STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035154	A. BUILDING _____ B. WING _____	**10/19/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROVIDENCE PLACE AT GLENCROFT	**8641 NORTH 67TH AVE GLENDALE, AZ 85302**

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, the facility's investigative report, staff interview, and policy, the facility failed to ensure one resident (#33) was not sexually abused by another resident (#195). Findings include: -Resident #195 was admitted on (MONTH) 30, (YEAR) with [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment dated (MONTH) 13, (YEAR) revealed a BIMS (Brief Interview for Mental Status) score of 3, which indicated severely impaired cognition. The assessment also included the resident had trouble concentrating, [MEDICAL CONDITION], dementia, and [MEDICAL CONDITION]. Review of the care plan dated (MONTH) 28, (YEAR) for behavioral symptoms revealed the resident had sexually inappropriate behavior towards others (staff and residents). Interventions included the following: - Do not leave the resident alone with female peers. - Allow distance in seating other residents around the resident. - Seat the resident where constant or near constant observation is possible. - If the resident becomes sexually abusive, move resident to a quiet calm environment. A social services note dated (MONTH) 29, (YEAR) at 5:11 p.m. revealed resident #195 was found by a nursing staff with his zipper down sitting next to a female resident (#33). The note included resident #195 placed resident #33's hand on his crotch area and that he stopped placing resident #33's hand on his crotch area when he was approached by a nurse. The note also included resident #195 had been too familiar with resident #33 in recent days, and to be aware when resident #195 is around other female residents. A nurse's note dated (MONTH) 29, (YEAR) at 7:13 p.m. revealed resident #195 had been observed (earlier), behaving inappropriately to another resident (#33) in the dining room. The note revealed the resident had been observed exposing his penis to resident #33 in the dining room. -Resident #33 was admitted on (MONTH) 4, (YEAR) with a [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 30, (YEAR) revealed resident #33 was unable to be understood, had short term and long term memory problems, and severe cognitive impairment. A social services note dated (MONTH) 29, (YEAR) at 4:57 p.m. revealed resident #33 had been observed sitting with a male resident (#195) and that resident #195 had her hand on his crotch area. The note included resident #33 was confused and unaware of the incident. The note also included that resident #33's family member had stated to the social worker that on another occasion resident #195 had touched resident #33 on her face in a gentle manner. Review of the facility's investigative report dated (MONTH) 29, (YEAR) revealed a nurse observed two residents seated (#195 and #33) together in the dining room at 10:00 a.m. and that the male resident (#195) had taken his penis out of his pants and placed the female resident's (#33) hand on his penis. The nurse stopped resident #195 immediately. Resident #33 did not indicate awareness of the action by resident #195 and continued to touch items on a table. The report included that staff had been alerted to keep the two residents apart. The report further included resident #195's medication was recently decreased. The report also included the social worker was interviewing more alert and oriented residents to determine if there were any residents who did not feel safe. The investigative report included a witness statement written by the nurse had observed resident #195 seated in his wheelchair next to resident #33 in the dining room. The nurse's statement included that she was behind the residents and had observed resident #195 expose his penis and hold resident #33's hand on his penis moving it in an up and down movement. The statement included the nurse told resident #195 to stop, which he did, and that resident #33 seemed to be unaware that resident #195 had placed her hand on his penis. An interview was conducted on (MONTH) 16, (YEAR) at 2:20 p.m. with the Administrator (staff #202). The Administrator stated that additional incidents had been documented that resident #195 had touched resident #33 because he believed that resident #33 was his wife. The administrator stated that resident #195 was moved to another unit on (MONTH) 4, (YEAR), and has since been discharged . The Administrator also stated that the responsible party for resident #33 did not consent to physical contact between resident #195 and resident #33. Review of the facility's policy titled Freedom from Abuse, Neglect, and Exploitation Policy and Procedure revealed the facility is to maintain an environment where residents are free from abuse, neglect, and exploitation. The policy included that sexual abuse is non-consensual sexual contact of any type with a resident. The policy also included that generally, sexual contact is non-consensual if the resident lacks the cognitive ability to consent to the contact.
