STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555799	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ridge Post Acute	1355 Clayton Road San Jose, CA 95127

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45853 Based on interview and record review, the facility failed to report an abuse allegation incident for one of one sampled resident (Resident 1, female) when the facility staffs found Resident 2 (male) on Resident 1 ' s bed. This failure had left the public agencies with jurisdiction over the facilities unaware of the event. Findings: Review of Resident 1 ' s facesheet (a document that gives a resident's information at a quick glance, including contact details and a brief medical history), indicated Resident 1 was admitted on [DATE], with diagnoses of status post left hip replacement surgery due to left femur neck fracture, major depressive disorder. During an interview on 7/24/23 at 3:30 p.m. with Licensed Vocational Nurse (LVN) A, she stated, on 6/15/23 at around 9:30 p.m., two Certified Nursing Assistants (CNA) from Station 1 told her Resident 2 was found sitting on the foot of Resident 1 ' s bed. LVN A stated Resident 1 told her I'm ok after the incident; however, Resident 1 appeared fearful. LVN A stated she documented the incident, but did not report it to the authorities. During an interview with Resident 1 on 8/17/23 at 9:16 a.m., she stated on the second day since her admission to the facility at around 8:00 p.m., a male stranger entered her room and sat on the end of her bed; and then, the man laid down and put his head on her legs. Resident 1 stated she was unable to move due to a recent surgery; so, she told the man to leave, but he did not move. Resident 1 stated she felt scared to death and screamed for help. Resident 1 stated she requested to be discharged the next day because she was too scared and nobody addressed the issue. Resident 1 stated since she had been discharged from the facility, she had been seeing a mental health therapist for nightmares related to the event. During an interview with CNA B on 9/13/23 at 12:40 p.m., CNA B stated she and another CNA went into Resident 1 ' s room immediately when they heard Resident 1 yelling for help repeatedly. CNA B stated Resident 2 was sitting at the foot of Resident 1 ' s bed, but there was no physical contact between the two residents. Resident 1 told CNA B she was scared, but did not tell her any details of the incident. CNA B stated she removed Resident 2 from Resident 1 ' s room and reported the incident to LVN A. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator (ADM) on 9/13/23 at 2:30 p.m., she confirmed the facility did not report the incident to any authorities. Review of the facility ' s policy and procedure Abuse, Neglect, Exploitation or Misappropriation - Reporting and investigating, revised April 2021, indicated, Reporting Allegations to the administrator and Authorities 1. If resident abuse, neglect, exploitation, misappropriation of resident property of injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; d. Law enforcement officials.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on interview and record review, the facility failed to ensure care and services were provided in accordance with professional standards of practice for two of three sampled residents (Residents 2 and 1) when: 1. Licensed nurses did not start to monitor Resident 2's whereabouts after the incident with Resident 3 on 1/15/2023; 2. Licensed nurses did not monitor Resident 2's whereabouts until the 6/15/2023's incident with Resident 1 and had some missing documentations on Resident 2's implementation of Elopement Risk/Wanderer care plan dated 6/15/2023; 3. Licensed nurses did not complete Resident 1's Admission Assessment in a timely manner, who was admitted on [DATE]; the Admission Assessment was only completed on 6/16/23; and 4. Licensed nurses did not complete Resident 2's follow-up assessment after the 6/15/2023 incident in a timely manner and the interdisciplinary team's (IDT, a group of health care professionals from diverse fields who work toward a common goal for residents) note was initiated three months after this incident on 6/15/2023; These failures had the potential to compromise Resident 1, Resident 2 and other residents' safety, health and well-being. Findings: 1. Review of Resident 2's Admission Record dated 3/6/2024 indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses including catatonic schizophrenia (a mental illness when the patient may not respond to what's happening around them, or they could have periods of high activity, where they could act violently), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a condition characterized by memory loss) with other behavioral disturbance (a pattern of disruptive behaviors). Review of Resident 2's quarterly minimum data set (MDS, an assessment tool), dated 7/14/2023, indicated, Resident 2 had short term (the capacity to recall a small amount of information from a recent time) and long-term memory (the capacity to recall memories from a longer time ago) problem. Review of Resident 2's clinical record titled, SBAR [Situation, Background, Assessment, Recommendation] & Initial COC [Change of Condition]/Alert Charting & Skilled Documentation, dated 1/15/2023, indicated, Resident slept on other resident's bed unoccupied at that time. Further review indicated, Resident 3 found Resident 2 on the bed which made Resident 3 angry, yelled at Resident 2, and grabbed Resident 2's right great toe but no injuries resulted. Review of Resident 2's clinical record titled, Wandering/Elopement Risk Assessment, dated 1/18/2023, it revealed Resident 2 was ambulatory, cognitively impaired, had history of wandering and high risk for elopement. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with certified nursing assistant B (CNA B) on 3/6/2024 at 11:45 a.m., CNA B confirmed Resident 2 had history of wandering. CNA B stated Resident 2 could walk before without any assistive device and wandered around the facility. CNA B further stated Resident 2 was not easily redirectable. During a concurrent interview with licensed vocational nurse C (LVN C) and observation on 3/6/2024 at 12:20 p.m., in Resident 2's room, Resident 2 was in bed, and LVN C confirmed Resident 2 had a wander guard (small device placed on the ankle or wrist of a resident, alarms to notify the staff if a resident tries to leave the facility) on his left ankle. LVN C stated, Resident 2 had history of wandering and an elopement risk. LVN C further stated, they (staff) should monitor Resident 2's whereabouts. During a concurrent interview and record review on 3/8/2024 at 9:36 a.m., nurse supervisor (NS) reviewed Resident 2's SBAR dated 1/15/2023. NS confirmed Resident 2 had history of lying on other resident's bed. NS stated nurses should have started to monitor Resident 2's whereabouts after the 1/15/2023 incident with Resident 3 and this would have prevented the 6/15/2023 incident with Resident 1. 2a. Review of Resident 1's nurse's notes dated 6/15/2023, indicated, Around 9:30 p.m. as CNAs (certified nursing assistants) were making rounds to check on their groups, a resident was noted calling out for help .2 CNAs rushed to the room and noted Resident (#2) was sitting at the foot of the bed (of Resident 1) .This LN (licensed nurse) went to check on 'Resident 1' and asked what happened to which 'Resident 1' replied that there was a patient who came over and sat down at the foot of the bed .Resident (#1) was anxious for the time being about the Resident (#2) . During an interview with certified nursing assistant A (CNA A) on 3/6/2024 at 2:30 p.m., CNA A confirmed she was assigned to Resident 1 on 6/15/2023. CNA A stated, she was doing her rounds on 6/15/2023 at around 9:30 p.m. with another CNA. CNA A further stated, she was in Room AA when she heard the call light and there was somebody yelling for help. CNA A stated, she ran to check who was yelling and found out it was Resident 1 yelling while she was lying on her bed. CNA A confirmed she found Resident 2 seated at the left side of the foot of the bed. CNA A stated, Resident 1 did not know Resident 2. During a concurrent interview and record review on 3/8/2024 at 9:36 a.m. with the NS, NS reviewed and checked Resident 2's clinical records for any monitoring of Resident 2's whereabouts. NS confirmed there was no documentation of Resident 2's wandering episodes or monitoring of his whereabouts prior to 6/15/2023 incident with Resident 1. During a concurrent phone interview with Resident 1 and her family member C (FM C) on 3/13/2024 at 9:46 a.m., Resident 1 stated, on Thursday night, I was lying in bed watching TV, there was this guy who entered my room, and sat down on my bed. I rang the bell, but nobody came. The guy laid down on my broken leg and arm, and I started screaming. Resident 1 confirmed she started to see a therapist after the incident. Resident 1 stated, .this stresses me out, and I am still having nightmares. 2b. Review of Resident 2's care plans titled, [Resident 2] is an elopement risk/wanderer r/t [related to] Impaired safety awareness, date initiated 6/15/2023, indicated some interventions, Identify [NAME] of wandering. Intervene as appropriate .MONITOR EPISODES OF WANDERING Q [every] SHIFT. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/8/2024 at 11:04 a.m. with the Administrator in Training (AIT), the AIT reviewed Resident 2's June 2023 Medication Administration Record (MAR) and checked entries of licensed nurses' documentation on Resident 2's, WANDERING IN FACILITY MONITORING - MONITOR EPISODES OF WANDERING IN THE FACILITY UNASSISTED every shift. AIT confirmed there were missing documentations on 6/16/2023 at 11 p.m.; 6/17/2023 at 7 a.m., 3 p.m., 11 p.m.; 6/18/2023 at 7 a. m., 3 p.m., 11 p.m.; and 6/19/2023 at 7 a.m. AIT stated nurses should have initialed their name in the MAR to indicate that they monitored Resident 2's wandering in the facility. AIT confirmed there was no monitoring of Resident 2's wandering or whereabouts before 6/15/2023. During a review of the facility's policy and procedure titled, Wandering and Elopements, date revised March 2019, indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. 