

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 034020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 6/18/2025
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF PLAINWELL	STREET ADDRESS, CITY, STATE, ZIP CODE 320 BRIGHAM ST PLAINWELL, MI 49080
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F0000 SS=	INITIAL COMMENTS Life Care Center of Plainwell was surveyed for an Abbreviated survey on 6/17/25 - 6/18/25. Intakes: MI00150785; MI00151225; MI00151426; MI00153382 Census = 86	F0000		
F0600 SS= D	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: This citation pertains to Intake MI00153382 Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse for 1 (Resident #102) of 7 residents reviewed for abuse, resulting in Resident #101 punching Resident #102 in the face. Findings include: Resident #101	F0600	Resident #102 still resides in the facility. The resident has not had any further encounters with other residents and continues to show no signs of distress from the 5/12/25 and 6/17/25 incidents. Resident #101 still resides in the facility and has not had any further issues of aggression with other residents. Facility residents have potential to be affected by the alleged deficient practice. The Social Services Director/designee completed facility wide interviews with residents to ensure there were not any unaddressed concerns on 7/1-7/3/25. Any discrepancies noted with the interviews were addressed at that time. The Staff Development Coordinator/Designee will provide re-education to all staff on the facility abuse prevention policy, and de-escalation tips for challenging behaviors on or before 7/14/25. Staff will not be allowed to work until education is completed. The IDT will review 24-hour report for resident-to-resident encounters for potential abuse. This audit will be conducted three days a week for eight weeks or until substantial compliance is achieved. The Social Service Director/Designee will audit resident concerns	7/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/08/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Review of an "Admission Record" revealed Resident #101 was a male, with pertinent diagnoses which included: schizophrenia and autistic disorder.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #101, with a reference date of 3/3/25 revealed a "Staff Assessment for Mental Status" assessment of "Short- and Long-term Memory" as Resident #101 having a "Memory problem."</p> <p>Resident #102</p> <p>Review of an "Admission Record" revealed Resident #102 was a male, with pertinent diagnoses which included: major depressive disorder, single episode, moderate and generalized anxiety disorder.</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #102, with a reference date of 3/20/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #102 was cognitively intact.</p> <p>Review of a "Facility Reported Incident" (FRI) "Incident Summary" Report dated 5/12/25 at 7:52 PM revealed, "Incident Summary On Monday, May 12, 2025, at approximately 6:40pm, it was reported to the Executive Director (ED "A") that resident (Resident #101) came running out of his room and hit resident (Resident #102) on the right side of his face and then (Resident #101) dropped himself on the floor ...A nurse examined (Resident #102) and there was some redness on his right cheek. (Resident #101) had a small laceration on his shin from contact with (Resident #102)'s wheelchair ..."</p> <p>In an interview on 6/17/25 at 10:17 AM,</p>		<p>to review for potential abuse allegations during IDT meeting. This audit will be conducted three days a week for eight weeks or until substantial compliance is achieved. Results of the audits will be submitted to the QAPI committee for its review and recommendations.</p> <p>The Executive Director is responsible for ongoing compliance.</p>	

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	<p>"Business Office Manager" (BOM) "Q" reported on 5/12/25 she had been the manager on duty for dinner and had come back to the Bridge unit from the dining room when she saw Resident #102 wheeling himself to the Bridge unit. BOM "Q" reported Resident #102 had asked her to push him up to the front corner across from where the Bridge nurses' station was. BOM "Q" reported she had turned around to let the nurse know that she had brought Resident #102 up front when out of the corner of her eye she saw Resident #101 run out of his room, grab Resident #102's shoulder, and hit Resident #102 in the face right over his cheek bone. BOM "Q" reported Resident #101 then put himself on the floor and continued to lay there. BOM "Q" reported there had not been any other staff in the hall, nor had there been anyone at the nurses' station until after the incident occurred.</p> <p>In an interview on 6/17/25 at 10:30 AM, "Dietary Aide" (DA) "N" reported she had witnessed the incident between Resident #101 and Resident #102. DA "N" reported she had been at the menu board right by the nurses' station changing the menu for the day. DA "N" reported out of the corner of her eye, she saw Resident #101 punch Resident #102. DA "N" reported besides herself, she had not seen any other staff in the hall at the time other than the staff member who was headed back toward the dining room.</p> <p>In an interview on 6/18/25 at 12:53 PM, "Registered Nurse" (RN) "DD" reported she had been the nurse for Resident #101 and Resident #102 on the evening of 5/12/25 when Resident #101 punched Resident #102 in the face. RN "DD" reported Resident #101 was known to go from "one extreme to the other with no warning." RN "DD" reported she saw Resident #101 punch Resident #102 and separated them. RN "DD" reported to her knowledge they had not been doing any increased supervision with Resident</p>				

