STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

March 14, 2012

Ms. Joanne Scafati, Administrator
Arden House Rehabilitation & Nursing Center
850 Mix Avenue
Hamden, CT 06514

Dear Ms. Scafati:

Unannounced visits were made to Arden House Rehabilitation & Nursing Center on February 21, 22, 23, 27, 28 and 29, 2012 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and a certification inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by March 28, 2012 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Karen Gworek RN.

Karen Gworek, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

KEG:lsl

CT #'s 12660, 12967, 12989, 13090, 13224, 13379

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An Equal Opportunity Employer

DATES OF VISIT: February 21, 22, 23, 27, 28 and 29, 2012

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and/or (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

2. Based on observations, clinical record reviews, review of facility documentation, and interviews, for three of six sampled residents (Resident #69, #197, and #471), the facility failed to provide care and services to maintain and/or enhance the resident's dignity and respect. The findings include:
   a. Resident #69's diagnoses included Alzheimer's disease and legal blindness. The quarterly Minimum Data Set (MDS) assessment dated 1/19/12 identified that Resident #69 was totally dependent on staff for all activities of daily living and had no behavioral symptoms present. The Resident Care Plan (RCP) dated 2/14/12 identified a problem with recreation and the resident needed to remain during the duration of the program. Interventions directed to keep the resident stimulated during programs and to encourage and praise efforts. Observations of a recreation program in progress located in dining room across from the C and D Units nurse's station on 2/23/12 at 10:54 AM identified that the therapeutic recreation staff was speaking loudly stating Resident #69's name and instructing the resident to be quiet, stay here, and move back. Further observation at 11:04 AM with Licensed Practical Nurse (LPN) #4 present, identified the therapeutic recreation staff again in a loud voice (audible at nurse station) stated to Resident #69 to be quiet, be quiet, be quiet. Interview with the therapeutic recreation staff on 2/23/12 at 11:52 AM indicated that Resident #69 was confused, called out a lot and it was his job to calm the resident. Interview with Recreation Director on 2/23/12 at 12:09 PM indicated that when residents require redirection the therapeutic recreation staff should alert other staff for assistance.
   b. Resident #197's diagnoses included diabetes, depressive disorder, anxiety disorder, and obesity. An initial nursing assessment dated 11/29/11 indicated the resident had no memory deficit, had independent decision-making skills for daily living, and was an assist with transfer. The RCP dated 11/29/11 noted a problem with urinary incontinence with the ability to improve bladder function. Interventions directed to toilet the resident before and after meals, prior to attending activities, and provide peril-care after each incontinent episode. Review of a reportable event and investigation dated 1/3/12 identified that at approximately 1:15 PM Resident #197 asked to be provided with incontinent care and was told by the nurse aide he/she would have to wait until 2:00 PM. The investigation indicated the allegation was substantiated and disciplinary action was taken against Nurse Aide (NA) #3. Interview and review of the 1/3/12 investigation with LPN #1 on 2/22/12 at 3:05 PM indicated that Resident #197 reported to her that NA #3 would not change him/her until 2:00 PM. LPN #1 identified that the resident was crying at that time and she instructed NA #3 to change Resident #197, the resident did not have to wait until 2:00 PM. Interview with Resident #197 on 2/23/12 at 1:15 PM identified that he/she wanted to be changed before bingo which started at 2:30 PM. Resident #197 did not recall the nurse aide's name but indicated NA #3 was mean. The

that repairs are ongoing and the facility has a phone system to report when repairs are needed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f)(j) Director of Nurses (2)(A) and/or (m) Nursing Staff (2)(A).

