DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165593	A. BUILDING _____ B. WING _____	C 04/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTISH RITE PARK INC	2909 WOODLAND AVENUE DES MOINES, IA 50312

(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: 4-29-21 The following deficiencies relate to the investigation of 96387-A and 96393-A conducted on March 16 - April 8, 2021. Additional findings related to 96387-A and 96393-A will be sent to the facility at a later date under separate cover. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §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 medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free	F 604		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		04/29/2021

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 604	Continued From page 1 from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, personnel file review, and facility policy and procedure review, the failed to ensure staff treated residents with respect and dignity and in a manner that recognized each resident's individuality, and also failed to ensure residents remained free from physical restraints imposed for convenience and not required to treat the resident's medical symptoms for 1 of 4 residents reviewed (Resident #1). The facility reported a census of 21 residents. Findings include: 1. An admission Minimum Data Set (MDS) assessment tool dated 1/25/21, documented Resident #1 had diagnoses that included: unspecified dementia with behavioral disturbance, psychotic disorder, restlessness and agitation, anxiety, and depression. The MDS revealed the resident scored of 12 of 15 possible points on a BIMS (brief interview for mental status) test, which meant the resident demonstrated moderately impaired cognitive function. The MDS also documented the resident exhibited fluctuating inattention and disorganized thinking, and feeling down, depressed or hopeless daily. The MDS identified Resident #1	F 604		

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F 604	Continued From page 2 required extensive assistance of one staff for bed mobility, surface-to-surface transfers, ambulation (walking), and toilet use, and was not steady but able to stabilize self without staff assistance when moving from a seated to standing position. An undated care plan with a focus area which included impaired cognitive function related to a diagnosis of unspecified dementia with behavioral disturbances, delusions and paranoia. The care plan documented the resident experienced anxiety and worried a lot which could lead to suicidal ideations and staff found the resident hard to redirect due to circle conversations that repeat over and over. The care plan also documented the resident could become combative during cares, may try to tip the wheelchair backwards, may try to walk independently, and refuse assistance with cares. The care plan directed staff to allow extra time to process questions or cues, reminisce using photos of family and friends, give one on one attention, report out of the norm suicidal ideations to the charge nurse immediately, switch out caregivers as needed, and keep the resident close to staff in an attempt to try to make them feel more secure and safe. The care plan revealed Resident #1 liked to fidget, tinker and stay keep busy with hands, say prayers, listen to Christian music or watch church services. The care plan directed staff to provide activities that allow the resident to keep their hands busy, and cue, re-orient and supervise as needed. During an interview on 4/1/2021 at 12:35 p.m. Staff A, Licensed Practical Nurse (LPN) stated on 3/1/21 Staff B, LPN used a gait belt to tie Resident #1 in a dining room chair, behind the nurse's station. Staff A described the gait belt as a	F 604		

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F 604	Continued From page 3	F 604		

typical gait belt with a metal buckle, fastened so that the resident could not reach the buckle. Staff A stated she reported her concern to the Chief Nursing Officer (CNO) on 3/2/21.

During an interview on 3/31/21 at 3:00 p.m. Staff C, Certified Nursing Assistant (CNA) stated on 3/1/21 after supper she observed Resident #1 at the nurse's station, seated in a dining chair with the chair back placed against the counter. Staff C demonstrated how she saw the gait belt wound through the fixed arms of a dining room chair and fastened. She responded she thought the buckle had been fastened behind the resident, but couldn't be sure. Staff C reported the resident would have been able to move around in the chair because the gait belt was loose, but unable to stand.

During an interview on 4/1/21 at 3:00 p.m. Staff D, CNA reported on 3/1/21 after supper she saw Resident #1 at the nurse's station, seated in a dining room chair with a gait belt fastened around her and the chair and Staff B, LPN sitting with her.

During an interview on 4/1/21 at 3:10 p.m. Staff E, CNA reported on 3/1/21 after supper, she saw Resident #1 at the nurse's station, seated in a dining room chair with a gait belt fastened around her waist and the dining room chair. Staff E stated this was not something she would do.

