VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 19, 2023

Ms. Sarah Rowan, Administrator
Lincoln House
120 Hill Street
Barre, VT 05641-3915

Dear Ms. Rowan:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 28, 2023.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0175	A. BUILDING: _____ B. WING _____	C 02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HOUSE	120 HILL STREET BARRE, VT 05641

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R100	Initial Comments: An unannounced on site investigation of two complaints was completed by the Division of Licensing and Protection on 2/21/23 followed by additional record review between 2/22-2/27/23. There were regulatory violations identified as a result of this investigation.	R100		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the Registered Nurse Medical Administrator (RN) failed to develop a care plan that describes the care and services necessary to assist the Resident to maintain independence and well-being related to nutrition, safety, and behaviors for 1 of 3 Residents in the sample (Resident #1). Findings include: 1. Per record review Unusual Occurrence (UO) forms completed by staff between 6/6/2021 - 2/22/23 reveal that Resident #1 has exhibited behaviors including yelling, swearing, threatening staff, refusing care, meals, and medications. Review of Resident #1's care plan initiated in October of 2021 the section titled Mood &	R145	Tag R145 Acceptedv on 6/16/2023 - C. Scott/S. Freeman	

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R145	Continued From page 1 Behavior indicates that the Resident does not exhibit verbal or physically abusive behaviors or socially inappropriate behaviors. The care plan was updated in January 2022 and continues to reflect that the Resident does not have Verbal, physical abusive or socially inappropriate behaviors. There is a notation written on the side of the care plan that states "Recently loud, swearing waving cane about in dining room spoke with [her/his] daughter." The care plan form has a section underneath Mood & Behavior that states "If yes to any, what is the intervention that is used to resolve behavior? There were no interventions added that indicate appropriate strategies to attempt to resolve her/his behavior. The care plan was reviewed and signed by the RN was on 2/10/23. An entry dated 2/10/23 states "[Name omitted] has been verbally abusive to staff. There were still no interventions added to the plan of care to indicate appropriate strategies to attempt to resolve her/his behavior. On 2/12/22 a UO was completed reflecting that Resident #1 was touching other Residents making them "very upset by [her/his] presence." The care plan does not address the unwanted interactions between Resident #1 and other Residents. Nor, is there any interventions in place to prevent further unwanted interactions. 2. Resident #1 has a history of nausea, stomach pain, and constipation that has resulted in transportation to the hospital for evaluation and treatment. A Nurses Note written by a Med Tech on 8/16/ states "[name omitted] requesting enema from staff did not give it. Did not have one. Paged at 4:00 AM in pain due to constipation.	R145		

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R145	Continued From page 2 Requested to be transferred to [hospital] to relieve himself. EMS came at 4:30 AM for transport." Review of the facility PRN (as needed) Explanation Sheet the Resident has received as needed medication for stomach upset, nausea, and constipation on 7 occasions since 1/14/23. The Resident's care plan last reviewed by the Registered Nurse on 2/10/23 has a section related to constipation with a line to indicate whether the Resident has or is at risk for constipation it also has a line to provide appropriate interventions to manage constipation. Both lines in the constipation section are blank, failing to indicate that the Resident has constipation issues and provide interventions to manage her/his bowel status.. Per interview with the Executive Director on 2/21/23 at 4:30PM s/he stated that the Resident has inappropriate behaviors that s/he does not belong in the facility. When asked what interventions are in place to manage these behaviors s/he stated that "[the Resident] knows the rules." The ED was also asked about meals and what accommodations are made when Residents are too sick to go to the dining room. S/he stated that all Residents are expected to go to the dining room for meals and if they are sick, they sit alone in a dining area just off the dining room. During this interview the ED confirmed that the Resident's care plan did not reflect care and services needed related to behaviors and meeting the Resident's nutritional needs.	R145		
R153 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (10)	R153	Tag R153 Acceptedv on 6/16/2023 - C. Scott/S. Freeman	

