STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165460	A. BUILDING _____ B. WING _____	C 09/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAREN ACRES CARE CENTER	3606 ELM DRIVE URBANDALE, IA 50322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 9/15/16 Investigation of facility-reported incidents # 61933-I and # 62266-I and of complaint # 61971-C resulted in deficiency. Investigation of facility-reported incidents # 61828-I and # 61833-I did not result in deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by state and federal law.	09/15/16
F 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to ensure 2 of 3 residents (Residents #1, & #3) were free from abuse. Resident to resident altercations occurred and residents were injured. The facility reported a census of 42 residents. Findings: 1. Resident #2 had a MDS with an assessment date of 5/9//16. The MDS identified the resident	F 223	Accept this as the facility's allegation of compliance. Resident #2 was issued an involuntary discharge notice on 7/25/2016. On 8/22/2016, Resident #2 was discharged from the facility. Director of Nursing, Assistant Director of Nursing, and Administrator have identified additional interventions such as 15 minute checks, 1:1, expedited transfer/alternative placement, and/or specific activities for redirection to be used in similar situations in the future. Concerns and/or identified issues will be present to the QA team. Correction: the facility reported...	09/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pam Harned, MHA, LNHA	Administrator	09/30/2016

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.

POC Accepted 10/14/16 VR

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F 223	Continued From page 1 had diagnoses of non-Alzheimer's dementia, anxiety and psychotic disorder. The MDS indicated physical and verbal behavioral symptoms toward others. The MDS indicated the resident needed extensive assistance of one staff person for transfers and used a walker and wheelchair for mobility. The MDS indicated the resident had a BIMS score of 4. A BIMS of 4 represented the resident had a severe cognitive impairment. The Care Plan with a focus area dated 1/27/15 identified the resident had a history of being combative with cares, needed assistance at times with transfers, and walked independently with a wheeled walker. An intervention dated 2/23/16 directed staff to assist the resident to and from meals. An intervention dated 4/4/16 directed the staff to redirect the resident when the resident hit. A focus area dated 4/28/16 identified a problem with the resident having inappropriate interactions with another resident in the past but no longer an issue. An intervention dated 1/28/15 directed staff to have the resident return to his/her room when the resident had episodes of increased anger or behavior (not defined). A Nursing Event Report dated 7/25/16 at 9:40 a.m. documented Resident #2 came into Resident #1's room and scratched Resident #1's hand causing a skin tear measuring a 5 inch long by 1 inch wide. The report directed staff to keep Resident #2 away from the 300 Hall. A Nursing Event Report dated 8/15/16 at 9:00 a.m. documented Resident #2 attempted to come into Resident #3's room. When Resident #3 attempted to stop her/him from entering, Resident #2 pinched Resident #3's left upper arm.	F 223	(continued from page 1) a census of 34 residents, not 42.	

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F 223	Continued From page 2 2. Resident #1 had an MDS (Minimum Data Set) with an (ARD) of 6/15/16. The MDS indicated the resident had diagnoses of non-Alzheimer's dementia, blindness in one eye and depression. The resident had a BIMS score of 15 which indicated no cognitive impairment. The resident used a wheeled walker with extensive assistance of one staff with ambulation and mobility. The Care Plan with a focus area dated 4/16/16 identified the resident needed assistance with cares and blind in the right eye and little vision in the left eye. The interventions included and directed the staff to assist with positioning, transfers and mobility. The Nurse's Notes dated 7/25/16 at 9:40 a.m. indicated staff went to the resident's room and found the resident's right hand bleeding. The resident reported another resident (Resident #2) had entered his/her room and attempted to take a notebook. The resident pulled the notebook from Resident #2 and Resident #2 scratched him/her. A form titled Employee Witness Statement, dated 7/25/16 at 9:40 a.m. identified a nursing assistant and physical therapist called Staff A to Resident #1's room. Staff A found Resident #2 present. Staff A noted the resident's right hand bleeding with a skin tear 5 inches long by 1 inch wide from three "claw marks." Staff removed Resident #2 from the room and Staff A cleansed the wound and applied steri-strips. Staff A reported Resident #1 told her Resident #2 came into his/her room and tried to take a notebook and Resident #2 scratched him/her. 3. Resident #3 had a MDS with an assessment	F 223		

