√ JK 12/14/16

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
	S0004	A. BUILDING _____ B. WING _____	C 10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MEADOW PLACE, L L C	17396 KINGBIRD AVE MASON CITY, IA 50401

(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) COMPLETE DATE
A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 13 Number of tenants with cognitive disorder: 21 Total Population of Program at time of on-site: 34 TOTAL census of Assisted Living Program: 34 The following regulatory insufficiencies were cited during the investigation of Incident #63491-I and Complaints #62668-C, 63228-C and 62722-C.	A 000	See attached POC 11/30/16	
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the Program failed to consistently provide adequate and appropriate cares. This affected 1 of 1 tenant with skin integrity issues reviewed during the investigation of #63491-I, #62668-C, #63228-C, and #62722-C.	A 013		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 013	Continued From page 1 Finding follows: 1. Record review revealed the following: a. Tenant #1 had diagnoses of dementia, type 2 diabetes, heart failure, and urinary retention. Tenant #1 was staged at six on the global deterioration scale, which indicated severe cognitive decline. b. Progress notes, dated 8-29-16, documented during a foot clinic Tenant #1 was noted to have open areas to the balls of both feet, which appeared moist. Staff were directed to soak Tenant #1's feet, leave socks off, and ensure his/her feet were completely dried. The notes further documented Tenant #1 was aggressive and often refused cares including bathing dressing, and grooming, as well as assistance with toileting. c. Tenant #1's August 2016 task sheet revealed after 8-29-16, staff were prompted by the task sheet to document aggressive behavior, assistance with dressing, toileting assistance every two hours, or notification of the nurse for shower refusal. Further review of the task sheet revealed showers were scheduled for Tenant #1 on Tuesdays and Fridays. There were nine scheduled days during the month marked "RR," which indicated Tenant #1 refused showers. The task sheet also provided space for documentation of unscheduled bathing assistance. There were six documented events which continued to indicate Tenant #1 refused showers. The task sheet documented the completion of one shower during the month of August 2016, on the evening of 8-17.	A 013		

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A 013	Continued From page 2 When interviewed on 10-20-16 at 12:50 p.m., the foot clinic registered nurse stated she saw Tenant #1 prior to the 8-29-16 visit. Usually Tenant #1 walked to the area of the building where the foot clinic was held, but this time the foot clinic nurse went to the tenant's apartment. Tenant #1's socks were removed slowly as the foot clinic nurse was afraid the skin would come off. Tenant #1 complained of pain. His/her socks were stuck to his/her feet, his/her feet were white and moist. Tenant #1's feet were very dirty with crusting between the toes and foot odor. The foot clinic nurse further reported Staff F informed her Tenant #1 slept in clothes and did not get dressed or undressed; further reporting he/she refused showers 90% of the time. The foot clinic nurse stated she had not seen Tenant #1 since the foot clinic on 8-29-16, as these clinics were no longer held at the Program. The foot clinic nurse provided photographs taken at the time of her visit on 8-29-16. Four photographs were received from the foot clinic nurse showing both of Tenant #1's feet. Review of the photographs revealed debris present around the toes and large white and brown patches around the balls of both feet. When interviewed on 10-25-16 at 8:55 a.m., the Nurse Clinician stated the nurse with the home care agency came to do foot clinic. When the nurse took Tenant #1's socks off, his/her feet were "sticky" and appeared moist as if the first layer of skin was gone. The Nurse Clinician stated the condition of Tenant #1's feet was "concerning." Tenant #1 was incontinent and she thought the socks were moist from urine. Toileting assistance was increased and discussions were held with the family related to	A 013		

