2nd POC accepted
2/13/18 @ 7:45am
36526 card ID

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056458	A. BUILDING _____ B. WING _____	C 01/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF SOUTH GATE	8465 STATE STREET SOUTH GATE, CA 90280

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the investigation of a complaint. Complaint number: 555644 Representing the Department: Health Facilities Evaluator Nurse ID: 36526 The inspection was limited to the specific entity-reported incident/complaint investigation and does not represent the findings of a full inspection of the facility. Four deficiencies were written as a result of complaint 555644.	F 000	This plan of correction (POC) constitute my written credible allegations of compliance to the deficiencies noted. This POC is submitted to meet requirements established by existing federal, state, and local statutes, rules and regulations.	
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 157	F 157 1/29/18 DON had 1:1 in service about notification of family if any change of condition. On 9/13/17 an IDT was done with responsible party and other family regarding incident and plan of care.	

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

NHA (1) 2/8/18 (2) 2/12/18

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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F 157	Continued From page 1 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow its policy by not notifying one of three sampled residents (Resident 1) family/responsible party of an allegation of rough handling by a Certified Nurse Assistant (CNA 1). This deficient practice placed Resident 1 and other residents at risk for further harm.	F 157	By 2/8/18 all licensed nurses will be in-service by the DON regarding notifying a resident's physician and or with his/her authority the resident's representative of any accidents, significant changes, and change in treatment including any alleged abuse and or a decision to transfer or discharge the resident from the facility. DON also emphasized informing family/responsible on any possible abuse allegations and reporting to Abuse Coordinator immediately. No other residents were affected by the same deficient practice. Medical records will audit daily up to 90 days for any COC and bring up to daily stand up. DON will monitor at random after the 90 days. DON will monitor COC binder and notifications daily up to 90 days or until deficient practice is resolved. Any findings will be brought up to monthly QA meeting up to 90 days. Completion date 2/28/18	

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F 157	Continued From page 2 Findings: A review of the facility's Final investigation report, dated 9/15/17, indicated the facility reported an allegation of physical abuse that occurred on 9/6/17 to the Department on 9/11/17. The report indicated that on 9/10/17, Resident 1's family contacted the Police Department (PD) to investigate an alleged abuse of CNA 1 holding Resident 1's hands down to prevent Resident 1 from striking out at CNA 1 during lunchtime. According to the report, Resident 1 did not want to eat, but was being forced by CNA 1. A review of the Resident 1's Admission Record (face sheet) indicated resident was admitted to the facility on 3/5/12. Resident 1's diagnoses included dementia (decreased in ability to remember) and anemia (deficiency of red blood cells or of hemoglobin in the blood). According to the face sheet, Family Member 1 (FM 1) was listed as Resident 1's Responsible Party (RP). A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 10/10/17, indicated the resident was severely impaired of cognition (thought process) and had a brief interview for mental status (BIMS) score of 4 (0-7 severe impairment). The MDS indicated Resident 1 required extensive assistance from one person with eating and all activities of daily living (ADL's), and was dependent on a wheelchair for locomotion. On 10/5/17 at 3:30 p.m., during a telephone interview, FM 1 stated that he contacted the PD because Resident 1 had injuries to both arms.	F 157		