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R153	Continued From page 3 Monitor stability of each resident's weight; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Registered Nurse failed to ensure adequate monitoring to ensure the stability of one of three Resident's weight (Resident #1) and prevent a significant weight loss. Findings include: Per record review Resident #1 has a history of frequently missing meals and has experienced a significant weight loss of 7.26%. Nurses Notes written by Med Techs are written that state whether the Resident attends meals reveals that between 2/1 - 2/20/23 the Resident missed meals on 8 days. However, there is no documentation that indicates what was done to ensure adequate nutrition or monitoring for weight loss. The Resident's care plan does not address the risk for weight loss, monitoring weight, or complications related to malnutrition. Documentation from a Physicians visit on 10/6/22 indicates that #1's weight was 169.9. A documented weight on 12/10/22 reflected 164.8lbs, on 1/15/23 s/he refused, and on 1/20/23 a weight was not documented, Per interview with the Executive Director (ED) on 2/21/22 at 4:30PM the Registered Nurse (RN) reviews weights, and staff notify her/himself or the RN if weight changes in monthly review. The ED reported that s/he was unaware of Resident #1's weight loss each month and did not know the reason for weight to not be taken in February 2023. During a telephone interview on 2/22/23 at 11:32 AM the RN confirmed that Resident #1's weight has been trending down. S/he has received	R153		

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R153	Continued From page 4 reports that the Resident lays in bed and doesn't go down for meals. The RN confirmed that the Resident was at risk for weight loss and that staff should obtain the Resident's current weight. On 2/24/23 the RN notified this surveyor via email that staff had attempted to obtain the Resident's weight twice on 2/23/23 and s/he refused. The RN stated that the Resident was asked 4 times on 2/24/23 and s/he continued to refuse. Per the RN staff should not have to continue attempting to obtain her/his weight. In the afternoon of 2/24/23 the RN sent an email that the Resident's weight was obtained, and it was 150.8lbs. This is a 7.26% weight loss in 4.5 months.	R153		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not	R179	Tag R179 Acceptedv on 6/16/2023 - C. Scott/S. Freeman	

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R179	Continued From page 5 limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide at least 12 hours of annual training for staff members who provide direct care to Residents. Findings include: Per review of staff training provided to direct care staff the only documented staff training provided since 2021 is Infection Control. There was no evidence that any of the following required training had been completed: Resident rights; Fire safety and emergency evacuation, Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid, policies and procedures regarding mandatory reports of abuse, neglect and exploitation, Respectful and effective interaction with residents, Infection control measures, and general supervision and care of residents. Per interview with the Registered Nurse (RN) on 2/24/2023 at approximately 9:30 AM education is provided during staff meetings and is not regularly documented. The RN confirmed that there was no documented evidence that training had occurred between 1/1/2022 and 2/24/2023 other than Infection Control.	R179		
R180 SS=F	V. RESIDENT CARE AND HOME SERVICES	R180	Tag R180 Acceptedv on 6/16/2023 - C. Scott/S. Freeman	

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R180	Continued From page 6 5.11 Staff Services 5.11.c All training to meet the requirements of 5.11.b shall be documented. Training in direct care skills by a home's nurse may meet this requirement, provided the nurse documents the content and amount of training This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide at least 12 hours of annual training for staff members who provide direct care to Residents. Findings include: Per review of staff training provided by the facility, the only documented staff training provided since 2021 is Infection Control. There was no evidence that any of the following required trainings had been completed: Resident rights; Fire safety and emergency evacuation, Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid, policies and procedures regarding mandatory reports of abuse, neglect and exploitation, Respectful and effective interaction with residents, Infection control measures, and general supervision and care of residents. Per interview with the Registered Nurse on 2/24/2023 at approximately 9:30AM education is provided at staff meetings however, s/he has not been good about record keeping. The RN confirmed that there was no documented evidence that training had occurred between 1/1/2022 and 2/24/2023 other than Infection Control.	R180		

