STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968310	**02/22/2019**
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT IVY RIDGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7179 40TH AVE N** **SAINT PETERSBURG, FL 33709**	

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

0000 - Initial Comments

Assisted Living Facility

From [redacted], a Complaint Survey (CCR#2018018141, CCR#2019000080, CCR#2019000720 and CCR#2019001008) was conducted at Inspired Living at Ivy Ridge. At the time of the survey, the facility had deficiencies.

(License #12224)

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

Based on record review, and interview, the Facility failed to employ or contract with the services of a licensed nurse to administer medications to one Residents (#9) of one sampled resident that required medication administration and did not meet the Facility's admissions criteria.

Findings Included:

A record review for Resident #9, conducted on [redacted], revealed that Resident #9's most recent Health Assessment Form dated [redacted] stated that the resident require medication administration and total care with Activities of Daily Living bathing and grooming. Resident #9's Health Assessment form was greater than 60-days prior to admission as the resident admitted in to the Facility on [redacted] and already under Hospice care. Resident #9's Health Assessment Form did not included the required nursing services of Hospice. There were no medication assessments or Physician orders in Resident #9's record that stated that the resident capable of administering medications with assistance. There was no Interdisciplinary Care Plan in Resident #9's record, which specified the care and services provided by Hospice and those provided by the Facility.

A review of Resident #9's [redacted], and [redacted] Medication Observation Records (MORs), conducted on [redacted], revealed that the Facility's Medication Technicians signed for medications as given on Resident #9's MORs, which included Staff B, H, I, J, and K.

During an interview with the Administrator, conducted on [redacted], the Administrator acknowledged and confirmed that Residents #9's Health Assessment Form stated that the resident required medication administration and was greater than 60-days prior to the resident's admission in to the Facility and that

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968310	**02/22/2019**
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT IVY RIDGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7179 40TH AVE N SAINT PETERSBURG, FL 33709**	

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

Resident #9 inappropriate for admission. The Administrator confirmed that the Facility does not employ licensed nurses to administer medications to residents who require medication administration. The Administration confirmed that the Facility's Medication Technicians signed Resident #9's , , and MORs as giving medications to the resident.

Class III

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

Based on observation, interview, and record review, the Facility failed to provide the level of supervision and oversight required to meet scheduled and unscheduled service needs for residents who presented with exit-seeking behaviors and also failed to maintain a written record updated with significant changes, including exit-seeking behaviors and attempts to leave the facility, including those attempted resulting in injury.

Findings Included:

Observations conducted on beginning at 10:15 am, revealed that in the secure Facility, the doors to the courtyard in the 200-hall were observed propped open at 10:15 am, with two female residents present in the courtyard and no staff present in the courtyard. Observed one male resident carry a chair from the activity area out to the courtyard. Staff were observed coming and going in the activity area and not checking the courtyard area. At 01:50 pm, observed Resident #13 outside in courtyard attempting to get in the closed courtyard door into the facility and the resident was unable to get through the door. There was no staff present in courtyard with Resident #13. At 02:05pm, Resident #13 knocked on the door five times in an attempt to get in to the Facility. After the fifth knock, Staff B opened the courtyard door and let Resident #13 in to the Facility.

Further observation at 02:10pm, observed one medication cart left unlocked and unattended with residents diagnosed with in the area and Resident #13 exited in to the courtyard through the propped open door. At 02:4, Staff B closed the courtyard door and did not check the courtyard for residents. At 02:40pm, observed Staff B walk up to the unlocked medication cart backwards, stood in front of the medication cart for 30-40 seconds, and walked across the room. When Staff B walked away from the medication cart, the medication cart observed as locked.

During interviews with Staff B and H, conducted on beginning at 10:20 am, Staff stated that the Facility left the courtyard door open, residents in the courtyard without the presence of staff. At 10:20 am, Staff H stated that the courtyard door was left open all the time so that residents could "go outside

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968310	02/22/2019
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT IVY RIDGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7179 40TH AVE N** **SAINT PETERSBURG, FL 33709**	

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

when they want to". Staff H stated that two Residents, Residents #2 and #15 attempted to go over the six- fence by pulling a chair or bench up to the fence.