4. Based on clinical record review, review of facility documentation and interviews for one of four sampled residents (Resident #469) that were reviewed for weight loss, the facility failed to obtain weekly weights after admission. The findings include:
    a. Resident #469's diagnoses included cerebral vascular accident with aphasia and dysphagia, hypertension and atrial fibrillation. The admission Minimum Data Set assessment dated 2/9/12 identified that Resident #469 had memory deficits, severe cognitive impairments and was totally dependent on staff for activities of daily living. The admission resident care plan dated 2/6/12 identified a nutritional risk related to the dysphagia and dependent on tube feeding to meet nutritional needs. Interventions directed to obtain and monitor weights, and to provide tube feeding and flush as ordered. Review of the resident weights and vital summary indicated that on 2/2/12 the resident weighed 175 pounds, on 2/21/12 the weight was 169 pounds and a reweigh on 2/23/12 the resident weighed 177 pounds. The summary failed to reflect that weekly weights had been obtained between 2/2/12 and 2/21/12. Review of the facility's policy directs that residents will be weighed within twenty-four hours of admission and then weekly for the first four weeks after the admission. Interview and review of the resident's weights with the Unit Manager on 2/23/12 at 3:00 PM identified that weights were not documented for the weeks of 2/6/12 and 2/13/12.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A) and/or (2)(C).

5. Based on observations, clinical record review, interviews and facility documentation for one sampled resident (Resident #3) who smoked, the facility failed to ensure the resident's safety while smoking, and/or failed to utilize precautions when filling a portable oxygen tank, and/or for one sampled resident (Resident #83) who sustained an injury of unknown origin, the facility failed to ensure that the resident received adequate supervision and/or assistance to prevent an accident. The findings include:
    a. Resident #3's diagnoses included hypertension and asthma. The quarterly Minimum Data Set (MDS) assessment dated 11/10/11 identified that Resident #3 had no cognitive impairments, no behaviors and utilized a wheelchair for locomotion off the unit. The quarterly smoking assessment dated 11/15/11 identified that the resident was an independent smoker. The Resident Care Plan (RCP) dated 11/23/11 identified the resident was found to be a safe smoker with an intervention to observe for burn holes in cloths and notify the licensed staff if noted. Observations of Resident #3 on 2/21/11 at 1:45 PM identified the resident smoking independently in the designated area, three burn holes were noted on the resident's camel colored coat and while smoking Resident #3

identified that they had transferred Resident #83 out of bed on 8/18/11. The nurse aides indicated that after morning care was provided Resident #83 was assisted to the edge of the bed to a sitting position and a gait belt was applied around the resident's waist. The resident was then assist to a standing position using the gait belt, the incontinent brief and pants were pulled up, the resident was turned, and seated in the customized wheelchair which had been placed close to the bed. NA #2 and NA #8 did not recall any issues with the provision of morning care, the transfer and did not recall transferring the resident back to bed. NA #2 identified that Resident #83 had a slight decline in transfer status. Interview with NA #7 identified that Resident #83 was not able to stand and was a difficult transfer even with assistance of two staff. Interview and review of a Physical Therapy Evaluation dated 11/2/10 with the Director of Rehabilitative Services on 2/27/12 at 1:30 PM identified that the assessment of 11/2/10 addressed transfer status as part of the assessment for tolerance of a new customized wheelchair with the goal of tolerating tilted and upright positions with neutral trunk and pelvic alignment to increase comfort, improve positioning, and decrease the risk for falls and skin breakdown. At that time, Resident #83 was a transfer with assistance of two staff and non-ambulatory. Additionally, physical therapy would not be involved with further assessments if the resident was on Hospice which Resident #83 was. Subsequent to the injury of unknown origin, the resident care plan was revised and directed transfer out of bed via a mechanical lift (Hoyer).

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

6. Based on observations, clinical record review, and interviews for one sampled resident (Resident #355) reviewed for foot care, the facility failed to ensure the resident received podiatry services. The findings include:
    a. Resident #355's diagnoses included dementia, peripheral vascular disease and diabetes mellitus. The annual Minimum Data Set assessment dated 1/5/12 identified that Resident #355 had severe cognitive impairments, was independent with most activities of daily living, required total assistance with bathing and had no infections of the feet, diabetic foot ulcers and/or open lesions. The resident care plan dated 1/19/12 identified that the resident had a potential for skin breakdown related to a history of hammertoes and peripheral vascular disease. Interventions directed weekly skin assessment and podiatry as scheduled. A physician's ordered dated 2/10/12 directed podiatry evaluation and treatment. Review of the clinical record identified that Resident #355 was seen by the podiatrist every three months from 1/13/11 through 7/9/11 and the podiatrist suggested care every two to three months secondary to a history of diabetes mellitus. The clinical record failed to reflect documentation that Resident #355 was seen by the podiatrist after 7/9/11. Interview and observations with Person #1 on 2/23/11 at 12:15 PM identified that Resident #355 had excessively long and thick toenails. Interview with the Unit Manager on 2/23/11 at 12:30 PM indicated that the resident was not seen