In an interview on 4/1/21 at 1:03 p.m., Staff B, LPN stated on 3/1/21 Resident #1 was transferred to a straight back dining room chair behind the nurse's station. She reported she placed a gait belt around the resident, through the fixed arms, and fastened the gait belt with the

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F 604	Continued From page 4	F 604		

buckle behind the chair, and then positioned the chair back against the nurse's station counter. Staff B reported the resident had been anxious and she was afraid she would tip over chair. Staff B stated she intended to keep the resident safe, although she acknowledged it was not ok to restrain a resident to keep them safe. After review of the facility camera footage of 3/1/21, Staff B confirmed the gait belt remained fastened around Resident #1 and the chair at the nurse's station from 6:36 p.m.-7:25 p.m.

During an interview on 4/6/21 at 12:05 p.m., the CNO stated on Tuesday 3/2/21 she received a report from Staff A, LPN of an incident involving Staff B, LPN. Staff B allegedly placed a gait belt around Resident #1 and a chair at the nurse's station on 3/1/21. The CNO stated she interviewed Staff B who reported she had loosely placed the gait belt around the resident for safety. The CNO reported on 3/2/21 Resident #1 had demonstrated the ability to independently remove a gait belt that had been placed to ambulate with the resident. The CNO stated Resident #1's abilities fluctuate and she did not feel that at this time Resident #1 would be able to consistently, independently remove the gait belt. The CNO reviewed the incident and had decided the incident did not meet the criteria for a restraint, and also felt there had been no ill intent. The CNO responded that she felt it was not an appropriate intervention and Staff B, LPN showed poor nursing judgement.

Observation on 3/16/21 at 3:30 p.m. revealed Resident # 1 seated in recline while staff provided 1:1 care with the resident interacting with staff.

Observation on 4/1/21 at 11:35 a.m. revealed

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F 604	Continued From page 5 resident attempting to stand. Staff applied a gait belt and transferred the resident with assist of two staff. Using the reasonable person standard, a reasonable person in our society would not want to be tied to a chair to prevent them from standing and in addition, would feel distress and humiliation. Review of an undated facility policy titled, Resident Screening, Training, Prevention, Identification, Investigation, Reporting, Protection of Abuse revealed the following expectations: Residents have the right to be free from verbal, sexual, physical, and mental abuse, neglect and mistreatment, corporal punishment, involuntary seclusion, and misappropriation of property. Abuse is defined as: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish. When reviewed, Staff B's personnel file revealed a hire date of 3/24/2009, a certificate for completion of the mandatory 2 hour dependent adult abuse for Iowa mandatory reporters dated 1/10/2019. Acknowledgement of the addition to the physical abuse policy dated 6/13/2017 reviewed the expectation to prevent personal degradation, and education on the abuse policy that was updated 1/5/2017 and signed on 1/18/17.	F 604		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		

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F 609	Continued From page 6 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 staff interview, clinical record review, and facility policy and procedure review, the facility failed to ensure incidents of abuse are properly reported for 1 of 4 residents reviewed (Resident #1). The facility reported a census of 21 residents. Findings include:	F 609		

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F 609	Continued From page 7 1. An admission Minimum Data Set (MDS) assessment tool dated 1/25/21, documented Resident #1 had diagnoses that included: unspecified dementia with behavioral disturbance, psychotic disorder, restlessness and agitation, anxiety, and depression. The MDS revealed the resident scored of 12 of 15 possible points on a BIMS (brief interview for mental status) test, which meant the resident demonstrated moderately impaired cognitive function. The MDS also documented the resident exhibited fluctuating inattention and disorganized thinking, and feeling down, depressed or hopeless daily. The MDS identified Resident #1 required extensive assistance of one staff for bed mobility, surface-to-surface transfers, ambulation (walking), and toilet use, and was not steady but able to stabilize self without staff assistance when moving from a seated to standing position. During an interview on 4/1/2021 at 12:35 p.m. Staff A, Licensed Practical Nurse (LPN) stated on 3/1/21 Staff B, LPN used a gait belt to tie Resident #1 in a dining room chair, behind the nurse's station. Staff A described the gait belt as a typical gait belt with a metal buckle, fastened so that the resident could not reach the buckle. Staff A stated she reported her concern to the Chief Nursing Officer (CNO) on 3/2/21. During an interview on 3/31/21 at 3:00 p.m. Staff C, Certified Nursing Assistant (CNA) stated on 3/1/21 after supper she observed Resident #1 at the nurse's station, seated in a dining chair with the chair back placed against the counter. Staff C demonstrated how she saw the gait belt wound through the fixed arms of a dining room chair and fastened. She responded she thought the buckle had been fastened behind the resident, but	F 609		

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couldn't be sure. Staff C reported the resident would have been able to move around in the chair because the gait belt was loose, but unable to stand. Staff C verified she had not reported the incident.