Record reviews for Residents #1, #2, #9, #10, #11 conducted on , revealed the following:

- According to Resident #1's Health Assessment Form dated , the resident had a diagnosis of , had a history of , and the resident was forgetful. Resident #1 required assistance with all Activities of Daily Living. Resident #1's Progress Notes dated stated that the resident was "determined to leave Facility" and redirection was given at the time. On , Resident #1's Progress Notes indicated that the resident "found outside trying to unscrew key , ". There was no follow-up documentation.

- According to Resident #2's Health Assessment Form (See Photographic Evidence2), dated , the resident had a diagnosis of Memory Loss and was noted to be an elopement risk and was independent with all Activities of Daily living but required daily oversight for well-being, whereabouts, and reminders for important tasks. Resident #2's Progress Notes dated (See Photographic Evidence4) at 02:fpm stated that the resident was "adamant [that the resident] does not belong here stating [that the resident] will find a way out". On at 10:40 am, Resident #2's Progress Notes stated that the resident was seen "climbing the fence" and "jumping over" [and] staff quickly ran to meet [the resident] on the outside fence". The resident was "escorted in to the Facility through the front door" [and the resident] complained of right , [and] right and sensitive to touch [and] noted to left ". Staff did not call Emergency Personnel on but instead walked the resident in to the Facility.
There was no documentation or evidence of monitoring or interventions for Resident #2 for elopements or exit seeking behavior from to . Resident #2 had no assessment conducted post- . Resident #2's undated Elopement Risk Assessment did not have all sections completed. (See Photographic Evidence4).
Continued record review revealed Resident #2 sustained to the left and right third and fifth and non- until the Orthopedic 's scheduled on . A evaluation (See Photographic Evidence8) conducted by the Advanced Nurse Practitioner for Resident #2 on , revealed that the resident displayed "theft and exit-seeking" behavior and for the Facility to "monitor for changes in or behaviors". There was no documentation in Resident #2's record that the Facility monitored the resident.
Resident #2's contract dated (See Photographic Evidence9) stated on page 5 stated that, "The Establishment is intended to be a safe harbor unit for Residents with who are an elopement risk or who require specialized programming or Residents with ".

- According to Former Resident #11's record, the resident was admitted in to the Facility on .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968310	02/22/2019
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT IVY RIDGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7179 40TH AVE N** **SAINT PETERSBURG, FL 33709**	

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

Resident #11 did not have a Health Assessment Form in the resident's record. There were no risk assessments for Resident #11 in the resident's record. Resident #11 had a sustaining a bone on . The Facility sent Resident #11 to the Hospital's Emergency Department and the resident never returned to the Facility.

A review of the Facility's Policy and Procedure (FP&P), conducted on , revealed that the Facility failed to follow their FP&P when Resident #2 had an unwitnessed from a six high fence and sustained to both left and . The FP&P Procedure #3 stated that the Facility evaluated and assessed the resident post for injury and "Associates will access Emergency Medical Services (call 911) for actual or suspected injuries that are medical emergencies or if the associate is uncertain."

- According to Resident #15's record, the resident's Health Assessment Form had no date of the examination and no type of assistance noted for medications. There was no documentation of Resident #15's elopement and exit seeking behavior. Resident #15 had a diagnosis of and an Elopement Risk. Resident #15's Elopement Risk Assessment dated stated that the Resident had a '14' risk level which indicated that the resident attempted to leave the Community daily. Resident #15's Elopement Risk Assessment dated stated that the resident had a '13' risk level which indicated that the resident attempted to leave the Community one to two times weekly. There were no care or service plans in the resident's record for the coordination of care and services that the resident required for elopement risk, exit seeking behaviors, and elopement.