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A 013	Continued From page 3 Tenant #1 requiring a higher level of care. Staff was instructed to provide hands-on assistance with hygiene and to document refusals of care and notify the nurse of care refusals. The Nurse Clinician reviewed the August 2016 task sheets for Tenant #1, specifically bathing. There were no documented baths for the month of August 2016. Observation on 10-24-16 revealed the RN entered Tenant #1's apartment accompanied by the monitor. The apartment had an odor of urine. Tenant #1 sat in the chair as the RN removed his/her socks and shoes with permission. Both feet appeared white and wrinkled across the balls of the feet, with some areas of brown. There were no debris noted around the toes. There was brown discoloration at the heels. The ankles had some swelling. When interviewed on 10-25-16 at 8:10 a.m., Staff C stated Tenant #1 had body odor. Tenant #1 refused showers and Staff C got other staff to attempt to shower or try later, but Tenant #1 continued to refuse showers. Staff C reviewed the task sheet and the handwritten shower schedule for August 2016. Staff C confirmed her electronic initials on the task sheet and confirmed Tenant #1 refused one of one showers When interviewed on 10-25-16 at 8:36 a.m. Staff F, who usually worked the day shift, stated when the foot nurse came Tenant #1 had a sore on the bottom of his/her foot. Tenant #1 normally refused showers and became aggressive, as Tenant #1 did not like water. Staff F didn't know how often Tenant #1 changed clothes. On 10-25-16 at 9:17 a.m., after confirmation of Staff F electronic signature, Staff F reviewed the August 2016 task sheet for Tenant #1. Staff F confirmed she documented Tenant #1 refused	A 013		

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A 013	Continued From page 4 showers and a shower was not given on dates associated with her electronic signature. Staff F documented refusal on five of five days. When interviewed on 10-24-16 at 1:15 p.m., Staff G reported Tenant #1 often refused cares. When interviewed on 10-24-16 at 11:34 a.m. the RN stated for the month of August 2016 there was documentation of the completion of only one shower for Tenant #1. The documentation was contained on the handwritten shower list. During further interview with the RN on 10-25-16 at 9:40 a.m. the RN reported when she was hired (September 2016) the Manager expressed concerns regarding cares not being provided. When interviewed on 10-25-16 at 9:50 a.m., the Manager stated when she hired the registered nurse (September 2016) she wanted to make sure all cares were done, as she had concerns regarding how many times cares could be refused. The Manager reported she did notice personal cares not completed for some tenants.	A 013		
A 146	481-67.3(9) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(9) To be free from restraints. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to consistently ensure tenants free from restraints. Facility staff utilized restrictive measures to intervene with a tenant's display of	A 146		

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A 146	Continued From page 5 inappropriate behavior. This affected 1 of 1 tenant identified as a result of facility self-reported incident #63491-I. Finding follows: Record review reveled an incident report completed by Staff B, dated 10-1-16. The report documented Staff B reported she heard the North breach go off while in the kitchen, and responded. She saw Tenant #2 pushing on the door trying to get out. Another staff walked toward the door. Staff B and another staff went out the door, as the tenant was already outdoors. She and her co-worker tried to escort Tenant #2 back into the building. Tenant #2 began to choke Staff B. Staff B redirected the client from her neck and the tenant began to flail his/her arms, trying to his and punch her and the other staff. They got Tenant #2 inside and he/she attempted to walk toward the front again, so Staff B and another staff stood in front of the door so he/she could not leave. Tenant #2 became verbally abusive, saying he/she would snap their necks to get out. Tenant #2 then attempted to punch Staff B and another staff, so they each grabbed an arm, so he/she could not punch at them. Tenant #2 fought against them, so Staff B and her co-worker lowered him/her to the floor and held both of his/her arms down. Another staff was called in to help and was able to calm the tenant down enough to walk him/her to his/her room. Further record review revealed an incident report completed by Staff A on 10-1-16 describing the same incident with Tenant #2. Staff A documented she responded to the door alarm, "North Breach." When Staff A got to the door, Tenant #2 was already outside. Two other staff from first shift were also outside and approached Tenant #2. Tenant #2 got "(his/her) hands around" Staff A. Staff A was able to remove one	A 146		

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A 146	Continued From page 6	A 146		

hand, and Staff B removed the other. According to Staff A's statement, "... We then carried (Tenant #2) backwards under the shoulders inside." Tenant #2 laid down in the hallway yelling for help, stating he/she was held against his/her will. Tenant #2 stood and slowly began walking toward the front door. Staff A and two other first shift staff stood in front of the door. Tenant #2 continued to yell for help, asking for the police to be called. The tenant then began to threaten staff, telling them he/she would break their necks. Tenant #2 ran up on the staff and Staff A and Staff B each grabbed an arm. Staff had Tenant #2 sit on the couch as he/she continued to yell for help. Tenant #2 grabbed Staff A's wrist and forearm, twisting it and holding it tightly. Another staff was called into the area to help calm the tenant.