F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, the facility's investigation report, staff interviews, and policy, the facility failed to ensure one resident's (#445) medication was not misappropriated. Findings include: Resident #445 was admitted to the facility on (MONTH) 30, (YEAR) with [DIAGNOSES REDACTED]. The resident expired on (MONTH) 27, (YEAR). The admission Minimum Data Set assessment dated (MONTH) 6, (YEAR) revealed a Brief Interview for Mental Status score of 12 which indicated the resident was moderately impaired. The assessment also included the resident required supervision with his activities of daily living. A physician's orders [REDACTED]. Review of the facility's investigation report revealed that on (MONTH) 19, (YEAR) a male person brought two medication cards of [MEDICATION NAME] tablets 600 mg for a total of 18 doses to the reception desk. He stated that he was a licensed practical nurse (staff #299) friend and that staff #299 had a box of medications at her apartment. He left the medications at the reception desk and left the facility before he was able to be interviewed. The report included that staff #299 stated that she had not taken the medications but that the friend had taken the medications when visiting her at work. Subsequent conversations with staff #299 occurred and she admitted to taking laxatives from the facility, but stated that it was the only medication she had taken. The report included staff #299 was asked to come to the facility and bring any medications she had with her. The nurse called the Administrator back and declined to come in. The report further included that based upon staff #299's statement that she took the laxatives and her refusal to come to the facility, the nurse was

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

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 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) terminated. The report also included the facility was unable to determine when the medications were removed from the facility. During an interview conducted on (MONTH) 17, (YEAR) at 9:25 a.m. with a licensed practical nurse (staff #301), he stated that the receptionist called him to the desk, stating that someone claiming he was staff #299's boyfriend had stated staff #299 was stealing medications from the facility and threw down two medication cards and left. He stated that the cards had resident #445's name on them, and that the resident expired (MONTH) (YEAR). Staff #301 stated that he took the cards to the Director of Nursing (DON/staff #300) for further investigation which would be conducted by himself, the DON, and the Administrator. He stated that the DON, the administrator and he called staff #299 via the phone and that she denied taking the medications. Staff #301 stated that staff #299 was asked to come to the facility to discuss the issue and that she originally agreed to do so, but then called back and said she could not come in. He stated that staff #299 was terminated. During an interview conducted on (MONTH) 17, (YEAR) at 9:41 a.m. with the Executive Assistant (staff #302), he stated that on (MONTH) 19, (YEAR) while giving the primary receptionist a break, a male person came to the facility and dropped off the medications and stated these pills are from one of your nurses and there are a bunch more at home. He stated that the male person left without stating his name. Staff #302 stated that he notified the Resource Nurse and the Director of Nursing. An interview was conducted on (MONTH) 17, (YEAR) at 9:47 a.m. with the DON. He stated the receptionist notified him that a male person had dropped off two cards of medications at the desk. The DON stated the receptionist stated the male person stated the medications belonged to a resident and that one of the nurses (staff #299) had more medications at home. He stated that the medication cards had resident #445's name on them and that the resident had expired (MONTH) (YEAR). The DON stated that they called staff #299 by phone and that she stated that she had never stolen any medications and that the friend must of taken the medications when he came to visit her. He stated staff #299 did finally admit to taking some of the over the counter laxatives, but denied taking any other medications. The DON stated that the nurse initially agreed into come to the office to speak with them, but called back later and stated that she could not come to the facility. He stated that at that point the nurse was terminated and a report was filed with the Arizona Board of Nursing. An interview was conducted on (MONTH) 17, (YEAR) at 10:09 a.m. with the Administrator (staff #202). She stated that the receptionist reported the incident to both the Resource Nurse (staff #301) and the Director of Nursing (staff #300). She further stated that she does not recall seeing the medication cards but was told by the DON and the Resource Nurse that the medications belonged to resident #445. She stated that during their investigation they were unable to determine when the medications were removed from the facility, but stated that the resident had expired in (MONTH) of (YEAR). She then stated that she, the DON and the Resource Nurse called staff #299. The Administrator stated that initially staff #299 stated that she did not take the medication and that maybe the boyfriend had taken the medications when he came to visit her at work, but staff #299 was unable to explain how the boyfriend would have been able to take the medications out of the locked medication room. She further stated that later, staff #299 admitted to taking some of the over the counter laxatives, but continued to deny taking the [MEDICATION NAME]. The administrator