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	<p>#101 at the time of the incident because "we didn't even think he could get up." RN "DD" explained she believed that staff had been using a sit-to-stand machine (a machine to assist a resident from seated to standing position) for transfers at the time.</p> <p>Review of Resident #101's "Behavior Note" dated 4/1/25 at 6:10 PM revealed, "Note Text: Resident came walking out of room with BM (bowel movement) on hands. CNA (certified nurse aide) redirected resident to shower room to clean him up. Resident came up behind CNA, grabbed her from behind and would not let go. Other CNA came in and finally got him to release CNA ..."</p> <p>Review of Resident #101's "Behavior Note" dated 4/4/25 at 5:54 PM revealed, "Note Text: pt (patient) kept putting himself on the floor then asking to get up then putting himself back on the floor. I went in to ask him if he was okay because it looked like he was crying and then he punched me in the face ...Later, another CNA was trying to feed him and he was saying he was sorry for punching the other girl and then she asked why he did it and he swung at her and kept trying to hit her."</p> <p>Review of Resident #101's "Behavior Note" dated 4/28/25 at 4:14 PM revealed, "Note Text: Patient up in wheelchair talking to nurse when he all of a sudden he started swinging at nurse and punched nurse 2 times in chest ..."</p> <p>Review of Resident #101's Care Plan with a focus of "(Resident #101) is physically aggressive with staff, he bites, hits, kicks, scratches" with a Date Initiated of 3/14/25 revealed no new interventions were initiated following Resident #101's behaviors as documented on 4/1/25, 4/4/25, and 4/28/25 in the "Behavior Notes."</p>			

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	<p>Review of Resident #101's "Behavior Note" dated 5/12/25 at 5:45 PM revealed, "Note Text: Patient came out of room and started running down the hallway with brief at ankles ...stopped resident and pulled up his brief and this RN (registered nurse) obtained patients wheelchair and had patient sit in wheelchair. Patient would not speak with staff and was rocking back and forth in wheelchair. Wheeled to front desk where staff were present. Patient asked if he wanted lemonade and he replied "yes". Staff gave patient a glass of lemonade and within 30 seconds a resident who was within 3 feet of patient started yelling. When RN look (sic) over patient had thrown his lemonade all over resident. Patient went back to not speaking and looking down towards lap."</p> <p>In an interview on 6/18/25 at 9:57 AM, "Executive Director" (ED) "A" reported the facility had not increased supervision for Resident #101 following the incident on 5/12/25 at 5:45 PM when he threw the lemonade at another resident.</p> <p>In an interview on 6/17/25 at 10:39 AM "Registered Nurse Infection Preventionist" (RNIP) "D" reported Resident #101 had schizophrenia and was autistic and he would be fine and then quickly he "flips" and then after he will lay himself on the floor and staff need to leave him without stimulation for 15-30 minutes and then he will be more cooperative to answer yes or no questions.</p> <p>Review of Resident #101's "Event Note" dated 6/17/25 at 9:32 PM revealed, "Note Text: Resident observed on floor in front of and to the right of nursing station. Informed that he was ambulating independently then he had struck another resident (referring to Resident #102) in the face, unprovoked ..."</p>				

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	<p>Review of Resident #102's "Event Note" dated 6/17/25 at 9:32 PM revealed, "Resident was struck in face by another resident (referring to Resident #101) walking down hallway. Pink area observed to right side of face below ear. Res (resident) denied pain. Res removed from area and provided snack per his request ..."</p> <p>Review of a current "Care Plan" for Resident #101 revealed a focus of "(Resident #101) is physically aggressive with staff, he bites, hits, kicks, scratches. (Resident #101) can be physically aggressive with other residents: hitting, throwing drinks" with a revision date of 5/13/25 and care planned interventions which included "15 minute checks" with a date initiated of 5/13/25.</p> <p>Review of "15 Minute Check" worksheets for the period 5/13/25 - 6/17/25 revealed no documentation that 15 minute checks had occurred on 6/17/25.</p> <p>In an interview on 6/18/25 at 1:50 PM, "Executive Director" (ED) "A" reported 15 minute checks had been initiated following the incident between Resident #101 and Resident #102 on 5/12/25. ED "A" confirmed there was no documentation of 15 minute checks having been completed on 6/17/25. ED "A" reported the purpose of 15 minute checks was so staff would "put eyes on" the resident every 15 minutes to make sure nothing negative was occurring and to make sure the resident needs were met.</p>				
F0726 SS= D	Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the	F0726	Resident #103 no longer resides at the facility. CNA S no longer works at the facility. Facility residents have the potential to be affected. The DON/ Designee conducted an	7/14/2025	