During an interview on 4/1/21 at 3:00 p.m. Staff D, CNA reported on 3/1/21 after supper observed Resident #1 at the nurse's station, seated in a dining room chair with a gait belt fastened around her and the chair. Staff B, LPN was observed to be sitting with resident. Staff D confirmed that she had not reported the incident.

During an interview on 4/1/21 at 3:10 p.m. Staff E, CNA reported on 3/1/21 they saw Resident #1 after supper at the nurse's station, seated in a dining room chair with a gait belt fastened around her waist and the dining room chair. Staff E said this was something she would not do. Staff E also confirmed she had not reported what she had seen.

In an interview on 4/1/21 at 1:03 p.m., Staff B, LPN reported on 3/1/21, the Resident #1 was transferred to a straight back dining room chair behind the nurse's station. Staff B also reported she placed a gait belt around resident, through the fixed arms, and fastened the gait belt with the buckle behind the chair and positioned with the back of the chair placed against the nurses station counter. Stated resident had been anxious and was afraid was going to tip chair. Staff B stated she intended to keep the resident safe, however acknowledged that it is not ok to restrain a resident to keep them safe. After review of facility camera footage of 3/1/21, Staff B confirmed the gait belt remained fastened around Resident #1 and the chair at the nurse's station

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F 609	Continued From page 9 from 6:36 p.m. - 7:25 p.m. During an interview on 4/6/21 at 12:05 p.m., the CNO stated on Tuesday 3/2/21 she received a report from Staff A, LPN of an incident involving Staff B, LPN. Staff B allegedly placed a gait belt around Resident #1 and a chair at the nurse's station on 3/1/21. The CNO stated she interviewed Staff B who reported that she had loosely placed the gait belt around the resident for safety. The CNO further stated that on 3/2/21 Resident #1 was observed to independently remove a gait belt that had been placed to ambulate with the resident. The CNO stated Resident #1's abilities fluctuate and she did not feel that at this time Resident #1 would be able to consistently, independently remove the gait belt. The CNO reviewed the incident and determined that it had not met the criteria for a restraint, and felt there had been no ill intent. The CNO responded that she felt it was not an appropriate intervention and Staff B, LPN showed poor nursing judgement. The CNO reported the facility did not report the incident to the Department of Inspections and Appeals. Review of an undated facility policy titled, Resident Screening, Training, Prevention, Identification, Investigation, Reporting, Protection of Abuse revealed the following expectations: a. Any allegation or suspicion of resident abuse, mistreatment, or neglect will be investigated promptly and thoroughly in order to protect the well-being of residents. b. All allegations of abuse shall be reported immediately and no later than 2 hours after allegation is made to the Department of	F 609		

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F 609	Continued From page 10 Inspection and Appeals (DIA). c. All allegations of resident neglect, exploitation, mistreatment, injuries of unknown origin, and misappropriation shall be reported to DIA, not later than 2 hours after the allegation is made.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 staff interview, record review, personnel file review, and facility policy and procedure review the facility failed to take action to prevent further abuse and ensure the safety of residents by permitting Staff B to continue to work while the investigation was still in process for one resident (Resident #1). The facility reported a census of 21 residents.	F 610		