When interviewed on 10-20-16 at 2:30 p.m., Staff A confirmed an incident with Tenant #2. Staff A explained she responded to a door alarm around 5:50 a.m. on 10-1-16, along with Staff B and Staff C. Tenant #2 was unhappy and exited through the North door. Tenant #2 grabbed Staff B's throat when she approached him/her. They were able to remove Tenant #2's hands and get him/her inside. Once inside, Tenant #2 called for someone to call the police. Tenant #2 then began to walk toward the front door again, with staff following behind. Tenant #2 began to pick up speed, so Staff A, Staff B, and Staff B stood in front of the door. Staff A reported they then carried Tenant #2 backwards. Staff A stated she should have let Tenant #2 go. She explained they should have calmly approached Tenant #2 and walked with him/her.

When interviewed on 10-24-16 at 9:09 a.m. Staff B stated it was she and Staff A who each grabbed

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A 146	Continued From page 7 an arm of Tenant #2 and held it. Staff B stated she had not encountered a situation such as this before and had not been trained on restraints. Staff B stated she thought that a tenant could be restrained if considered a danger to self or others. In an incident report dated 10-1-16 Staff C documented Staff A and Staff B grabbed Tenant #2's arms because Tenant #2 was swinging at them. Staff C also documented Tenant #2 threatened staff and Staff A and Staff B held Tenant #2's arms at sides and lowered Tenant #2 to the floor. When interviewed on 10-20-16 at 1:49 p.m. Staff C stated Staff A and Staff B were both bringing Tenant #2 in the door with one on each side each having a hand on an elbow and a wrist. Staff C also stated when Tenant #2 attempted to strike staff, Staff A and Staff B each grabbed a hand of Tenant #2 and told Tenant #2 he/she could not leave. Tenant #2 sat on the floor. Staff A and Staff B each had a hand on one of Tenant #2's hands which kept Tenant #2's hands on the floor. Staff training records were reviewed for the six staff members working on 10-1-16 at the time of the incident with Tenant #2. There was no documentation provided related to what constitutes a restraint or when or when not to use restraints. In an interview with the Nurse Clinician on 10-20-16 at 11:30 a.m. she stated she had been at the Program on 10-19-16 and reviewed the incident of 10-1-16. Upon review of the incident reports, it was determined Tenant #2 may have been restrained and two employees were placed on suspension.	A 146		

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A 146	Continued From page 8 In an interview with the Manager on 10-24-16 at 10:30 a.m., she confirmed there was no documentation of training on restraints. In an interview with the registered nurse on 10-24-16 at 8:37 a.m. she stated it was not appropriate for a tenant to be carried backwards or be restrained so a tenant could not strike.	A 146		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the Program failed to ensure service plans adequately met the needs of tenants. This pertained to 2 of 2 tenants reviewed with behaviors (Tenant #1 and Tenant #2). Findings follow: 1. Record review revealed the following: a. Tenant #1 had diagnoses of dementia, type 2 diabetes, heart failure, and urinary retention.	A 083		

