STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165270	A. BUILDING _____ B. WING _____	C 01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD SPECIALTY CARE	1200 HIGHWAY 175 EAST STRATFORD, IA 50249

(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: 02/15/17 The following deficiencies result from the investigation of #64754-C, #64622-C, #64747-I, and #64688-I completed 1/2/2017 to 1/25/2017. Complaint #64754-C substantiated. Complaint #64622-C substantiated. Incident # 64747-I substantiated. Incident # 64688-I substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	F 000 PLAN OF CORRECTION Preparation and/or submission of the Plan of Correction is not a legal admission that the violations existed or exist or that the deficiencies herein are correctly cited, and it is not to be construed as an admission against the interests of Stratford Specialty Care (the "facility") or its affiliates, employees, agents, or individuals who drafted/submitted or may be discussed in this Plan of Correction. Rather, submission of this Plan of Correction is to respond to the specific matters addressed in the Statement of Deficiencies related to the alleged deficiencies and demonstrate how the facility's programs, policies, and practices promote its commitment to assure that all residents receive services that are of quality that meet professionally recognized standards of care and that comply with all requirements for licensure and participation. The facility's credible allegation of compliance date for all prefix tags is 02/15/2017. This allegation of compliance does not constitute guilt, but that the facility is in compliance will all areas cited in the Statement of Deficiencies. Submitted by Alec Steils, LNHA, Administrator	
F 223 SS=G	483.12 FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and facility policy, the facility failed to ensure one (1) of four (4) residents were free from resident to resident abuse. Record review identified resident to resident physical altercations between Resident #1 and Resident #4. Record review identified Resident #1 lacked the ability to express his/her emotions or possible fear of Resident #4's aggressive actions; and a reasonable person would find Resident #4's actions towards Resident #1 as abusive. The	F 223	F 223 483.12 FREE FROM ABUSE/INVOLUNTARY SECLUSION Preparation and/or execution of the Plan of Correction including all statements herein does not constitute an admission or agreement by this provider to the accuracy of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alec Steils LNHA	Administrator	02/25/2017

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 223	Continued From page 1 facility reported a census of 47 residents during the investigation. Findings include: The facilities "Dependent Adult Abuse" policy updated 5/16 section revealed each resident had the right to be free from abuse. The policy indicated Residents must not be subjected to abuse by anyone including but not limited to other residents. The policy included the abuse definition as the willful infliction of injury, intimation, pain or mental anguish. Physical abuse included hitting and slapping. Mental abuse included but not limited to harassment. When resident to resident physical contact occurred, which included but was not limited to resident hitting or slapping which is considered resident to resident abuse. The facility will presume that instance of abuse caused physical harm, pain or mental anguish in residents with cognitive and or physical impairments which may result in a resident unable to communicate physical harm, pain or mental anguish in the absence of evidence to the contrary. The policy listed an example of a resident slapping another resident who is physical or cognitively impaired even though the resident showed no reaction; it is presumed the resident experienced pain. The policy for resident to resident altercations indicated the facility will do whatever possible to control resident to resident altercation in order to prevent mental, physical, sexual and verbal abuse from occurring. 1.The Minimum Data Set (MDS) assessment dated 11/24/16 identified Resident #1's cognitive skills for daily decision making as moderately impaired with decisions poor. The MDS identified the resident had diagnoses of Alzheimer's disease and anxiety disorder. Resident #1's care plan up dated 12/20/16	F 223	Correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. This is the facility's credible allegation of compliance for prefix tag F 223; this allegation does not constitute guilt, but that the facility is in compliance with prefix tag F 223. Stratford Specialty Care ensures residents are free from abuse, neglect, misappropriation of resident property, and exploitation including corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat the resident's symptoms. Resident #4 was involuntarily discharged from the facility on 12/19/2016. Resident #1 remains in the facility free of abuse through staff education and changes in the plan of care that include medication regimen reviews, ARNP psychiatric specialty visits to decrease agitated/yelling out behaviors, and increased timed monitoring of Resident #1 location within CCDI Unit . All residents with potential to be affected have been protected through involuntary discharge of Resident #4 and staff education. Staff education occurred on the abuse policy on 12/22/2016 including practices to prevent abuse between residents. Staff education on supervision expectations occurred on 01/25/2017. The administrative staff will conduct ongoing audits of supervision, abuse prevention understanding, and supervision to ensure	

