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F 000	INITIAL COMMENTS Special Focus Facility Annual Recertification Survey	F 000		
F 158 SS=C	483.10(c)(1) RIGHT TO MANAGE OWN FINANCIAL AFFAIRS The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that residents have timely access to personal funds, by limiting resident banking to one day per week. This has the potential to affect all 31 residents residing in the facility. The findings include: On 4/5/16 at 9:25 am there was an undated sign posted on the Business Office door that stated "CASH DAY Every Wednesday at 2:00 pm we will meet in the Day Room. If you want money from your trust fund this will be the designated day from now on that we can disperse money. Thank you". The Resident Trust Fund Policy Notification and Authorization form dated 11/2015 stated "Residents of this facility have the right to manage their own financial affairs and handle their own spending money. Residents also have the right to have the facility keep their money in a	F 158		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 158	Continued From page 1	F 158		

trust account to safeguard and manage personal spending money...Residents and/or their authorized representatives are asked to observe the trust fund banking hours that are posted in the facility. Those residents wishing to withdraw or deposit money may do so at these times."

On 4/5/16 at 9:45 am the resident personal trust funds account records were reviewed with Business Office Manager E24. E24 stated at that time when she first started working at the facility since 12/20/15 there was no designated day for banking. Residents could come to her anytime during the week for money. E24 stated "I was told by my regional coordinator to designate a specific day for banking because money was being dispersed all the time and it was hectic." E24 stated the new policy went into effect on 3/2/16. The first two weeks when residents came to E24 for money she would inform the residents that from now on banking would be on Wednesdays. E24 still gave the residents their money, then after the two weeks was over, E24 would normally ask residents to wait until Wednesday.

E24 continued that she questioned the new policy at that time as they have no check book for the Resident Fund Management Account (RFMA), which is located in a bank in the city where the facility corporate headquarters is located. E24 just has access to petty cash. E24 stated she asked the company if the facility could have a resident trust account in town so the residents wouldn't have to wait for E24 to request a check if the cash was not available in the trust fund. E24 stated at that time she has made some exceptions to the Wednesday bank day when a resident family requests money or if there was a

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F 158	Continued From page 2 reason a resident needed money sooner. E24 stated on 4/5/16 at 10:00 am that she was unaware that the federal regulations specify that a resident should have ready and reasonable access to their trust funds which includes within 24 hours for resident requests for less than $50.00 and requests for $50.00 or more should be honored within three banking days. The resident Trust Trial balance report dated 3/01/16 documents 29 residents with current personal trust fund balances. The Resident Census and Conditions of Residents report dated 4/4/16 documents 31 residents in the facility. The facility Resident Census and Conditions of Residents form dated 4/4/16 document a resident census of 31 residents.	F 158		
F 225 SS=C	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		

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F 225	Continued From page 3 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to check the Health Care Worker Registry for an ancillary staff member prior to contact with residents and failed to initiate a livescan fingerprint check. This failure has the potential to affect all 31 residents residing in the facility. Findings include: 1. The Illinois Healthcare Registry was not checked for prior reports of abuse, neglect or misappropriation of resident property and for disqualifying offenses on previous livescan fingerprint checks until 4/6/16 for E20, Dietary. There is no documentation of a livescan fingerprint check being done or initiated for E20.	F 225		

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F 225	Continued From page 4 The undated list of staff hired in the last four months documents that E20, Dietary was hired on 3/11/16. On 4/6/16 at 8:30am E1, Administrator verified that the Healthcare Worker Registry was not checked for any of the new staff hired in the last four months, including E20. On 4/6/16 at 8:50am E3, Activity Director and E24, Business Office confirmed that the Healthcare Worker Registry does not document a livescan fingerprint check being done for E20. E3 stated they would do a fingerprint check for E20. On 4/6/16 at 10:36am E26, Dietary Manager stated that E20 works in the evening and at times will pass drinks to residents in the dining room. E26 stated E20 will also pass fresh water to each resident's room. E26 stated E20 has been fixing things in the facility, and fixed a heater in a resident's room the other day. On 4/6/16 at 10:45am E1, Administrator stated that E20 fixed the heater and changed a light bulb in R14's room, in the absence of a maintenance person. E1 stated that E20 has also done some work in the shower rooms. The facility Abuse Prevention Program dated 1/1/15 documents the following: "The facility will not knowingly employ any individual convicted of resident abuse, neglect or misappropriation of property. The facility will not knowingly employ any staff convicted of any of the crimes listed in the Illinois Healthcare Working Background Check Act....or with findings of abuse, neglect or misappropriation of resident property listed on the Illinois Health Care Registry. Prior to a new	F 225		