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A 083	Continued From page 9 Tenant #1 was staged at six on the global deterioration scale, which indicated severe cognitive decline. b. Progress notes, dated 8-29-16, documented during a foot clinic Tenant #1 was noted to have open areas to the balls of both feet, which appeared moist. Staff were directed to soak Tenant #1's feet, leave socks off, and ensure his/her feet were completely dried. The notes further documented Tenant #1 was aggressive and often refused cares including bathing dressing, and grooming, as well as assistance with toileting. When interviewed on 10-20-16 at 12:50 p.m., the foot clinic registered nurse stated she saw Tenant #1 prior to the 8-29-16 visit. Usually Tenant #1 walked to the area of the building where the foot clinic was held, but this time the foot clinic nurse went to the tenant's apartment. Tenant #1's socks were removed slowly as the foot clinic nurse was afraid the skin would come off. Tenant #1 complained of pain. His/her socks were stuck to his/her feet, his/her feet were white and moist. Tenant #1's feet were very dirty with crusting between the toes and foot odor. The foot clinic nurse further reported Staff F informed her Tenant #1 slept in clothes and did not get dressed or undressed; further reporting he/she refused showers 90% of the time. The foot clinic nurse stated she had not seen Tenant #1 since the foot clinic on 8-29-16, as these clinics were no longer held at the Program. The foot clinic nurse provided photographs taken at the time of her visit on 8-29-16. When interviewed on 10-25-16 at 8:55 a.m., the Nurse Clinician stated the nurse with the home care agency came to do foot clinic. When the	A 083		

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A 083	Continued From page 10	A 083		

nurse took Tenant #1's socks off, his/her feet were "sticky" and appeared moist as if the first layer of skin was gone. The Nurse Clinician stated the condition of Tenant #1's feet was "concerning." Tenant #1 was incontinent and she thought the socks were moist from urine. Toileting assistance was increased and discussions were held with the family related to Tenant #1 requiring a higher level of care. Staff was instructed to provide hands-on assistance with hygiene and to document refusals of care and notify the nurse of care refusals. The Nurse Clinician reviewed the August 2016 task sheets for Tenant #1, specifically bathing. There were no documented baths for the month of August 2016.

Observation on 10-24-16 revealed the RN entered Tenant #1's apartment accompanied by the monitor. The apartment had an odor of urine. Tenant #1 sat in the chair as the RN removed his/her socks and shoes with permission. Both feet appeared white and wrinkled across the balls of the feet, with some areas of brown. There were no debris noted around the toes. There was brown discoloration at the heels. The ankles had some swelling.

When interviewed on 10-25-16 at 8:10 a.m., Staff C stated Tenant #1 had body odor. Tenant #1 refused showers and Staff C got other staff to attempt to shower or try later, but Tenant #1 continued to refuse showers.

When interviewed on 10-25-16 at 8:36 a.m. Staff F, who usually worked the day shift, stated when the foot nurse came Tenant #1 had a sore on the bottom of his/her foot. Tenant #1 normally refused showers and became aggressive, as Tenant #1 did not like water. Staff F didn't know how often Tenant #1 changed clothes.

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A 083	Continued From page 11 When interviewed on 10-24-16 at 1:15 p.m., Staff G reported Tenant #1 often refused cares. Review of Tenant #1's August 2016 task sheet revealed after 8-29-16, staff were prompted by the task sheet to document aggressive behavior, assistance with dressing, toileting assistance every two hours, or notification of the nurse for shower refusal. Further review of the task sheet revealed showers were scheduled for Tenant #1 on Tuesdays and Fridays. There were nine scheduled days during the month marked "RR," which indicated Tenant #1 refused showers. The task sheet also provided space for documentation of unscheduled bathing assistance. There were six documented events which continued to indicate Tenant #1 refused showers. The task sheet documented the completion of one shower during the month of August 2016, on the evening of 8-17. The Nurse Clinician reviewed the August 2016 task sheets specifically bathing. The "RR" on the schedule indicated Tenant #1 had refused cares. There were no documented baths for the month of August 2016. When interviewed on 10-25-16 at 8:10 a.m. Staff C reviewed the task sheet and the handwritten shower schedule for August 2016. Staff C confirmed her electronic initials on the task sheet and confirmed Tenant #1 refused one of one showers On 10-25-16 at 9:17 a.m., after confirmation of Staff F electronic signature, Staff F reviewed the August 2016 task sheet for Tenant #1. Staff F	A 083		

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A 083	Continued From page 12	A 083		

confirmed she had documented Tenant #1 refused showers and a shower was not given on dates associated with her electronic signature. Staff F documented refusal on five of five days.