stated that staff #299 was asked to come to the facility and bring any other medications that she may have. She stated that staff #299 initially agreed to do so, but then called back and stated that she could not come to the facility. She stated that staff #299 was terminated when she refused to come to the facility. The administrator further stated that several days after the incident, she received a letter from the boyfriend retracting his statement about staff #299 taking the medications and that he had found the medications laying in the parking lot in a handicapped space. The facility's policy Disposal of Medication and Treatment Solutions revealed that when non-controlled medications have been discontinued or expired, they will be removed from the medication cart or other storage area by licensed staff. The policy included the medications will be placed in an area designated in the medication room for return to the pharmacy if the medication card is intact. The facility's policy regarding Freedom from Abuse, Neglect, Misappropriation of Property and Exploitation revealed each resident has the right to be free from misappropriation of property.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, the facility's investigative report, the State Agency data base, staff interviews, and policy, the facility failed to implement their abuse policy regarding prevention, reporting, and investigating for two residents (#33 and #195). Findings include: -Resident #195 was admitted on (MONTH) 30, (YEAR) with [DIAGNOSES REDACTED]. A social services note dated (MONTH) 29, (YEAR) at 5:11 p.m. revealed resident #195 was found by a nursing staff with his zipper down sitting next to a female resident (#33). The note included resident #195 placed resident #33's hand on his crotch area and that he stopped placing resident #33's hand on his crotch area when he was approached by a nurse. The note also included resident #195 had been too familiar with resident #33 in recent days, and to be aware when resident #195 is around other female residents. A nurse's note dated (MONTH) 29, (YEAR) at 7:13 p.m. revealed resident #195 had been observed (earlier), behaving inappropriately to another resident (#33) in the dining room. The note revealed the resident had been observed exposing his penis to resident #33 in the dining room. Review of a nurse's note dated (MONTH) 31, (YEAR) revealed the resident was observed caressing resident #33's arm inappropriately in the dining room. The note included that when staff instructed resident #195 to stop, he became verbally aggressive and was removed from the dining room. -Resident #33 was admitted on (MONTH) 4, (YEAR) with a [DIAGNOSES REDACTED]. A social services note dated (MONTH) 29, (YEAR) at 4:57 p.m. revealed resident #33 had been observed sitting with a male resident (#195) and that resident #195 had her hand on his crotch area. The note included resident #33 was confused and unaware of the incident. The note also included that resident #33's family member had stated to the social worker that on another occasion resident #195 had touched resident #33 on her face in a gentle manner. Review of the facility's investigative report dated (MONTH) 29, (YEAR) revealed a nurse had observed two residents seated (#195 and #33) together in a dining room at 10:00 a.m. The male resident (#195) had taken his penis out of his pants and placed the female resident's (#33) hand on his penis. The report included the nurse stopped resident #195 immediately and that resident #33 did not indicate awareness of the action by resident #195. The report included the social worker was interviewing more alert and oriented residents to determine if there were any residents who did not feel safe. The investigative report further included the incident was reported to the State Agency on (MONTH) 29, (YEAR) at 4:17 p.m. However, review of the report did not include documented evidence that additional residents and staff had been interviewed and review of the State Agency data base did not reveal evidence the allegation had been reported to the State Agency. The facility was also unable provide evidence that the incident that occurred on (MONTH) 31, (YEAR) had been investigated. An interview was conducted on (MONTH) 16, (YEAR) at 2:20 p.m. with the Administrator (staff #202). The Administrator stated that additional incidents had been documented that resident #195 had touched resident #33 because resident #195 believed resident #33 was his wife. The Administrator also stated that the responsible party for resident #33 did not consent to physical contact between resident #195 and resident #33. The Administrator stated that she thought the social worker had obtained the additional resident and staff interviews necessary to rule out that resident #195 had not abused any additional residents. She also stated that the incident that occurred on (MONTH) 31, (YEAR) had not been investigated. An interview was conducted on (MONTH) 17, (YEAR) at 1:51 p.m. with the social worker (staff #303). The social worker stated that when she assists with abuse investigations, she interviews other residents and staff who were in the area, documents the interviews, and provides the written statements to the administrator. The social worker stated that if an allegation of abuse involved resident to resident contact she would speak with other residents. She stated that resident #195 had previously been housed on a different unit and had not exhibited inappropriate sexual behavior prior to being moved. She stated that she did not believe the incident that occurred on (MONTH) 29, (YEAR) at 10:00 a.m. was abuse because both residents were confused. The social worker stated that there were possibly three other residents and an activity staff that she could have interviewed but that she did not conduct the interviews because she had never observed resident #195 show an interest in other female residents. She further stated that she did not feel abuse had occurred because He (resident #195) was so confused and it was a split second. The social worker stated that the additional incidents that involved resident