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F 610	Continued From page 11 Findings include: 1. An admission Minimum Data Set (MDS) assessment dated 1/25/21, documented that Resident #1 had diagnosis of unspecified dementia with behavioral disturbance, psychotic disorder, restlessness and agitation, anxiety, depression and a score of 12 of 15 on a BIMS (brief interview for mental status), which indicated moderately impaired cognitive function. The MDS further documented the resident as fluctuating inattention and disorganized thinking, and feeling down, depressed or hopeless daily. The MDS further documented Resident #1 required extensive assistance of one staff for bed mobility, transfer, ambulation, and toilet use, and not stead but able to stabilize self without staff assistance when moving from a seated to standing position. An undated care plan with a focus area which included the following: I have impaired cognitive function related to a diagnosis of unspecified dementia with behavioral disturbances, and experience delusions and paranoia. Am anxious and worried a lot which can lead to suicidal ideations. Am hard to redirect because have circle conversations that repeats over and over. May become combative during cares, may try to tip my wheelchair backwards, may try to walk on my own and may refuse for you to assist me with cares. Interventions included the following: Allow extra time to process questions or cues. Reminisce using photos of family and friends. Enjoy one on one attention and like to be near staff, it makes feel more secure and safe. Likes to fidget, tinker and keep busy with hands, provide activities that allow to do so. Please cue, re-orient and supervise as needed. Like to say prayers, listen to Christian music or watch church	F 610		

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services. Report suicidal ideation to charge nurse immediately that are out of the norm for me. Switch out caregivers as needed, seeing a different face may change my mood.

During an interview on 4/1/2021 at 12:35 p.m. Staff A, Licensed Practical Nurse (LPN) stated on 3/1/21 Staff B, LPN used a gait belt to tie down Resident #1 in a dining room chair, behind the nurse's station. Staff A described the gait belt as a typical gait belt with a metal buckle, fastened so that the resident could not reach the buckle. Staff A stated she reported her concern to the Chief Nursing Officer (CNO) on 3/2/21.

During an interview on 3/31/21 at 3:00 p.m. Staff C, Certified Nursing Assistant (CNA) stated on 3/1/21 after supper observed Resident #1 at the nurse's station, seated in a dining chair that had been placed with the back of the chair against the counter. Staff C demonstrated gait belt placed through the fixed arms of a dining room chair and fastened. Staff C, responded she thought the buckle had been fastened behind the resident, but couldn't be for sure. Stated the belt was loose, so resident would have been able to move around in the chair but unable to stand. Staff C, confirmed she had not reported the incident.

During an interview on 4/1/21 at 3:00 p.m. Staff D, CNA reported on 3/1/21 after supper observed Resident #1 at the nurse's station, seated in a dining room chair with a gait belt fastened around her and the chair. Staff B, LPN was observed to be sitting with resident. Staff D confirmed that she had not reported the incident.

During an interview on 4/1/21 at 3:10 p.m. Staff E, CNA reported on 3/1/21 observed Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165593	A. BUILDING _____ B. WING _____	C 04/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTISH RITE PARK INC	2909 WOODLAND AVENUE DES MOINES, IA 50312

(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 610	Continued From page 13	F 610		

after supper at the nurse's station, seated in a dining room chair with a gait belt fastened around her waist and the dining room chair. Staff E confirmed that she had not reported what she had seen, and added this was not something that she would do.

In an interview on 4/1/21 at 1:03 p.m. Staff B, LPN responded on 3/1/21 Resident #1 was transferred to a straight back dining room chair behind the nurse's station, and she placed a gait belt around resident, through the fixed arms, and fastened the gait belt with the buckle behind the chair and positioned with the back of the chair placed against the nurses station counter. Stated resident had been anxious and was afraid was going to tip chair. Staff B stated she intended to keep the resident safe, however acknowledged that it is not ok to restrain a resident to keep them safe. After review of facility camera footage of 3/1/21, Staff B confirmed that the gait belt remained fastened around Resident #1 and the chair at the nurse's station from 6:36 p.m.-7:25 p.m. Staff B further confirmed that she had worked on 3/2/21, 3/9/21, and 3/11/21 prior to being notified on 3/16/21 by the CNO that an allegation had been reported and she would be unable to work during the investigation.