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F 157	Continued From page 3 On 10/5/17 at 4:22 p.m., during an interview, the Director of Nursing (DON) stated that she told Licensed Vocational Nurse 1 (LVN 1) to contact Resident 1's family and notify them about the incident of alleged abuse. A review of the licensed progress note, dated 9/6/17 to 9/12/17, indicated there was no documentation of attempts made by the facility staff to contact FM 1. A review of the Interdisciplinary Team ([IDT] group of disciplines that meet for a common goal for the resident) note, dated 9/13/17, indicated that on 9/10/17, FM 2 inquired about Resident 1's arm injuries. The IDT note indicated that Resident 1's roommate (Resident 2) notified FM 2 of the injuries that were caused by CNA 1. According to the note, FM 1 was immediately contact. A review of the facility's policy titled, "Plan of Care for Resident Concern and/on Change of Condition," dated 7/2012, indicated that the family or RP must be notified if there was any concern or injury and/or prior to implement any plan/transferring the resident from the facility. If the license nurse was unable to notify the family or RP and resident must be transferred, a few hourly documentation on the nurses' notes was to be done regarding the attempt to notify until the notification has been completed.	F 157		
F 223 SS=G	FREE FROM ABUSE/INVOLUNTARY SECLUSION CFR(s): 483.12(a)(1) 483.12 The resident has the right to be free from abuse,	F 223	F 223 Cna 1 was immediately suspended upon notification of alleged abuse. After further investigation Cna was terminated for not following proper abuse prevention protocol.	

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F 223	Continued From page 4 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 symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from rough handling and abuse. Certified Nurse Assistant 1 (CNA 1) held Resident 1's arms down while trying to force her to eat. This deficient practice resulted in injuries to Resident 1's bilateral (both sides) forearms; right forearm skin tear measured 14 centimeters (cm) by (x) 3 cm, and the left forearm measuring 11cm x 3cm. Findings: A review of the facility's Final Investigation Report, dated 9/15/17, indicated the facility reported an allegation of physical abuse that occurred on 9/6/17 to the Department of Public Health (DPH) on 9/11/17. The report indicated that while feeding Resident 1, CNA 1 held Resident 1's hands down to prevent Resident 1 from striking out at CNA 1. According to the report, Resident 1 did not want to eat, but was being forced by CNA 1.	F 223	On 2/2/18 Abuse binder made immediately available for all staff located at the nursing station. By 2/9/18 all staff were in-serviced on Abuse policy and procedures. DSD and Administrator will in service all staff by 2/9/18 regarding Abuse policies and procedures emphasizing on prevention, identification and reporting. In-service will stress the importance of all serious injuries to report within 2 hours to DPH and Ombudsman and immediately to law enforcement. By 2/9/18 Treatment nurse will perform a skin sweep of any suspicious skin injuries. Licensed nurses will monitor every shift for behavior manifestations. Also during monthly resident council meetings and department head daily room rounds, if any concerns regarding possible allegations of abuse will be reported to Administrator immediately. No other residents have been affected by the same deficient practice.	

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F 223	Continued From page 5 A review of the Resident 1's Admission Record (face sheet) indicated resident was admitted to the facility on 3/5/12 with diagnoses that included dementia (decreased in ability to remember) and anemia (deficiency of red blood cells or of hemoglobin in the blood). A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 10/13/17 indicated a brief interview for mental status (BIMS) score of 4 (0-7 severe impairment), indicated Resident 1 was severely impaired of cognition. The MDS indicated Resident 1 required extensive assistance from one person assistance for eating and all activities of daily living (ADL's), and was dependent on a wheelchair for locomotion. A review of Resident 1's care plan titled, "At risk for further ADL's decline," dated 6/11/16, indicated that the goal was for Resident 1 to have no decline in ADL's through 10/13/17. The staff interventions included to encourage participation in performing ADLs within resident's capability including washing face, combing hair, feeding self, and dressing. On 10/5/17 at 2:42 p.m., during an interview, Resident 1's roommate (Resident 2) stated that CNA 1 hit Resident 1 hard on the resident's bad hand. Resident 2 stated that Resident 1 just wheeled herself out of the room bleeding and dripping blood over the floor. Resident 2 stated that CNA 1 walked out of the room when she asked why she had hit Resident 1. Resident 2 stated that Resident 1 was yelling and complaining that it hurt her. A review of the Resident 2's Admission Record	F 223	On 2/13/18 Psychology representative will perform in-service with all nursing staff regarding how to care for residents with dementia and or behavior. DSD and Administrator will conduct monthly Abuse in-services up to 3 months. Any incidents will be brought up at daily stand up meeting and will be reported to Administrator and or DON. Administrator and all Department heads will conduct random daily spot checks with staff ensuring they are knowledgeable of abuse prevention, identification and reporting up to 90 days or until deficient practice is resolved. Any findings will be brought up to monthly QA meeting up to 90 days. Completion date 2/28/18	