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F 223	Continued From page 2 reported that the resident will reach out to other with his/her hands once someone holds them the resident becomes agitated and yells out. a). Incident/Accident/Unusual Occurrences Form dated 11/19/16 at 9:10 a.m. reported Resident #4 held on to Resident #1's hand and pulled his/her arm straight forward. Resident #4 continued to pace up the hallway. Nurses Notes date 11/19/16 at 10:10 a.m. late entry for 9:40 a.m. revealed the panic button sounding on Memory Lane (the locked unit). The staff reported that Resident #4 had been pacing in the hallway while Resident #1 was holding on to the handrail in the hallway. Resident #4 held onto Resident #1's hand and Resident #1 tried to lift Resident #4's hand off his/hers. Resident #4 pulled Resident #1 arm straight out and continued to pace in the hallway. b). Incident/Accident/Unusual Occurrences Form dated 12/9/16 at 4:40 p.m. revealed Resident #4 had been ambulation in the hallway in staffs view when Resident #4 grabbed a hold of Resident #1's hand. The Certified Nursing Assistant (CNA) and Certified Medication Assistant (CMA) separated the two residents immediately. Nurses Notes dated 12/9/16 at 4:40 p.m. revealed Resident #1 reported the resident ambulating in the hallway when staff witnessed Resident #4 grab a hold of Resident #1's hand. The residents were separated and head to toe assessment done. c). Nurses Notes dated 12/18/16 late entry for 12/17 16 at 8:30 p.m. for Resident #4 reported that Resident #4 was walking in the hallway with CNA providing one to one. Resident #4 got close to Resident #1 and reached out to touch his/her hand. The CNA stepped between the two residents causing Resident #4 to tighten his/her grip. Resident #1 yelled and hit Resident #4 CNA	F 223	compliance. The quality assurance and performance improvement team will review audits during routine meetings at least quarterly to ensure solutions are permanent. Date of Compliance: 02/15/2017 F 323 483.25(d) (1) (2) (n) (1)-(3) FREE OF ACCIDENT HAZARDS/ SUPERVISION/DEVICES Preparation and/or execution of the Plan of Correction including all statements herein does not constitute an admission or agreement by this provider to the accuracy of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. This is the facility's credible allegation of compliance for prefix tag F 323; this allegation does not constitute guilt, but that the facility is in compliance with prefix tag F 323. Stratford Specialty Care ensures sufficient staff to provide adequate supervision to prevent potential hazards in the residents' environment. Resident #6 no longer resides in the facility. All residents with potential to be affected are protected through additional staff education related to supervision and safe environment establishment. Nursing staff received education on actively ensuring the safety and wellbeing of all residents and maintaining staffing levels	

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F 223	Continued From page 3 called for assistance and the staff were able to separate the two residents. During an interview on 1/19/17 at 11:50 a.m. with Staff A CNA explained that Resident #4 was a very busy and would not sit down for a minute. He/she had been very resistive to cares and had even head butted her. Staff A acknowledged that once Resident #4 came to Memory Lane the other residents were kind of afraid, before they would walk up and down the hallway. Once Resident #4 came he/she was always in the hallway. Resident #4's room and Resident #1's room were on the same side of the hallway right next door to each other. Resident #4 was in the last room in the hallway on the south side. During an interview on 1/19/17 at 4:21 p.m. with Staff F CNA explained she worked in the Memory unit with one other CNA on 12/17/16 and had been assigned one to one ' s with Resident #4. That night he/she punched me in the mouth. Later, walking down the hallway toward his/her room Resident #1 was walking in the hallway and Resident #4 started to walk toward Resident #1 and Staff F got between the two residents. Resident #4 reached around and grabbed Resident #1's hand and pulled. Resident #1 started to yell and hit Resident #4. Staff F pushed the panic button and it took 10 to 12 minutes for a nurse to respond. It had been a very hectic night in the unit and out front. Staff F reported that Resident #4's room had been at the end of the hallway and Resident#1's room right next door to him/her. During an interview on 1/23/17 at 3:45 p.m. with Staff G CNA explained she worked on 12/17/16 out front as a float. Staff G acknowledged she heard Resident #1 yelling and went back to Memory Lane. Staff G explained all four were standing there at the time Staff F, Staff E and	F 223	within the CCDI Unit (Memory Lane) on 01/25/17 and12/09/16 respectively. Administrative staff will perform routine auditing of staff understanding of safe environment establishment, supervision expectations, supervision provisions, and adequate staffing levels to ensure problem does not reoccur. The quality assurance and performance improvement team will review audits during routine meetings at least quarterly to ensure solutions are permanent. Date of Compliance: 02/15/2017 F 353 483.35(a) (1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS Preparation and/or execution of the Plan of Correction including all statements herein does not constitute an admission or agreement by this provider to the accuracy of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. This is the facility's credible allegation of compliance for prefix tag F 353; this allegation does not constitute guilt, but that the facility is in compliance with prefix tag F 353. Stratford Specialty Care ensures sufficient nursing staff is available to promote residents' physical, mental, and psychosocial well-being. Resident #6 no longer resides in the facility.	

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F 223	Continued From page 4 Resident #4 had Resident #1 hand. Staff G at that time redirected Resident #1. 2. The 11/29/16 quarterly Minimum Data Set (MDS) assessment dated 11/29/16 identified Resident #4's cognitive skills for daily decision making as moderately impaired with decisions poor. The MDS identified the resident had diagnoses of Alzheimer's disease, anxiety disorder, depression, psychotic disorder and wandered daily. The 11/23/16 care plan recorded Resident #4 had difficulty making decisions and communication and required checked on every 15 minutes. The 12/9/16 update to the care plan recorded the resident required one to one with staff at all times. The 12/17/16 update to the care plan recorded the resident requires one to one with staff at all times with staff between resident and others at all times. a). The Incident/Accident/Unusual Occurrences Form dated 11/19/16 at 9:10 a.m. reported that Resident #4 held on to Resident #1's hand and pulled his/her arm straight forward and then continued to pace up the hallway. Nurses Notes for Resident #4 on 11/19/16 at 10:40 a.m. documented the panic button sounding on Memory Lane (the locked unit). The staff reported Resident #4 had been pacing in the hallway while Resident #1 was holding on to the handrail in the hallway. Resident #4 held onto Resident #1's hand and Resident #1 tried to lift Resident #4's hand off his/hers. Resident #4 pulled Resident #1 arm straight out and continued to pace in the hallway. Record review of Resident #4's behaviors included the following: Nurses Notes dated 11/26/16 at 9:00 p.m. documented 15 minute checks continued, but the one (1) to one's (1) were done most of the	F 223	Resident #4 no longer resides in the facility. Resident #1 remains in the facility free of abuse through policy changes and staff education. All residents with potential to be affected are protected through one-to-one supervision changes and staff education. Nursing staff received education on actively ensuring the safety and wellbeing of all residents, practices to prevent abuse, and maintaining staffing levels within the CCDI Unit (Memory Lane) on 01/25/2017, 12/22/2016, and 12/09/2016 respectively. Guidance to administrative staff related to assignment of separate dedicated staff for one-to-one care provisions has occurred. Administrative staff or designee will audit the resident care plan needs through review of staffing sheets, staff interviews, and acuity level of residents adjusting staffing levels as indicated to ensure the problem does not reoccur. The quality assurance and performance improvement team will monitor through auditing, staff scheduling, and resident acuity review during IDT meetings, no less than quarterly, to make sure solutions are permanent. Date of Compliance: 02/15/2017	