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) #195 inappropriately touching resident #33 were not investigated because resident #195 believed that resident #33 was his wife. Review of the facility's policy titled Freedom from Abuse, Neglect, and Exploitation Policy and Procedure revealed the facility is to maintain an environment where residents are free from abuse, neglect, and exploitation. The policy included that reports of abuse, mistreatment and exploitation are promptly and thoroughly investigated. The policy also included that the investigation will include resident statements, resident roommate statements, involved staff and witness statements and observation of resident and staff behaviors during the investigation. The policy further included Have evidence that all alleged violations are thoroughly investigated. The policy also revealed that all alleged violations involving abuse or mistreatment are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, the facility's investigative report, staff interview, the State Agency data base, and policy, the facility failed to ensure that an allegation of sexual abuse for one resident (#33) and an allegation of verbal abuse for one resident (#100) was reported within 2 hours to the State Agency. Findings include: -Resident #195 was admitted on (MONTH) 30, (YEAR) with [DIAGNOSES REDACTED]. -Resident #33 was admitted on (MONTH) 4, (YEAR) with a [DIAGNOSES REDACTED]. Review of the facility's investigative report dated (MONTH) 29, (YEAR) revealed that at 10:00 a.m. a nurse observed two residents seated together in a dining room. The report included the male resident (#195) had taken his penis out of his pants and placed the female resident's (#33) hand on his penis and that the nurse stopped the male resident immediately. The investigative report further included the incident was reported to the State Agency on (MONTH) 29, (YEAR) at 4:17 p.m. However, review of the State Agency data base did not reveal evidence the allegation had been reported to the State Agency. -Resident #100 was admitted on (MONTH) 10, (YEAR) and readmitted on (MONTH) 25, (YEAR) with a [DIAGNOSES REDACTED]. An interview was conducted with the resident on (MONTH) 15, (YEAR) at 1:03 p.m. Resident #100 stated that approximately two weeks prior, a nurse on the night shift had told her to shut up. The resident stated that she had not told other staff about the incident. During an interview conducted with the Administrator (staff #202) on (MONTH) 15, (YEAR) at 1:47 p.m., the Administrator was informed of the allegation of verbal abuse and stated that she would report the allegation to the State Agency within two hours. However, review of the State Agency data base revealed the allegation via the online complaint system was not reported to the State Agency until (MONTH) 15, (YEAR) at 4:33 p.m. An interview was conducted on (MONTH) 17, (YEAR) at 2:26 p.m. with the Administrator. The Administrator stated that all allegations of abuse including allegations of sexual abuse are reported to the State Agency and includes the name of the alleged victim, the facility name and phone number, and that the name of the alleged perpetrator is not immediately reported, because they do not know who the perpetrator is until they investigate. The facility's policy titled Freedom from Abuse, Neglect, and Exploitation revealed all alleged violations involving abuse or mistreatment are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.
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** Based on clinical record reviews, the facility's investigative report, staff interviews, and policy, the facility failed to thoroughly investigate an allegation of sexual abuse for one resident (#33). Findings include: -Resident #195 was admitted on (MONTH) 30, (YEAR) with [DIAGNOSES REDACTED]. A social services note dated (MONTH) 29, (YEAR) at 5:11 p.m. included that resident #195 was observed by a nursing staff to have his zipper down sitting next to a female resident (#33), and he had placed resident #33's hand on his crotch area. Resident #195 stopped placing resident #33's hand on his crotch area when he was approached by the nurse. The note included that resident #195 had been too familiar with resident #33 in recent days, and to be aware when resident #195 is around other female residents. A nurses note dated (MONTH) 29, (YEAR) at 7:13 p.m. included that resident #195 had been observed (earlier), behaving inappropriately to another resident (#33) in the dining room, and had been observed exposing his penis to the other resident (#33) in the dining room. Continued review of the clinical record revealed a nurse's note dated (MONTH) 31, (YEAR). The note included that resident #195 was observed caressing a female resident's (#33) arms inappropriately in the dining room. The note also included when staff instructed the resident to stop, resident #195 became verbally aggressive and was removed from the dining room. -Resident #33 was admitted on (MONTH) 4, (YEAR) with a [DIAGNOSES REDACTED]. A social services note dated (MONTH) 29, (YEAR) at 4:57 p.m. revealed resident #33 had been observed sitting with a male resident (#195) and that resident #195 had her hand on his crotch area. The note included resident #33 was confused and unaware of the