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
	S0228	A. BUILDING: _____ B. WING _____	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW MEMORY CARE VILLAGE	3005 F AVENUE NW CEDAR RAPIDS, IA 52405

(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	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 23 Total Census of Assisted Living Program for People with Dementia: 25 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program:	A 000		
A 120	481-67.2(1)c Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: c. The person in charge at the time of the incident shall prepare and sign the report. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to have incident reports signed by the staff who completed the reports. This potentially affected all tenants (census of 25). Findings follow: 1. On 4-12-22 a review of Incident Report Forms	A 120	The Plan of Correction is attached.	

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

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from January 2022 to April 2022 revealed two different incident report forms were utilized. January 2022 and February 2022 incidents were documented on an Incident Report Form that included the name of the person who completed the report and a place to designate if there was a witness to the incident. The March 2022 and April 2022 incident reports were changed and lacked designated areas to include the signature of the person who completed the report and also if there was a witness to the incident and the name of the witness.

The revised Incident Report Form was used for 12 incidents in March between 3-10-22 and 3-31-22. Two of the incident report forms included a signature of staff who completed the report in the narrative of the description of the incident. The remaining incident reports lacked the signature of the staff who completed the incident report. The revised Incident Report Form was used for 4 incidents in April 2022 between 4-5-22 and 4-10-22. One of the incident report forms included the signature of the staff who completed the report in the narrative of the description of the incident. The remaining incident reports lacked the signature of the staff who completed the incident report.

2. Review of the Program's policy and procedure related to incident reports revealed staff were to document unusual accidents and incidents that involved tenants, visitors, staff or other people in the building or on the grounds. Tenant accidents, incidents and medication errors were to be documented on the Incident Report Form. A witness statement would be completed by those who witnessed the incident. The policy and procedure did not reflect the person in charge at the time would prepare and complete the form.

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A 120	Continued From page 2 3. When interviewed on 4-14-22 at 4:50 p.m. the Nurse Consultant said the revised form had been updated to include additional space for staff to write. The signature line had since been added back to the form to reflect the signature of the person completing the form. She confirmed the policy and procedure did not include the person who was in charge at the time of the incident would complete and sign the report.	A 120		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow its policy and procedure related the completion of incident reports for 4 of 5 tenants reviewed related to incident reports (Tenant #1, #2, #3, #4, #5). Findings follow: Review the Program's policy and procedure related to incident reports reflected staff would document unusual accidents and incidents that involved tenants, visitors, staff or other people in the building or on the grounds. Tenant accidents, incidents and medication errors would be documented on the Incident Report Form. A witness statement would be completed by those who witnessed the incident. 1. When interviewed on 4-13-22 at 10:30 a.m. Staff F said Tenant #1 and Tenant #4 had a sexual relationship approximately five to six months ago. The tenants had been observed in each their apartments without clothing and	A 150		

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touching each other in private areas.

Record review on 4-13-22 and 4-14-22 of Tenant #1's file revealed a diagnosis of Alzheimer's disease. Tenant #1 was staged a six on the Global Deterioration Scale (GDS) which indicated severe cognitive decline.

Review of Tenant #4's file on 4-14-22 file revealed diagnoses including bipolar disorder and delusional disorders. Tenant #4 was staged at a five on the GDS which indicated moderately severe cognitive decline.

A Nurse Review document dated 4-8-21 indicated the presence of a female/male companion was added to Tenant #1's and Tenant #4's service plans. Staff reported Tenant #4 was noted in Tenant #1's apartment. They were holding hands in the community and she stated she loved Tenant #1. Both Tenant #1 and Tenant #4's legal representatives were contacted and no concerns were voiced regarding the relationship. Staff were to report any increased agitation or aggression to the nurse.

An incident report was not completed when Tenant #1 and Tenant #4's sexual relationship was first noted.

2. Review of Tenant #2's file on 4-13-22 and 4-14-22 revealed a diagnosis of Alzheimer's disease with late onset. Tenant #2 was staged at a six on the GDS which indicated severe cognitive decline. A Progress Note indicated on 2-17-22 (late entry) Tenant #2 did not receive his medications. He was asleep before the medications were administered and she did not want to wake him due to his behavior in the day. He had used profanity, urinated on the floor and

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threw water on another tenant while she was asleep.

An incident report was not completed for the incident noted above (2-17-22) related to when Tenant #2 threw water on another tenant while she slept.