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F 223	Continued From page 5 2p.m.-10 p.m. shift pacing and moving chairs unable to redirect the resident while pushing right through a person. The resident began to run into the walls banging his/her head attempted to elbow and hit staff getting aggressive and agitated. Nurses Notes dated 11/27/16 at 3:30 a.m., revealed staff assisted the resident back to bed he/she grabbed the staff's neck. Nurses Notes dated 11/27/16 at 2:30 p.m. identified staff notified the nurse that when assisting Resident #4 with toileting he/she made contact with staff three times. Nurses Notes dated 11/27/16 at 10:00 p.m. noted the resident pacing and wandering into room one to one most of the evening. The resident attempted to kick the door at the end of the hallway able to redirect from the exit. In the dining room the resident picked up a table and attempted to tip it over. Earlier in the day the CNA reported the resident stabled her with a fork one to ones during dinner. Nurses Notes dated 11/29/16 at 4:00 a.m. reported upon entering Memory Lane noted resident with increased anxiety and ponding on walls, turning tables over in dining area and gritting teeth. One to ones done and attempted to direct to sit or lay down resident combative and attempting to it staff. Nurses Notes dated 11/29/16 at 1:040 p.m. revealed the resident very anxious, moving and tipping furniture over. Nurses Notes dated 11/29/16, 11/30/16, and 12/2/16 and 12/5/16 and 12/9/16 documented Resident #4 paced up and down the hallway and staff continued 15 minute checks. Nurses Notes dated 12/3/16 at 1:30 p.m. revealed the resident very restless and pacing and turning tables and chairs over in the dining	F 223	Please see prior page(s) for Plan of Correction.	

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F 223	Continued From page 6 room. b). The Incident/Accident/Unusual Occurrences Form dated 12/9/16 at 4:40 p.m. reported that Resident #4 had been ambulation in the hallway in staffs view Resident #4 grabbed a hold of Resident #1's hand. The Certified Nursing Assistant (CNA) and Certified Medication Assistant (CMA) separated the two residents immediately. The Nurses Notes dated 12/9/16 at 4:40 p.m. Resident #4 reported the resident ambulating in the hallway when staff witnessed Resident #4 grab a hold of Resident #1's hand. The residents were separated while doing a head to toe assessment on Resident #4 he/she became agitated and attempted to head butt staff while taking blood pressure. Resident #4 one to one at this time for an intervention and continued to pace the hallway. Nurses Notes dated 12/9/16 at 5:20 p.m. revealed the resident remained agitated pacing the hallway. Nurses Notes date 12/10/16 at 3:00 p.m. identified one to one with resident unable to redirect will reach out and grab staff while pacing and not rest. Nurses Notes dated 12/10/16 at 3:30 p.m. revealed the resident continued pacing moving chairs attempted to tip over tables and trying to enter other resident's rooms. Nurses Notes dated 12/10/16 at 8:00 p.m. identified the resident punched the nurse in the stomach and snapped the toothbrush in half when in the shower. Nurses Notes dated 12/11/16 at 10:30 p.m. Resident #4 reported the resident up and down the hallway attempted entering other resident's rooms and continued one to one with staff. Nurses Notes dated 12/11/16 at 3:30 p.m.	F 223	Please see prior page(s) for Plan of Correction.	

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F 223	Continued From page 7 reported the resident agitated and pushing and swinging at staff. The resident will not stop pacing up and down the hall and attempted to hit staff twice. Nurses Notes dated 12/11/16 at 10:30 p.m. revealed the resident stopped for approximately 20 minutes to eat diner. Then the resident got back up pacing again and will not stop walking when other people are in front of him/her and will try to walk through them. Nurses Notes at 12/12/16 at 9:40 p.m. revealed the resident pacing all evening unable to redirect moving chairs and tables and being aggressive with staff. Nurses Notes dated 12/14/16 at 1:25 p.m. revealed while doing cares the resident became combative grabbing staff by the hair and head butted staff. Nurses Notes dated 12/14/16 at 3:30 p.m. identified the resident aggressive turning chairs over and pacing up and down the hallway. Nurses Notes dated 12/14/16 at 9:30 p.m. revealed the resident very resistive with cares and punched the nurse in the ribs. Then the resident hit nurse on top the head with his/her fist. Nurses Notes dated 12/15/16 at 6:00 a.m. reported the resident with increased aggression and anxiety when staff attempts to assist. Nurses Notes dated 12/15/16 at 10:00 a.m. reported the resident continued one to one with staff up and down the hallway and redirected out of other resident's rooms. Nurses Notes dated 12/16/16 at 4:20 p.m. the resident head butted the CNA while attempting to do cares. Nurses Notes dated 12/16/16 at 4:30 p.m. the Resident #4 reported the resident became agitated wand head butted the nurse while doing cares. Later, the resident was in chair with foot	F 223	Please see prior page(s) for Plan of Correction.	