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F 223	Continued From page 3 reference date of 7/7/16. The MDS did not list any medical diagnoses but the admission record indicated the resident had diagnoses of dementia without behavioral disturbances, weakness and adult failure to thrive. A BIMS indicated a score of 8 which moderate cognitive impairment. The MDS indicated the resident needed extensive assistance of one staff with ambulation, limited assistance of one staff with transfers and used a wheelchair for mobility. The Care Plan with a focus area dated 6/25/16, identified impaired cognitive function, difficulty making decisions and a risk for falls. The Nurse's Notes dated 8/15/16 at 3:10 p.m. identified the staff documented Resident #2 attempted to enter the resident's room and when the resident wouldn't let Resident #2 into the room, Resident #2 pinched the resident leaving a red bruise 3 centimeters (cm) by 3 cm to the left upper arm. The resident's physician ordered Bactrim DS (antibiotic) twice daily for 10 days. An Employee Witness Statement dated 8/15/16 at 9:00 a.m. indicated Resident #3 called the nurse into his/her room and stated Resident #2 attempted to enter his/her room and when not allowed in, Resident #2 pinch her/his left arm. The left upper arm had a bruise which measured 3 by 3 centimeters. The nurse immediately separated and Resident #2 received checks every 15 minutes.	F 223		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279	Accept this as the facility's credible allegation of compliance. Director of Nursing, Assistant Director of Nursing, and	09/15/16

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F 279	Continued From page 4 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident and staff interviews, the facility failed to establish behavioral interventions and ambulation and transfer interventions for one resident (#2) with a history of falls and combative behaviors. The facility also failed to establish interventions related to a resident's history of paranoia and visual and auditory hallucinations (Resident #1). The facility reported a census of 34 and the sample included 4 total residents. Findings include: 1. Resident #2's Minimum Data Set (MDS) assessment dated 5/9/16 documented s/he had diagnoses that included Non-Alzheimer's dementia, anxiety and psychotic disorder. The	F 279	Administrator have identified additional interventions to be used in similar situations in the future. These interventions will be documented on the care plan. Facility transferred Resident #2 to a higher level of care on 8/22/16. Concerns and/or identified issues will be presented to the QA team.	

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F 279	Continued From page 5	F 279		

assessment documented the resident had a Brief Interview for Mental status score of 4, indicating severe memory and cognitive impairment. The assessment also documented that Resident #2 displayed physical and verbal behavioral symptoms toward others during 4 to 6 days of the 7-day assessment period. The resident needed the assistance of one staff with transfers, walked with setup help only and used a walker and wheelchair for mobility.

The resident ' s Care Plan showed a focus area that Resident #2 had depression/anxiety, a history of being combative with cares and had past inappropriate interactions with another resident (no longer an issue). An intervention for this focus area, dated 1/28/15, directed staff to have the resident return to h/her room when the resident had episodes of increased anger or behavior and an intervention dated 4/4/16 instructed to redirect the resident when s/he hit. The Care Plan also documented the focus area of the risk for falls and injury, use of medication, impaired cognitive status and poor safety awareness with direction that Resident #2 needed assistance at times getting up from the chair and bed and that s/he can walk with a front wheeled walker independently. An intervention dated 2/23/16 directed staff to assist the resident to and from meals.

Nurse's notes dated 5/26/16 at 10:15 a.m. and 6/2/16 at 11:00 a.m. documented the resident wandered the halls and into other resident rooms and took items not belonging to the resident.

Nurse's notes dated 6/4/16 at 9:00 p.m. documented a nurse passed medications close to the assisted eating table in the dining room and