hallway. Review of the nurse aide assignment directed contact precautions for C-Diff and a sign was noted on the resident's doorway to see nurse before entering room. Interview and review of the clinical record and the facility's C-Diff precaution procedure with the Infection Control Nurse on 2/23/12 at 8:00 AM identified that the resident's bed should have been moved back to his/her room so that care could be provided in an appropriate setting and the staff should have gowned and gloved prior to providing incontinent care.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or the Connecticut General Statutes Section 19a-562 Alzheimer's special care units or programs Disclosure requirements and/or Section 19a-562a Staff training requirements.

9. Based on clinical record review, review of facility documentation, and interviews for one sampled residents (Resident #440) who resided on a secured unit, the facility failed to maintain compliance with the Connecticut General Statues. The findings include:
   a. Resident #440's diagnoses included dementia and the resident resided on a secured Alzheimer's Special Care Unit. The Elopement and Wander Risk Evaluation Form dated 10/3/11 identified that Resident #440 as an elopement potential. The Resident Care Plan dated 10/3/11 identified that the resident was at risk for wandering from a secure location. Interventions directed to allow the resident to wander freely in the secured environment and apply an electronic safety device as necessary. A physician's order dated 10/3/11 directed to apply a wanderguard unit on Resident #440's left ankle and to monitor for proper placement and check the function every shift. The admission Minimum Data Assessment dated 10/8/11 identified that Resident #440 had severe cognitive impairments, behavioral symptoms that included rejection of care, and wandering four to six days per week, required limited assistance of one staff for dressing, toilet use, and personal hygiene, and was independent with bed mobility, transfers, and walking in the room and/or hallway. The Reportable Event Form dated 10/12/11 at 3:45 PM identified that Resident #440 was found by the first floor staff in the hallway near the laundry department. The report indicated that on 10/13/11 the camera footage was reviewed and the resident was noted to follow a laundry staff person into the elevator. Review of the facility's investigation identified that a written statement dated 10/26/11 was provided by the laundry staff person. The statement explained that the laundry staff person had encountered an older individual on the secured unit who said he/she was lost and asked for directions to the lobby. The laundry person asked the individual if he/she was a resident and the person replied "no" but was visiting a family member and wished to take the elevator. At that time the laundry person escorted Resident #440 off the unit, to the elevator and down to the first floor where instructions were given to the lobby. Interview with the laundry staff person on 2/28/11 at 9:10 AM identified that she did not recognize Resident #440 and the resident looked like a visitor. The laundry person indicated that she had not received Dementia specific training during her first eight months of employment and/or after the incident. Interview with

Caring is the Key in Life

March 22, 2012

Karen Gworek, R.N.
Supervising Nurse Consultant
Facility Licensing & Investigations Section
State of Connecticut
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut

Dear Ms. Gworek;

Enclosed please find our Plan of Correction dated March 22, 2012 responding to the survey conducted at Arden House Care and Rehabilitation Center ending on February 29, 2012.

Our Plan of Correction should serve as allegation of compliance to cited violations to the regulations of Connecticut State Agencies.

This Plan of Correction is being filed as a matter of compliance but should not be construed as to the validity of any cited violations.

Arden House takes the cited violations very seriously and has been committed to implementing the Plan of correction as expeditiously as possible. Please be assured that Arden House has undertaken the necessary measures to assure that substantial compliance is achieved by March 29, 2012.