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F 223	Continued From page 8 rest up and attempted to climb out. Nurse put hand on the resident's leg to wait till the foot rest was down and the resident became agitated and punched the nurse in the head. The resident stood up walked toward the nurse out of the TV room. Three female residents were in the hallway and Resident #4 walked toward them. This nurse stood between Resident #4 and the female residents encouraging them to backup, which they did not do. Resident #4 became aggressive and punched this nurse grabbing and scratching the right side of nurse's neck. The nurse immediately backed up the 3 female residents into a room for safety. Nurses Notes dated 12/17/16 at 8:00 a.m. revealed the resident hit staff in the head two times during cares. This nurse attempted to do cares and the resident head butted, kicked and punched at staff. Nurses Notes dated 12/17/16 at 12:00 p.m. while doing cares the resident attempted to head butt staff and hit them in the stomach. The resident continued to be very agitated and combative toward staff. The resident attempted to stand on chairs and difficult to redirect. Nurses Notes dated 12/17/16 at 2:20 p.m. reported the resident hit a CNA in the face. At 3:00 p.m. Resident #4 paced the hallway. Nurses Notes dated 12/17/16 at 7:00 p.m. the resident alternates between pacing from the family room to his/her room and the end of the hallway by exit doors. c). Nurses Notes dated 12/17/16 at 8:30 p.m. the resident walked in the hallway with CNA providing one to one. Resident #4 got closer to Resident #1 and reached out to touch his/her hand. The CNA stepped between the two residents causing Resident #4 to tighten his/her grip. Resident #1 yelled and hit Resident #4, the CNA called for	F 223	Please see prior page(s) for Plan of Correction.	

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F 223	Continued From page 9 assistance and the staff were able to separate the two residents. Incident/Accident/Unusual Occurrences Form dated 12/17/16 at 8:30 p.m. reported Resident #4 had been ambulating in the hallway with CNA one to one with resident. Resident #4 got closer to Resident #1 and reached out and touched Resident #4. Staff F CNA stepped between the residents causing Resident #4 to tighten his/her grip. Resident #1 started to yell and hit Resident #4 while Staff F attempted to block and redirect Resident #4. Nurses Notes dated 12/18/16 at 5:00 a.m. the resident pacing up and down the hallway agitated. The resident continued to move furniture, pushing and attempting to hit staff. Nurses Notes dated 12/18/16 at 5:20 a.m. reported the resident hit staff in the head with his/her fist and had increased agitation. Nurses Notes dated 12/18/16 at 5:30 a.m. reported the resident hit staff and continued pacing up and down the hallway. Nurses Notes dated 12/18/16 at 9:45 a.m. the resident combative hitting and pushing staff. Nurses Notes dated 12/18/16 at 10:30 a.m. revealed the resident continued pacing up and down the hallway combative and pushing staff. Nurses Notes dated 12/18/16 at 1:15 p.m. revealed the panic button sounding in Memory Lane. Two CNA's were with Resident #4 while doing cares, the resident head butted one CNA and then stood up and head butt the other one. Nurses Notes dated 12/18/16 at 2:30 p.m., revealed the resident up pacing the hallway and agitated. The resident pounding on walls and pushed staff. Nurses Notes dated 12/19/16 at 1:20 p.m. documented the resident up and down the hallway with some increased agitation. . The	F 223	Please see prior page(s) for Plan of Correction.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD SPECIALTY CARE	1200 HIGHWAY 175 EAST STRATFORD, IA 50249

(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 223	Continued From page 10 resident attempted to pick up and move dining room table and chairs. Nurses Notes dated 12/19/16 at 7:30 p.m. the ambulance here to transport resident to the hospital for psychiatric evaluation.	F 223	Please see prior page(s) for Plan of Correction.	
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility failed to ensure staff provided adequate supervision to prevent	F 323		

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F 323	Continued From page 11 potential hazards in the environment for 1 of 6 residents reviewed (Resident #6). The facility reported a census of 47 residents. Findings include: The 11/23/16 Minimum Data Set (MDS) recorded Resident #6 Brief interview for Mental Status (BIMS) score of 11, which indicated the resident had moderately impaired cognition. The resident required supervision of staff for transfers and walking in his/her room and corridors. The MDS further recorded the resident's diagnoses as Non-Alzheimer's dementia, anxiety disorder depression and dementia with behavior disturbances. The MDS reported the resident received an antipsychotic, antianxiety and an antidepressant for 7 out of 7 days reviewed. The 11/30/16 care plan recorded Resident #6 had behaviors related to anxiety and early dementia. The 12/1/16 update indicated 15 minute checks started. The 12/12/16 update to the care plan recorded the resident had made a laceration to his/her right wrist and was transferred to emergency room and on 12/13/16 a medication change and referral for consulting. The 12/18/16 update recorded the resident signed a no self harm contract. The 11/30/16 at 10:00 p.m. "Nurses Notes" for Resident #6 reported that at dinner time the resident had taken knives and forks and hid a knife down the back of her pants. The 12/1/16 at 12:30 p.m. "Incident/Accident/Unusual Occurrences Form" reported that Resident #6 with a scabbed and bruised area to the left shin when replacing the wanderguard (a tracking device). The 12/1/16 at 8:15 p.m. "Nurses Notes" for Resident #6 reported that during cares staff found the wanderguard in the resident ' s pocket. Staff	F 323	Please see prior page(s) for Plan of Correction.	