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F 225	Continued From page 5 employee starting a work schedule, this facility will:.....Check the Illinois Health Care Worker Registry on any individual being hired for prior reports of abuse, neglect or misappropriation of resident property, previous fingerprint check results....and Initiate an Illinois State Police livescan fingerprint check for any unlicensed individual being hired without a previous fingerprint check..." The Resident Census and Conditions of Residents report dated 4/4/16 documents 31 residents reside in the facility.	F 225		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed operationalize their Abuse Prevention Policy by failing to check the Health Care Worker Registry for direct care and ancillary staff prior to contact with residents, and failed to initiate a livescan fingerprint for an unlicensed ancillary staff. This failure has the potential to affect all 31 residents residing in the facility. Findings include: The facility Abuse Prevention Program dated 1/1/15 documents the following: "The facility will	F 226		

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not knowingly employ any individual convicted of resident abuse, neglect or misappropriation of property. The facility will not knowingly employ any staff convicted of any of the crimes listed in the Illinois Healthcare Working Background Check Act....or with findings of abuse, neglect or misappropriation of resident property listed on the Illinois Health Care Registry. Prior to a new employee starting a work schedule, this facility will:.....Check the Illinois Health Care Worker Registry on any individual being hired for prior reports of abuse, neglect or misappropriation of resident property, previous fingerprint check results....and Initiate an Illinois State Police livescan fingerprint check for any unlicensed individual being hired without a previous fingerprint check..."

1. The Illinois Healthcare Registry was not checked for prior reports of abuse, neglect or misappropriation of resident property and for disqualifying offenses on previous livescan fingerprint checks until 4/6/16 for E20, Dietary. There is no documentation in the file of a livescan fingerprint check being done for E20. The undated list of staff hired in the last four months documents that E20, Dietary was hired on 3/11/16.

On 4/6/16 at 8:50am E3, Activity Director and E24, Business Office confirmed that the Healthcare Worker Registry does not document a livescan fingerprint check being done for E20. E3 stated they will do a fingerprint check for E20.

2. The Illinois Healthcare Worker Registry was not checked for prior reports of abuse, neglect or misappropriation of resident property and for disqualifying criminal offenses on previous

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livescan fingerprint checks for direct care and ancillary staff until 4/6/16.

The undated CNA (Certified Nurse Aide) Roster and undated list of staff hired in the last four months and currently employed documents the following:

E6, CNA (Certified Nurse Aide) hired on 1/11/16.
E7, CNA hired on 2/29/16.
E8, CNA hired on 1/28/16.
E9, CNA hired on 2/11/16.
E10, CNA hired on 3/18/16.
E11, Dietary hired on 12/3/16.
E13, Housekeeping hired on 1/11/16.
E15, Dietary hired on 1/4/16.
E16, Dietary hired on 1/21/16.
E17, Housekeeping hired on 1/28/16.
E19, Dietary hired on 2/11/16.
E21, Marketing hired on 3/21/16.

On 4/4/16 at 3:45pm E24, Business Office stated she did not check the results of the prior background checks which were done for the unlicensed staff.

3. The Illinois Healthcare Worker Registry was not checked for prior reports of abuse, neglect or misappropriation of resident property for newly hired licensed staff.

The undated list of staff hired in the last four months and currently employed documents the following:

E14, LPN (Licensed Practical Nurse) hired on 1/29/16.
E18, LPN, hired on 2/12/16.
E1, Administrator, hired on 1/25/16.

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F 226	Continued From page 8 E2, Director of Nursing (DON) hired on 2/19/16. On 4/6/16 at 8:30am E1, Administrator verified that the Healthcare Worker Registry was not checked for any of the CNAs or new staff hired in the last four months. E1 stated the results of prior background checks were not checked. The Resident Census and Conditions of Residents dated 4/4/16 documents 31 residents reside in the facility.	F 226		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280		

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Based on observation, record review and interview the facility failed to revise the careplan for one of ten residents (R15) reviewed for careplans in the sample of 10 to address specific behaviors related to the use/non use of dentures.