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F 223	Continued From page 6 (face sheet) indicated the resident was admitted to the facility on 12/10/15 with diagnoses that included hypertension (high blood pressure) and dizziness. A review of Resident 2's MDS, dated 7/2/17, indicated the resident had a BIMS score of 14 (13-15 cognition intact) and did not have any memory problems. On 10/5/17 at 2:54 p.m., during an observation and a concurrent interview, Resident 1 was noted with bilateral forearms bandages. Resident 1 stated, "What happened to my arms was bad," and proceeded to wheel herself away. On 10/5/17 at 4 p.m., during an interview, Licensed Vocational Nurse (LVN 1) stated that on 9/6/17, during lunchtime (approximately 12-12:30 p.m.), CNA 1 called her into Resident 1's room. Upon entering the room, LVN 1 stated that Resident 1 was bleeding from her bilateral forearms. LVN 1 stated that CNA 1 was not able to state why the resident was bleeding. LVN 1 stated there was no documentation in the Nurses Progress Notes regarding Resident 1's injuries. During the review of the Licensed Progress Note, dated 9/6/17, indicated there were no documentation regarding Resident 1's injuries. A review of a Licensed Progress Note, dated 9/11/17, and timed at 11 a.m., indicated that on 9/6/17 at approximately noontime, CNA 1 called LVN 1 into Resident 1's room. The Progress Note indicated that Resident 1 had sustained bilateral forearm skin tears. The Director of Nurses (DON) and Supervisor were notified regarding the left skin tear measuring 11cm x 3cm and the right	F 223		

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F 223	Continued From page 7 skin tear measured 14cm by 3cm. A review of the facility undated CNA 1's written declaration indicated, on 9/6/17 at lunchtime, CNA 1 was getting Resident 1 ready to eat when resident hit CNA 1. The declaration indicated that CNA 1 held Residents 1's hands down when resident attempted to hit her a second time. CNA 1 stated she was trying to prevent harm to herself and walked out the room. CNA 1 then returned to the room to attempt to feed Resident 1 when she observed the resident bleeding from her arms. A review of a second undated written declaration by CNA 3, indicated that CNA 3 was told by CNA 1 on 9/9/17 that she held Resident 1's hand down to prevent her from hitting her. On 10/5/17 at 4:22 p.m., during an interview, the Director of Nursing (DON) stated she reported to the administrator (ADM) on 9/6/17 regarding Resident 1's skin tears. The DON stated that physical abuse needed to be reported to DPH within 24 hours of the alleged abuse. The DON stated that during the facility's investigation, CNA 1 stated that she held Resident 1's hands down to protect herself from being hit by the resident. On 10/5/17 at 4:52 p.m., during an interview, the ADM stated that she was made aware of the incident the night of 9/6/17. The ADM stated she failed to report to DPH timely because she thought there was a possibility that the injuries were caused by Resident 1 not wearing her Geri sleeves while in the wheelchair. On 1/10/18 at 9:45 a.m., during a telephone interview, CNA 2 stated that, on 9/6/17 during lunchtime, she was feeding a resident when CNA	F 223		