3. Review of Tenant #3's file on 4-14-22 revealed a diagnosis of Alzheimer's disease. Tenant #3 was staged at a five on the GDS which indicated moderately severe cognitive decline. A Progress Noted 2-10-22 reflected Tenant #3 refused her medication and vital signs. She was hitting other tenants, slapped one of the tenants in the face, removed the computer mouse from the computer, knocked over the water pitcher off of the cart, would not let go of another tenant's walker as she called him "obscene" names and was aggressive to other tenants.

An incident report dated 2-10-22 was located for Tenant #5 (not for Tenant #3). It indicated Tenant #5 was seated across from the nurse's station when a tenant seated next to her (Tenant #3) knocked over the water pitcher and then hit Tenant #5. The witness statement attached to Tenant #5's incident report documented Tenant #3 aggressed against two other tenants before being removed from the area. An incident report for Tenant #3 could not be located for the actions documented in the progress note dated 2-10-22.

4. When interviewed on 4-13-22 at 10:57 a.m. Staff E reported she heard Tenant #5 got outside of the building on Sunday on the p.m. shift.

Review of the April 2022 incident reports revealed an incident report dated 4-10-22 at 4:00 p.m. indicating Staff H responded to an alarm and saw

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A 150	Continued From page 5 Tenant #5 inside the building by the east exit door with Staff G. The Incident Report Form was crossed through and reflected a handwritten entry of "witness statement." The document was signed by Staff H. A witness statement document was completed by Staff G, which indicated on 4-12-22 at approximately 2:00 p.m. she was seated at the front desk, the door alarm sounded and she went to check on the alarm. Tenant #5 was walking around in the hallway and she got her back through the door. The document was signed by Staff G on 4-12-22. The witness statement provided by Staff G was dated two days after the incident and the date and time were reflected differently than the incident report. 5. When interviewed on 4-14-22 at 4:50 p.m. the Nurse Consultant confirmed an incident report was not found for Tenants #1 and #4 related to the sexual relationship. The incident report related to Tenant #5 was completed by Staff H on Monday (day after the incident).	A 150		
A 340	481-67.9(4)a Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated.	A 340		

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A 340	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse delegated training for 2 of 6 staff reviewed within 60 days of the registered nurse's employment (Staff C and D). Findings follow: 1. Review of the ALP Monitoring Entrance Form indicated the Director of Nursing (DON) was hired on 1-28-22. 2. Review of Staff C's training documents on 4-13-22 revealed a hire date of 3-10-22. Staff C had not received nurse delegated training by the current DON at the time of the recertification visit. 3. Review of Staff D's training documents on 4-13-22 revealed a hire date of 4-6-21. Staff D had not received nurse delegated training by the current DON at the time of the recertification visit. 4. When interviewed on 4-14-22 at 4:50 p.m. the Nurse Consultant said Staff D was on a leave of absence from the middle of February and had been there only a few weeks from when the DON started. She confirmed nurse delegated training was not found for Staff C.	A 340		
A 430	481-67.19(4) Record Checks 67.19(4) Validity of background check results. The results of a background check conducted pursuant to this rule shall be valid for a period of 30 calendar days from the date the results of the background check are received by the program.	A 430		

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A 430	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure 1 of 6 staff reviewed was hired within 30 days of the completion of background checks (Staff A). Findings follow: Review of Staff A's training documents on 4-13-22 revealed a hire date of 5-12-21. A Single Contact License & Background Check (SING) was completed on 3-31-22. Further research was requested for the criminal history background check and on 4-2-21 it indicated no record was found. Staff A was not hired until 5-12-21. The background check completed on 3-31-21 was no longer valid as it exceeded 30 days. When interviewed on 4-14-22 at 4:50 p.m. the Nurse Consultant confirmed this information.	A 430		
A 350	481-69.26(1) 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 observation, interview and record review the Program failed to update service plans as needed to reflect current needs of 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow:	A 350		

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1. Review of Tenant #1's file on 4-13-22 and 4-14-22 revealed a diagnosis of Alzheimer's disease. Tenant #1 was staged a six on the Global Deterioration Scale (GDS) which indicated severe cognitive decline.

When interviewed on 4-13-22 at 10:30 a.m. Staff F said Tenant #1 and Tenant #4 had a sexual relationship approximately five to six months prior. The tenants had been observed in each their apartments without clothing and touching each other in private areas.

A Nurse Review document dated 4-8-21 indicated the presence of a female companion was added to Tenant #1's service plan. Staff reported Tenant #4 was noted in Tenant #1's apartment. They were holding hands in the community and she stated she loved Tenant #1. Both Tenant #1 and Tenant #4's legal representatives were contacted and no concerns were voiced regarding the relationship.

