify any of the medications in the containers.

Review of the Medication Observation Record (MOR) confirmed that medications were scheduled for 08:00 a.m. for all eight (#1, #2, #3, #4, #5, #6, #7 and #8) of eight residents who resided at the Facility and received supervision or assistance with self-administration of medication.

During interview with the Administrator, on , at 07:08 a.m., the Administrator observed and confirmed that medications were removed from original packaging, and placed in containers for all eight residents. Administrator stated that staff are trained to pass medication the right way, she does not know why Staff A did that.

On , at 07:41 a.m. Staff A was handed Resident #6 container, labeled with resident's name, with previously dispensed medication dosages. Staff A did not have original packaging, label or the Medication Observation Record (MOR). Staff A did not inform Resident #6 of what medications were provided. Staff A did not document in MOR for medications provided to Resident #6.

During observation of assistance with medication self-administration for Resident #4, on , at 09:21 a.m., Staff A removed a medication capsule from container, labeled with resident's name, with previously dispensed medication dosages and placed the medication in a table spoon of water. Staff A administered the oral medication dosage for Resident #4 with a spoon. Staff did not have the original medication packaging, label, or the MOR with her. Staff A did not inform Resident #4 of medications provided. Staff A confirmed that medications were scheduled at 08:00 a.m., but resident received the medications at 09:21 a.m.

Review of the , 2018 MOR, with the Administrator and Staff A, on at 09:34 a.m., revealed that Staff A did not document any of the scheduled 08:00 a.m., medications for . Administrator informed Staff A that she needed to sign the MOR when medications were provided to the

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residents.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interview, and record review, the facility failed to ensure that only licensed staff administered medications to one (Resident #4) of two observed for assistance with medication self-administration.

Findings included:

During observation of assistance with medication self-administration, on . . . . . , at 09:21 a.m., Staff A removed medication capsule from container, labeled with resident's name, with previously dispensed medication dosages and placed the medication in a table spoon of water. Staff A administered the oral medication dosage for Resident #4 with a spoon.

During interview with Hospice Nurse, who was present for observation, on at 09:24 a.m., Hospice Nurse stated that Resident #4 was bedbound and needed medication administration. Hospice nurse stated that hospice only administers medications that were ordered by hospice.

Review of, undated, health assessment for Resident #4 revealed documentation that Resident #4 needed medication administration.

During interview with the Administrator, on . . . . . at 09:27 a.m., the Administrator confirmed with Staff A that resident needed and received medication administration by Facility staff who are not licensed.

Class III

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

Based on interview and record review, the facility failed to ensure that Medical Observation Records (MOR) were updated each time a medication (med) was offered to eight (#1, #2, #3, #4, #5, #6, #7 and #8) of eight sampled residents, and the Facility failed to complete a a MOR for one (Resident #1) of eight residents who received assistance with self-administration of medication.

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Findings included:

Record review revealed no evidence that Facility maintained a Medication Observation Record (MOR)for Resident #1.
On at 06:21 a.m., clear container, with Resident #1's name, was observed with medications in it. Original containers, with tablets , and as needed medications for pain were observed in the medication cabinet for Resident #1.

On , at 07:41 a.m. Staff A handed Resident #6 a container, labeled with resident's name, with previously dispensed medication dosages. Staff A did not have the Medication Observation Record (MOR). Staff A did not document in MOR for medications provided to Resident #6.

During observation of assistance with medication self-administration for Resident #4, on , at 09:21 a.m., Staff A removed a medication capsule from container, labeled with resident's name, with previously dispensed medication dosages and placed the medication in a table spoon of water. Staff A administered the oral medication dosage for Resident #4 with a spoon. Staff A did not have the MOR with her.

On , at approximately 06:21 a.m., Staff A stated that the Facility did not have a MOR for Resident #1. Staff confirmed that she assisted all eight residents, to included Resident #1, with medications.

Class III

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

Based on record review and interview, the facility failed to maintain an accurate staffing schedule, reflecting the current staffing in the facility.

Findings included:

Facility tour, conducted on , at 06:00 a.m., revealed that the posted Facility direct care staffing was for the month of , 2018.

When the Administrator was asked for the Facility direct care staffing schedule, on , at 07:27 a.m., the Administrator pointed at the staffing schedule posted on the living . Review of staffing schedule revealed that the schedule did not indicate which staff worked on which shift.

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On , at 07:28 a.m., the Administrator confirmed that the direct care staff schedule was for the month , 2018.

On , at 07:33 a.m., the Administrator created a , 2018 staffing schedule, but the schedule did not reflect which staff was working on which shift to accurately the staffing hours for the current census of eight residents.