The findings include:

R15's April 2016 Physician Order Sheet (POS) lists a diagnosis of Alzheimer's Disease. R15's current diet order is for Pureed diet with Nectar thickened liquids. R15's quarterly Minimum Data Set (MDS) dated 3/10/16 documents R15 requires extensive assistance of one staff for eating and total assistance of one staff for grooming and dressing. The Oral/Denture status checks "None of the above were present". The MDS does not indicate if R15 has dentures, broken dentures or natural teeth.

On 4/4/16 and 4/5/16 at the lunch meal R15 was served a Pureed diet. R15 fed herself with assistance. R15 was not wearing dentures.

On 4/5/16 at 4:00 pm Power of Attorney (Z2) stated that R15 has behaviors during personal care of fighting staff, hitting, cursing and also tries to bite the staff. Z2 stated she visits approximately once per week. Z2 stated the staff no longer put R15's dentures. Z2 stated "I guess because R15 tries to bite them." Z2 stated R15 is on a Pureed diet because she pockets food in her mouth.

On 4/6/16 at 10:15 am R15 was in the Day Room. R15 was not wearing dentures. On 4/6/16 at 10:35 am R15's top denture was in a dry denture cup in R15's bed stand and the lower denture was laying loose in the drawer. Certified

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F 280	Continued From page 10 Nurse Aide E8 stated she has been back to work since February 2016 and they do not put R15's dentures in. E8 stated R15 has dentures but she hits, slaps and tries to bite the staff. E8 stated they couldn't put the dentures in or take them out for cleaning because R15 would try to bite. On 4/6/16 at 10:45 am Licensed Practical Nurses E5 and E14 confirmed that R15 had not been wearing dentures because she fights staff who try to put them in or out of R15's mouth. R15's Self Care careplan revised 11/23/15 states "(R15) is at risk for self care deficits related to impaired cognition due to Alzheimer's disease. (R15) needs staff assist with ADLs (Activities of Daily Living)." The approaches include, "If (R15) refuses to cooperate with staff with cares, walk away and re-attempt at a later time or try a different care giver..Staff to assist with oral and denture care in morning and night and PRN (as needed)." R15's Nutrition care plan last with a target date of 6/10/16 states "(R15) is at nutritional risk dt (due to) dx (diagnoses) of Dementia and Alzheimer's disease. (R15) receives a pureed diet." The approaches do not mention the use of dentures. Nurse's notes reviewed from 10/15-4/6/16 do not address any biting behaviors, nor mention of denture use. R15's behavior care plan revised 1/16/16 states R15 had the potential to be physically aggressive related to Dementia, Poor impulse control. The goal: "The resident will not harm self or others". There are no specific behaviors addressed to describe what type of behavior R15 exhibits nor	F 280		

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F 280	Continued From page 11 any mention of the discontinued use of R15's dentures due to biting behaviors. MDS/Care Plan coordinator E4 stated on 4/6/16 at 11:10 am that she was not aware that R15 had dentures. E4 was unaware that R15 had behaviors of biting the staff so dentures were not being provided to R15. E4 confirmed that no specific behaviors were included in the care plan for resisting care related to dentures.	F 280		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that over the counter pain medications, potentially hazardous cleaning chemicals and disposable razors were stored in locked areas to prevent resident access. The facility also failed to maintain intake filters for hair dryers in the Beauty Shop in a clean condition to prevent possible overheating. This has the potential to affect four residents (R6, R8, R10, R13) reviewed for safety in the sample of 10 and five residents (R1, R18, R19, R22, R23) in the supplemental sample. The findings include:	F 323		

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1. On 4/4/16 at 1:20 pm in the West Bathing room, the storage cabinet above the sink counter was ajar, with a key in the lock. A dispenser of Bleach wipe towels (sodium hydrochloride .65%), and dozens of disposable safety razors were on the bottom shelf . A bottle of Ibuprofen 200 milligram (mg) tablets was on the second shelf. The pain medicine had no pharmacy label or name. The West Bathing room was not provided with a lock to prevent resident access. On 4/4/16 at 1:25 pm Certified Nurse Aid (CNA) E8 and CNA E9 came into the West Bathing room. When asked E8 and E9 stated the pain medicine belonged to the staff. E8 and E9 stated the storage cabinet was supposed to be locked.

On 4/5/16 at 9:30 am the West Shower room storage cabinet was closed but had the key in the lock and the lock was not engaged. The cabinet opened when the handle was pulled. The Bleach Wipes, and safety razors were still in the cabinet. Two bottles of over the counter pain medication that were labeled "Staff" were on the second shelf. One bottle contained Acetaminophen 250 mg, 100 tablets. The other bottle was "Menstrual Relief" containing 32 pills of 250 mg Acetaminophen.