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F 323	Continued From page 12 noted butter knife, 2 bobby pins and glasses out on the bed. Staff redirected the resident out to the family room. The 12/4/16 at 2:30 a.m. "Incident/Accident/Unusual Occurrences Form" reported that Resident #6 with multiple abrasions to bilateral ankles from attempting to remove wanderguard. The 12/4/16 at 9:15 a.m. " Nurses Notes " for Resident #6 reported staff noted multiple abrasions and bruises to bilateral ankles and wrists. During breakfast the resident reported he/she need to use the bathroom. The nurse followed the resident in to his/her room as the resident stuck a butter knife under his/her mattress. The Certified Nursing Assistant (CNA) reported to the nurse that during breakfast a knife fell out of the residents pants. The 12/6/16 at 9:00 p.m. "Nurses Notes" for Resident #6 reported staff found silverware, toothbrush and comb hidden in resident's room. The 12/10/16 at 3:00 p.m. "Nurses Notes" for Resident #6 reported that the nurse had been notified of the resident ' s comment to staff. The staff had asked what happened to resident's wrist the resident replied "I did it to kill myself and to get out of this place and go home." The resident's room search initiated and to continue every hour by staff and to be one to one with the resident. The 12/10/16 at 11:05 p.m. "Nurses Notes" for Resident #6 reported that the resident commented she wanted to go home and she wanted to die, and denies having a plan to hurt his/her self. The 12/12/16 at 4:00 p.m. "Incident/Accident/Unusual Occurrences Form" reported that Resident #6 noted with a 2 centimeter (cm) by 0.4 cm laceration to the right	F 323	Please see prior page(s) for Plan of Correction.	

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F 323	Continued From page 13 wrist and the resident had been sent to emergency room. The 12/12/16 at 5:00 p.m. "Notes Notes" for Resident #6 reported that the nurse to the Memory Lane at 4:00 p.m. due to the resident noted with a laceration on right wrist. The resident had made a comment he/she attempted to cut wrist with a knife. The resident had been placed on constant supervision by facility staff and the Primary Care Provider notified and obtained an order to transport resident to the emergency room. The 12/12/16 at 7:00 p.m. "Nurses Notes" for Resident #6 reported that the resident would be returning to the facility from the emergency room and the resident will continue new suicide checklist upon return. The 12/17/16 at 11:00 a.m. "Incident/Accident/Unusual Occurrences Form" reported that Resident #6 with scant amount of blood on bilateral wrist. The 12/18/16 at 8:00 a.m. "Incident/Accident/Unusual Occurrences Form" reported that Resident #6 with a scant amount of blood on right wrist. Resident acknowledged they used a barrette that was under my pillow. The barrette had a scant amount of blood on it and was removed. The resident explained they did not want to die they just wanted to go home. The 12/18/16 at 8:00 a.m. "Nurses Notes" for Resident #6 reported that the resident ha a scant amount of blood. Staff found a butter knife from the dining room in her underwear. The 12/18/16 at 5:45 p.m. "Nurses Notes" for Resident #6 reported that during the 15 minute checks of the resident staff observed the resident in the family room rubbing a plug end from a radio against his/her right wrist. Staff reported that no digging motions noted, just repetitive rubbing	F 323	Please see prior page(s) for Plan of Correction.	

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F 323	Continued From page 14 against the cut on his/her right wrist. The 12/18/16 at 8:15 p.m. "Incident/Accident/Unusual Occurrences Form" reported that Resident #6 had been found in his/her room standing at the dresser cutting his/her wrist with a butter knife. The 12/18/16 at 8:15 p.m. "Nurses Notes" for Resident #6 reported that during the 15 minute checks staff found the resident in his/her bedroom standing by the dresser cutting his/her right wrist with a butter knife. During an interview 1/19/17 at 10:00 am with Staff B CNA reported the resident needed to be watched because they would try to hurt them self. During an interview 1/19/17 at 11:50 a.m. with Staff A CNA reported staff had to watch Resident #6 very carefully, he/she would take silver ware from the dining room and hide them in their room and try to hurt them self. We had to do room searches all the time. He/She would come to the dining room sit down for a minute and grab silverware and say they had to go to the bathroom and would have silverware down his/her pants where ever they could place them. Staff found silverware on the shelf in his/her closet, under mattress; we even found some under her roommate's mattress. It got to the point we did not let him/her go to the bathroom a lone. During an interview on 1/19/17 at 12:10 p.m. with Staff C CNA reported they were at the facility during one of the incidents with resident #6. Staff would have to watch the resident very carefully he/she was always trying to her them self. During an interview on 1/19/17 at 1:23 p.m. with Staff D CNA reported she did not work with Resident #6 often but knew the resident was always trying to cut off the wander guard and needed 15 minute checks and hourly room checks.	F 323	Please see prior page(s) for Plan of Correction.	

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F 323	Continued From page 15 During an interview on 1/19/17 at 2:54 p.m. with Staff E explained that Resident #6 needed 15 min check because he/she liked to hurt them self. During an interview on 1/19/17 at 4:21 p.m. with Staff F CNA reported that Resident #6 needed 15 min checks and there were times I found him/her trying to hurt them self so I did leave Resident #4 (a one to one resident) alone at the times I was attending to Resident #6. Staff had to keep a close eye on him/her. During an interview on 1/23/17 at 3:45 p.m. with Staff G CNA explained Resident #6 had been on 15 min checks Staff G had checked on him/ her and they appeared to be in bed sleeping. The next 15 min check he/she was standing in their room by the dresser in the dark with his/her back toward the door. While entering the room, observed the resident pulling a butter knife away from his/ her wrist. The Resident commented they were trying to cut his/her wrist. Resident comment they wanted to go home. Prior to that day Staff G knew he/she had made comments he/she wanted to die. Staff G did not know the resident stored things in his/her closet.	F 323	Please see prior page(s) for Plan of Correction.	
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 353		

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F 353	Continued From page 16 accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview the facility failed to ensure sufficient nursing staff to promote resident's physical, mental and	F 353	Please see prior page(s) for Plan of Correction.	