Review of Tenant #1's Progress Notes indicated the following:
- On 1-29-22 Tenant #1 had some increased agitation, picked up his walker and slammed it back to down to the floor. Tenant #1 banged on the door to the medication room and screamed help loudly.
- On 2-9-22 Tenant #1 refused his medication, hit the table, spit his medication on the table, yelled out in the dining room and used profanity.
- On 2-10-22 Tenant #1 yelled in the hallway, said he needed help but when asked what assistance was needed he said he was fine, picked up his walker and slammed it to the floor and hit the walker against the wall.
- On 2-12-22 Tenant #1 yelled help and hit his walker up against the wall, yelled in the dining

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room, hit the table, refused to eat and said the food was not safe.
- On 2-13-22 Tenant #1 yelled in the hallway and hit his walker against the walls.
- On 2-18-22 Tenant #1 yelled, hit his walker against the walls, picked up the walker and slammed it down and screamed that he needed help. When asked what staff could to assist he said he was fine.
- On 2-21-22 Tenant #1 yelled in the hallway and said he needed help but could not state what was needed. He hit his walker up against the wall, picked up the walker and slammed it down to the floor.
- On 3-31-22 an order was received to crush medications and administer them in applesauce or pudding as needed.

An Order Summary Report reflected an order to apply anti-embolism hose in the morning and remove at night.

Tenant #1's service plan dated 2-18-22 reflected staff administered medications; however, did not reflect at times Tenant #1 chewed his medications and an order to crush medications was obtained. The service plan also did not include staff assisted with the application and removal of his anti-embolism hose. The service indicated to redirect Tenant #1 as needed when agitated which occurred at times when he woke up from a nap and was alone. The service plan did not reflect the extent of Tenant #1's behavior as noted above. The service plan did not include the history of the relationship with another tenant or directives for staff should the relationship begin again.

2. Review of Tenant #2's file on 4-13-22 and 4-14-22 revealed a diagnosis of Alzheimer's

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disease with late onset. Tenant #2 was staged at a six on the GDS which indicated severe cognitive decline. The tenant received hospice services.

When interviewed on 4-13-22 at 10:57 a.m. Staff E said Tenant #1 urinated in the common areas almost every day. He urinated in places other than his toilet. He had defecated in places other than his toilet; however, it was determined Tenant #2 was lactose intolerant and that had improved.

When observed on 4-13-22 at lunch Tenant #2 sat in a wheelchair while staff propelled him. Prior to eating he sat with his head down and appeared to be asleep. Staff assisted him at times with his meal. On 4-14-22 Tenant #2 was observed walking with his walker while Staff E followed behind him with his wheelchair. Tenant #2 verbalized for staff to leave him alone as she attempted to assist him. Tenant #2's bilateral legs were wrapped with an ACE wrap.

Progress Notes indicated the following:
- On 2-3-22 Tenant #2 was aggressive in the dining room. He used profanity at the staff and other tenants and attempted to his staff.
- On 2-17-22 (late entry) Tenant #2 did not receive his medications. He was asleep before the medications were administered and staff did not want to wake him due to his behavior earlier in the day. He used profanity, urinated on the floor and threw water on another tenant while she was asleep.
- On 3-10-22 it was noted during the last check Tenant #2 refused to get up or be changed. He got agitated and said he was going to kick staff if they did not get out.

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Continued record review revealed a Long Term Care Facility Acute Visit dated 2-17-22 indicating over the past few weeks he had been more agitated and aggressive towards staff and other tenants. His scheduled lorazepam was increased to three times daily and staff reported his moods were more manageable.

March 2022 and April 2022 medication administration records (MARs) reflected a 24.2 pound weight loss from 3-5-22 to 4-5-22. The MARs also reflected an order to apply ACE wraps to bilateral lower extremities (if tolerated) and remove at bedtime for edema.

The tenant's service plan dated 4-1-22 reflected the use of the walker; however, did not reflect the wheelchair. The service plan did not reflect a weight loss, despite a 24.2 pound loss in one month. The service plan reflected Tenant #2 had a history of searching for a toilet and staff assisted to prevent voiding in common areas. The service plan did not reflected the extent of Tenant #2's voiding in common areas. The service plan also did not reflect the bilateral ACE wraps and edema. The service plan reflected if Tenant #2 was agitated to redirect as needed and provide interventions. It identified Tenant #2 was a potential safety risk to self or others. The service plan did not reflect the extent of Tenant #2's behavior as noted above.