Yours truly,

Joanne Scafati
Administrator

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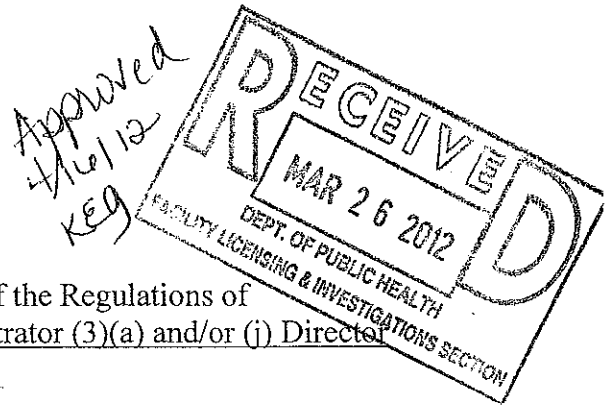


Arden House Care and Rehabilitation Center
Dates of Visits on February 21,22, 23,27,28 and 29 2012

The following is our Plan of Correction for the violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(a) and/or (j) Director of Nurses (2) and/or (g) Reportable Event (6).

1. Resident # 83's medical record was reviewed by the DNS and no further injuries of unknown origin were identified since August 19,2011.Audits of injuries of unknown origin and their investigations that have occurred within the last 90 days were completed on March 24, 2012 by the DNS. Licensed staff have been reeducated by the Staff Development Coordinator on March 19 to March 25, 2012 regarding investigation of unknown origin. Investigations of bruises of unknown origin will be audited as they occur by the DNS for 3 months or until substantial compliance has been achieved then randomly thereafter.

The PI Committee will review the audit results and make further recommendations as necessary to maintain substantial compliance.

The DNS is responsible for overseeing this plan.

Completion Date: March 29, 2012

The following is our Plan of Correction for the violation of the Regulations of Connecticut State Agencies Section 19-13-D8t(f) Administrator (3)(D) and/or Director of Nursing (2) and/or (m) Nursing Staff (2)(A).

2a. Resident #69 has demonstrated no negative outcome from the event on2/23/2012. The Staff Development Coordinator reeducated the therapeutic recreation staff member on resident rights, dignity and respect in full recognition of his/her ability on 2/28/2012.

b. Resident # 197 has demonstrated no negative outcome from the reportable event that occurred on 1/03/2012 based on an interview with the resident by Social Services. The Staff Development Coordinator reeducated NA # 3 on Abuse and Neglect and Resident Rights on 1/06/2012.

c. Resident # 471 has demonstrated no negative outcome from the incident that occurred on February 23, 2012 as demonstrated by behaviors . NA #4 was reeducated on provision of care and Resident Rights and Dignity by the Human Resource Director and the ADON on 3/02/2012.

Residents identified with a diagnosis of Dementia with behavioral disturbances or residents who require incontinent care have the potential to be affected by this alleged deficient practice. Licensed Nurses and Nursing Assistants have been reeducated by the Staff Development Coordinator on March 19 to March 25, 2012 on provision of care and services to maintain and/or enhance the resident's dignity and respect.

Random audits will be completed 3 times a week of recreation programs by the Director of Therapeutic Recreation for 90 days or until substantial compliance has been achieved. Random audits of incontinent care provision and toileting will be completed 3 times a week by the nursing management team for 90 days or until substantial compliance is achieved then randomly thereafter.

The DNS and the Director of Therapeutic Recreation are responsible for overseeing this plan.

Completion Date: March 29, 2012.

The following is our Plan of Correction for the violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A).

3. No resident has demonstrated any negative outcome from the observations made on February 23, 2012.

a. Repairs to all rooms and areas noted with alleged deficiencies will be completed as of March 29, 2012 by the maintenance department. All residents have the potential to be affected by this alleged deficient practice. Any environmental issues will be reported to and addressed by the maintenance department per facility protocol. "Wall Project Rigid PCV" covering has been ordered with anticipated delivery on April 17, 2012 to prevent future deterioration of head and foot board walls.