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R213	Continued From page 7	R213		
R213 SS=D	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to treat all Residents with consideration, respect and full recognition of their dignity, individuality, and privacy. Findings include: Review of documents provided by the facility Executive Director on 2/21/23 revealed that there had been 67 documented Unusual Occurrence (UO) forms completed regarding Resident #1 between 6/6/2021 and 2/22/23. Per review of these facility UO forms several notes document communication and interactions where the Resident was not treated with dignity and respect by staff. On 1/20/22 Resident #1 reported to the Med Tech that s/he was not feeling well. The Med Tech documented a UO form at 4:00 PM that reflects that Resident #1 was not treated with respect and dignity. The Med Tech documented on the UO form that s/he responded to Resident #1's call bell to find her/him lying in bed complaining of left sided pain. After asking what the Resident wanted/needed the Med Tech left the room saying they would see her/him at dinner, the Resident stated they would not be down, and	R213	Tag R213 Acceptedv on 6/16/2023 - C. Scott/S. Freeman	

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R213	Continued From page 8 someone could bring something. The Med Tech documented "advised needs to come to dinner hall for dinner. As left [the Resident] started yelling s/he was going to sue this place and s/he was sick." The UO continues to dinner time 5:00 PM "[name omitted] arrived after 5:00 PM walking very slow and limping. I asked [her/him] what s/he would like for dinner." The Resident requested two sandwiches and was told that [s/he] could start with one and if still hungry staff would get another. The Resident wrapped the sandwich to take to her/his room and the Med Tech "Explained food was to be eaten in the dining room. [The Resident] escalated the situation and I walked away." The Med Tech then prepared the Resident's 6:00 PM medications and the Resident refused to take the medications at that time. The Med Tech further documented "I refused to let [her/him] take them back to [her/his] room. [S/he] said guess you will just need to bring them up to my room. I replied guess you will need to come down to the office which [s/he] started yelling more. I let it go for a minute and then told [her/him] to leave the dining room." At 5:45 PM the Med Tech brought the medications to the Resident's room with another staff member present. After the Resident took the medications the Med Tech "told [her/him] to have a good night [the Resident] replied that [s/he] would not, and I just walked out and closed the door as [s/he] continued to complain." An Unusual Occurrence form completed by a Med Tech on 2/1/22 during the evening shift reflects that Resident #1 had not attended breakfast or lunch and was a "no show" for dinner. At 6:15 PM the Med Tech was alerted to Resident #1's room where s/he was complaining of stomach cramps reporting s/he had two bowel movements and 2 boosts today. The Med Tech	R213		

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R213	Continued From page 9 documents "[The Resident] was hungry. Advised [her/him] they need to come to dinner/meals. [S/he] said he couldn't. Asked for soup or something. Refused to make {her/him} anything. Advised I could bring [her/him] a yogurt when I do med pass around [7:00 PM - 8:00 PM] Left the room. Upon return to the room with a yogurt [name omitted] informed me we can't withhold food. I advised [s/he] is in a level 3 facility, there are certain expectations of Residents and coming to the dining hall for food was one of them." The Med Tech told the Resident that her/his other option is for his family to provide food for him to have in her/his room. S/he asked the Med Tech if they would microwave any food for her/him that her/his family brought in and the Med Tech "Declined and advised it would be her/his responsibility. As leaving the room s/he said s/he would be calling her/his doctor. I closed the door and left." A Nurse Note written by a Med Tech on 2/11/22 reveals that the Resident reported that s/he was not being treated with respect and dignity. The note states "[name omitted] down for lunch complaining about the girls always on [her/his] back." A Nurses Note written by a Med Tech on 2/12/22 states "[name omitted] is a continual problem in the dining room." A UO form dated 8/19/22 beginning around 8:55 PM reflects an interaction between Resident #1 and a Med Tech where the Resident became angry and aggressive after being told to get out of another Resident's room. The Med Tech documents that when s/he became aware that the Resident #1 was in the other Resident's room s/he told her/him "OUT!" Resident #1 "became	R213		