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F 279	Continued From page 6 saw Resident #2 on the floor by a table on their left side. The resident had been eating prior the fall with the resident's walker lay on its side. Staff recorded the resident wouldn't lie still when staff attempted to assist him/her up from the floor. The resident had been combative, confused and easily agitated. An entry dated 6/5/16 at 8:00 p.m. revealed staff observed a purple bruise on the resident ' s left hip. Staff contacted the resident ' s physician, who ordered a portable X-ray of the left hip and pelvis. The X-ray showed fracture of the resident ' s left femoral neck (or a hip fracture). Local emergency personnel transported the resident by ambulance to a local hospital for evaluation and possible admission. Nurse's notes dated 6/8/16 at 2:30 p.m. revealed the resident remained in the hospital. Nurse's notes dated 6/9/16 at 6:00 p.m. documented the resident returned to the facility by ambulance with an incision to the left hip and intact staples. The resident needed 2 staff to assist with transfers. Nurse's notes dated 6/10/16 at 5:55 p.m. recorded that at 4:50 p.m. staff found the resident lying on the floor in the bathroom and their wheelchair next to the sink. Staff noted a reddened area measuring 5 centimeter (cm) x 5 cm noted on the left knee and a 6 cm x 2 cm scrape on the midline of the back and no apparent injury to the left hip. The notes recorded the resident now had a bed/chair alarm at all times. Nurse's notes dated 6/16/16 at 12:15 p.m. documented that in the morning, staff found the resident on the floor in between the bed and a	F 279		

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F 279	Continued From page 7	F 279		

dresser lying on h/her side. The resident could not move or straighten h/her left leg and cried out in pain with the attempt. Staff noted the bed/chair alarm did not sound. Staff notified the physician who ordered the resident be evaluated and treated by a local hospital emergency room. Hospital staff called the facility at 12:15 p.m. and reported the resident would be admitted. Nurse's notes dated 6/20/16 at 2:00 p.m. revealed Resident #2 returned to the facility with orders for partial weight bearing only.

A Nursing Event Report dated 7/25/16 at 9:40 a.m. documented Resident #2 came into Resident #1's room and scratched Resident #1's right hand, causing a skin tear measuring 5 inches long by 1 inch wide. The report directed staff to keep Resident #2 away from 300 Hall.

A Nursing Event Report dated 8/15/16 at 9:00 a.m. documented Resident #2 attempted to come into Resident #3's room. When Resident #3 attempted to stop Resident #2, Resident #2 pinched Resident #3's left upper arm.

During an interview on 9/8/16 at 12:30 p.m. the Director of Nursing (DON) stated that Resident #2 walked independently with ambulation despite the need for staff to provide stand by assistance with transfer and continuous stand by assistance with ambulation. The resident's combative behavior had been a deterrent for staff to provide the necessary assistance with transfer and ambulation. Additional interventions were needed in the care plan to direct staff to be in close proximity when the resident walked or attempted to transfer alone.

During additional interview on 9/13/16 at 9:20

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a.m., the DON stated the care plan should have included the use of the bed/chair alarm, to check its functionality every shift, especially after the fall of 6/16/16. The resident had been hospitalized for observation after the fall, returned to the facility on 6/20/16 and needed 2 staff to assist with transfer and used a wheelchair for mobility. After the incident of 7/25/16 with Resident #2, staff were to monitor the resident and for staff to be alongside him/her when in 300 hall and to keep the resident in eyesight when in the dining room and commons area.

2. Resident #1 ' s MDS assessment dated 6/15/16 recorded a BIMS score of 15, indicating intact memory and cognition. The assessment documented the resident experienced a fluctuating altered level of consciousness and psychomotor retardation. The resident had diagnoses that included Non-Alzheimer's dementia, blindness in one eye and depression. The resident used a walker and required the assistance of one staff with ambulation and mobility. The assessment documented Resident #1 entered the facility on 12/11/15.

A Psychological Initial Evaluation dated 8/29/16 documented the resident was seen following referral due to delusions, hallucinations and paranoia. The initial diagnosis documented an unspecified neurocognitive disorder with behavioral disturbances and major depressive disorder.

The Care Plan with a focus area dated 12/23/15 documented a diagnosis of dementia with confusion/delusions and paranoia. Interventions dated 12/23/15 directed staff to administer medications as ordered, provide redirection,

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repeat questions or statements made by staff, monitor for cognitive changes and notify the physician as needed and to have the resident's guardian make all major decisions. A focus area dated 12/23/15 documented the resident at risk for behavior/mood/psychosocial issues due to a past history of paranoia, depression, anxiety and dementia. The resident has a history of suicidal ideation, but not recently. Interventions included initiation of therapy services on 3/30/16, pharmacy review of psychoactive medications (dated 12/30/15), 1:1 activities/social services (dated 12/23/15), encourage socialization with staff and others (dated 12/23/15), offer the resident magazines and offer diversional activities with increased behaviors (both dated 4/16/16).