Class III

0080 - Training - Core & Competency Test - 429.52(1-2) FS; 58A-5.0191(1) FAC

Based on interview and record review, the facility's administrator of record failed to meet the training and testing requirements for an administrator of an assisted living facility. The administrator failed to complete the core competency exam within the required timeframe.

Findings included:

Record review of the Administrator's personnel file on revealed that the Facility's Administrator was the administrator of record since , and completed the 26-hour assisted living facility core training on . There was no evidence that the Administrator passed the Core Competency exam.

Review of Facility's roster on the Clearing house webpage revealed that the roster was updated to reflect the Administrator of record on .

During interview with the Administrator, on , at 09:29 a.m., Administrator stated that she was the Administrator of record for two years, and confirmed that she had not successfully completed the Core Competency exam.

Class III

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

Based on observation, interview and record review, the facility failed to ensure that each resident was provided with a designated bed for sleeping; specifically, the facility admitted eight residents that required 24-hour assisted living services, with seven beds. One resident (#6) used a loveseat/pullout bed for sleeping.

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Findings included:

During Facility tour with Staff A, on [redacted], at 06:00 a.m., Resident #6 was observed using a red love seat as a bed (photographic evidence).

During observation and interview with Resident #6, on [redacted] at 06:15 a.m., Resident #6 stated she stated she slept on the red love seat observed, and sometimes the staff pull out the bed of the love seat for her. Resident #6 stated that she used to have a bed, but the facility Owner moved her to the love seat with pull out [redacted] bed. Staff A, who was present for the interview, confirmed that the [redacted] three residents, and Resident #6 slept on the love seat for over one month.

Class III

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

Based on record review and interview, the facility failed to maintain an up-to-date admission and discharge log reflecting the admission and the discharge date, the reason for discharge, and where each resident was discharged to.

Findings included:

During interview with Staff A, on [redacted] at 06:00 a.m., she stated that that she worked at the Facility for about three months. Staff A stated that the Facility had eight assisted living residents who lived at the Facility for at least one month. Facility tour conducted with Staff A revealed that the Facility has a total of eight residents (#1, #2, #3, #4, #5, #6, #7 and #8) who slept at the Facility.

During entrance conference with the Administrator, on [redacted] at 06:43 a.m., the Administrator confirmed that the Facility had seven assisted living residents (#1, #2, #3, #4, #5, #6, an #7), and confirmed that Resident #8 resided at the Facility for more than 24 consecutive hours.

Review of the Facility's admission discharged log, on [redacted], revealed that Resident #5, Resident #6, Resident #7 and Resident #8 were not listed on the admission discharge log. The Facility's admission discharge log also indicated that Resident #9 was discharged on [redacted] to another licensed assisted living facility.

During interview with the Administrator, on [redacted] at 07:02 a.m., Administrator stated that she did

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not understand why four residents were not included on the Admission discharge log.

Interview with Case Manager for Resident #9, on , at 10:27 a.m., revealed that Resident #9 lived at the Facility as an assisted living resident until .

Interview with the Administrator of the licensed Facility who received Resident #9, on , at 02:30 p.m., revealed that Resident #9 did not arrive there until , and not , as indicated on the Admission discharge log.

Class III

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

Based on employee record review and interview, the facility failed to maintain) applications and references for one of two employee records reviewed (Staff A).

Findings Included:

Employee record review conducted on revealed there was no application or references for Staff A with an unknown date of hire.

An interview with the Administrator was conducted on at 9:58am. The Administrator confirmed there was no application on file for Staff A.

Class III

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

Based on record review and interview, the facility failed to maintain or furnish a contract for ## resident (#3, #4, #7 and #8), and health assessment (AHCA Form 1823) for one resident (#3, #7, and #8) of eight residents who received 24-hour continuous assisted living services; and the Facility failed to retain discharged resident's record for two years, and five years for resident contracts, following departure for three (#9, #10, and #11) of three discharged/ resident selected for record review.

Findings included:

During entrance conference with the Administrator, on at 06:43 a.m., the Administrator confirmed that the Facility had seven assisted living residents (#1, #2, #3, #4, #5, #6, an #7), and

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confirmed that Resident #8, who she identified an adult daycare client, resided at the Facility for more than 24 consecutive hours, while family was out of town. Administrator confirmed that all eight residents received assistance with medications by the Facility

Record review, on , revealed that Resident #3's admission dates were documented as on the Facility's admission discharge log, and as on Resident #3's demographic sheets. There was no health assessment or contract at the Facility for Resident #3.

Record review, on , revealed that Resident #4's admission dates were documented as on the Facility's admission discharge log, and as on Resident #4's demographic sheets. Record review revealed that the Facility contract for assisted living was not signed by the resident or legal representative. Resident #4 had an active Durable Power of Attorney, dated .