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R213	Continued From page 10 very angry and bullying." Resident #1 insisted that s/he could do what s/he wanted to do, and that the other Resident had invited her/him in. The staff member documents "I repeatedly told [her/him] that [s/he] knew the rules..." The Resident continued to follow the Med Tech around the building swearing and yelling. The Med Tech documents telling the Resident "There was nothing left to talk about" and "[s/he] was told to go to bed. [s/he] said [the Resident] wanted to talk even though it was made clear I had work to do." The Med tech also documents "I could have been nicer (said "plz" [please]) but this is NOT the 1st or 3rd time I have had to remind [name omitted] of the rules." The UO A UO form dated 11/15/22 at 6:00 PM reveals that a Med Tech was alerted to Resident #1's room and found her/him lying in bed stating, "I can't walk" and "I am too weak to get up and walk. The staff member documents "Advised I have no fix for that. We can follow[her/him] to the bathroom to make sure [s/he] doesn't fall. Discussed that [s/he] had walked down to lunch so why 6 hours later can [s/he] not walk? No resolution other than [s/he] will alert if feels weak and needs to walk to the bathroom." Per interview with a direct care giver on 2/21/23 at 1:22 PM Resident #1 has never been inappropriate with her/him. S/he stated that it is how you approach her/him. S/he also stated that other Residents also have behaviors and are not "targeted" like Resident #1. During interview with a Med Tech on 2/21/23 at 1:47 PM s/he reported that there have never been any negative interactions with Resident #1 and has not witnessed any negative interactions between Resident #1 and others.	R213		

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R213	Continued From page 11 During interview with the Executive Director on 2/21/23 at 4:30 PM s/he stated that the Resident has inappropriate behaviors that s/he does not belong in the facility. When asked if staff receive training related to dementia and managing difficult behaviors s/he stated that staff are told to "just calm down" and that the RN would know more about training provided. When asked if there are any specific strategies staff can use to prevent Resident #1 from escalating s/he stated "residents are provided with the facility rules on admission and [Resident #1] knows the rules."	R213		
R999 SS=D	MISCELLANEOUS The Lincoln House is currently licensed as a level 3 Residential Care Home. Level 3 Residential Care Homes are required to provide nursing overview as defined by these regulations. The definition states: 2.2.cc. "Nursing overview" means a process in which a nurse assures that the health and psychosocial needs of the resident are met. The process includes observation, assessment, goal setting, education of staff, and the development, implementation, and evaluation of a written, individualized treatment plan to maintain the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the Registered Nurse (RN) failed to provide appropriate overview to assure that the health and psychosocial needs of the Resident was met for 1 of 3 Residents in the sample (Resident #1). Findings include:	R999	Tag R999 Acceptedv on 6/16/2023 - C. Scott/S. Freeman	

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R999	Continued From page 12 Per record review Resident #1 has experienced several episodes of illness that were not reported to the nurse to ensure appropriate assessment of the Resident and her/his needs. Review of the Nurses Notes completed by the Med Techs these episodes included aggressive behaviors, reporting to unlicensed staff that s/he was experiencing hallucinations, panic attacks, weakness, constipation, and unwitnessed falls with head injury. An Unusual Occurrence (UO) form was completed on 1/20/22 at 4:00 PM staff responded to Resident #1's call bell to find her/him lying in bed complaining of left sided pain. S/he showed staff where the pain was and asked for powder. The staff left the room saying they would see her/him at dinner, and s/he stated they would not be down, and someone could bring something. The staff member "advised needs to come to dinner hall for dinner. As left s/he started yelling s/he was going to sue this place and s/he was sick." The UO continues to dinner time 5:00 PM "[name omitted] arrived after 5:00 PM walking very slow and limping. I asked [her/him] what s/he would like for dinner." A Nurses note written on 1/20/22 reflects that the RN spoke to the Resident after hearing that s/he was not feeling well however, there is no documentation that reflects that the Resident was assessed. 10/4/22 at 4:00AM a UO form revealed that Resident #1 had rang her/his call bell to notify staff that s/he was experiencing hallucinations. S/he told staff that s/he has seen 5 canine females who spread food all around her/his room and that s/he had seen angles. Staff documented that they had listened for a few minutes then asked if s/he was okay and if what s/he was seeing was okay and not threatening, s/he said	R999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0175	A. BUILDING: _____ B. WING _____	C 02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HOUSE	120 HILL STREET BARRE, VT 05641