Nurse's notes dated 2/28/16 at 6:30 p.m. documented staff noted bruises on the resident ' s hands. The resident stated that ' people over across hall ' caused the bruising on the resident ' s hands.

Nurse's notes dated 5/24/16 at 4:30 a.m. documented the resident as paranoid and suspicious of every movement in h/her room.

Nurse's notes dated 7/3/16 at 6:00 p.m. documented the resident displayed confusion, talked to the television and complained that "people were visiting". When asked who had visited, the resident stated ' how am I supposed to know that? '

Nurse's notes dated 7/4/16 at 9:40 a.m. documented the resident talked to unseen people. The resident reported s/he could not state who s/he had been talking to.

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Nurse's notes dated 7/6/16 at 9:30 a.m. recorded the resident as delusional; the resident reported the man in the television came into h/her room. Staff reported the resident also had conversations with unseen people.

Nurse's notes dated 7/8/16 at 7:45 p.m. documented a head to toe assessment completed. The resident was very confused and seemed to be visually hallucinating. The resident asked why cars are driving in there and pointed.

Nurse's notes dated 7/27/16 at 10:30 p.m. noted the resident reported h/she is to call if h/she saw that man again, s/he just saw him and pointed to the television screen. Staff stepped back, framed the television and asked the resident if this is where the resident saw the man. The resident said yes. Staff attempted to show the resident it is a television but the resident didn't seem to understand.

Nurse's notes dated 7/28/16 at 10:35 a.m. documented the resident continued to be delusional and paranoid, thinking people in the television are live in h/her room and reported people are drugging h/her ice water.

Nurse's notes dated 7/30/16 at 10:30 a.m. indicated the resident as confused and delusional and insisting the man in the television is in h/her room.

Nurse's notes dated 7/31/16 at 3:20 p.m. revealed the resident continued to be confused and could not determine reality from television.

During an interview on 9/13/16 at 11:00 a.m., the DON stated the resident is delusional and has

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F 279	Continued From page 11 auditory and visual hallucinations. She reviewed the care plan and stated there needed to be interventions directing how staff should respond to the delusions and hallucinations. Staff members are directed to have two staff provide cares due to the accusations the resident continues to make.	F 279		
F 323 SS=G	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 clinical record review, observation and staff interviews, the facility failed to ensure an environment free of accident hazards, adequate supervision and implementation of safety measures for 1 of 4 residents reviewed (Resident #2- sustaining a hip fracture when attempting to stand up while sitting in the dining room.) The facility reported a census of 34 residents. Findings include: Resident #2's Minimum Data Set (MDS) with an assessment reference date (ARD) of 5/9//16. The MDS indicated diagnoses of non Alzheimer's dementia, anxiety and psychotic disorder. The MDS indicated physical and verbal behavioral symptoms toward others. The MDS indicated the	F 323	Accept this as the facility's credible allegation of compliance. Direct care staff was educated to assist with gait belt when residents are observed ambulating or attempting to transfer without assistance for residents who are non-compliant with asking staff for assistance. Concerns and/or identified issues will be reported to nursing and presented to the QA team.	09/15/16

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F 323	Continued From page 12 resident needed extensive assistance of one staff with transfers and used a walker and wheelchair for mobility. A BIMS indicated a score of 4. A BIMS of 4 indicated severe cognitive impairment. The Care Plan with a focus area dated 1/27/15 identified the resident having a history of being combative with cares, needs assistance at times with transfers, and walks independently with a wheeled walker. An intervention dated 2/23/16 indicated staff to assist to and from meals. An intervention dated 4/4/16 indicated the resident hitting and for staff to redirect. Nurse's notes dated 6/4/16 at 9:00 p.m. documented a nurse passing medications close to the assisted eating table in the dining room saw the resident on the floor by a table. The resident had been eating prior the fall with the resident's walker on its side. It had been noted the resident wouldn't lay still when staff attempted to assist the resident up from the floor. The resident had been combative, confused and easily agitated. Nurse's notes dated 6/5/16 at 8:00 p.m. revealed staff observed a purple bruise on the left hip. A physician's order for a portable x-ray of the resident left hip and pelvis. Nurse's notes dated 6/5/16 at 8:00 p.m. documented the x-ray taken of the left hip and pelvis revealed a left femoral neck fracture. Local emergency personnel transported the resident by ambulance to a local hospital for evaluation and possible admission. Nurse's notes dated 6/8/16 at 2:30 p.m. revealed the resident remained in the hospital. Nurse's notes dated 6/9/16 at 6:00 p.m. documented the resident returned to the facility	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165460	A. BUILDING _____ B. WING _____	C 09/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAREN ACRES CARE CENTER	3806 ELM DRIVE URBANDALE, IA 50322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13	F 323		