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	<p>highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to intake number MI00151225</p> <p>Based on interview and record review, the facility failed to ensure nursing staff had appropriate skill sets and completed required annual trainings, resulting in the potential for the delivery of nursing and related services that did not support the attainment or maintenance of the Resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>Findings include:</p>		<p>audit to identify CNA□s who have not completed Dementia training on 7/2/25.</p> <p>The Staff Development Coordinator/ Designee will educate licensed nurses and certified nursing aides on education and training requirements and Tips for Managing Agitation, Aggression, and Sundowning on or before 7/14/25. Staff will not be allowed to work until education is completed. CNA□s will be required to have completed at least 2 dementia related training courses within the past 12-months prior to 7/14/25.</p> <p>The DON/Designee will conduct weekly audits of CNA education assignments to ensure that education is being completed. The audit will be conducted one time per week for eight weeks or until substantial compliance is achieved. Results of the audits will be submitted to the QAPI committee for its review and recommendations.</p> <p>The Director of Nursing is responsible for ongoing compliance.</p>		

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	<p>Review of an "Education and Training Requirements" policy with a reference date of 10/3/24 revealed "Policy: The facility will maintain an effective in-service and orientation program for: a. all associates ...Procedure ...6. Training, in-service, and education should be based on the needs of the facility and the facility assessment. 7. Competencies and skill sets will for all new and existing staff, be consistent with their expected roles. 8. The facility will need to ensure staff are trained to be able to interact in a manner that enhances the resident's quality of life and quality of care ...9. The following training requirements should be met ...annually ...c. iii. Dementia Management and Resident abuse ...13. The Staff Development Coordinator/designee will be responsible for maintaining training records ...".</p> <p>Review of a "Facility Assessment" with a reference date of 8/6/24 revealed: "Diagnosis Potentially Treated at the Facility: Dementia-Alzheimer's or Non-Alzheimer's Dementia, Number of residents served during previous 2 quarters: 19, ...Competent Support and Care for Resident Population, Topic: ...Dementia and care of the cognitive impaired ...Which staff are trained: All staff, Upon hire, annually and as needed".</p> <p>In an interview on 6/18/25, at 1:12pm, Certified Nursing Assistant (CNA) "CC" on 3/4/25 at approximately 9:30pm, Resident #103 began yelling for help in the hallway and as she walked toward him, she saw CNA "S" standing behind the resident as he sat in his wheelchair. CNA "CC" reported CNA "S" pulled the resident's gown up from the shoulder area, covering Resident #103's mouth for several seconds. CNA "CC" reported she arrived in front of Resident #103, crouched down to gain his attention and make eye contact with him, and he was almost calmed down when CNA "S" sprayed him with</p>				

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	<p>the aroma therapy mist. CNA "CC" reported CNA "S" sprayed an aroma therapy bottle toward Resident #103 and CNA "CC", hitting them both in the face with the mist. CNA "CC" reported Resident #103 "flipped out" when the mist hit him. CNA "CC" reported the actions of CNA "S" made Resident #103 more upset and she should have not of sprayed him with anything.</p> <p>In an interview on 6/17/25 at 10:59am, CNA "S" reported on 3/4/25 at approximately 9:30pm, Resident #103 began yelling in the hallway near the rooms to which she was assigned. CNA "S" reported she was stressed because she thought the resident's yelling might awaken the other resident's she had already assisted to bed. CNA "S" confirmed she sprayed an aroma therapy mist on Resident #103. CNA "S" described working at the facility as "very stressful" because many residents had behaviors. When further queried about dementia care training provided by the facility, CNA "S" reported she did not recall receiving any dementia care training.</p> <p>Review of a "(name of online training organization omitted) Training Report" for CNA "S" with a reference date of 3/6/24-4/8/25 revealed the staff member did not complete 60 of 62 required trainings during the 13-month period. Incomplete trainings included: "Alzheimer's Disease: The Facts", "Challenging Behaviors: Care and Interventions for Individuals Experiencing Dementia", "Cognitive Impairment: Advanced", "Mental Health: Caring for the Older Adult in LTC (long-term care)" and "Understanding Dementia", along with many additional topics.</p> <p>In an interview on 6/17/25 at 2:03pm, Registered Nurse/Staff Development Coordinator (RN/SDC) "C" reported staff were assigned monthly computer-based trainings at the corporate level</p>				