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R999	Continued From page 13 no. Staff told the Resident to call if anything changes, the interaction lasted about 12 minutes total. The staff also documented that the Resident then again started telling anyone who would listen that s/he was seeing and experiencing events that only he could see or hear. The form also states that the Nurse was notified " yes (eventually as behavior became more bizarre.)" Staff then called rescue to evaluate the Resident and s/he refused to go to the hospital for eval. On 10/4 6:00AM - 2:00PM a UO form completed reveals that the Resident stayed in bed throughout the day and that s/he stated "the fairies have been in her/his room this afternoon. No animals but bears and tigers are humans. Asked her/him to please come down for supper. The Nurse was notified however, there is no documentation that reflects that the RN assessed the Resident. An UO form written on 11/10/22 at 3:00AM reflects that the Resident used her/his call bell to alert staff that s/he was experiencing "cramps" when asked what kind of cramps s/he cried out "just let me die." Staff asked what s/he wanted or needed, and s/he would only answer "fix it" and "make it stop." S/he seemed to just want to complain. Recently [s/he] has complained of both stomach cramps and chest cramps." The line that asks if Nurse was notified the staff wrote "no, aware of [her/his] issues." An UO dated 1/14/23 states that the Resident came to lunch with a bruise on her/his right eye. S/he reported that they felt dizzy and fell on the bathroom floor. The unlicensed staff member checked for vision issues, The Resident denied headache and no joint pain and refused transport to ER for further examination. However, there is no documentation that the Registered Nurse was	R999		

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R999	Continued From page 14 notified of the fall or bruise. A Nurses Note written by a Med Tech on 8/16/22 (no time documented) states Resident "requesting enema from staff did not give it. Did not have one. Paged at 4:00 AM in pain due to constipation. Requested to be transferred to [hospital] to relieve [her/himself]. EMS came at 4:30 AM for transport." There is no documented evidence that the RN was notified of the request for the enema, that an enema was not available, or the Resident was assessed by the RN. Per interview with the RN on 2/22/23 at 11:32 AM staff are expected to contact her/him when Residents experience a change in condition. The RN confirmed that s/he is not always notified when the Resident complains that s/he is not feeling well. S/he stated that s/he "does review the Unusual Occurrence forms and the Nurses Notes when s/he is at the building." and assesses the Residents when needed." However, there is not documented evidence that assessments occur with changes in condition.	R999		

Deficiency Statement Plan of Correction (POC)

Survey Date:

Facility Name:

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R145 – 5.9 C (2)	Care Plan updated to reflect that client has a history of aggressive behavior and interventions to avoid conflict when communicating with the resident. Also updated regarding history of constipation and interventions for when the client has bouts of constipation and stomach upset. Staff meeting held to instruct the staff in therapeutic conversation and how and when to report findings to the nurse. Snacks will be available to residents in their floor kitchenette. An alternative meal will be offered when resident is not able to come down to dining room. A company restructure happened as of May 1, 2023. There is now an RN on site 40 hours per week and an LPN on site 20 hours per week.	6/1/23-staff meeting held and education provided. Snacks/meals being offered in client's room will start Monday 6/5/23	Education provided to staff about therapeutic conversation and how to report finding to the nurse for further need for evaluation and updating care plans.	Executive Nurse Administrator will update care plans with any changes. All care plans reviewed and changes made as warranted. Plan to review care plans annually with annual assessments. Spread sheet used to track annual assessments needed and care plan corrections will be made at that time.
R153 – 5.9C (10)	Staff meeting held and staff education provided around ability to deliver meal alternatives to the client's room to assure that they don't miss meals. Snacks and meal alternatives will be in the refrigerators on each floor to allow for easy access and variety when the client is unable to come to the dining room for meals and/or when they feel hungry in between meals. Plan to	As of Monday 6/5/2023 snacks will be available in kitchenettes on each floor. When a resident misses a meal, they will be offered and alternative in their room.	Food will be made more readily available on an ongoing basis and the staff will offer food when the resident is unable to come to the dining room. Snacks will be put into the floor refrigerators and monitored for expiration dates weekly.	Executive Nurse Administrator will assure that all residents will be offered meal. Weights will be monitored and reviewed by nurse monthly and will be changed to weekly/daily as needed for trends of weight loss or weight gain.

	continue monthly weights and if the resident is noted to regularly be missing scheduled dining room meals resident will be weight as need to assure that weight loss is not happening. Discussed plan with resident and updated care plan.			
R179 – 5.11, 5.11b	Staff meeting held and mandatory education identified. All staff read resident's rights and signed and dated the material so review could be reflected with plan moving forward for annual update and discussion. At this time we are working on a spread sheet to identify what trainings are needed and to provide tracking for further educational needs annually. I.C.A.R. assessment scheduled with the Department of Health to assure that Lincoln House is following correct infection control techniques and responding appropriately when issues are identified. This assessment will take place on 6/6/23. Education will be completed for the 12 hours by staff within 90 days or staff will not be able to work.	I.C.A.R assessment scheduled for 6/6/23 Mandatory education will be provided to staff and appropriately documented within 90 days. (Thursday, August 31st, 2023)	Monthly staff meetings to include updates on process. Spread sheet to track educational material.	Executive Nurse Administrator will run staff meetings and have minutes taken. Documentation will be kept in personnel files.
R180 – 5.11, 5.11.c, 5.11b	Education will be completed and accurately documented within 90 days. Education began immediately upon receiving notice of deficiency.	Educational material will be provided to follow mandatory subjects. Plan to have all staff complete within 90 days.	Education spread sheet created and education started. Educational series created to fulfill the requirements. Annual education will be tracked and documentation will be put into personnel files.	Executive Nurse Administrator. LPN that is working part time. Will track at each staff meeting and at time of hire.
R213 – 6.1	Resident rights were read, reviewed, and discussed by staff. Staff meeting was held. Resident has been encouraged to join group activities and meals times. He has felt	Annual Education will include therapeutic approach and dealing with different personalities and difficult behaviors. Care plan	Moving forward annual education will be provided. Supervision will be provided on a regular basis.	Executive Nurse administrator will assure that education is done at hire and annually. Will keep track with a spread sheet and review with each staff meeting.

	comfortable in common areas and participated in foot care. Resident was informed of ability to access food when he is unable to attend the dining room. Staff education provided around therapeutic conversation and approach.	updated. Supervision of staff to assure respectful interaction with all residents. Corrective action was taken immediately.		
R999 – 2.2	Care plan reviewed and updated. New nursing staff on site Monday – Friday to allow for greater access to real time assessment and assuring that the resident's physical, emotional, and psychological needs are met.	Corrective action taken upon receiving deficiencies.	All charts will be reviewed and care plans will be updated as needed.	Executive Nurse Administrator will review care plans with changes in ADLs/iADLs and/or will annual assessments. Spread sheet designed to track dates of needed assessments and care plan review.