Record review for Resident #7 and Resident #8, on , revealed only the Facility only provided the medication observation record. Resident #8 and Resident #9 were not listed on the Facility's admission discharge log presented by the Facility on .

Review of Facility's previously provided, admission discharge log, revealed that Resident #7 was listed as an assisted living resident from , and discharge to "Family House" on .

Review of Facility's previously provided, admission discharge log, revealed that Resident #8 was listed as an assisted living resident from , and discharge to "House" on .

During interview with the Administrator, on , at 07:14 a.m., the Administrator stated that the Facility did not have any record for Resident #8, because she considered Resident #8 as an adult day care client, and confirmed that Resident #8 was staying at the Facility, while Resident #8's family was out of town.
Administrator also confirmed that the Facility did not have records, which included a contract or health assessment, onsite for Resident #7.

Attempted record review, and record request, on at 08:59 a.m., for resident listed as discharged on the Facility's admission discharge log (Resident #9 - discharged on), Resident #10 (discharged on), and Resident #11 (discharged on), revealed no evidence that the Facility maintained the records for the discharged residents at the Facility. The Administrator confirmed that there were no record at the Facility for discharged Resident #9, Resident #10, and Resident #11.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968284	**09/14/2018**
NAME OF PROVIDER OR SUPPLIER **DANIELLA'S LIFE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1910 W FERN ST** **TAMPA, FL 33604**	

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

During a follow-up interview with the Administrator, on [redacted] at 10:05 a.m., the Administrator stated that she has none of the records requested for discharged residents, Resident #9, Resident #10, and Resident #11. The Administrator also confirmed that the Facility did not have records for Resident #7 and Resident #8 for continued assisted living residency, or timeframe of assisted living residency listed on the [redacted] admission discharge log that included [redacted] to [redacted] for Resident #7; and [redacted] to [redacted] for Resident #8.

Class III

0163 - Records - Resident, Penalties for Alteration - 429.49 FS

Based on observation, record review and interview, the Facility altered, or falsified documentation while above the licensed capacity of six; and omitted information to cover continued residency for two current resident (Resident #7 and Resident #9), and one former resident (Resident #9).

Findings included:

Review of the Facility admission discharge log, provided on [redacted], indicated that Resident #9 was discharged on [redacted], to a licensed assisted living facility (Gaining Facility). In addition, the admission discharge log did not include Resident #7 and Resident #8.

During interview with the Legal Representative for Resident #9, on [redacted] at 04:51 p.m., he indicated that the Facility Owner asked him lie to tell the Agency that Resident #9 was a daycare resident and not an assisted living resident. The Legal Representative said the Facility then moved Resident #9 without informing him. Legal Representative for Resident #9 stated that the Facility did not inform him that Resident #9 was moved from the Facility until [redacted], when the Administrator of the Gaining Facility contacted him about a contract on the day Resident #9 was admitted to the Gaining Facility.

On [redacted] at 10:05 a.m., the Administrator stated that she did not remember speaking to Resident #9's Responsible Party about Resident #9's discharge.

During interview with the Administrator of the Gaining Facility, on [redacted] at 02:30 p.m., the administrator confirmed that Resident #9 first day at the Gaining Facility was [redacted], and that the Administrator contacted the legal responsible party for Resident #9 to complete a contract for admission.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968284	**09/14/2018**
NAME OF PROVIDER OR SUPPLIER **DANIELLA'S LIFE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1910 W FERN ST** **TAMPA, FL 33604**	

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

Review of Admission Discharge log for the Gaining Facility, on , revealed the documented admission date Resident #9 was . Review of contract for the Gaining Facility revealed that contract was completed by Resident #9's responsible party on .

Interview with Case Manager for Resident #9, on , at 10:27 a.m., revealed that Resident #9 lived at the Facility as an assisted living resident until , when his status was changed to an adult daycare, and Facility moved him to an unlicensed location at 7410 West Elm Street, 33616.

When the admission discharge log was compared to previously provided admission discharge log ( ), it revealed that Resident #7 and Resident #8 were initially listed on the Facility's admission discharge log. The admission discharge log indicated:
Resident #7 was admitted to the Facility on , and discharged to "Family House" on .
Resident #8 was admitted to the Facility on , and discharged to "House" of .
Resident #9 was admitted to Facility on and discharged to "House [illegible]" on .

During interview with the Administrator, on at 07:02 a.m., Administrator stated that she did not understand why four residents were not included on the Admission discharge log.

During interview with the Pharmacy Technician for Resident #7, and Resident #8, on at 09:44 a.m., the technician confirmed that Resident #7 and Resident #8 continued to received medications at the Facility since 2018 until current date.

Class III