A review of the Facility's Elopement Policy and Procedure (EP&P), conducted on , revealed that the Facility failed to follow their EP&P. The EP&P stated that residents had a "right to live in a safe and secure environment" and that the Community had the responsibility "for ensuring that effective systems in place to reduce the risk of elopement by residents". The EP&P stated that the Community would "identify residents at risk for elopement" and complete an Elopement Risk Assessment completed upon move-in, annually, and upon changes in condition and conduct elopement drills quarterly each calendar year. The EP&P state that the Community would complete an Incident Report, analyze and determine the elopement reasons, and submit the required regulatory reporting documents on page four.

A review of the Facility's Admission Packet, conducted on , revealed that within the General Safety Section, the Facility stated that:
- Concern for your safety and well-being is a high priority
- Staff members monitor entrances and common areas 24-hours a day
- At dusk, the front door is locked [and] other doors will be locked at all times
- Please assist us by making sure the exterior doors are locked at all times

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968310	02/22/2019
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT IVY RIDGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7179 40TH AVE N** **SAINT PETERSBURG, FL 33709**	

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

Interviews with Staff J, L, and O, conducted on , revealed that the Facility left the courtyard doors open and unsecured and that the staff did not call Emergency Personnel when Resident #2 got out of the secured Facility and from a six- high fence sustaining to the resident's left and right . Staff unable to state which resident were elopement risks.

- At 02:30pm, Staff L stated that, "I was working on the 3 - 11 shift that night" and indicated that (Resident #2) went over the fence at approximately 10:15 or 10:20. Staff L stated that "we went outside and [the resident] was already over the fence and we brought her in [and the resident "was limping and complaining of ankle and , ". Staff L stated that Staff N was working but "in a room with someone else" at the time of occurrence and that "no one discussed calling 911". Staff L stated that the courtyard was easily accessible to residents". Staff L sated that two residents in the Facility were elopement risks, Resident #2 and Resident #15. Staff L was unable to identify other residents deemed as elopement risks. Staff L indicated that the Facility left the courtyard door "open in the day time and the doors are locked at nighttime after 08:00pm".

- At 03:00pm on , Staff J stated that, "I was there" when Resident #2 went over the fence. Staff J stated that, "I found her over the fence and that's when we found her on the other side and got her up [and] no one saw her go out in to the Courtyard". Staff J stated that Staff M and Staff L were also present that night and that Staff N, a Licensed Practical Nurse, was not present. Staff J stated that, "we had to call the (Former Wellness Director) [and the Wellness Director] told us to document it in the book or tell the nurse in the morning [and] have the nurse check her in the morning". Staff J stated that Resident #2 "was limping on the way in". Staff J stated that the Staff were "supposed to know where residents are" and do undocumented -counts with their rounds. Staff J stated that Resident #15 "got out a few times [and] we seen him on the sidewalk" and Resident #17 "packs up stuff and says I'm leaving" [and Resident #2]was "determined ever since [the resident] got here to get out". Staff J was unable to identify other residents deemed as elopement risks.

- At 03:40pm, Staff O stated that the courtyard door was propped open during the day and locked after dinner about 05:30. Staff O stated that Resident #18 liked to "take a stroll out [in the courtyard] before bed". Staff O stated that if the staff saw someone in the courtyard the staff would check the courtyard and that the Facility had no policy that staff had to be present in the courtyard when a resident was out there. Staff O stated that Staff O had "never seen anyone do a count" of residents before. Staff O stated that there were "no residents at risk for elopements" residing in the Facility. Staff O stated that Resident #15 liked "to open the door a lot [and the resident] definitely wants to go through the door".

During interviews with the Administrator on at 12:40pm, the Administrator declined to produce

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968310	02/22/2019
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT IVY RIDGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7179 40TH AVE N** **SAINT PETERSBURG, FL 33709**	

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

the requested Facility Incident Report of Resident #2's incident with injury, resulting from going over the fence of the Facility and stated that, "Corporate won't allow me to release the incident report" and that the Facility "did not submit an Adverse Incident Report". At 03:45pm, the Administrator still would not provide Resident #2's incident report which Agency staff requested for clarification in the discrepancies of time line, event accounts, and staff accounts, as well as documentation of notification to the resident's responsible party. At 04:3, the Administrator continued to refuse to over Resident #2's Incident Report for Elopement with injury. The Administrator stated that resident counts were "done sporadically and not documented". The Administrator stated that Resident #2 had a previous incident with "pulling a bench up to the fence" and acknowledged that the previous incident not documented in the resident's record. At 03:50pm, the Administrator stated that the Facility had no policy and procedure on courtyard checks or resident counts and that the video feed from the courtyard was not reviewed during the investigation of the incident regarding Resident #2 going over the facility fence and was no longer available to view. The Administrator stated that, "I educate staff that everyone here is an elopement risk".