by ambulance. The resident had an incision to the left hip with staples intact. The resident is now skilled and would receive physical, occupational and speech therapy. An assessment indicated diminished lung sounds in base, swelling and bruising to the left upper leg and thigh. The resident needed 2 staff to assist with transfer. Nurse's notes dated 6/10/16 at 10:25 a.m. documented the resident's left leg swollen and bruised and needed 2 staff with transfers.

A Major Injury Determination Form dated 6/6/16 indicated the resident's physician designee documented that after reviewing the circumstances of the incident causing the injury, the previous functional ability of the resident and the resident's prognosis she believed the injury sustained is not a major injury.

During an interview dated 9/8/16 at 11:29 a.m., Staff B, a licensed practical nurse (LPN) stated the resident refused assistance with ambulation and transfer. The resident falls were caused from h/her being non-compliant. The resident needed assistance with transfer from a seated position, had an unsteady gait; as h/she leaned too far forward and looking down instead of looking forward. The resident also wandered throughout the facility.

During an interview dated 9/8/16 at 11:57 a.m. Staff C, a certified nursing assistant reported the resident needed assistance with ambulation after each fall but had been combative with staff who attempted to assist h/her. The resident had a history of sitting on the side of an arm rest. Staff stopped providing assistance with transfer and ambulation because h/she wouldn't accept staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165460	A. BUILDING _____ B. WING _____	C 09/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAREN ACRES CARE CENTER	3605 ELM DRIVE URBANDALE, IA 50322

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F 323	Continued From page 14 assistance. During an interview dated 9/8/16 at 2:10 p.m., Staff D CNA stated she provided continuous stand by assistance when the resident ambulated or self-transferred. During an interview dated 9/8/16 at 12:30 p.m. the director of nursing reported the resident independent with ambulation despite the need for staff to provide stand by assistance with transfer and continuous stand by assistance with ambulation prior to the fall of 6/4/16. The resident's physician designee determined the injury sustained had not been a major injury and it needn't be reported the Department.	F 323		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0612	A. BUILDING: _____ B. WING _____	C 09/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAREN ACRES CARE CENTER	3605 ELM DRIVE URBANDALE, IA 50322

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C 137	50.7(1)a Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(1) Of any accident causing major injury. a. " Major injury " shall be defined as any injury which: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the Iowa Department of Inspections and Appeals of a major injury which required admission into the hospital and surgical repair of the fractured hip (Resident #2). The sample consisted of 4 residents reviewed and the facility reported a census of 34 residents. Findings include: 1. Resident #2 had a MDS (Minimum Data Set) assessment with a reference date of 5/9/16. The MDS identified the resident had diagnoses including: non Alzheimer's dementia, anxiety and psychotic disorder. The MDS indicated the resident had physical and verbal behavioral symptoms toward others. The MDS indicated the resident needed extensive assistance of one staff with transfers and used a walker and wheelchair for mobility. A BIMS (Brief Interview for Mental Status) determined a score of 4. A score of 4 identified the resident with severely impaired cognitive impairment. The Nurse's Notes dated 6/5/16 at 8:00 p.m.	C 137	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by state and federal law. Director of Nursing, Assistant Director of Nursing, Administrator, and Nurse Consultant reviewed definition of "ambulatory" as defined by 481--57.1 (135C). Future occurrences will be reported to the Department regardless of physician response to Major Injury Determination form. Concerns and/or identified issues will be presented to the QA team.	9/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pam Harned, MHA, LNHA	Administrator	09/30/16

POC accepted 10/17/16 SK minus