On 4/5/16 at 9:35 am the unlocked cabinet and medications, bleach wipes and razors were shown to Director of Nurses E2 who stated that all medication should be locked to prevent resident access. E2 stated the bleach wipes were a 1:10 dilution of bleach.

The precautionary warning label for the bleach wipes stated the active ingredient was .65% Sodium hypochlorite. The label stated "KEEP

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OUT OF REACH OF CHILDREN ..Hazardous to humans and domestic animals..Caution: Causes moderate eye irritation, avoid contact with eyes and clothing."

The facility Medication Storage policy dated 12/1/15 states: "Medications must only be accessible to authorized staff and locked when not under the direct observation of authorized staff...No medication should be left unattended.."

The facility "Storage of Hazardous Chemicals" policy dated 12/2015 states "(The facility) safely stores all chemicals and/or hazardous materials..Hazardous chemicals are stored and maintained as listed in the attachment to this policy." The list of chemical storage includes "Bleach - stored in locked closet."

E2 provided a list of independent ambulatory residents dated 4/5/16 that includes R1, R6, R13, R18, R19. These residents could potentially gain access to the medications, chemicals and razors stored in the unlocked cabinets.

2. On 4/4/16 at 2:00 pm the intake foam air filters for three of three hood hair dryers were clogged with lint that could cause overheating. Housekeeping Supervisor E22 stated at that time the housekeeping staff do not clean the hair dryer filters. E22 stated that Beautician Z1 is responsible for that. E22 stated that Z1 provides hair care to residents once per week on Fridays.

The Beauty Shop list of residents who receive hair care dated 4/6/16 includes R8, R10, R18, R19, R22, R23.

F 363	483.35(c) MENUS MEET RES NEEDS/PREP IN	F 363		

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ADVANCE/FOLLOWED

Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview the facility failed to serve residents with Low Concentrated Sweet diet orders for Diabetic blood sugar control the reduced portion dessert per the menu plan. This affected six residents (R3, R4, R20, R21, R22, R23) reviewed for nutrition in the supplemental sample.

The findings include:

The menu for the 4/5/16 noon meal planned for Beef Taco Casserole, Spanish Rice, Corn Relish and Sweet Peach Cobbler. The menu planned for residents on Low Concentrated Sweet (LCS) diets to receive a half portion (#12 scoop =3 ounce) of Peach Cobber instead of a full portion (#6 scoop =6 ounce) planned for the general diets.

On 4/5/16 at 12:00 pm Dietary E27 brought out a large sheet pan of peach cobbler. E27 placed a #6 scoop in the pan of cobbler. E27 also placed a #6 scoop in the Pureed Peach Cobbler pan that was held on the steam table for service. E27 did not have a #12 scoop out.

From 12:00 pm-1:00 pm E27 served the hot

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F 363	Continued From page 15 entrees for resident trays including the Pureed Peach Cobbler, and Dietary Manager E26 served the regular Peach Cobbler. E26 served R3, R4, R20, R21, R22 with tray slips that designated LCS diet orders the full #6 scoop of Peach Cobbler. E27 served R23, who's tray slip stated Pureed LCS diet a full #6 scoop of Pureed Peach Cobbler instead of the reduced portion. On 4/5/16 at 12:45 pm R3, R4, R20, R22, R23 had consumed the Peach cobbler, and R21 had eaten 50 percent. On 4/5/16 at 1:00 pm Dietary E27 confirmed that she had set up the steam table with the serving scoops and had placed #6 scoops in the Cobblers. E27 stated she did not notice on the menu that #12 servings should be given to residents on LCS diets. Dietary Manager E26 reviewed the menu on 4/5/16 at 1:10 pm and confirmed that the residents on LCS diets should have received a reduced portion of dessert. E26 stated that she did not review the menu for serving sizes prior to assisting E27 serve the meal. The Client List Diet Report dated 4/1/16 documents R3, R4, R20, R21, R22, R23 all had diet orders for LCS diets. The April 2016 Physician Order Sheets for each resident (POS) documents R3, R4, R20, R21, R22, R23 each have a diagnosis of Diabetes Mellitus. R3, R21, R22, and R23 have physician orders on their POSs for scheduled and sliding scale insulin for blood sugar control.	F 363		
F 517	483.75(m)(1) WRITTEN PLANS TO MEET	F 517		

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F 517 SS=C	Continued From page 16	F 517		

EMERGENCIES/DISASTERS

The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview the facility failed to have a written plan and procedure related to loss of electrical service and the emergency generator. The facility also failed to follow its notification policy to report all disasters - an extended power outage - to administration. This has the potential to affect all 31 residents residing in the facility.