3. Review of Resident 1's Admission Record dated 3/6/2024, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including displaced fracture (the trauma moves the bone fragments out of alignment) of base of neck of left femur (hip bone), presence of left artificial hip joint, displaced fracture of left radial styloid process (a bone found in the wrist area), displaced fracture of left ulna styloid process (another bone found in the wrist area) and history of falling. Further review of Resident 1's Admission Record indicated; Resident 1 was discharged home on 6/16/2023. During a concurrent interview and record review on 3/8/2024 at 10:39 a.m., with the Director of Nursing (DON), the DON reviewed Resident 1`s Admission Nursing Assessment. DON confirmed Resident 1's admission assessment was signed and completed on 6/16/2023. DON stated the admission assessment should have been completed upon Resident 1's admission which was on 6/14/2023. During an interview with medical record director (MRD) on 3/22/2024 at 11:19 a.m., MRD stated the admission assessment should be done and completed by nurses on the day the resident was admitted . During an interview with LVN D on 3/22/2024 at 11:25 a.m., LVN D stated residents' admission assessment should be completed on the day of admission. 4a. During an interview with MRD on 3/22/2024 at 11:19 a.m., MRD stated when an assessment or documentation was initiated, it will be electronically signed and dated on the completion date. During a concurrent interview and record review on 3/22/2024 at 11:27 a.m., with the DON, the DON reviewed Resident 2's Alert Charting (a follow up assessment/documentation) related to the 6/15/2023 incident with Resident 1. DON confirmed Resident 2's Alert Charting on 6/15/2023 for night shift was signed completed on 1/28/2024; on 6/16/2023 for night shift was signed completed on 1/28/2024; and on 6/16/2023 for day shift was signed completed on 7/21/2023. DON stated Resident 2's Alert Charting were completed late. 4b. During a concurrent interview and record view on 3/22/2024 at 11:30 a.m., with the DON, the DON reviewed Resident 2's progress note date created 9/13/2023. DON confirmed she was the one who created Resident 2's progress notes on 9/13/2023 and it was an IDT note. DON stated she couldn't recall who were the attendees at that time because the documentation was lacking that information. DON further stated the note was a late entry for 6/17/2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Charting and Documentation, revised on 7/2017, indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Review of the California Board of Registered Nursing website, California Business and Professions Code, Division 2, Chapter 6, Article 2, Section 2725(b)(2), indicated RNs should ensure the safety, protection of residents; administration of medications, and therapeutic agents, necessary to implement a treatment, disease prevention, ordered by and within the scope of the licensure of a physician.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on interview and record review, the facility failed to provide appropriate social services (SS) support for two of three residents (Residents 2 and 3) when: 1) There was no SS support following Resident 2 and Resident 3's altercation (a heated or angry dispute) on 1/15/23; and 2) There was no SS support following an abuse allegation against Resident 2 and no documentation on SS follow up to address Resident 2's psychosocial needs and behaviors. These failures resulted in a lack of timely social services interventions for Resident 2 and Resident 3. These failures had potential not to address Resident 2, Resident 3 and other residents' mental distress. Findings: 1. Review of Resident 2's Admission Record dated 3/6/2024 indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses including catatonic schizophrenia (a mental illness when the patient may not respond to what's happening around them, or they could have periods of high activity, where they could act violently), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a condition characterized by memory loss) with other behavioral disturbance (a pattern of disruptive behaviors). Review of Resident 2's quarterly minimum data set (MDS, an assessment tool), dated 7/14/2023, indicated, Resident 2 had short term (the capacity to recall a small amount of information from a recent time period) and long-term memory (the capacity to recall memories from a longer time ago) problem. Review of Resident 2's clinical record titled SBAR [Situation, Background, Assessment, Recommendation] & Initial COC [Change of Condition]/Alert Charting & Skilled Documentation, dated 1/15/2023, indicated, Resident slept on other resident's bed unoccupied at that time. Further review indicated, Resident 3 found Resident 2 on the bed which made Resident 3 angry, yelled at Resident 2 and grabbed Resident 2's right great toe but no injuries resulted. Review of both Resident 2 and Resident 3's progress notes following the incident on 1/15/2023, indicated there were no SS follow up or support found on both residents' progress notes dated 1/16/23 to 1/18/2023. During an interview with director of nursing (DON) on 5/22/2024 at 11:27 a.m., DON confirmed there was no SS follow up on both Resident 2 and Resident 3 after the altercation on 1/15/2023. During an interview with the administrator in training (AIT) on 5/22/2024 at 12:03 p.m., AIT confirmed there was no SS follow up on both Resident 2 and Resident 3 after the altercation on 1/15/2023. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident 1's Admission Record dated 3/6/2024, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including displaced fracture (the trauma moves the bone fragments out of alignment) of base of neck of left femur (hip bone), presence of left artificial hip joint, displaced fracture of left radial styloid process (a bone found in the wrist area), displaced fracture of left ulna styloid process (another bone found in the wrist area) and history of falling. Review of Resident 1's admission minimum data set (MDS, an assessment tool) assessment dated [DATE], indicated Resident 1's brief interview for mental status [BIMS, a tool used to assess cognition (knowing, learning, and understanding things)] score of 13 [score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact]. Review of Resident 1's nurse's notes dated 6/15/2023, indicated, Around 9:30 p.m. as CNAs (certified nursing assistants) were making rounds to check on their groups, a resident was noted calling out for help .2 CNAs rushed to the room and noted resident (Resident 2) was sitting at the foot of the bed (of Resident 1) . This LN (licensed nurse) went to check on resident (Resident 1) and asked what happened to which the resident (Resident 1) replied that there was a patient (Resident 2) who came over and sat down at the foot of the bed .resident (Resident 1) was anxious for the time being about the resident (Resident 2) . During an interview with certified nursing assistant A (CNA A) on 3/6/2024 at 2:30 p.m., CNA A confirmed she was assigned to Resident 1 on 6/15/2023. CNA A stated, she was doing her rounds on 6/15/2023 at around 9:30 p.m. with another CNA. CNA A further stated, she was in Room AA when she heard the call light and there was somebody yelling for help. CNA A stated, she ran to check who was yelling and found out it was Resident 1 yelling while she was lying on her bed. CNA A confirmed she found Resident 2 seated at the left side of the foot of (Resident 1's) the bed. CNA A stated, Resident 1 did not know Resident 2. CNA A stated, she took Resident 2 out of the room because Resident 1 was yelling and then she reported to the nurse. CNA A further stated, the nurse talked to Resident 1 because she was so scared of Resident 2. During a concurrent interview and record review on 3/12/2024 at 11:24 a.m., social service director (SSD) reviewed Resident 2's progress notes dated 6/15/23 to 6/18/2023. SSD confirmed there was no SS follow up after the alleged abuse against Resident 2. SSD further confirmed she started working at the facility on 7/24/2023. SSD reviewed all the SS progress notes for Resident 2 and confirmed the last SS follow up with Resident 2 to address his behaviors was on 5/3/2023. At 11:30 a.m., SSD reviewed Resident 2's IDT (Interdisciplinary team - a team composed of members from different departments involved in resident's care) -Psychotropic Assessment (a periodic monitoring for medication prescribing issues including indications, dosages, efficacy, and side effects)/Review/GDR (gradual dose reduction, tapering of a medication dose) dated 12/7/2023, indicated, .GDR at this time will put resident at risk for escalation of behavioral symptoms .SSD to continue to provide non-pharmaceutical interventions, provide ongoing support, weekly room visits to monitor for any signs/symptoms of depression in mood/behavior. Provide positive reinforcement during visits . SSD confirmed she did not implement Resident 2's planned interventions discussed during their IDT Psychotropic Assessment to manage Resident 2's mood/behavior. SSD stated, she was not even aware about Resident 2's planned interventions to manage his mood/behavior. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent phone interview with Resident 1 and her family member C (FM C) on 3/13/2024 at 9:46 a.m., Resident 1 stated, on Thursday night, I was lying in bed watching TV, there was this guy [Resident 2] who entered my room and sat down on my bed. I rang the bell, but nobody came. The guy laid down on my broken leg and arm, and I started screaming. Resident 1 confirmed she started to see a therapist after the incident. Resident 1 stated, .this stresses me out, and I am still having nightmares. During a review of the undated facility's document titled, Job Description: Director of Social Service, indicated, The primary purpose of your job description is to assist in planning, developing organizing, implementing evaluating, and directing social service programs in accordance with current federal, state, and local standards, guidelines, and facility policies and procedures, to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis .Make routine visits to residents and perform services as necessary. Record and maintain regular Social Service progress notes indicating response to the treatment plan and/or adjustment to institutional life. Perform other charting duties as necessary. 