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F 223	Continued From page 8 1 came to the nurses' station stating that Resident 1 was bleeding from her arms. CNA 2 stated that CNA 1 told her that she was trying to feed Resident 1 because she was refusing, when Resident 1 attempt to hit her. CNA 1 proceeded to hold Resident 1's arms down and accidentally tore the residents' skin from both arms. CNA 2 stated when a resident refused to eat, the staff was supposed to leave the resident and notify the charge nurse or supervisor immediately. A review of the facility's Interdisciplinary ([IDT] group of disciplines that work toward a common goal for a resident) Team Meeting Note, dated 9/13/17, indicated that the facility initiated the investigation on 9/6/17 by asking CNA 1 what had happened. The IDT note did not indicate that the facility's staff interviewed the roommates on 9/6/17 and per Resident 1's family member, Resident 2 witnessed CNA 1 cause the injuries to the resident's arm. A review of the facility's policy and procedure titled, "Preventing Resident Abuse," revised 7/2012, indicated to enforce and maintain an abuse free environment for all residents. A review of the facility's policy and procedure titled, "Abuse Investigation," revised 12/2014 indicated that all reports of Resident abuse, neglect and injuries of unknown source shall be immediately and thoroughly investigated by the facility and interview the resident's roommates, family members, staff and visitors.	F 223		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4)	F 225	F 225 1/29/18 Clinical nurse consultant had 1:1 in service with Administrator and DON regarding following policy on investigating and reporting any injuries and accurate assessment of injuries.	

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F 225	Continued From page 9 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 225	DSD and Administrator will in service all staff by 2/9/18 regarding Abuse policies and procedures emphasizing on prevention, identification, investigating and reporting within 24 hours to DPH. An Abuse binder will be held at the nursing station containing policies and procedures making it available for all staff. No other residents have the potential to be affected by the same deficient practice. DSD and Administrator will conduct monthly Abuse in-services up to 3 months. Administrator will ensure that any unusual occurrences related to abuse will be reported within 24 hours to DPH.	

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F 225	Continued From page 10 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to investigate and report within 24 hours to the Department of Public Health (DPH) an alleged allegation of physical abuse with injury by Certified Nurse Assistant (CNA 1) as indicated in the facility's policy and procedure for one of three sampled residents (Resident 1). This deficient practice resulted in injuries to Resident 1's bilateral forearms; right forearm skin tear measured 14 centimeters (cm) by (x) 3 cm, and the left forearm measuring 11 cm x 3 cm. Findings:	F 225	Any incidents will be brought up at daily stand up meeting and will be reported to Administrator and or DON. Administrator and all Department heads will conduct random daily spot checks with staff ensuring they are knowledgeable of abuse prevention, identification and reporting up to 90 days or until deficient practice is resolved. Any findings will be brought up to monthly QA meeting up to 90 days. Completion date 2/28/18	

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F 225	Continued From page 11 A review of the facility's Final Investigation report, dated 9/15/17, indicated the facility reported an allegation of physical abuse that occurred on 9/6/17 to the Department of Public Health (DPH) on 9/11/17. The report indicated while feeding Resident 1, CNA 1 held the resident's hands down to prevent the resident from hitting CNA 1. According to the report, Resident 1 did not want to eat. A review of Resident 1's Admission Record (face sheet) indicated the resident was admitted to the facility on 3/5/12. Resident 1's diagnoses included dementia (decreased in ability to remember) and anemia (lack of red blood cells). A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 10/10/17, indicated the resident had severe impaired cognition (ability to think and reason) and a brief interview for mental status (BIMS) score of 4 (0-7: severe impairment). The MDS indicated Resident 1 required extensive assistance from one staff for eating and activities of daily living and was dependent on a wheelchair for locomotion. On 10/5/17 at 4:22 p.m., during an interview, the Director of Nursing (DON) stated on 9/6/17, she reported Resident 1's skin tears to the Administrator. The DON stated physical abuse needed to be reported to DPH within 24 hours of the alleged abuse incident. The DON stated that during the facility's investigation, CNA 1 stated that she held Resident 1's hands down to protect herself from being hit by the resident. On 10/5/17 at 4:52 p.m., during an interview, the	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056458	A. BUILDING _____ B. WING _____	C 01/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF SOUTH GATE	8455 STATE STREET SOUTH GATE, CA 90280