Class II

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(I)

Based on record review and interview the facility failed to follow their policy and procedure for conducting resident elopement drills.

Findings included:

A record review conducted on of the facility Elopement Risk Management Policy and Procedure, (policy date 2014 and modified , ,) revealed that the policy stated "The Executive Director will ensure that the Elopement Drills are no less than four times per year." (photographic evidence obtained)

A record review conducted on of the Elopement Drills Log, revealed that the facility had conducted only two Elopement Drills in 2018 on at 9:30am and at 7:30am.

During an interview conducted on at 2:22pm, the Executive Director Acknowledged and confirmed that they had only conducted 2 elopement drills in 2018 and that the facility policy was to have four elopement drills annually. The Executive Director stated "I have only two elopement drills

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968310	**02/22/2019**
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT IVY RIDGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7179 40TH AVE N** **SAINT PETERSBURG, FL 33709**	

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

documented for 2018 and the policy says we have to have four annually."

Class III

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

Based on observation, record review, and interview, the Facility (a secured Memory Care facility) failed to keep centrally stored medications locked and secured at all times.

Findings Included:

A review of the Facility profile, conducted on , revealed that the Facility was a secured Memory Care Facility.

During an observation on the 200 hall, conducted on at 02:00pm, one of the two medication carts was observed unlocked. Memory Care residents were observed in the area and staff were observed coming and going through the area, which included Staff B. No staff addressed the unlocked medication cart until 02:25pm when Staff B walked up to the unlocked medication cart backwards and stood in front of the cart for thirty to 40 seconds. Staff B walked away from the medication cart across the room and sat next to a male resident and it was noted the medication cart was locked.

During an interview with Staff B, conducted on at 02:45pm, Staff B acknowledged and confirmed that the medication cart was left unlocked and unattended for greater than twenty-five minutes and stated that, "we are supposed to keep it locked at all times".

During an interview with the Administrator, conducted on at 04:35pm, the Administrator confirmed that the medication carts were supposed, "to be locked at all times when a Med Tech (Medication Technician) is not in attendance".

Class III

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

Based on record review and interview, the Facility failed to have an Interdisciplinary Care Plan specifying care and services that Hospice provided and the Facility provided for Hospice residents and to have

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968310	02/22/2019
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT IVY RIDGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7179 40TH AVE N** **SAINT PETERSBURG, FL 33709**	

SUMMARY STATEMENT OF DEFICIENCIES
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completed Health Assessment Forms with all required data for two Residents (#10 and #15) of three sampled Residents.

Findings Included:

A record review for Resident #10, conducted on , revealed that Resident #10's Health Assessment Form dated did not contain the resident's required Hospice nursing services noted on the Health Assessment Form. There was no information on Resident #10's diet or whether the resident was an Elopement Risk noted on Resident #10's Health Assessment Form, as required. There was no Interdisciplinary Care Plan in Resident #10's record specifying care and services that Hospice provided and those that the Facility provided. Resident #10 was admitted to the Facility on and admitted to Hospice services on .

A record review for Resident #15, conducted on , revealed that Resident #15's Health Assessment Form had no date of the examination and no type of assistance noted for medication administration as required. Resident #15 was admitted to the Facility on . There were no other Health Assessment Forms in Resident #15's record.

During an interview with the Administrator, conducted on at 04:35pm, the Administrator acknowledged and confirmed that Resident #10's Health Assessment Form was missing the resident's diet and Hospice services was not noted on the resident's Health Assessment Form as required. The Administrator was unable to provide Resident #10's Interdisciplinary Care Plan. The Administrator acknowledged and confirmed that Resident #15's Health Assessment Form not dated and did not specify the resident's diet and type of medication assistance the resident needed as required.