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F0744 SS= D	<p>and until recently, staff completion of education assignments was not being monitored by the facility. RN/SDC "C" reported she recently learned that several staff members had not completed the required online trainings and due to the number of assignments, it would take time for them to complete them. RN/SDC "C" reviewed the "(name of the online training organization omitted) Training Report" for CNA "S" and confirmed the staff member had not completed 60 of 62 trainings in the 13 months. RN/SDC "C" reported staff could only complete the required trainings while in the facility and several staff had expressed difficulty finding an available computer.</p> <p>In an interview on 6/17/25 at 2:11pm, Human Resources Director (HRD) "R" confirmed any training topic marked as "not attempted" on "(name of online training organization omitted) Training Report" had not been completed. HRD "R" confirmed CNA "S" worked at the facility for more than 12 months and should have completed the assigned training but had not done so.</p> <p>In an interview on 6/18/25 at 2:06pm, Nursing Home Administrator (NHA) "A" confirmed CNA "S" had not completed most of the required computer-based training in the last 13 months, including the education related to dementia care. NHA "A" reported other than orientation training, the facility had no documentation of CNA "S" attending any in-person dementia care related training during her 13 months of employment. NHA "A" confirmed the facility had not tracked staff compliance with corporate assigned computer-based training until recently.</p>	F0744	<p>Resident #103 no longer resides in the facility.</p> <p>Facility residents with a diagnosis of dementia have the potential to be affected. The DON/</p>	7/14/2025

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	<p>his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to intake number MI00151225</p> <p>Based interview and record review, the facility failed to ensure individualized approaches were provided to 1 (Resident #103) of 3 residents reviewed for dementia care, resulting in Resident #103 experiencing avoidable stress responses to care interventions.</p> <p>Findings include:</p> <p>Review of "The Unmet Needs Model", Cohen-Mansfield and Warner (1995), revealed that those with Dementia develop problem behaviors from an imbalance in the interaction between life-long habits and personality, current physical and mental states and less than optimal environmental conditions.</p> <p>Review of an "Admission Record" revealed Resident #103 was originally admitted to the facility on 2/18/25 with pertinent diagnoses which included: metabolic encephalopathy (a change in how your brain works due to an underlying condition), dementia (a term used to describe a group of symptoms affecting memory, thinking, and social skills that interfere with daily life) and cognitive communication deficit (difficulty understanding and expressing thoughts through spoken or written words).</p> <p>Review of a "Minimum Data Set" (MDS) assessment for Resident #103 with a reference date of 2/20/25, revealed a "Brief Interview for Mental Status" (BIMS) score of 4/15 which</p>		<p>Designee conducted an audit to identify those residents who have been diagnosed with dementia and were reviewed by the Interdisciplinary Team for appropriate interventions and their personalized care plans will be reviewed for accuracy on or by 7/11/25.</p> <p>The SDC/ Designee will educate nurses and CNA's on the Caring for Dementia policy, creating and following individualized care plan interventions, 10-Tips to De-Escalate Challenging Situations, and Tips for Managing Agitation, Aggression, and Sundowning on or before 7/14/25. Staff will not be allowed to work until education is completed.</p> <p>The DON/designee will complete audits three times a week for eight weeks or until substantial compliance is achieved of newly admitted and readmitted residents with a dementia diagnosis to ensure their care plan includes individualized interventions. Results of the audits will be submitted to the QAPI committee for its review and recommendations.</p> <p>The Director of Nursing is responsible for ongoing compliance.</p>		

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF PLAINWELL			STREET ADDRESS, CITY, STATE, ZIP CODE 320 BRIGHAM ST PLAINWELL, MI 49080	
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	<p>indicated Resident #103 was severely cognitively impaired.</p> <p>Review of a "Care Plan" for Resident # 103 with a reference date of 2/19/25, revealed a focus/goal/interventions of: "(Resident #103) has impaired cognitive ability r/t (related to) dementia dx (diagnosis). BIMS of 4. Goal: (Resident #103) will follow 1 to 2 step instructions. Interventions: Allow extra time for resident to respond to questions and instructions, Ask yes/no questions in order to determine resident's needs ...Identify yourself at each interaction, face the resident when speaking and make eye contact, reduce distractions ...the resident understands consistent, simple, directive sentences, provide the resident with necessary cues-stop and return if agitated".</p> <p>Review of an "Incident Report" for Resident #103 with a reference date of 3/4/25 revealed "Incident Summary: On 3/4/25 ...CNA (Certified Nursing Assistant) "CC" reported ...she witnessed CNA "S" with an agitated resident, (Resident #103) who was yelling and making loud noises. CNA "S" had (Resident #103's) gown pulled up by the shoulders so it ...covered his mouth ...CNA "S" sprayed an "essential oils type spray" toward (Resident #103 and CNA "CC") and was pretty close (sic) to their faces ...".</p> <p>In an interview on 6/18/25, at 1:12pm, CNA "CC" on 3/4/25 at approximately 9:30pm, Resident #103 began yelling for help in the hallway and as she walked toward him, she saw CNA "S" standing behind the resident as he sat in his wheelchair. CNA "CC" reported CNA "S" pulled the resident's gown up from the shoulder area, covering Resident #103's mouth for several seconds. CNA "CC" reported she arrived in front of Resident #103, crouched down to gain his attention and make eye contact with him, and he was almost calmed down when CNA "S" sprayed</p>			