The findings include:

On 4/4/16 at 9:30 am there was an undated sign posted at the nurses station that stated in bold lettering "Disaster Committee - In the event of a disaster, these people need to be called immediately!" The list included the names and phone numbers for E23, Former Maintenance Supervisor, E3 Activity Director and E4 Care Plan Coordinator.

On 4/04/16 at 3:45 pm R19 stated that last Thursday night (3/31/16) that the all the power was off in the facility for a "long time". R19 stated she had to use a flashlight to find things in her room.

On 4/04/16 at 4:00 pm Administrator E1 confirmed that the facility had been without power on the evening and night shift of 3/31/16. E1

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stated "I did not find out about it until the next day.." E1 stated staff should have called her to report the power outage so she could come to town and follow up "in case a fire watch needed to be started." E1 did not know how long the power was out. E1 said she was told it was less than four hours. E1 did not have any written documentation from the evening/night staff to confirm the duration of the outage.

Acting Maintenance Director/ Housekeeping Supervisor E22 stated on 4/4/16 at 4:15 pm that no one call E22 to report the power outage. E22 stated she found out at the morning meeting the next day. E22 stated that if the power was out after four hours "we would have to do 15 minutes checks for fire". E22 stated "if I would have been notified I would have come in and made sure we used the red outlet (emergency power) to plug in electrical equipment and would have to put residents on portable oxygen tanks if needed." E22 did not know what all equipment was covered by the generator. E22 stated the Maintenance Director E23 quit in February 2016 and she was filling in. E22 stated she thought the fire alarm system was on the emergency generator.

The facility's Disaster Manual and Plan was reviewed on 4/4/16 at 4:00 pm with Administrator E1. The table of contents did not include Loss of Utilities such as electrical power. The table of contents listed #6 "Equipment on Emergency Power" however there was no policy to in the manual that detailed any information about the emergency generator or what equipment was currently covered by the generator.

The fire watch policy dated 7/1/14 stated "The

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F 517	Continued From page 18 facility shall implement the Fire Watch policy as soon as it is determined that the normal fire protection system will not be functioning for four or more hours. The Director of Environmental Services shall notify the Administrator when the facilities normal fire safety system will be offline for four or more hours. On 4/05/16 at 8:30 am E1 stated she was unable to verify if the fire alarm system was on the generator and did not have a policy detailing this information. On 4/5/16 at 2:00 pm E1 stated that she was unclear whether the fire alarm system functions when the power is off or if it was tied into the emergency generator. E1 stated she would think if the power was out that the fire system would down. E1 stated she was told by her corporate person to use the Fire Watch Policy as their power outage policy. E1 still did not have a list of what is covered on the generator. E1 stated she had a call out to the former Maintenance Director E23 to determine what is on the generator. On 4/5/16 at 5:00 pm the local police department stated the power was out on 3/31/16 from 9pm-2am (five hours). On 4/6/16 at 5:30 am Licensed Practical Nurse E25 confirmed that she was working the evening/night of 3/31/16 while the power was out. E25 stated that the power was out for several hours. E25 did not recall what time the power went on or what time the power was restored. E25 stated they had emergency lighting and the emergency nurse calls were functioning. E25 did not know if the fire detection system was working. E25 did not know what a fire watch was. E25 stated she did not call the E1 Administrator or	F 517		

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F 517	Continued From page 19 Maintenance/ Housekeeper E22 during the outage. E25 stated she reported to the oncoming day shift that the power outage had occurred. On 4/6/16 at 9:45 am E1 stated that she contacted the company that provided the emergency generator and the security company that monitors the fire alarms system transmissions. E1 confirmed that the fire alarm system was on the generator and that there was no interruption in the fire alarm system during the 3/31/16 power outage. E1 stated on 4/6/16 at 9:45 am that "The Disaster Plan should have contained all that information so that they staff would have the information at their finger tips." The facility Resident Census and Conditions of Residents report dated 4/4/16 documents a census of 31 residents.	F 517		