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F 225	Continued From page 12 Administrator stated that she was made aware of the incident the night of 9/6/17. The Administrator stated that she failed to report the incident to DPH because there was a possibility that the injuries were caused by Resident 1 not wearing her Geri sleeves while in the wheelchair. A review of the facility Policy titled, "Unusual Occurrences," dated 12/2007 indicated that the facility would report allegations of abuse, neglect, and misappropriation of property. Unusual occurrences will be reported via telephone to appropriate agencies as required by current law and/or regulations, and within 24 hours of such incident or as otherwise required by federal and state regulations.	F 225		
F 250 SS=D	PROVISION OF MEDICALLY RELATED SOCIAL SERVICE CFR(s): 483.40(d) (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow its policy by not providing medically-related social service interventions after an injury caused by a certified nurse assistant (CNA 1) for one of three sampled residents (Resident 1). This deficient practice had the potential for Resident 1 and other residents to not receive psychosocial and emotional support.	F 250	F 250 2/5/18 Administrator in-serviced SSD regarding providing medically-related social service interventions after an injury caused by staff. If SSD unavailable on weekends, then Manager of the Day will provide interventions. IDT and care plan will be created upon notification of injury. No other residents were found to be affected by this deficient practice.	

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	056458	A. BUILDING _____ B. WING _____	C 01/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF SOUTH GATE	8465 STATE STREET SOUTH GATE, CA 90280

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F 250	Continued From page 13 Findings: A review of the Resident 1's Admission Record (facesheet) indicated resident was admitted to the facility on 3/5/12. Resident 1's diagnoses included dementia (decreased in ability to remember) and anemia (deficiency of red blood cells or of hemoglobin in the blood). A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 10/10/17, indicated the resident was severely impaired of cognition (thought process) and had a brief interview for mental status (BIMS) score of 4 (0-7: severe impairment). The MDS indicated Resident 1 required extensive assistance from one staff with eating and activities of daily living and was dependent on a wheelchair for locomotion. A review of the Nurses Progress note, dated 9/11/17, and timed at 11 a.m., indicated Resident 1 was noted bleeding from both forearms. The note indicated that the left forearm injury measured 11 centimeters (cm) by (x) 3 cm and the right arm's injury measured 14 cm x 3 cm. On 10/5/17 at 2:34 p.m., during an interview, Resident 1 was unable to recall the incident on 9/6/17 involving CNA 1. On 10/5/17 at 2:42 p.m., during and interview, Resident 2 stated CNA 1 hit Resident 1 on her hand hard. Resident 2 stated that Resident 1 was dripping blood all over the floor when she was wheeling herself out of the room and saying that it hurt. On 10/5/17 at 4 p.m., during an interview, LVN 1	F 250	Any allegation of abuse and or injury, will be brought up immediately to the Administrator or DON will inform SSD immediately to provide social services interventions. Administrator will monitor any allegations of abuse during daily stand up and daily room rounds up to 90 days. Any findings will be brought up to monthly QA meetings up to 90 days. Completion date 2/28/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	058458	A. BUILDING _____ B. WING _____	C 01/29/2018

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F 250	Continued From page 14 stated that CNA 1 notified her that she found Resident 1 bleeding from her arms. On 10/5/17 at 4:23 p.m., during an interview and concurrent record review, the Social Services Coordinator (SSC) stated that he did not follow up with Resident 1 until 9/11/17, five days after the alleged abuse. SSC stated that he did not document any of the follow-ups he had with the resident after the alleged incident. A review of the facility's policy and procedure titled, "Social Services," revised 2/2005, indicated the social services designee was responsible for maintaining an adequate record system of social services data and to maintain or improve each resident's ability to control every day physical needs (i.e. appropriate adaptive equipment for eating, ambulation, etc.) and mental and psychological needs (i.e. sense of identity, coping abilities, and sense of meaningfulness or purpose).	F 250		