45853 Based on interview and record review, the facility failed to provide appropriate social services support following an abuse allegation for one of one resident (Resident 1) when there was no social service personnel onsite to assess residents ' psychosocial well-being. This failure resulted in a lack of timely social services intervention for a resident. Findings: Review of Resident 1 ' s facesheet (a document that gives a resident's information at a quick glance, including contact details and a brief medical history), indicated Resident 1 was admitted on [DATE], with diagnoses of status post left hip replacement surgery due to left femur neck fracture, major depressive disorder. Review of Resident 1 ' s Minimum Data Set (MDS, a clinical assessment tool) dated 6/16/23, indicated Resident 1 ' s Brief Interview for Mental Status (BIMS, a tool used to screen and identify the cognitive condition) score was 13, which meant the resident had no cognitive impairment. During an interview with Resident 1 on 8/17/23 at 9:16 a.m., she stated on the second day since her admission to the facility at around 8:00 p.m., a male stranger entered her room and sat on the end of her bed. Resident 1 stated she was unable to move due to a recent surgery; so, she told the man to leave, but he did not move. Resident 1 stated she felt scared to death and screamed for help. Resident 1 stated social service did not follow up with her regarding the incident. Resident 1 stated she requested to be discharged the next day because she was too scared and nobody addressed the issue. Resident 1 stated since she had been discharged from the facility, she had been seeing a mental health therapist for nightmares related to the event.During an interview on 8/23/23 at 3:09 p.m. with Resident 1 ' s mental health therapist, the therapist stated Resident 1 was showing symptoms of PTSD (Post-traumatic stress disorder, a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event). The resident was on guard, fearful, and emotionally distressed. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Social Service Director (SSD) on 9/13/23 at 10:57 a.m., she stated social service should have follow-up with both residents after this incident to provide psychosocial well-being support; and that, a Social Service Progress Note should be documented for each follow-up visit. During a concurrent interview and record review with the Administrator (ADM) on 9/13/23 at 12:00 p.m., the ADM stated there was no social service personnel on site between 6/7/23 and 7/23/23. The admission coordinator/case manager, the director of nursing, and herself were covering social service assessments for all residents during that period. There was no documented evidence in Resident 1 ' s clinical record to indicate a social service assessment focused on psychosocial well-being was done after the incident. During a review of the facility ' s policy and procedure Social Services, revised September 2021, it indicated, 1. The director of social services is a qualified social warker and is responsible for: f. meeting or assisting with the medically-related social service needs of residents. 3. the facility staff is able to identify and address factors that have a potentially negative effect on psychosocial functioning of a resident, for example: [.] c. distress resulting from depression, chronic diseases, [.] d. abuse of any kind; [.] g. behavioral problems (i.e., confusion, anxiety, loneliness, depressed mood, anger, fear, wandering, psychotic episodes); 4. The social worker/social services staff are responsible for: b. advocating for and assisting residents with asserting their rights in the facility; c. assisting residents in voicing and obtaining resolution to grievances about treatment, living conditions, visitation rights and accommodation of needs; [.] k. identifying and seeking ways to support resident needs through the assessment and care planning process; [.] Review of the facility ' s undated job description for Director of Social Service, indicated, Social service duties and responsibilities: Interview residents/families as necessary. Evaluate social and family information and assist in determining plan for social treatment. Make routine visits to residents and perform services as necessary. Record and maintain regular Social Service progress notes indicating response to the treatment plan and/or adjustment to institutional life. [.] Work with emotional problems including assisting resident/family with anxieties and stress, and the need for institutional and specialized care. Assist in providing solutions for social and practical environmental problems including [.] discharge planning (including collaboration with community agencies), and referrals to other community agencies when specialized assistance is required.