3. Review of Tenant #3's file on 4-14-22 revealed a diagnosis of Alzheimer's disease. Tenant #3 was staged at a five on the GDS which indicated moderately severe cognitive decline.

Progress Notes indicated the following:
- On 2-10-22 Tenant #3 refused her medication and vital signs. She hit other tenants, slapped one

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of the tenants in the face, removed the computer mouse from the computer, knocked the water pitcher off of the cart, would not let go of another tenant's walker as she called him "obscene" names and was aggressive with other tenants.
- On 3-5-22 Tenant #3 was agitated with staff and took the red bag off of the scale. Tenant #3 was resistive to assistance. When in the hallway for a storm warning she told other tenants they did not have to listen to the nurse and could do as they liked.
- On 4-5-22 Tenant #3 was in an altercation with staff and other tenants.

A review of Nurse Reviews indicated the following:
- On 2-10-22 a nurse review was completed related to Tenant #3 being "physically combative" towards other tenants. She slapped one tenant open handed across the face. She punched a second tenant in the arm/chest area with a closed fist punch. She grabbed the computer mouse from the medication cart and threw it and "purposefully" pushed the water pitcher off the medication cart. She grabbed another tenant's walker, would not let go and called him "obscene" names, which upset the other tenant. Tenant #3 refused her morning medications that morning as well as vital signs.
- On 2-14-22 it was noted Tenant #3 was uncooperative with cares at times. Tenant #3 was aggressive with another tenant that morning. Tenant #3 attempted to take another tenant's walker and said it was her walker. Both tenants kicked each other. Staff reported Tenant #3 refused her medications at times and had a history of care refusals.
- On 4-5-22 it was noted Tenant #3 was agitated and aggressive at times. She was upset when another tenant fell on the floor and she thought it

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MEADOWVIEW MEMORY CARE VILLAGE	3005 F AVENUE NW CEDAR RAPIDS, IA 52405

(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 350	Continued From page 13	A 350		

was her child and attempted to get her off the floor. She started using profanity and became combative towards staff.

Further record review revealed a Long Term Care Facility Acute Visit note dated 2-17-22 reflected over the past few weeks she had frequently refused medications, had become more agitated and irritable. She was possessive of other people's things and over some male tenants. It caused her to be "quiet upset and belligerent at times." She was started on a scheduled topical lorazepam due to her frequent refusals of medications.

Tenant #3's service plan dated 3-25-22 reflected to redirect the tenant as needed when agitated, re-approach, watch for aggression towards other tenants and remove her or the other tenant from the situation. The service plan did not reflect the extent of Tenant #3's behavior towards staff and other tenants or the being possessive of things or other tenants. The service plan reflected if Tenant #3 refused her medications to document the refusal. The service plan did not reflect the use of topical lorazepam due to frequent refusals of oral medications.

4. Record review on 4-14-22 of Tenant #4's file revealed diagnoses included bipolar disorder and delusional disorders. Tenant #4 was staged at a five on the GDS, which indicated moderately severe cognitive decline.

When interviewed on 4-13-22 at 10:30 a.m. Staff F said Tenant #1 and Tenant #4 had a sexual relationship approximately five to six months prior. The tenants had been observed in each their apartments without clothing and touching each other in private areas.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0228	A. BUILDING: _____ B. WING _____	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW MEMORY CARE VILLAGE	3005 F AVENUE NW CEDAR RAPIDS, IA 52405

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A 350	Continued From page 14 A Nurse Review document dated 4-8-21 indicated the presence of a male companion was added to Tenant #4's service plan. Staff reported Tenant #4 was noted in Tenant #1's apartment. They were holding hands in the community and she stated she loved Tenant #1. Tenant #1 and Tenant #4's legal representatives were contacted and no concerns were voiced regarding the relationship. Further record review revealed the current service plan dated 3-22-22 did not reflect the history of the relationship with the other tenant or directives for staff should the relationship begin again. 5. When interviewed on 4-14-22 at 4:50 p.m. the Nurse Consultant confirmed all current service plans were provided for the tenants listed above.	A 350		

Department of Inspections and Appeals
Attn: Deb Dixon
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Dixon:

On behalf of Meadowview Memory Care Village in Cedar Rapids, Iowa, I respectfully submit our Plan of Correction for your approval. This response is specific to the recertification report for the onsite visit between 04/12/2022-04/14/2022. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the alleged facts or conclusions set forth in the statement of insufficiencies. The Plan of Correction is executed solely because it is required by the provisions of Iowa Law.