During an interview on 4/6/21 at 12:05 p.m. the CNO stated on Tuesday 3/2/21 she received a report from Staff A, LPN of an incident involving Staff B, LPN. Staff B allegedly placed a gait belt around Resident #1 and a chair at the nurse's station on 3/1/21. The CNO stated she interviewed Staff B who reported that she had loosely placed the gait belt around the resident for safety. The CNO further stated that on 3/2/21 Resident #1 was observed to independently

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	165593	A. BUILDING _____ B. WING _____	C 04/12/2021

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F 610	Continued From page 14	F 610		

remove a gait belt that had been placed to ambulate the resident. The CNO stated Resident #1's abilities fluctuate and she did not feel that at this time Resident #1 would be able to consistently, independently remove the gait belt. The CNO reviewed the incident and determined that had not met the criteria for a restraint, and felt there had been no ill intent. The CNO responded that she felt it was not an appropriate intervention and Staff B, LPN showed poor nursing judgement. The CNO reported the facility gave disciplinary action, and allowed the nurse to work with Resident #1 that shift on 3/2/21 and additional shifts on 3/9/21 and 3/11/21 prior to Staff B, LPN going on vacation. The CNO confirmed Staff B, LPN was put off work on 3/16/21 after received notification from DIA of allegation of abuse.

Review of an undated facility policy titled, Resident Screening, Training, Prevention, Identification, Investigation, Reporting, Protection of Abuse revealed the following expectations:

a. Any allegation or suspicion of resident abuse, mistreatment, or neglect will be investigated promptly and thoroughly in order to protect the well-being of residents.

b. Upon receiving report of an allegation of resident abuse, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. This will be accomplished by separating the employee accused of abuse from all residents.

c. Following completion of the facility investigation, if the facility concludes that the

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F 610	Continued From page 15 allegation of resident abuse are unfounded, the employee will be allowed to return to job duties involving resident contact, but the employee must maintain a separation and have no contact with the resident alleged to have been abuse d, by reassigning the accused employee to an area of the facility where no contact will be made between the accused employee and the resident alleged to have been abused. This separation must be maintained until the DIA concludes its investigation and issues the written results of its investigation. Review of a timesheet titled Retro Report for the time period 3/1/2- 3/12/1 revealed Staff B worked on 3/2/21, 3/9/21, and 3/11/21, which were all after the alleged incident occurred on 3/1/21.	F 610		

PLAN OF CORRECTION

Provider/Supplier Name:	Scottish Rite Park
Street Address, City, Zip:	2909 Woodland Ave Des Moines, Iowa 50312
Date of Survey:	March 16th thru April 12th 2021

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER - 165593

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F604	Scottish Rite Park ensures that resident is free from physical or chemical restraints & free from abuse. Scottish Rite Park ensures that staff treat residents with respect and dignity and in a manner that respects the resident's individuality.	4/29/2021
	Resident #1 remains free from chemical, physical restraints thru pharmacy review, Geri psychiatric treatment & staff education. All resident with potential to be affected are protected thru staff education related to restraints and abuse.	
	Resident # 1 has had pharmacy consultation & review of medications on March 5th,2021, March 26th,2021 & April 6th,2021. Ongoing follow up with Geriatric Psychiatry on March 25th,2021 & April 27th,2021. Dementia Workshop related to appropriate interventions & recognizing signs of unmet needs was provided on March 12th, 2021.	
	Professional Staff received education related to definitions of restraints, examples of types of restraints and alternative methods to restraint use on April 20th,2021.	
	Staff provided with abuse reporting protocol with contact numbers and email for immediate reporting of abuse.	
	CNO or designee will audit staff's understanding and knowledge of restraints and abuse thru routine audits.	
	QAPI team will review audits periodically.	
F609	Scottish Rite Park ensures that allegations of abuse are properly reported. Resident #1 remains free from abuse. thru staff education & auditing. All residents with potential to be affected are protected thru staff education related to restraints and abuse.	4/29/2021
	Staff provided with abuse reporting protocol with contact numbers and email for immediate reporting of abuse.	
	CNO or designee will audit routinely for understanding and knowledge of reporting requirements and reporting channels.	
	QAPI Team will review audits periodically.	

F610	Scottish Rite Park takes action to separate and protect all residents from future abuse.	4/29/2021
	Staff B remains on suspension.	
	Nurse Consultant provided education to CNO and Nurse Managers related to separation & protection guidelines on April 29 ,2021.	
	Resident #1 remains at the facility and has no contact with Staff B.	
	All residents with potential to be affected are protected thru education.	
	Nurse Consultant will review grievances and allegations routinely and audit for reporting compliance routinely.	
	QAPI team will review audits periodically.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.