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F 353	Continued From page 17 psychosocial well-being in the CCDI Unit. The facility reported a CCDI census of 13 residents. Findings include: According to the Minimum Data Set dated 11/23/16 Resident #6 had a diagnoses that included Non-Alzheimer's dementia, anxiety disorder depression and dementia with behavior disturbances. The MDS documented the resident had a Brief interview for Mental Status (BIMS) score of 11, which indicated the resident had moderately impaired cognition. The MDS indicated Resident #6 required supervision of staff for transfers and walking in his/her room and corridors. The MDS further recorded the resident's received an antipsychotic, antianxiety and an antidepressant for 7 out of 7 days reviewed. The care plan dated 11/30/16 documented Resident #6 had behaviors related to anxiety and early dementia. The care plan updated 12/1/16 indicated 15 minute checks started. The 12/12/16 update to the care plan recorded the resident had made a laceration to his/her right wrist and was transferred to emergency room and on 12/13/16 a medication change and referral for consulting. The clinical record documented the following: Nurse's Notes dated 11/30/16 at 10:00 p.m., Resident #6 at dinner time had taken knives and forks and hid a knife down the back of his/her pants. The 12/17/16 at 11:00 a.m. " Incident/Accident/Unusual Occurrences Form " reported that Resident #6 with scant amount of blood on bilateral wrist.	F 353	Please see prior page(s) for Plan of Correction.	

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F 353	Continued From page 18 The 12/18/16 at 8:00 a.m. " Incident/Accident/Unusual Occurrences Form " reported that Resident #6 with a scant amount of blood on right wrist. Resident acknowledged they used a barrette that was under my pillow. The barrette had a scant amount of blood on it and was removed. The resident explained they did not want to die they just wanted to go home. The 12/18/16 at 8:00 a.m., " Nurses Notes " for Resident #6 reported that the resident had a scant amount of blood. Staff found a butter knife from the dining room in her underwear. The 12/18/16 at 5:45 p.m., " Nurses Notes " for Resident #6 reported that during the 15 minute checks of the resident staff observed the resident in the family room rubbing a plug end from a radio against his/her right wrist. Staff reported that no digging motions noted, just repetitive rubbing against the cut on his/her right wrist. The 12/18/16 at 8:15 p.m., " Incident/Accident/Unusual Occurrences Form " reported that Resident #6 had been found in his/her room standing at the dresser cutting his/her wrist with a butter knife. The 12/18/16 at 8:15 p.m. " Nurses Notes " for Resident #6 reported that during the 15 minute checks staff found the resident in his/her bedroom standing by the dresser cutting his/her right wrist with a butter knife. During an interview 1/19/17 at 10:0 0 am with Staff B CNA reported the resident needed to be watched because they would try to hurt them self.	F 353	Please see prior page(s) for Plan of Correction.	

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F 353	Continued From page 19 During an interview 1/19/17 at 11:50 a.m. with Staff A CNA reported staff had to watch Resident #6 very carefully, he/she would take silver ware from the dining room and hide them in their room and try to hurt them self. We had to do room searches all the time. He/She would come to the dining room sit down for a minute and grab silverware and say they had to go to the bathroom and would have silverware down his/her pants where ever they could place them. Staff found silverware on the shelf in his/her closet, under mattress; we even found some under her roommate's mattress. It got to the point we did not let him/her go to the bathroom a lone. During an interview on 1/19/17 at 12:10 p.m. with Staff C CNA reported they were at the facility during one of the incidents with resident #6. Staff would have to watch the resident very carefully he/she was always trying to hurt them self. During an interview on 1/19/17 at 1:23 p.m. with Staff D CNA reported she did not work with Resident #6 often but knew the resident was always trying to cut off the wander guard and needed 15 minute checks and hourly room checks. During an interview on 1/19/17 at 2:54 p.m. with Staff E explained that Resident #6 needed 15 min check because he/she liked to hurt them self. During an interview on 1/19/17 at 4:21 p.m. with Staff F CNA reported that Resident #6 needed 15 min checks and there were times I found him/her trying to hurt them self so I did leave Resident #4 (a one to one resident) alone at the times I was attending to Resident #6. Staff had to keep a close eye on him/her.	F 353	Please see prior page(s) for Plan of Correction.	

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F 353	Continued From page 20 During an interview on 1/23/17 at 3:45 p.m. with Staff G CNA explained Resident #6 had been on 15 min checks Staff G had checked on him/ her and they appeared to be in bed sleeping. The next 15 min check he/she was standing in their room by the dresser in the dark with his/her back toward the door. While entering the room, observed the resident pulling a butter knife away from his/ her wrist. The Resident commented they were trying to cut his/her wrist. Resident comment they wanted to go home. Prior to that day Staff G knew he/she had made comments he/she wanted to die. Staff G did not know the resident stored things in his/her closet. 2. The 11/29/16 quarterly Minimum Data Set (MDS) assessment dated 11/29/16 identified Resident #4's cognitive skills for daily decision making as moderately impaired with decisions poor. The MDS identified the resident had diagnoses of Alzheimer's disease, anxiety disorder, depression, psychotic disorder and wandered daily. The 11/23/16 care plan recorded Resident #4 had difficulty making decisions and communication and required checked on every 15 minutes. The 12/9/16 update to the care plan recorded the resident required one to one with staff at all times. The 12/17/16 update to the care plan recorded the resident requires one to one with staff at all times with staff between resident and others at all times. Incident/Accident/Unusual Occurrences Form dated 12/17/16 at 8:30 p.m. reported Resident #4 had been ambulating in the hallway with CNA one to one with resident. Resident #4 got closer	F 353	Please see prior page(s) for Plan of Correction.	