Program Policies and Procedures

1. Elements detailing how the program will correct each regulatory insufficiency
    - The accident, incident, and medication error policy was updated to include the specific regulatory requirements of the incident report form.
    - The incident report will be signed by the person completing the form.
2. Measures taken to ensure the problem does not recur
    - Staff will be re-educated on the policy and procedure for reporting of accident, incidents, and medication errors including but not limited to requirement of signature by the person completing the form.
    - The incident report form in use within the facility includes all regulatory requirements including signature of the person completing the form.
3. How the Program Plans to monitor performance to ensure compliance
    - The Executive Director, Director of Nursing, and/or Nurse Designee will review each completed incident report for the required elements at the time a report is submitted by staff to ensure compliance.
    - The Executive Director, Director of Nursing, and/or Nurse Designee will provide ongoing education to staff at least annually on the accident, incident, and medication error reporting policy.

✓ 5/20/22

Program Policies and Procedures

1. Elements detailing how the program will correct each regulatory insufficiency
    - An incident report will be completed for all tenants related to any accident, incident, or unusual occurrence that occurs per the Accident, Incident, and Medication Error Policy.
    - A witness statement will be included with the incident report as applicable.
2. Measures taken to ensure the problem does not recur
    - Staff will be provided re-education on the Accident, Incident, and Medication Error Policy including but not limited to the requirement for an incident report to be completed for all accidents, incidents, and unusual occurrences.
3. How the Program plans to monitor performance to ensure compliance
    - The Executive Director, Director of Nursing, and/or Nurse Designee will provide ongoing education to staff at least annually on the accident, incident, and medication error reporting policy.
    - At the time the Executive Director, Director of Nursing, and/or Nurse Designee become aware of any accident, incident, or unusual occurrence, they will ensure staff complete an incident report per the policy.
4. The date the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before June 3, 2022.

Staffing

1. Elements detailing how the program will correct each regulatory insufficiency
    - The Director of Nursing has completed delegations with Staff C as of April 5, 2022. (This was done, and DON just found documentation)
    - Staff D returned and was delegated on May 10, 2022.
2. Measures taken to ensure the problem does not recur
    - All staff will receive delegations within 30 days of initial employment.
    - If not completed within 30 days of hire date, staff will be removed from the schedule until training is finished.
3. How the Program plans to monitor performance to ensure compliance
    - The Executive Director, the Director of Nursing, and/or Designee will monitor completion of delegation for all new employees. Staff who do not complete within 30 days of hire will be removed from the schedule.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before June 3, 2022.

Record Checks

1. Elements detailing how the program will correct each regulatory insufficiency
    - Staff A has had a background check completed as of May 10, 2022.
2. Measures taken to ensure the problem does not recur
    - All staff will have the results of a background check validated within 30 calendar days of hire date.
    - If the hire date exceeds 30 days the background check will be re-validated prior to employment.
3. How the Program plans to monitor performance to ensure compliance

- The Executive Director and/or Designee will complete background check for all employees prior to offer of employment.
- The Executive Director and/or Designee will audit the employee files at least quarterly for compliance.

4. The date by which the regulatory insufficiency will be corrected
   - The regulatory insufficiency will be corrected on or before June 3, 2022.

Service Plans

1. Elements detailing how the Program will correct each regulatory insufficiency
   - Tenant #1 no longer resides at the facility.
   - Tenant #2 no longer resides at the facility.
   - Tenant #3 service plan was updated on May 10, 2022 to reflect the extent of behavior toward staff and other tenants, being possessive of things or other tenants, and use of topical Lorazepam due to refusal of oral medications.
   - Tenant #4 service plan was updated on May 10, 2022 to reflect history of a relationship with a male tenant and directives for the staff should a relationship begin again.
2. Measures taken to ensure the problem does not recur
   - Re-education was provided to the Director of Nursing and Nurse Designee regarding Service Plans. This was completed on May 5, 2022.
   - Service Plans will be based on the evaluation, individualized, updated whenever changes are needed and at least annually in accordance with regulation.
3. How the Program plans to monitor performance to ensure compliance
   - The Director of Nursing and/or Nurse Designee will audit tenant service plans at least quarterly to ensure they are following regulatory requirements.
4. The date by which the regulatory insufficiency will be corrected
   - The regulatory insufficiency will be corrected on or before June 3, 2022.