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	<p>him with the aroma therapy mist. CNA "CC" reported CNA "S" sprayed an aroma therapy bottle toward Resident #103 and CNA "CC", hitting them both in the face with the mist. CNA "CC" reported Resident #103 "flipped out" when the mist hit him. CNA "CC" reported Resident #103 became "very angry and began trying to hit us, grabbed the railing in the hallway and would not let go". CNA "CC" reported it took several minutes for Resident #103 calm down after the incident. CC" reported after she was able to get Resident #103's attention again, she told him they could go call his spouse together which was always "his way of calming down".</p> <p>In an interview on 6/17/25 at 10:59am, CNA "S" reported on 3/4/25 at approximately 9:30pm, Resident #103 began yelling in the hallway near the rooms to which she was assigned. CNA "S" reported she was stressed because she thought the resident's yelling might awaken the other resident's she had already assisted to bed. CNA "S" confirmed she sprayed an aroma therapy mist on Resident #103. When queried about where she got the aroma therapy spray, CNA "S" reported she bought it at a pharmacy and brought it in to use on residents. CNA "S" described Resident #103 as "out of control" after she used the spray, as he began hitting the railing in the hallway, then refused to release his left hand from the railing and tried to hit the staff with his right arm. CNA "S" described working at the facility as "very stressful" because many residents had behaviors. When further queried about dementia care training provided by the facility, CNA "S" reported she did not recall receiving any dementia care training.</p> <p>In an interview on 6/17/25 at 2:32pm, Licensed Practical Nurse (LPN) "W" reported he arrived to assist with Resident #103 after her heard yelling coming from the hallway and ultimately assisted with getting the resident back to his own unit.</p>				

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	<p>LPN "W" reported CNA "S" had not asked him for permission to use aroma therapy mist on residents.</p> <p>In an interview on 6/18/25 at 9:03am, CNA "EE" reported CNA "S" provided his orientation when he started working at the facility and during that time, he witnessed CNA "S" spray aroma therapy mist on several residents.</p> <p>In an interview on 6/18/25 at 10:17am, Registered Nurse (RN) "V" reported on the night of 3/4/25 she saw Resident #103 upset and several staff members were trying to calm him down around 9:30pm. RN "V" reported she did not witness CNA "S" spraying Resident #103, but CNA "S" had told her previously that she used the aroma therapy mist on residents. RN "V" reported CNA "S" never asked her for permission to use the mist on residents.</p> <p>In an interview on 6/18/25 at 12:51pm, LPN/Unit Coordinator (LPN/UM) "BB" reported she worked on the night of 3/4/25 and CNA "CC" told her about the incident that took place involving Resident #103 and CNA "S". LPN/UM "BB" reported CNA "S" had never asked her for permission to use aroma therapy mist on any residents.</p> <p>In an interview on 6/18/25 at 2:06pm, Nursing Home Administrator (NHA) "A" reported staff were assigned education courses, including education related to Dementia Care", on a computer-based training program. NHA "A" confirmed until recently, staff compliance with completion of the assigned trainings had not been monitored by the facility. NHA "A" confirmed that CNA "S" had not completed the required computer-based training related to caring for residents with dementia.</p>				

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	<p>Review of "Physician Orders" for Resident #103 revealed no orders for the use of aroma therapy products.</p> <p>Attempts to contact the facility's Medical Director were unsuccessful at the conclusion of the survey.</p> <p>Attempts to contact Resident #103's spouse were not successful at the conclusion of the survey.</p> <p>Review of a "Care of the Cognitively Impaired (Dementia Care)" policy with a reference date of 9/6/24 revealed "Policy: The facility will provide dementia treatment and services which may include, both are not limited to the following: 1. Ensuring adequate medical care, diagnosis, and supports based on diagnosis; 2. Ensuring that the necessary care and services are person-centered and reflect the resident's goals, while maximizing the resident's dignity, autonomy ...Procedure ...Develop individualized interventions related to the resident's symptomology ...".</p>				