Class III

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

Based on observation, record review, and interview, the Facility failed to report adverse incidents to the Agency as required for events in which residents eloped from the Facility and sustained bone for two residents (Resident #1 and Resident #2).

Findings Included:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968310	02/22/2019
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT IVY RIDGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7179 40TH AVE N** **SAINT PETERSBURG, FL 33709**	

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

Interviews with Staff B and H, conducted on , revealed that the Facility left the courtyard door open, residents in the courtyard without the presence of staff. At 10:20am, Staff H stated that the courtyard door left open all the time so that residents could "go outside when they want to". Staff H stated that two Residents, #2 and #15, attempted to go over the six- fence by pulling a chair or bench up to the fence.

Interviews with Staff J, L, and O, conducted on , revealed that the Facility staff did not call Emergency Personnel when Resident #2 got out of the secured Facility and from a six- high fence sustaining to the resident's left and right .
- At 02:30pm, Staff L stated that, "I was working on the 3 - 11 shift that night" and indicated that Resident #2 went over the fence at approximately 10:15pm or 10:20pm. Staff L stated that the resident "we went outside and [the resident] was already over the fence and we brought her in [and] the resident "was limping and complaining of ankle and , ". Staff L stated that "no one discussed calling 911". Staff L sated that there were only two residents, that were elopement risks, Resident #2 and Resident #15. Staff L unable to identify other residents deemed as elopement risks. Staff L indicated that the Facility leaves the courtyard door "open in the day time and the doors locked at nighttime after 08:00pm".

- At 03:00pm, Staff J stated that, "I was there" when Resident #2 went over the fence. Staff J stated that, "I found her over the fence and that's when we found her on the other side and got her up [and] no one saw her go out in to the Courtyard". Staff J stated that, "we had to call the Former Wellness Director [and the Wellness Director] who told us to document it in the book or tell the nurse in the morning [and] have the nurse check her in the morning". Staff J stated that Resident #2 "was limping on the way in". Staff J stated that the Staff were "supposed to know where residents are" and do undocumented -counts with their rounds. Staff J stated that Resident #15 "got out a few times [and] we seen him on the sidewalk" and Resident #17 "packs up stuff and says I'm leaving" [and Resident #2] "determined ever since [the resident] got here to get out". Staff J was unable to identify other residents deemed as elopement risks.

A record review for Resident #1, conducted on , revealed documentation in Resident #1's record that the resident "determined to leave Facility" on and on the resident "found outside trying to unscrew key , ".

A review of the Facility's Admission Packet, conducted on , revealed that the Facility failed to follow their Mission Statement "to set standards of for providing a watchful oversight ...for our clients". Within the General Safety Section, the Facility stated that:
- Concern for your safety and well-being is a high priority

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968310	**02/22/2019**
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT IVY RIDGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7179 40TH AVE N** **SAINT PETERSBURG, FL 33709**	

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

- Staff members monitor entrances and common areas 24-hours a day
- At dusk, the front door is locked [and] other doors will be locked at all times
- Please assist us by making sure the exterior doors are locked at all times

A review of the Facility's Policy and Procedure (FP&P), conducted on , revealed that the Facility failed to follow their FP&P when Resident #2 had an unwitnessed from a six high fence and sustained to both left and . The FP&P Procedure #3 stated that the Facility evaluated and assessed the resident post for injury and "Associates will access Emergency Medical Services (call 911) for actual or suspected injuries that are medical emergencies or if the associate is uncertain.

Interviews with the Administrator, conducted on and , revealed that the Facility failed to submit an Adverse Incident Report with the Agency for Health Care Administration for the Elopements of Residents #2 and #15. On at 12:45pm, the Administrator stated that the Facility "did not submit an Adverse Incident Report". The Administrator stated that Resident #2 had a previous incident with "pulling a bench up to the fence" and acknowledged that the previous incident was not documented in the resident's record.

Class III