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F 353	Continued From page 21 to Resident #1 and reached out and touched Resident #4. Staff F CNA stepped between the residents causing Resident #4 to tighten his/her grip. Resident #1 started to yell and hit Resident #4 while Staff F attempted to block and redirect Resident #4. Nurses Notes dated 12/18/16 at 5:00 a.m. the resident pacing up and down the hallway agitated. The resident continued to move furniture, pushing and attempting to hit staff. Nurses Notes dated 12/18/16 at 5:20 a.m. reported the resident hit staff in the head with his/her fist and had increased agitation. Nurses Notes dated 12/18/16 at 5:30 a.m. reported the resident hit staff and continued pacing up and down the hallway. Nurses Notes dated 12/18/16 at 9:45 a.m. the resident combative hitting and pushing staff. Nurses Notes dated 12/18/16 at 10:30 a.m. revealed the resident continued pacing up and down the hallway combative and pushing staff. Nurses Notes dated 12/18/16 at 1:15 p.m. revealed the panic button sounding in Memory Lane. Two CNA's were with Resident #4 while doing cares, the resident head butted one CNA and then stood up and head butt the other one. Nurses Notes dated 12/18/16 at 2:30 p.m., revealed the resident up pacing the hallway and agitated. The resident pounding on walls and pushed staff. Nurses Notes dated 12/19/16 at 1:20 p.m.	F 353	Please see prior page(s) for Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165270	A. BUILDING _____ B. WING _____	C 01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD SPECIALTY CARE	1200 HIGHWAY 175 EAST STRATFORD, IA 50249

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F 353	Continued From page 22 documented the resident up and down the hallway with some increased agitation. . The resident attempted to pick up and move dining room table and chairs. Nurses Notes dated 12/19/16 at 7:30 p.m. the ambulance here to transport resident to the hospital for psychiatric evaluation. During an interview on 1/19/17 at 4:21 p.m. with Staff F CNA explained she worked in the Memory unit with one other CNA on 12/17/16 and had been assigned one to one's with Resident #4. That night he/she punched me in the mouth. Later, walking down the hallway toward his/her room Resident #1 was walking in the hallway and Resident #4 started to walk toward Resident #1 and staff F got between the two residents. Resident #4 reached around and grabbed Resident #1's hand and pulled. Resident #1 started to yell and hit Resident #4. Staff F pushed the panic button and it took 10 to 12 minutes for a nurse to respond. It had been a very hectic night in the unit and out front. Staff F reported that Resident #4's room had been at the end of the hallway and Resident#1's room right next door.	F 353	Please see prior page(s) for Plan of Correction.	

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
	IA0138	A. BUILDING: _____ B. WING _____	C 01/25/2017

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C 135	50.7(10A, 135C) 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: This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to report to the Department of Inspections and Appeals an incident in where a Resident # 6 tried to harm him/her (self). The facility reported a census of 47 residents at the time of the investigation. Findings include: The admission Minimum Data Set (MDS) assessment dated 11/23/16 identified Resident #6 Brief interview for Mental Status (BIMS) score of 11, which indicated the resident had moderately impaired cognition. The resident required supervision of staff for transfers and walking in his/her room and corridors. The MDS further recorded the resident's diagnoses as Non-Alzheimer's dementia, anxiety disorder depression and dementia with behavior disturbances. The MDS reported the resident received an antipsychotic, antianxiety and an antidepressant for 7 out of 7 days reviewed. The11/30/16 care plan recorded Resident #6 had behaviors related to anxiety and early dementia. The 12/1/16 update indicated 15 minute checks started. The 12/12/16 update to the care plan recorded the resident had made a laceration to his/her right wrist and was transferred to emergency room and on 12/13/16 a medication	C 135	F 000 PLAN OF CORRECTION Preparation and/or submission of the Plan of Correction is not a legal admission that the violations existed or exist or that the deficiencies herein are correctly cited, and it is not to be construed as an admission against the interests of Stratford Specialty Care (the "facility") or its affiliates, employees, agents, or individuals who drafted/submitted or may be discussed in this Plan of Correction. Rather, submission of this Plan of Correction is to respond to the specific matters addressed in the Statement of Deficiencies related to the alleged deficiencies and demonstrate how the facility's programs, policies, and practices promote its commitment to assure that all residents receive services that are of quality that meet professionally recognized standards of care and that comply with all requirements for licensure and participation. The facility's credible allegation of compliance date is 02/15/2017; this allegation of compliance does not constitute guilt, but that the facility is in compliance will all areas cited in the Statement of Deficiencies. Submitted by Alec Steils, LNHA, Administrator C 135 481-50.7 (10A, 135C) ADDITIONAL NOTIFICATION. THE DIRECTOR OF THE DIRECTOR'S DESIGNEE SHALL BE NOTIFIED WITHIN 24 HOURS, OR THE NEXT BUSINESS DAY, BY THE MOST EXPEDITIOUS MEANS AVAILABLE This is the facility's credible allegation of compliance for prefix tag C 135; this allegation does not constitute guilt, but that	