The registered nurse was interviewed on 10-24-16 at 11:34 a.m. and stated for the month of August 2016 there was documentation of the completion of only one shower for Tenant #1. The documentation was contained on the handwritten shower list.

The Nurse Clinician was interviewed on 10-25-16 at 8:55 a.m. and stated toileting assistance was increased and discussions were held with the family related to Tenant #1 requiring a higher level of care. Staff was instructed to provide hands-on assistance with hygiene and to document refusals of care and notify the nurse of care refusals.

A review of the service plan dated 9-29-15 and current at the time of the findings of the foot clinic nurse was not updated with continued refusals of care. The nurse failed to update the service plan as needed to meet the needs of Tenant #1.

2. Record review revealed the following:

a. Tenant #2 had a diagnosis of frontotemporal dementia and was staged at five on the GDS, which indicated moderately severe cognitive decline.

b. Progress notes dated 9-6-16 documented Tenant #2 was exit-seeking and became agitated. Tenant #2 calmed down, but later tried to exit through the apartment window.

c. Notes of 9-15-16 documented Tenant #2 refused to come into the Program and the sheriff

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
	S0004	A. BUILDING: _____ B. WING _____	C 10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MEADOW PLACE, L L C	17396 KINGBIRD AVE MASON CITY, IA 50401

(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) COMPLETE DATE
A 083	Continued From page 13 was called for assistance. Tenant #2 was transported to the hospital. d. Notes of 9-27-16 revealed Tenant #2 returned to the Program and discussed plans to leave. e. Notes of 9-30-16 documented Tenant #2's exit-seeking behavior had been escalating. Tenant #2 packed bags and offered to pay money for a ride. Medication was refused and Tenant #2 knocked the medication cup out of staff hands. f. Notes of 10-1-16 documented an incident in which Tenant #2 attempted to leave the building. Based on incident reports from 10-1-16, staff physically returned Tenant #2 to the building and held arms down to stop Tenant #2 from hitting. Review of Tenant #2's service plan, with signature dates of 9-23-16 and current at the time of the 10-1-16 incident, failed to identify Tenant #2's exit seeking behavior and interventions for exit-seeking. When interviewed on 10-20-16 at 1:30 p.m. the registered nurse reported the service plan of 9-23-16 did not identify interventions for exit-seeking.	A 083		

Country Meadow Place
17396 Kingbird Avenue
Mason City, Iowa 50401

November 14, 2016:

Complaint Intake #: 63491-1, 62668-C, 63228-C, 62722-C

Plan of Correction (POC) Submitted For:
- Investigation Date: October 20, 24, 25, 2016
- Monitor: Lori Miner, Department of Inspections and Appeals

POC:

A. Regulatory Insufficiency A013 - Tenant Rights: 481-67.3(2) Insufficiency: A013
481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate

Program POC:

1. Elements detailing how insufficiency was corrected for residents:

a. Resident 1 had been given a 15-day corrective action on 9/9/16 to correct behaviors related to bathing and incontinence.

b. Resident 1 had failed to improve behaviors and was given a written 30-day notice on 10/5/16, due to the need for higher level of care and no longer meeting occupancy criteria for assisted living. Resident 1 discharged from the community 10/26/16 to higher level of care.

2. Actions program taking to protect tenants in similar situations:

a. The Program RN has provided training with staff to ensure that if tasks are being refused that manager and RN are notified. Training provided 10/28/16 in-service. Additional training will be provided at scheduled monthly in-services and one on one as needed.

b. The program RN and manager will continue to provide hands on assistance and training with staff on re-approach, redirection and initial approach to minimize refusal of cares.

c. The program RN and manager will conduct random visual checks on approach to service with staff and provided one-on one training as needed.

d. The program RN reviewed task sheets 10/24/16 to ensure all tasks are being completed timely. The program RN observed staff individually and provided additional training to approach to service. This will continue on going as residents needs or services change.