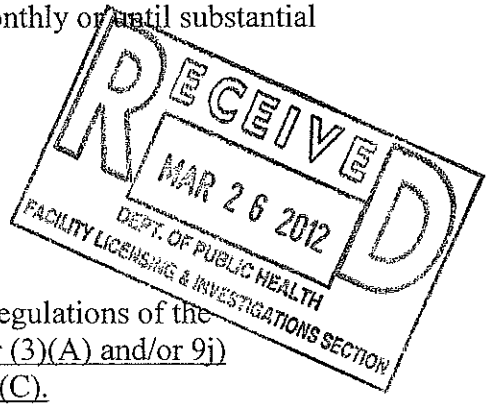
The Assistant Administrator and the Assistant Director of Maintenance are responsible for overseeing this plan.

Completion Date: March 29,2012.

The following is our Plan of Correction for the violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A) and/or (2)(C).

4. Resident #469 has demonstrated no negative outcome from this incident. He has gained 6.4 pounds since admission on February 2, 2012. All new admissions and/or readmissions have the potential to be affected by this alleged deficient practice. Audits of weights on residents admitted to the facility since 2/27/2012 have been completed and reviewed by the DNS. No concerns were identified. Licensed and Nursing assistants have been reeducated on the facility's weight management policy by the Staff Development Coordinator on March 19 to March 25,2012. Admission/readmission weights will be audited by unit managers and reviewed weekly at CARE meetings per facility policy.

Results of any findings will be reviewed by the PI Committee monthly or until substantial compliance is achieved.



The DNS is responsible for overseeing this plan.

Completion Date: March 29, 2012

The following is our Plan of Correction for the violation of the Regulations of the Connecticut State Agencies Section 19-13-D8T (f) Administrator (3)(A) and/or 9j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A) and/or (2)(C).

5a. Resident #3 has demonstrated no negative outcome from the incident on February 21, 2012. No concerns were identified during the skin check done by the unit manager on February 21, 2012. Subsequent to the incident the resident was reassessed and was made a supervised smoker. On March 14, 2012 after resident reeducation and reassessment, the resident was deemed safe to smoke independently using a smoking apron. Residents who smoke independently have the potential to be affected by this alleged deficiency. All identified residents have been reassessed and their care plans adjusted as needed by the Interdisciplinary Team. all smokers will be assessed quarterly and as needed per facility policy in order to assure that the resident receives adequate supervision to prevent an accident.
random audits of independent smokers will be completed 3 times a week for 90 days or until substantial compliance is achieved. Findings will be reviewed by the PI Committee monthly or until substantial compliance is achieved.

b. No adverse effects resulted from this alleged deficient practice. Any time the oxygen room is accessed for the filling of portable oxygen tanks could result in an accident hazard. Only 2 filled oxygen tanks will be stored in the unit oxygen storage rooms at any time. Additional tanks will be removed as noted. Unit oxygen storage rooms will be audited twice a day by the maintenance staff for 90 days or until substantial compliance has been achieved for this alleged deficiency. Results of findings will be reviewed by the PI Committee monthly or until substantial compliance is achieved.

The assistant Administrator and the Assistant Director of Maintenance are responsible for this plan.

Completion Date: March 29,2012

Staff responsible for filling portable oxygen tanks have been reeducated by the Staff Development Coordinator on March 19 to March 25, 2012. Transfilling procedures will be reviewed upon hire, annually at the facility's competency fair and as needed. Random audits of transfilling oxygen tanks will be completed 3 times a week by the nursing management team for 90 days or until substantial compliance is achieved. Results will be reviewed by the PI Committee monthly or until substantial compliance is achieved.

The DNS is responsible for overseeing this plan.

Completion Date: March 29, 2012

c. Resident #83 has demonstrated no negative outcome from the incident. The resident's transfer was changed to a mechanical transfer and the care plan was revised to reflect this change. Residents who experience change in transfer ability have the potential to be affected. Residents identified by staff and those identified through the RADAR report data as having had a decline in mobility have been reviewed by the Interdisciplinary team for evaluation by the therapy department. Licensed nurses and Nursing Assistants have been reeducated by the Staff Development Coordinator on March 19 to March 25, 2012 regarding communication and investigation of a resident's change in condition in order to provide adequate supervision and/or assistance to prevent an accident. these findings will be reviewed weekly at CARE meetings for 90 days or until substantial compliance has been achieved then as identified thereafter. Results of findings of this alleged deficiency will be reviewed by the PI Committee monthly or until substantial compliance is achieved.