DEPARTMENT OF INSPECTIONS AND APPEALS

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C 135	Continued From page 1 change and referral for consulting. The 12/18/16 update recorded the resident signed a no self harm contract. According to the nurse's notes dated 12/18/16 at 8:00 a.m., revealed staff summoned the nurse to the memory lane; Resident # 6 had been sitting in family room in a chair with a scan amount of blood on his/her right wrist. Resident reported he/she used a barrette which is under his/her pillow. The barrette had been removed from the resident's room. The resident had a complete room search down with routine checks; and 1 to 1 provided. Resident #6 had been tearful and stated, "no, I don't want to die" and he/she just wanted to go home. The notes documented the resident nodded "yes" when asked if cutting him/her self. Staff placed the resident on 15 minute checks. On 12/18/16 at 8:00 a.m. the Incident/Accident/Unusual Occurrences Form reported Resident #6 with a scant amount of blood on right wrist. Resident acknowledged they used a barrette that was under my pillow. The barrette had a scant amount of blood on it and was removed. Staff provided 1:1 at this time. The resident had been tearful and stated he/she did not want to die, they just wanted to go home. The form asked if there had been any signs/symptoms of pain, and staff documented " to kill him/her self. The staff notified the physician at 9:00 on12/18/16 as well as the resident's family at 10:18 a.m.. The nurse's notes dated 12/18/16 at 4:15 p.m., the resident had been in the hallway and staff noticed the resident removed the bandage from right wrist which was bleeding a small amount from he/she rubbing it. Resident #6 told staff	C 135	the facility is in compliance with prefix tag C 135. The facility ensures incidents requiring notification under state and/or federal law are reported to the State of Iowa Department of Inspections and Appeals as required by state and/or federal law. All incidents requiring Department of Inspections and Appeals notification will be reported by the administrator or designee timely. The facility administrator was reeducated by corporate Director of Quality Assurance regarding reporting requirements on 01/11/2017. The administrator reeducated facility management staff on reporting requirements on 01/12/2017. All facility staff were educated on 01/13/2017. Administrator or designee will perform routine auditing to ensure staff understanding of reporting requirements. The quality assurance committee will ensure ongoing compliance through monitoring incidents and self-reported events monthly through continuous quality assurance committee meetings and quarterly through quality assurance and assessment committee meetings. The quality assurance and performance improvement committee will determine the need for further corrective action. Date of Compliance: 02/15/2017	

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C 135	Continued From page 2 he/she wanted to die. The nurse's notes identified the resident went to the dining room to eat meals with others and then left the table at the dining room and went to the bathroom. Staff questioned the resident and found a butter knife in his/her underwear which was removed from the resident. The nurse's notes dated 12/18/16 at 8:15 p.m., during 15 minute checks staff found the resident standing by his/her dresser cutting his/her wrist with a butter knife. The dressing on his/her wrist had been off and staff reapplied it. Staff called the DON to update him/her. On 12/18/16 at 8:15 p.m. the Incident/Accident/Unusual occurrences Form revealed the Resident #6 had been found in his/her room standing at the dresser cutting his/her wrist with a butter knife. The physician had been notified on 12/19/16 at 6 a.m. and the resident's family on 12/19/16 at 12:20 a.m. On 12/19/16 at noon the Nurse's notes documented staff received an order to transport Resident #6 for a psyche evaluation and treatment due to continued suicide idealization and multiple attempts of self harm. The resident reported he/she did not want to hive anymore and the nursing home can no longer meet the resident's needs. Record review identified a similar incident which had been timely reported to the Department on 12/12/16 as follows: The 12/10/16 at 3:00 p.m. Nurses Notes for Resident #6 reported that the nurse had been notified of the resident's comment to staff. The staff had asked what happened to resident's wrist the resident replied "I did it to kill myself and to	C 135	Please see prior page(s) for the Plan of Correction.	

DEPARTMENT OF INSPECTIONS AND APPEALS

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C 135	Continued From page 3 get out of this place and go home." The resident's room search initiated and to continue every hour by staff; staff also provided 1 to 1 to the resident. On 12/12/16 at 4:00 p.m., the Incident/Accident/Unusual Occurrences Form reported a 2 centimeter (cm) by 0.4 cm laceration to the right wrist and the resident had been sent to emergency room. On 12/12/16 at 5:00 p.m. the Nurses Notes for Resident #6 reported that the nurse to the Memory Lane at 4:00 p.m. due to the resident noted with a laceration on right wrist. The resident had made a comment he/she attempted to cut wrist with a knife. The resident had been placed on constant supervision by facility staff and the Primary Care Provider notified and obtained an order to transport resident to the emergency room On 12/12/16 at 7:00 p.m. the Nurses Notes reported the resident would be returning to the facility from the emergency room and the resident will continue new suicide checklist upon return. On 12/10/16 at 11:05 p.m. the Nurses Notes for Resident #6 reported that the resident commented she wanted to go home and she wanted to die, and denies having a plan to hurt his/her self. During an interview 1/19/17 at 11:50 a.m. with Staff A Certified Nurse Aide (CNA) reported staff had to watch Resident #6 very carefully, he/she would take silver ware from the dining room and hide them in their room and try to hurt them self. We had to do room searches all the time. He/She would come to the dining room sit down for a minute and grab silverware and say they had to go to the bathroom and would have	C 135	Please see prior page(s) for the Plan of Correction.	

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C 135	Continued From page 4 silverware down his/her pants where ever they could place them. Staff found silverware on the shelf in his/her closet, under mattress; we even found some under her roommate's mattress. It got to the point we did not let him/her go to the bathroom a lone. During an interview on 1/23/17 at 3:45 p.m. with Staff G CNA explained Resident #6 had been on 15 min checks Staff G had checked on him/ her and they appeared to be in bed sleeping. The next 15 min check he/she was standing in their room by the dresser in the dark with his/her back toward the door. While entering the room, observed the resident pulling a butter knife away from his/ her wrist. The Resident commented they were trying to cut his/her wrist. Resident comment they wanted to go home. Prior to that day Staff G knew he/she had made comments he/she wanted to die. Staff G did not know the resident stored things in his/her closet.	C 135	Please see prior page(s) for the Plan of Correction.	