3. Measures taken to ensure problem does not recur:

a. The Program RN will continue to provide training to staff on approach to service for residents to include behaviors and solutions for refusals in bathing and tasks. This will be completed annually and randomly as needed.

b. The Program RN will continue to provide and train staff alternatives to bathing, including sponge baths or spa baths if showers are being refuse. The Program RN will provide one on one hands on training as needed on-going.

c. The Program RN will update the Individual Service Plans to include an individualized approach to service to minimize refusal of service by residents upon move in. If the individual has history of refusals, progression to GDS of 4 or above, current resident service plans will be updated by 11/30/16.

d. The Program RN and Manager will audit tasks at minimum weekly, and at random on-going to ensure compliance.

B. Tenant Rights: 481-67.3(9) *Regulatory Insufficiency: A146: Tenants have the right to be free from restraints.*

Program POC

1. Elements detailing how insufficiency was corrected

a. Tenant 2 was given a written 30-day notice on 10/4/16 due to exceeding level of care due to aggressive behaviors. At the time of the incident Tenant 2 was new to the community. Tenant 2 was discharged from the Program on November 15, 2016.

2. Actions the program is taking to protect tenants in similar situations:

a. The Program RN and Manager provided staff with Restraint Training. All staff completed training on 10/31/16. Training included: What is a Restraint? Risks Caused by Restraints, alternatives to restraints, methods to improve a resident's safety, resident's rights, managed risk, physical and chemical restraint use and behavioral interventions plans.

3. Measures taken to ensure problem does not recur:

a. The Program RN will update Individualized Service Plans as needed to include intervention plans for residents with behaviors, related to approach to service for staff, re-direction for residents during certain behaviors such as exit seeking.

b. The Program RN and manager will complete random audits to tasks, observation and assist with cares. Staff have been instructed to immediately notify the Program RN of any in aggressive resident behaviors for instruction on interventions and redirection.

c. The Program RN and Manager will monitor staff performance daily to ensure solutions are effective

C. Service Plans: 481-69.26(1)*Regulatory Insufficiency: A083 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1)and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.*

Program POC:

1. **Elements detailing the insufficiency was corrected:**

a. The Program RN to review and update service plans to ensure the plans adequately meet the needs of the residents. Review and updates to be completed on 11/30/16.

b. The Program RN ill ensure the Service Plan reflects specific individual needs to each resident. Resident service plans will outline behaviors and interventions for refusing tasks, and exit-seeking, or other behaviors.
c. Staff will notify the Program RN and utilize the Nurse communication form to ensure follow up and provide additional training as needed.

2. Actions program taking to protect tenant in similar situations:

a. Service plans will outline behavioral issues, interventions for refusing tasks and exit-seeking. Individualized approach to service is noted on the service plan to provide staff with interventions to redirect and re-approach residents for services.

b. The Program RN and Manager will conduct random audits of staff approach to service to observe resident refusals and wandering concerns at random and provide interventions and re-direction training. This will be conducted on-going based on residents' individual needs.

3. Measures taken to ensure problem does not reoccur:

a. The Program RN and Manager will continue to provide one-on-one hands on training with staff regarding restraint risks and alternatives to restraints, methods to improve a resident's safety by demonstrating restraint training scenarios. Interventions and redirect techniques training was completed 10/31/16. This training will be provided annually and at random as needed based on the Program RN's observations.

b. The Program RN and Manager will monitor performance daily to ensure solutions are permanent for the next 30 days. The Program RN and manager to evaluate staff approach to service daily and provide interventions and re-direction as needed.

c. The Program RN will ensure staff is utilizing redirection techniques, spontaneous and planned activities the resident enjoy by reviewing the individualized service plans. This will be completed upon hire, annually and randomly on-going as needed based on the Program RN's observation of staff approach to service.

The Program will be in substantial compliance by 11/30/16.

Disclaimer for POC

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the program of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law