The DNS is responsible for overseeing this plan.

Completion Date: March 29, 2012

The following is our Plan of Correction for the violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

6. Resident #355 was seen and treated by podiatry on February 29, 2012.
Residents who require the services of a podiatrist could be affected by this alleged deficient practice. All residents have been reviewed for podiatric needs by the unit managers and referrals were made as appropriate with responsible party approval. Licensed nurses and Nursing Assistants have been reeducated regarding the communication of resident needs and change in condition by the Staff Development Coordinator on March 19 to March 25, 2012. Random audits of podiatry needs/ visits will be completed weekly by unit managers for 90 days or until substantial compliance is achieved for this alleged deficient practice. Results of any findings will be reviewed by the PI Committee monthly or until substantial compliance has been achieved for this alleged deficient practice.

The DNS is responsible for overseeing this plan.

Completion Date: March 29,2012.

The following is our Plan of Correction for the violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (t) Infection Control (2)(A).

7. No negative outcomes resulted from this observation.
The dietary aide involved in this observation was reeducated on infection control techniques by the Staff Development Coordinator and the Director of Dietary Services on February 23, 2012.
All residents have the potential to be affected by this alleged deficiency. Dietary staff have been reeducated on infection control policy and infection control techniques by the Staff Development Coordinator and the Director of Dietary Services on March 22 to March 25, 2012. Random audits of infection control technique will be completed by the Director of Dietary Services/ designee 3 times a week for 90 days or until substantial compliance has been achieved. Findings will be reviewed by the PI Committee monthly or until substantial compliance has been achieved.

The Assistant Administrator and the Director of Dietary Services are responsible for overseeing this plan.

Completion Date: March 29, 2012

The following is our Plan of Correction for the violation of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(A) and/or (t) Infection Control (2)(A).

8. Resident #471 has demonstrated no negative outcome from the incident as demonstrated by behaviors.
Residents who require contact precautions have the potential to be affected. Licensed Nurses and Nursing Assistants have been reeducated on provision of care in a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection by the Staff Development Coordinator and the Infection Control Nurse on march 19 to March 25, 2012. Random care audits will be completed 3 times a week by the nursing management staff for 90 days or until substantial compliance has been achieved for this alleged deficient practice. Findings will be reviewed by the PI Committee monthly or until substantial compliance has been achieved for this alleged deficient practice.

The Staff Development Coordinator and the Infection Control Nurse are responsible for overseeing this plan.

Completion Date: March 29, 2012.

The following is our Plan of Correction for the violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or the Connecticut General Statutes Section 19a-562 Alzheimer's special care units or programs Disclosure requirements and/or Section 19a-562a Staff training requirements.

9a. Resident #440 has experienced no negative outcome from this incident.
The laundry staff member was removed from job duties on the dementia unit until she completed dementia training with the Staff Development Coordinator on March 21, 2012.All contracted laundry and Housekeeping staff who have been identified as not having received dementia training have been educated by the Staff Development Coordinator and the Director of Housekeeping and Laundry Services on March 21, 2012 to March 25, 2012 and will receive annual training per facility policy thereafter. All new employees will receive dementia training as part of their orientation.

The Staff Development Coordinator and the Director of Housekeeping and Laundry Services are responsible for overseeing this plan.

Completion date: March 29, 2012

Any resident who is admitted to a designated Alzheimer's Unit has the potential to be affected. As required by State Regulation, a form addressing Connecticut General Statutes Section 19a-562a Alzheimer's Special Care Units or Program Disclosure Requirements will be completed by residents and/or families being admitted to a designated Alzheimer's Unit (Solana Unit) effective April 1, 2012.

Director of Admissions and the Director of the Solana Unit/Designee are responsible for overseeing this plan of correction.

Completion Date: March 29, 2012.