incident. The note also included that resident #33's family member had stated to the social worker that on another occasion the male resident (#195) had touched resident #33 on her face in a gentle manner. Review of the facility's investigative report dated (MONTH) 29, (YEAR) revealed a nurse observed two residents seated together (#195 and #33) in a dining room at 10:00 a.m. The report included the male resident (#195) had taken his penis out of his pants and placed the female resident's (#33) hand on his penis. The nurse stopped the male resident immediately. Resident #33 did not indicate awareness of the action by resident #195 and continued to touch items on a table afterwards. The report included that staff had been alerted to keep the two residents apart and that resident #195 had recently had a decrease in medication. The report also included the social worker was interviewing more alert and oriented residents to determine if there were residents who did not feel safe. The investigative report included a witness statement written by the nurse who had witnessed the incident. However, the report did not include any documented evidence that any additional residents had been interviewed, or that any additional staff interviews had been conducted. No documented evidence was found that the incident that occurred on (MONTH) 31, (YEAR) had been investigated. An interview was conducted on (MONTH) 16, (YEAR) at 2:26 p.m. with the Administrator (staff #202). The Administrator stated that she thought the social worker had obtained the additional resident and staff interviews necessary to rule out that resident #195 had not abused any additional residents. The Administrator also stated that the incident that had occurred on (MONTH) 31, (YEAR) regarding resident #195 caressing resident #33 arms inappropriately had not been investigated. An interview was conducted on (MONTH) 17, (YEAR) at 1:51 p.m. with the social worker (staff #303). The social worker stated that when she assists with abuse investigations, she interviews other residents and staff who were in the area, documents the interviews, and provides the written statements to the administrator. The social worker stated that if an allegation of abuse involved resident to resident contact she would speak with other residents. The social worker stated that she did not believe that the incident that occurred on (MONTH) 29, (YEAR) at 10:00 a.m. had been abuse, because both of the residents were confused. She stated that there were possibly three other residents and an activity staff on the unit that she could have interviewed. She stated that she did not conduct the additional interviews because she had never observed resident #195 show an interest in other female residents, and did not feel that abuse had occurred because He (resident #195) was so confused and it was a split second. The social worker stated that additional incidents that involved resident #195 inappropriately touching resident #33 were not investigated because resident #195 believed that resident #33 was his wife. The facility's policy titled Freedom from Abuse, Neglect, and Exploitation Policy and Procedure included a statement that it is the policy of the facility that reports of abuse, mistreatment and exploitation are promptly and thoroughly investigated. The policy included that the investigation will include resident statements, resident roommate statements,

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) involved staff and witness statements, and observation of resident and staff behaviors during the investigation. The policy also included a statement that read Have evidence that all alleged violations are thoroughly investigated.
F 0655 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy, the facility failed to ensure one resident (#57) and their representative was provided with a summary of the baseline care plan. Findings include: Resident #57 was admitted on [DATE] with [DIAGNOSES REDACTED]. A Care Conference note dated 6/21/2018 revealed the resident was not in the facility when his admission care plan conference was scheduled. Review of the quarterly MDS (Minimum Data Set) assessment dated [DATE], revealed the resident had a BIMs (Brief Interview for Mental Status) score of 14 which indicated the resident was cognitively intact. A care plan summary dated 8/13/2018, revealed the goals were summarized and that the medications, the dietary order, and the treatments were outlined. However, further review of the clinical record revealed no documentation that the resident was provided a copy of the summary of the baseline care plan. On 10/16/18 at 08:25 AM, an interview was conducted with the resident. The resident stated that he was not aware that he had a care plan. He stated that no one had spoken to him regarding his treatment goals and that No, I was never given any paperwork on that. An interview was conducted with the Administrator (staff #202) on 10/17/18 at 08:30 AM. She stated that a care plan summary was reviewed with the resident but was unable to find documentation that the summary had been reviewed with the resident. Staff #202 stated that it was not documented that the facility had provided this information to the resident. She stated that they have now changed the process that requires a resident or their representative to sign an acknowledgement of receipt. The facility's policy regarding Baseline Care Planning included, The resident and their representative will be provided (verbal, written and/or resident or family preference tool of communication) a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services or treatments to be administered by the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary.