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	17E596	A. BUILDING _____ B. WING _____	04/12/2013

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BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Extended Health Resurvey.	F 000		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Requirement is not met as evidenced by: The facility had a census of 49 residents. The facility reported they hired 8 new employees during the last six months, the sample included 5 new employees. Based on record review, and staff interview, the facility failed to provide evidence of reference verification prior to hire for 5 of 5 new employees hired. Findings included: - Review of the personnel file of licensed nurse staff K with a hire date of 2/13/13 lacked evidence of reference checks obtained prior to employment. During an interview on 4/9/13 at 1:50 P.M. administrative staff B reported it was the responsibility of the individual department heads to obtain reference checks for potential new employees for their department. Administrative staff B verified the personnel files lacked reference checks. During an interview on 4/10/13 at 12:46 P.M. administrative staff A reported it was the responsibility of the individual department heads	F 226		

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

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to obtain the pre-employment screening verification of potential new employees. Administrative staff A verified the facility should obtain pre-employment references.

The Policy and Procedure dated January 2007 for Background Checks provided by the facility recorded background investigations included an examination and verification of references.

The facility failed to complete pre-employment background screening for this newly hired employee.

- Review of the personnel file of dietary staff EE with a hire date of 12/6/12 lacked evidence of reference checks obtained prior to employment.

During an interview on 4/9/13 at 1:50 P.M. administrative staff B reported it was the responsibility of the individual department heads to obtain reference checks for potential new employees for their department. Administrative staff B verified the personnel files lacked reference checks.

During an interview on 4/10/13 at 12:46 P.M. administrative staff A reported it was the responsibility of the individual department heads to obtain the pre-employment screening verification of potential new employees. Administrative staff A verified the facility should obtain pre-employment references.

The Policy and Procedure dated January 2007 for Background Checks provided by the facility recorded background investigations included an examination and verification of references.

The facility failed to complete pre-employment

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F 226	Continued From page 2 background screening for this newly hired employee. - Review of the personnel file of dietary staff FF with a hire date of 11/2/12 lacked evidence of reference checks obtained prior to employment. During an interview on 4/9/13 at 1:50 P.M. administrative staff B reported it was the responsibility of the individual department heads to obtain reference checks for potential new employees for their department. Administrative staff B verified the personnel files lacked reference checks. During an interview on 4/10/13 at 12:46 P.M. administrative staff A reported it was the responsibility of the individual department heads to obtain the pre-employment screening verification of potential new employees. Administrative staff A verified the facility should obtain pre-employment references. The Policy and Procedure dated January 2007 for Background Checks provided by the facility recorded background investigations included an examination and verification of references. The facility failed to complete pre-employment background screening for this newly hired employee. - Review of the personnel file of direct care staff O with a hire date of 10/5/12 lacked evidence of reference checks obtained prior to employment. During an interview on 4/9/13 at 1:50 P.M. administrative staff B reported it was the responsibility of the individual department heads to obtain reference checks for potential new	F 226		

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F 226	Continued From page 3 employees for their department. Administrative staff B verified the personnel files lacked reference checks. During an interview on 4/10/13 at 12:46 P.M. administrative staff A reported it was the responsibility of the individual department heads to obtain the pre-employment screening verification of potential new employees. Administrative staff A verified the facility should obtain pre-employment references. The Policy and Procedure dated January 2007 for Background Checks provided by the facility recorded background investigations included an examination and verification of references. The facility failed to complete pre-employment background screening for this newly hired employee. - Review of the personnel file of direct care staff P with a hire date of 2/26/13 lacked evidence of signed and dated reference checks prior to employment. During an interview on 4/9/13 at 1:50 P.M. administrative staff B reported it was the responsibility of the individual department heads to obtain reference checks for potential new employees for their department. Administrative staff B verified the personnel files lacked completed reference checks. During an interview on 4/10/13 at 12:46 P.M. administrative staff A reported it was the responsibility of the individual department heads to obtain the pre-employment screening verification of potential new employees. Administrative staff A verified the facility should	F 226		

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F 226	Continued From page 4 obtain pre-employment references. The Policy and Procedure dated January 2007 for Background Checks provided by the facility recorded background investigations included an examination and verification of references. The facility failed to complete pre-employment background screening for this newly hired employee.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: The facility reported a census of 49 residents. The sample included 16 residents. Based on observation and interview the facility failed to provide a comfortable and clean environment for residents on 3 of 3 hallways. Findings included: - Environmental tour on 4/9/13 between 1:00 P.M. to 2:25 P.M. with administrative staff A revealed the following: - The semi private rooms on the 3 hallways had towel bars that were not labeled for the individual residents. - Two rooms on the North hallway had urine odors in the bathroom. - The semi private rooms on the 3 hallways had unlabeled care equipment for the individual	F 253		

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F 253	Continued From page 5 residents. - One room on the North hallway had handles missing from 2 of 3 drawers. - The main hallway had scrape marks on the walls. - The carpet on the main hallway and at the nursing station were stained. Staff interview on 4/9/13 at 2:30 P.M. with administrative nursing staff A stated the facility had plans to remove all carpets and replace those areas with hardwood flooring, nursing staff should label the resident's personal care items, housekeeping staff should increase the cleaning frequency with the rooms with urine odors, and nursing staff would label the towel bars for resident identification. The facility failed to maintain a clean and comfortable environment for the residents.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication;	F 272		

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F 272	Continued From page 6 Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This Requirement is not met as evidenced by: The facility reported a census of 49 residents. The sample included 16 residents. Based on observation, record review, and staff interview the facility failed to comprehensively assess 2 (#24 and #46) residents of the sampled. Findings included: - The annual Minimum Data Set (MDS) 3.0 dated 3/1/13 for resident #24 revealed a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) and the resident received antipsychotic, antidepressant and diuretic medications. The Care Area Assessment (CAA) dated 3/8/13	F 272		

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for psychotropic drug use revealed the resident received several psychotropic medications. Nursing staff would monitor the resident for therapeutic and side effects. The CAA lacked documentation of causal factors for the use of psychotropic medications.

Observation on 4/9/13 at 12:00 P.M. revealed the resident ambulated independently in the hallway with no behaviors noted.

Staff interview on 4/10/13 at 2:56 P.M. with administrative nursing staff D stated it was her/his expectation the CAA for psychotropic drug use included causal factors for the use of psychotropic drugs.

Staff interview on 4/10/13 at 3:25 P.M. with administrative nursing staff E stated she/he included causal factors in the CAA for psychotropic drug use and not just diagnoses.

The facility failed to comprehensively assess for the use of psychotropic drugs.

- The Quarterly Minimum Data Set (MDS) 3.0 dated 1/4/13 for resident #46 revealed a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). The resident received antipsychotic, antidepressant, hypnotic, anticoagulant, and diuretic medications.

The Care Area Assessment (CAA) dated 10/5/12 for psychotropic drug use revealed the resident continued to receive daily doses of psychotic medications related to ongoing treatment of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and mood disorders (all types of depression and

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F 272	Continued From page 8 bipolar disorder). The resident was at risk for potential side effects that may cause discomfort. The CAA lacked documentation of causal factors for the use of psychotropic medications. Observation on 4/9/13 at 8:01 A.M. revealed the resident sat quietly in the dining room and ate breakfast. Staff interview on 4/10/13 at 2:56 P.M. with administrative nursing staff D stated it was her/his expectations the CAA for psychotropic drug use included causal factors for the use of psychotropic drugs. Staff interview on 4/10/13 at 3:25 P.M. with administrative nursing staff E stated she/he included causal factors in the CAA for psychotropic drug use and not just diagnoses. The facility failed to comprehensively assess for the use of psychotropic drugs.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who	F 278		

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willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This Requirement is not met as evidenced by:
The facility identified a census of 49 residents. The sample included 16 residents. Based on observation, record review and staff interview, the facility failed to provide an accurate assessment for one (#10) resident of the sample.

Findings included:

- The March 2013 Physician's Order Sheet (POS) for resident #10 listed a diagnosis of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). It also listed the following medication for this resident: Serzone (an antidepressant medication)(initiated in 2006).

The 03/01/13 Annual Minimum Data Sheet (MDS) 3.0 noted the resident received antipsychotic and antianxiety medications for 7 of the last 7 days. It also noted the resident did not receive an antidepressant medication in the last 7 days.

This MDS lacked evidence that this resident had taken an antidepressant within the previous 7

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F 278	Continued From page 10 days of the MDS. On 04/10/13 at 10:15 A.M., administrative nursing staff E stated he/she obtained the information for the MDS from medication administration records, treatment administration records, resident and staff interviews, and behavior records. On 04/10/13 at 2:00 P.M., licensed nursing staff H stated that it was an oversight regarding the omission of the information on the MDS about the resident taking an antidepressant medication. The facility failed to complete an accurate MDS assessment for this resident that received an antidepressant medication.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		

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F 279	Continued From page 11 This Requirement is not met as evidenced by: The facility identified a census of 49 residents. The sample included 16 residents. Based upon record review, interviews, and observation, the facility failed to develop a comprehensive and individualized care plan for 5 (#27, #1, #23, #32, and #30) of the sampled residents. Findings included: - Resident #1's quarterly Minimum Data Set (MDS) 3.0 dated 1/18/13 recorded a Brief Interview of Mental Status (BIMS) score of 9 (mildly impaired cognition); the resident required supervision and set up with eating, and independent with all other Activities of Daily Living (ADL)s. The Care Area Assessment (CAA) dated 8/1/12 for ADLs recorded the nursing staff provided the resident set up and supervision related to personal hygiene tasks. The care plan dated 8/1/12 for ADLs recorded the nursing staff would continue to provide the resident with reminders related to shaving. An observation on 4/4/13 at 11:22 A.M. noted the resident with facial hair, unshaven. An observation on 4/10/13 at 3:04 P.M. revealed direct care staff O shaved the resident while he/she sat in the barber chair. During an interview on 4/10/13 at 3:04 P.M. direct care staff O reported the resident was not allowed to keep shaving supplies in his/her private room for safety precautions. He/she reported all residents were supervised or assisted with	F 279		

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shaving, and resident #1 preferred shaved with a safety razor usually every other day.

During an interview on 4/10/13 at 1:02 P.M. administrative staff A reported administrative nursing staff D and E were responsible for resident care plan development and revision.

The facility policy dated 7/2009 for care plan process recorded the interdisciplinary team would coordinate with the resident and/or their legal representative an appropriate care plan for the resident's needs based on the assessment.

The facility failed to develop an individualized plan of care for shaving for this cognitively impaired resident.

- The Significant Change in Status Minimum Data Set (MDS) 3.0 dated 3/28/13 for resident #27 revealed a Brief Interview for Mental Status (BIMS) score of 6 (severe cognitive impairment). The resident required extensive assistance of two plus persons with bed mobility and walking in room; required extensive assistance of one person with transfers, locomotion on the unit/corridor, dressing, and personal hygiene; required total dependence of one person with eating; and required total dependence of two plus persons with toilet use and bathing. The resident had a life expectancy of less than six months and received hospice services.

The care plan dated 3/16/13 for activities of daily living (ADLs) revealed nursing staff referred to the hospice care plan and referred staff to contact hospice regarding care needs. The care plan lacked documentation regarding hospice staff visits, services, and supplies provided.

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F 279	Continued From page 13 Observation on 4/9/13 at 8:08 A.M. revealed the resident sat upright and alert in a Broda chair at the nurses' station. Staff interview on 4/10/13 at 2:56 P.M. with administrative nursing staff D stated the facility provided a care plan according to the care plan hospice provided. Staff interview on 4/10/13 at 3:25 P.M. with administrative nursing staff E stated nursing staff updated care plans quarterly and the care plan summary monthly. The policy and procedure dated 7/2009 titled Care Plan Process revealed the plan of care should include interventions, discipline's specific services, and frequency. The facility failed to develop an individualize care plan for this cognitively dependent resident that received hospice services. - Review of the Annual Minimum Data Sheet (MDS) 3.0 dated 10/08/12 for resident #30 revealed it was very important to the resident to do things with groups of people, and to go outside to get fresh air when weather was good. It also revealed a Brief Interview for Mental Status score of 9, which indicated mild cognitive impairment. Review of the activity assessment dated 09/27/12 revealed the resident liked the following activities: animals/pets, arts/crafts, beauty/barber, bingo, community outings, cooking/baking, current events/news, dominoes, exercise, family/friend visits, gardening, group discussions, movies,	F 279		

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music, radio, reading, religious services and studies, resident council, shopping, sing-a-longs, social/parties, sports and television. He/she did not like board games or playing cards.

Review of the care plan dated 10/11/12 revealed the intervention: encourage the resident to participate in facility planned activities to prevent isolation, decrease the possibility of depression, and help keep his/her cognition at optimum.

On 04/03/13 at 12:52 P.M. the resident stated there was not much to do on the weekends except to watch television.

On 04/09/13 at 1:30 P.M. the resident stated he/she liked to watch television and straighten up his/her room.

Observation on 04/10/13 at 10:00 A.M. revealed the resident sat in a chair twiddling his/her thumbs for several minutes. No staff interactions were observed.

The facility's policy for the care plan process revealed the Interdisciplinary Team would coordinate with the patient/resident and their legal representative an appropriate care plan for the patient's/resident's needs or wishes based on the assessment and reassessment process.

The facility failed to develop an individualized care plan for this resident's activities.

- Review of Annual Minimum Data Sheet (MDS) 3.0 dated 10/01/12 for resident #32 documented this resident needed supervision with one person physical assistance for personal hygiene. It also documented a Brief Interview for Mental Status score of 9, which indicated mild cognitive

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F 279	Continued From page 15 impairment. Review of the care plan dated 1/15/13 lacked the intervention to assist the resident with personal hygiene. The Care Area Assessment dated 10/01/12 for Functional Status/Rehabilitation Potential documented the facility continued to provide assistance and supervision as needed with activities of daily living. Observation on 4/03/13 at 1:23 P.M. revealed the resident had an unshaven mustache and goatee. Observation on 4/08/12 4:10 P.M. revealed the resident appeared clean-shaven. Observation on 4/09/13 7:25 A.M. revealed the resident had very minimal hair stubble. On 04/10/13 at 12:45 P.M., the resident stated the staff could shave him/her whenever they felt it was needed. Interview on 4/10/13 at 2:00 P.M., licensed nursing staff K stated the care plans were developed by the MDS coordinator. The facility failed to develop an individualized care plan for this resident's shaving needs. - The quarterly Minimal Data Set 3.0 (MDS) dated 2/15/13 for resident #23 recorded he/she required supervision with setup for eating, dressing and personal hygiene. The Brief Interview for Mental Status (BIMS) scored 14 which indicated intact cognition.	F 279		

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The Care Plan dated 2/20/13 for Activities of Daily Living (ADL) recorded he/she needed reminders at times related to personal hygiene, and the nursing staff would provide assistance with personal hygiene such as shaving as needed.

The Nursing Monthly Summary dated 3/27/13 recorded the resident required assistance with grooming.

The Certified Nurse Assistant (CNA) ADL book for 4/13, recorded the resident needed set assistance for personal hygiene.

On 4/4/13 at 10:30 A.M. and 4/9/13 at 2:45 P.M. the resident was unshaven.

Observation on 4/10/13 at 2:35 P.M. the nursing staff shaved the resident.

The resident on 4/4/13 at 10:30 A.M. stated the staff shave him/her.

Direct care staff R on 4/10/13 at 2:15 PM stated the nursing staff offered to shave the resident and the resident usually allowed this staff person to shave him/her.

Licensed staff L on 4/10/13 at 2:15 P.M. stated the resident chose who shaved him/her and frequently would allow evening shift to shave him/her.

The facility policy for Care Plan Process dated 7/2/2009 recorded The Interdisciplinary Team would coordinate with the resident/legal representative to develop an appropriate care plan for the resident's needs or wishes based on the assessment and reassessment process.

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F 279	Continued From page 17 The Physicians Order Sheets (POS) signed on 3/6/13 included Miralax (used for constipation) 17 grams (gms) every day. The Care Plan dated 2/20/13 recorded the staff would ask the resident if he/she had a bowel movement within the past 3 days if he/she exhibited anxious behaviors. The care plan did not list the interventions for the prevention of constipation. Direct care staff Q on 4/9/13 at 1:20 P.M. stated the nursing staff asked the resident daily, usually on the 2 to 10 P.M. shift if he/she had a Bowel movement. On 4/10/13 at 1:02 P.M. administrative staff A reported administrative nursing staff D and E were responsible for resident care plan development and revision. The facility failed to develop a comprehensive plan of care for this resident's shaving needs and prevention of constipation.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		

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F 280	Continued From page 18 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility reported a census of 49 residents. The sample included 16 residents. Based on observation, record review, and staff interview, the facility failed to revise/update the care plan for 1 (#24) resident for falls. Findings included: - The annual Minimum Data Set (MDS) dated 3/1/13 for resident #24 revealed a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). The resident was independent with no set up with bed mobility, transfers, walking in the room/corridor, and locomotion on/off the unit; the resident required supervision with no set up with dressing; was independent with set up with toilet use; and required supervision with set up with bathing. The resident was steady at all times and had no falls since admission/entry or prior assessment. The Care Area Assessment (CAA) dated 3/8/13 for potential for falls revealed the resident was at risk for falls due to use of psychotic medications, incontinence, the potential for electrolyte imbalance related to over hydration, and diuretic medication use.	F 280		

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F 280	Continued From page 19 The revised care plan dated 3/25/13 for falls revealed nursing staff would continue to monitor labs as ordered, would continue to provide medications per physician's orders, would continue to monitor for bowel movements daily and, if no bowel movements in 3 days, nursing staff would provide a laxative per standing order, nursing staff would offer use of water socks for bathing stability and continue to supervise resident while bathing to ensure safety as the resident allowed. The Fall Investigation Worksheet dated 4/6/13 revealed the resident tripped over her/his continuous positive airway pressure (c-pap) machine, and the recommendation was to remind the resident of proper storage of the c-pap machine. Observation on 4/9/13 at 10:30 A.M. revealed the resident slept in bed and wore her/his c-pap face mask. Staff interview on 4/10/13 at 2:43 P.M. with licensed nursing staff L stated the care plan should include the nursing staff educated the resident on storing her/his c-pap after use. Staff interview on 4/10/13 at 3:25 P.M. with administrative nursing staff E stated nursing staff updated care plans quarterly and nursing staff completed the care plan summary monthly. The policy and procedure dated 7/2009 titled Care Plan Process revealed the interdisciplinary team met and created/reviewed the care plans on admission, annually, with a significant change, and quarterly. The plan of care should include interventions, discipline specific services, and frequency.	F 280		

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F 280	Continued From page 20 The facility failed to revise/update the care plan to include the recommendation for the 4/6/13 fall.	F 280		
F 286 SS=D	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This Requirement is not met as evidenced by: The facility reported a census of 49 residents and the sample included 16 residents. Based on record review and staff interview the facility failed to maintain Minimum Data Set 3.0 assessments for the previous 15 months readily accessible to all professional staff for 2 (#1 and #23) residents of the sample. Findings included: - On 4/9/13 at 12:13 P.M. administrative nursing staff D and administrative staff A reported all professional nursing staff did not have access to the nursing office where the Minimum Data Sets were kept prior to being placed in the clinical record. They verified if the assessments were not present in the clinical record, then the licensed nursing staff did not have access to the assessment. Resident #1's clinical record lacked a quarterly Minimum Data Set (MDS) 3.0 dated 1/18/13. Resident #27's clinical record lacked evidence of a Significant Change Minimum Data Set (MDS)3.0 dated 3/28/13.	F 286		

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F 286	Continued From page 21 The facility failed to maintain the residents' MDS assessments for the previous 15 months accessible to all professional staff.	F 286		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility reported a census of 49 residents. Based on observation, record review, and staff interview the facility failed to monitor and maintain water temperatures below 120 degrees. This deficient practice placed the residents in Immediate Jeopardy. Findings included: - Observation on 4/4/13 at 9:00 A.M. revealed a hot water temperature of 132.4 degrees Fahrenheit (F) in the Personal Care room. Observation on 4/4/13 at 11:30 A.M. revealed a hot water temperature of 159.0 degrees F in the room of residents #35 and #29. Observation on 4/4/13 at 11:53 A.M. dietary staff DD obtained the hot water temperature in the room of residents #35 and #29, of 156.5 degrees F. The hot water temperature in residents #6 and #36's room, was 157 degrees F on 4/4/13 at	F 323		

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F 323	Continued From page 22 12:10 P.M. Residents #45 and #47 room's hot water temperature was of 160.0 degrees F. Residents #28 and #46 room's hot water temperature was 160.0 degrees F. Observation on 4/4/13 from 9:00 A.M. to 5:00 P.M. revealed these residents were independently mobile and able to access the water independently. On 4/4/13 at 11:35 A.M. with dietary staff DD stated the facility did not monitor the water temperatures. The facility currently did not have maintenance staff. Staff interview on 4/4/13 at 12:20 P.M. dietary staff DD stated she/he called a local company to service the water temperatures on the south hallway. She/he was not sure what the policy and procedure was for the hot water temperatures. Dietary staff DD stated she/he provided the general maintenance for the facility until the facility hired a maintenance staff. The facility should check the water temperatures weekly. Record review on 4/4/13 at 12:30 P.M. of the weekly water temperature log lacked the documentation facility staff checked the water temperatures for the month of March 2013 and April 2013. On 4/4/13 at 12:35 P.M. administrative nursing staff D stated the facility did not have maintenance staff, so the water temperatures were not checked. She/he stated the facility's policy and procedure revealed the resident's hot water should be between 110 to 115 degrees F. The policy and procedure dated 3/2006 titled Domestic Hot Water revealed the facility should	F 323		

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F 323	Continued From page 23 maintain domestic hot water temperature at 110 to 115 degrees F at the outlet. Observation on 4/4/13 at 12:50 P.M. revealed the hot water was turned off to the affected residents' rooms. On 4/4/13 at 4:25 P.M. consultant staff HH stated the hot water line for the washing machine was connected to the affected residents' rooms and the mixing valve past the washing machine broke. The plumber would fix the mixing valve problem tomorrow. The temperature to the laundry was decreased and the facility would send the laundry out as needed. The facility would continue to check the hot water temperatures twice a day and over the weekend with parameters to call administration if the hot water temperatures began to rise. The facility's failure to monitor and maintain the water temperatures in acceptable parameters placed the residents in immediate jeopardy for the potential of burns. The facility abated the immediate jeopardy on 4/8/13 at 10:00 A.M. when: 1. The facility shut the water off to the affected rooms. 2. Contractor replaced the mixing valve and temperature valve. 3. Nursing staff and/or administrator would check and document the water temperatures in the affected rooms every hour for eight hours then two times a shift for 2 weeks, one time a shift for two weeks and then daily for one week. 4. The interim maintenance director would check	F 323		

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F 323	Continued From page 24 and document all water temperatures weekly. 5. The interim maintenance director would immediately notify the administrator of any water temperatures outside the acceptable range. 6. The interim maintenance director would provide a monthly preventative maintenance report to the administrator. 7. A local company would conduct inspections of the temperatures every 6 months. 8. The Quality Assessment and Performance Improvement team would review the weekly water temperatures monthly for 6 months and then quarterly thereafter. The deficient practice remained at a scope and severity of an E.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		

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F 329	Continued From page 25 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility reported a census of 49 residents. The sample included 10 residents. Based on record review and staff interview, the facility failed to provide parameters for blood pressure (BP) and failed to monitor the blood pressure of 1 (#24) resident on antihypertensive (high blood pressure) medications and failed to monitor 2 (#46 and #20) residents on antipsychotic medications. Findings included: - The signed Physician's Order Sheet (POS) dated 3/6/13 for resident #24 revealed diagnoses of diabetes mellitis (irregular blood sugar), and hypertension (high blood pressure). The Annual Minimum Data Set (MDS) 3.0 dated 3/1/13 revealed a Brief Interview for Mental Status (BIMS) score of 15 (cognitive intact). The resident received antipsychotic, antidepressant, and diuretic medications. The signed POS dated 3/6/13 revealed orders for Actos (antidiabetic) 45 milligrams (mg) by mouth (PO) daily and Metformin 1 gram (gm) PO twice daily (BID) for diabetes. Norvasc (antihypertensive) 5 mg PO BID for hypertension (HTN) and Cozaar 100 mg PO daily for HTN. Obtain the blood pressure weekly on Thursday	F 329		

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and the blood glucose at 6:00 A.M. 4 times (x) weekly on Monday, Wednesday, Friday, and Sunday, and 2 hours after breakfast 3 x weekly on Tuesday, Thursday, and Saturday.

The Medication Administration Record (MAR) for January 2013 revealed the BP was taken 2 out of 5 Thursdays and the March 2013 MAR lacked documentation the BP was obtained. The orders lacked documentation for BP and blood glucose parameters.

Record review on 4/9/13 at 8:10 A.M. revealed blood glucose were obtained as ordered for January 2013, February 2013, and March 2013. The MAR lacked documentation for parameters to notify the physician.

Observation on 4/9/13 at 12:00 P.M. revealed the resident ambulated independently in the hallway.

Staff interview on 4/9/13 at 11:25 A.M. with administrative nursing staff D stated nursing staff should document BPs on the MAR and there were no standing orders for blood pressure parameters.

Staff interview on 4/10/13 at 9:45 A.M. with direct care staff S stated she/he obtained blood pressures for residents on blood pressure medications and would notify the nurse if the blood pressure was too low or too high.

Staff interview on 4/10/13 at 2:43 P.M. with licensed nursing staff L stated nursing staff monitored the BP before giving the antihypertensive medication or the BP was checked weekly. Nursing judgement was used for BP parameters. She/he stated the nursing staff documented the BP on the MAR.

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F 329	Continued From page 27 The facility failed to provide a policy and procedure for BP monitoring for antihypertensive medications. The facility failed to monitor for the effectiveness of the antihypertensive medications and failed to obtain BP parameters for physician notification. - The signed Physician's Order Sheet (POS) dated 3/6/13 for resident #46 revealed diagnoses of behavioral mood disorder (disturbance in a person's mood) and psychosis (any major mental disorder characterized by a gross impairment in reality testing). The Quarterly Minimum Data Set (MDS) 3.0 dated 1/4/13 revealed a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). The resident received antipsychotic, antidepressant, hypnotic, anticoagulant, and diuretic medications. The signed POS dated 3/6/13 revealed orders for Zyprexa (an antipsychotic)10 milligrams (mg) by mouth (PO) daily for psychosis, Depakote (an antiseizure) 500 mg PO daily twice a day for behavioral mood disorder, and Fluoxetine (antidepressant) 40 mg PO daily for behavioral mood disorder. The Behavioral Monitoring forms for January, February, and March 2013 revealed a list of behaviors monitored. The form lacked documentation which medications the behaviors were monitored for. Observation on 4/9/13 at 8:01 A.M. revealed the resident sat quietly in the dinning room and ate breakfast.	F 329		

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F 329	Continued From page 28 Staff interview on 4/10/13 at 9:28 A.M. with licensed nursing staff K stated nursing staff should list the behavioral medications on the behavioral monitoring form. Staff interview on 4/10/13 at 9:48 A.M. with administrative nursing staff D stated nursing staff should list the behavioral medications on the behavioral monitoring form. The facility failed to monitor for the effectiveness of the behavioral medications the resident received. - The signed Physician's Order sheet dated 3/6/13 for resident #20 revealed diagnosis of schizoaffective disorder (a mental disorder characterized by recurring abnormal mood and psychotic components), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Quarterly Minimum Data Set (MDS) 3.0 dated 1/2/5/13 revealed a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact), and the resident received antipsychotic, antianxiety, antidepressant, and hypnotic medications. The signed POS dated 3/6/13 revealed orders for Geodan (an antipsychotic) 80 milligrams (mg) by mouth (PO) twice daily (BID), Klonopin (a Benzodiazepine) 1 mg PO three times daily (TID), and Zyprexa (an antipsychotic) 20 mg PO daily for schizoaffective disorder.	F 329		

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F 329	Continued From page 29 The Behavioral Monitoring forms for January, February, and March 2013 revealed a list of behaviors monitored. The form lacked which medications the behaviors were monitored for. Observation on 4/8/13 at 4:03 P.M. revealed the resident stood patiently in line to receive her/his medications. Staff interview on 4/10/13 at 9:28 A.M. with licensed nursing staff K stated nursing staff should list the behavioral medications on the behavioral monitoring form. Staff interview on 4/10/13 at 9:48 A.M. with administrative nursing staff D stated nursing staff should list the behavioral medications on the behavioral monitoring form. The facility failed to monitor for the effectiveness of the behavioral medications the resident received.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility reported a census of 49 residents.	F 428		

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F 428	Continued From page 30 The sample included 10 residents. Based on record review and staff interview, the facility's pharmacy consultant II failed to identify and report the lack of parameters for blood pressure (BP) and failed to monitor the blood pressure of 1 (#24) resident on antihypertensive (high blood pressure) medications; and failed to identify the lack of monitoring of antipsychotic medications for 2 (#46 and #20) residents medications. Findings included: - The signed Physician's Order Sheet (POS) dated 3/6/13 for resident #24 revealed diagnoses of diabetes mellitis (irregular blood sugar), and hypertension (high blood pressure). The Annual Minimum Data Set (MDS) 3.0 dated 3/1/13 revealed a Brief Interview for Mental Status (BIMS) score of 15 (cognitive intact). The resident received antipsychotic, antidepressant, and diuretic medications. The signed POS dated 3/6/13 revealed orders for Actos (antidiabetic) 45 milligrams (mg) by mouth (PO) daily and Metformin 1 gram (gm) PO twice daily (BID) for diabetes. Norvasc (antihypertensive) 5 mg PO BID for hypertension (HTN) and Cozaar 100 mg PO daily for HTN. Obtain the blood pressure weekly on Thursday and the blood glucose at 6:00 A.M. 4 times (x) weekly on Monday, Wednesday, Friday, and Sunday, and 2 hours after breakfast 3 x weekly on Tuesday, Thursday, and Saturday. The Medication Administration Record (MAR) for January 2013 revealed the BP was taken 2 out of 5 Thursdays and the March 2013 MAR lacked documentation the BP was obtained. The orders lacked documentation for BP and blood glucose	F 428		

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F 428	Continued From page 31 parameters. Record review on 4/9/13 at 8:10 A.M. revealed blood glucose were obtained as ordered for January 2013, February 2013, and March 2013. The MAR lacked documentation for parameters of when to notify the physician. The Medication Regimen Review (MRR) dated 1/13/13, 2/6/13, 3/6/13, and 4/3/13 did not identify the POS lacked parameters for BP and blood glucose monitoring. Observation on 4/9/13 at 12:00 P.M. revealed the resident ambulated independently in the hallway. Staff interview on 4/9/13 at 11:25 A.M. with administrative nursing staff D stated nursing staff should document BPs on the MAR and there were no standing orders for blood pressure parameters. Staff interview on 4/10/13 at 9:45 A.M. with direct care staff S stated she/he obtained blood pressures for residents on blood pressure medications and would notify the nurse if the blood pressure was too low or too high. Staff interview on 4/10/13 at 2:43 P.M. with licensed nursing staff L stated nursing staff monitored the BP before giving the antihypertensive medication or the BP was checked weekly. Nursing judgement was used for BP parameters. She/he stated the nursing staff documented the BP on the MAR. Staff interview 4/11/13 at 2:41 P.M. with pharmacy consultant II stated she/he reviewed the medical records for current physician orders, lab, nursing notes, physician notes, and some	F 428		

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behavioral monitoring forms, and if the physician did not provide parameters for BPs she/he referred to the accepted values depending on the resident's age.

The facility failed to provide a policy and procedure for BP monitoring for antihypertensive medications.

The facility's pharmacy consultant II failed to identify and report the lack of monitoring for the effectiveness of the antihypertensive medications and failed to obtain BP parameters for physician notification.

- The signed Physician's Order Sheet (POS) dated 3/6/13 for resident #46 revealed diagnoses of behavioral mood disorder (disturbance in a person's mood) and psychosis (any major mental disorder characterized by a gross impairment in reality testing).

The Quarterly Minimum Data Sheet (MDS) 3.0 dated 1/4/13 revealed a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). The resident received antipsychotic, antidepressant, hypnotic, anticoagulant, and diuretic medications.

The signed POS dated 3/6/13 revealed orders for Zyprexa (an antipsychotic)10 milligrams (mg) by mouth (PO) daily for psychosis, Depakote (an antiseizure) 500 mg PO daily twice a day for behavioral mood disorder, and Fluoxetine (antidepressant) 40 mg PO daily for behavioral mood disorder.

The Behavioral Monitoring forms for January, February, and March 2013 revealed a list of behaviors monitored. The form lacked which

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F 428	Continued From page 33 medications the behaviors were monitored for. The Medication Regimen Reviews (MRR) dated 1/2/13, 2/1/13, 3/6/13, and 4/3/13 failed to identify the Behavioral Monitoring forms lacked the behavioral medications monitored for effectiveness. Observation on 4/9/13 at 8:01 A.M. revealed the resident sat quietly in the dinning room and ate breakfast. Staff interview on 4/10/13 at 9:28 A.M. with licensed nursing staff K stated nursing staff should list the behavioral medications on the behavioral monitoring form. Staff interview on 4/10/13 at 9:48 A.M. with administrative nursing staff D stated nursing staff should list the behavioral medications on the behavioral monitoring form. Staff interview 4/11/13 at 2:41 P.M. with pharmacy consultant II stated she/he reviewed the medical records for current physician orders, lab, nursing notes, physician notes, and some behavioral monitoring forms, and if the physician did not provide parameters for BPs she/he referred to the accepted values depending on the resident's age. The facility's pharmacy consultant II failed to identify and report the lack of monitoring for the effectiveness of the behavioral medications the resident received. - The signed Physician's Order sheet dated 3/6/13 for resident #20 revealed diagnosis of schizoaffective disorder (a mental disorder	F 428		

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characterized by recurring abnormal mood and psychotic components), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The Quarterly Minimum Data Set (MDS) 3.0 dated 1/2/5/13 revealed a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact), and the resident received antipsychotic, antianxiety, antidepressant, and hypnotic medications.

The signed POS dated 3/6/13 revealed orders for Geodan (an antipsychotic) 80 milligrams (mg) by mouth (PO) twice daily (BID), Klonopin (a Benzodiazepine) 1 mg PO three times daily (TID), and Zyprexa (an antipsychotic) 20 mg PO daily for schizoaffective disorder.

The Behavioral Monitoring forms for January, February, and March 2013 revealed a list of behaviors monitored. The form lacked which medications the behaviors were monitored for.

Observation on 4/8/13 at 4:03 P.M. revealed the resident stood patiently in line to receive her/his medications.

The Medication Regimen Reviews (MRR) dated 1/2/13, 2/6/13, and 4/3/13 failed to identify the Behavioral Monitoring forms lacked the behavioral medications monitored for effectiveness.

Staff interview on 4/10/13 at 9:28 A.M. with licensed nursing staff K stated nursing staff should list the behavioral medications on the

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F 428	Continued From page 35 behavioral monitoring form. Staff interview on 4/10/13 at 9:48 A.M. with administrative nursing staff D stated nursing staff should list the behavioral medications on the behavioral monitoring form. Staff interview 4/11/13 at 2:41 P.M. with pharmacy consultant II stated she/he reviewed the medical records for current physician orders, lab, nursing notes, physician notes, and some behavioral monitoring forms, and if the physician did not provide parameters for BPs she/he referred to the accepted values depending on the resident's age. The facility's pharmacy consultant II failed to identify and report the lack of monitoring for the effectiveness of the behavioral medications the resident received.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		

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F 441	Continued From page 36 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility identified a census of 49 residents. The sample included 16 residents. Based on observation, record review and staff interview, the facility failed to sanitize a community counter after an unsampled resident (#50) performed a blood sugar test, and failed to properly store nebulizer masks for 2 sample residents (#35 and #24). Findings included: - On 04/05/13 at approximately 12:15 P.M., resident #50 self performed a blood glucose monitoring test. The resident stood at the nurses' station counter and stuck himself/herself with a lancet, wiped his/her finger with an alcohol wipe before and after sticking himself/herself, and placed the used alcohol wipe and the used lancet on the counter. He/she then placed blood on the blood glucose machine strip, holding his/her	F 441		

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F 441	Continued From page 37	F 441		

finger and the machine over the counter. After the results were obtained, the resident handed the blood glucose machine to administrative nursing staff D and threw away the debris from the test. No barrier was observed on the nurses' station counter between the counter and the blood glucose machine and used supplies. This area was observed until administrative nursing staff D walked away. The counter was not sanitized after the test was performed. This area was accessible by other residents and staff.

Interview on 04/08/13 at 12:15 P.M., administrative nursing staff D stated each resident had their own blood glucose machine. He/she said he/she visually inspected each unit for blood after each use. This staff said he/she used a sanitizing wipe to clean the blood glucose machines if needed.

The facility failed to provide a policy on Infection Control.

The facility failed to provide care in a sanitary manner.

- Observation on 4/4/13 at 11:30 A.M. revealed resident #35's nebulizer mask laid on the side table unbagged.

Observation on 4/9/13 at 11:07 A.M. revealed resident #35's nebulizer mask laid on the side table unbagged.

On 4/4/13 at 11:35 A.M. the resident stated nursing staff usually stored the nebulizer mask in a plastic bag.

Staff interview on 4/4/13 at 11:37 A.M. with

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F 441	Continued From page 38 licensed nursing staff J stated nursing staff should store nebulizer masks in a plastic bag after use. Staff interview on 4/4/13 at 1:10 P.M. with administrative nursing staff D stated nursing staff should store nebulizer masks in plastic bags after use. The undated policy and procedure titled Maximist and Tubing Policy revealed the staff would clean the masks every 24 hours and place in a clean plastic container. The facility failed to store the nebulizer mask in a sanitary manner. - Observation on 4/9/13 at 10:00 A.M. revealed resident #24's nebulizer mask laid on clothes in a recliner chair and a stuffed animal laid on top of the mask. The mask was not stored in a plastic bag. Staff interview on 4/4/13 at 11:37 A.M. with licensed nursing staff J stated nursing staff should store nebulizer masks in a plastic bag after use. Staff interview 4/4/13 at 1:10 P.M. with administrative nursing staff D stated nursing staff stored nebulizer masks in plastic bags after use. The undated policy and procedure titled Maximist and Tubing Policy revealed the staff would clean the masks every 24 hours and place in a clean plastic container. The facility failed to store the nebulizer mask in a sanitary manner.	F 441		

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F 497	Continued From page 39	F 497		
F 497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This Requirement is not met as evidenced by: The facility identified a census of 49 residents. Based on record review and staff interview, the facility failed to provide 12 hours of inservice training annually for the direct care staff. Findings included: - The facility provided inservice training revealed the facility since 5/2012 provided inservices on 6/24/12, 8/24/12, 9/29/12, 10/19/12, 11/30/12, 1/7/13, 1/15/13, 2/8/13, 3/22/13, and 4/5/13. Consisting of 10 hours of inservices in one year. Administrative staff A on 4/10/13 at 4:00 P.M. stated he/she could not locate any further inservice training provided by the facility. The facility failed to provide the 12 hours of inservice training annually.	F 497		
F 514	483.75(l)(1) RES	F 514		

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F 514 SS=E	Continued From page 40 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This Requirement is not met as evidenced by: The facility reported a census of 49 residents and the sample included 16 residents. Based on record review and staff interview the facility failed to maintain complete and organized resident clinical records readily accessible for resident care for 5 (#1, #23, #46, #24, #10) residents of the sample. Findings included: - On 4/9/13 at 12:13 P.M. administrative nursing staff D and administrative staff A reported all professional nursing staff did not have access to the nursing office where the medical records filing was kept prior to being placed in the clinical record. They verified if the documents were not present in the clinical record, the previous 3 months documents were stored in the nursing office and had not been filed in the clinical record. On 4/10/13 at 3:31 P.M. administrative nursing staff D reported the residents' medication	F 514		

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F 514	Continued From page 41 regimes could not be evaluated for effectiveness by the licensed nursing staff or facility consultants when the nursing office was secured after business hours. He/she acknowledged the facility had failed to complete all medical record filing for approximately 3 months due to staffing issues. During resident record review on survey the January, February, and March 2013, Medication Administration Record, Behavior Monitoring Flow Sheets, Physician's Order Sheets, and Pain Monitoring Records were not located in resident #1, #23, #46, #24, and #10's clinical record. The facility failed to maintain complete and organized clinical records readily accessible for resident care.	F 514		
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This Requirement is not met as evidenced by: The facility identified a census of 49 residents. Sample size included 5 employees. Based on record review and interviews, the facility failed to train 3 employees on emergency procedures when hired. Findings included: - Licensed nurse J's personnel file revealed a date of hire of 12/10/12. The personnel file lacked evidence the facility had trained this staff on emergency procedures when hired.	F 518		

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F 518	Continued From page 42 Administrative staff B on 4/9/13 at 4:15 P.M. confirmed he/she did not have evidence the facility had provided this nurse training on emergency procedures. The facility lacked evidence licensed nurse J received training on emergency procedures when hired. - Direct care staff O's personnel file revealed a date of hire of 12/7/12. The personnel file lacked evidence the facility had trained this staff on emergency procedures when hired. Administrative staff B on 4/9/13 at 4:15 P.M. confirmed he/she did not have evidence the facility had provided this direct care staff training on emergency procedures. The facility lacked evidence direct care staff O received training on emergency procedures when hired. - Direct care staff P's personnel file revealed a date of hire of 1/26/13. The personnel file lacked evidence the facility had trained this staff on emergency procedures when hired. Administrative staff B on 4/9/13 at 4:15 P.M. confirmed he/she did not have evidence the facility had provided this direct care staff training on emergency procedures. The facility lacked evidence direct care staff P received training on emergency procedures when hired.	F 518		