DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
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STATE SURVEY REPORT

NAME OF FACILITY: Brookdale Dover

DATE SURVEY COMPLETED: January 20, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from January 12, 2016 through January 20, 2016. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was eighty five (85). The survey sample totaled fourteen (14) residents, plus an additional six (6) sub sampled residents. **Abbreviations and definitions used in this state report are as follows:** ED – Executive Director; HWD – Health and Wellness Director; RN – Registered Nurse; LPN – Licensed Practical Nurse; NP - Nurse Practitioner; CNA – Certified Nurse's Aide; BP (Blood Pressure) –measurement of the force of blood against the walls of a blood vessel; FEMA – Federal Emergency Management System; MAR – Medication Administration Record; OCD (Obsessive-Compulsive Disorder) – type of anxiety disorder leading to doing something repeatedly; OT (Occupational Therapy) - therapy to maintain/improve functional use of the body; PT (Physical Therapy) – rehabilitation to heal injuries and/or improve function/mobility; PRN – as needed; TAR – Treatment Administration Record;	**Administrators Plan for Correction** This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors.	

Provider's Signature Mary F Brandorff Title Executive Director Date 3/7/16

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	UAI (Uniform Assessment Instrument) – a standardized resident assessment tool used in Assisted Living facilities; Ambulate – to walk around; Anxiety – unpleasant state of feeling worried, nervous or restless; Cognitive/Cognition – mental process, thinking; Contracture – tightening and shortening of muscles causing restricted movement of a joint; Cueing – verbal instruction or encouragement; Dementia - brain disease that causes difficulty with memory and decision making; Claire Bridge Unit – secured, locked unit for residents with memory impairment; Elopement – walks away unnoticed; Ensure – nutritional supplement drink; Episodic Agitation – periods of restlessness or worry; Flexed Hand – closed fist; bent inward with fingers toward the palm; Hoarding – collecting a large amount of things and unable to get rid of them; Hospice – service that provides care to residents who are terminally ill; Passive Range of Motion – assistance with moving and stretching muscles to straighten out the joint; Psychosocial – dealing with mind, behavior and social relations; Sub-Sample (SS) – additional residents reviewed for a specific care area; Traumatic Brain Injury – brain damage. **Regulations for Assisted Living Facilities**		

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3225 3225.5.0 3225.5.1	**General Requirements** **All written information provided by the assisted living facility including the written application process shall be accurate, precise, easily understood and readable by a resident, and in compliance with all applicable laws. If an applicant is rejected the facility shall provide clear reasons for the rejection in writing upon request.** **This requirement is NOT MET as evidenced by:** Based on review of facility information, it was determined that not all written information provided by the facility was accurate. A marketing folder used for prospective residents included inaccurate information about RN staffing and facility ownership. Findings include: On 1/19/16 at 8:45 AM, a marketing folder was found on the table where the survey team was working. The folder contained a form with the name of an individual planning to take a pre-admission tour of the facility. An undated cover letter inside this folder included an inaccurate statement indicating that the facility had twenty-four hour a day, seven days a week RN care. The letter also erroneously referred to a previous corporate owner of the facility. On 1/19/16 at 1:15 PM, E2 (HWD) confirmed to the surveyors that the statement about RN care twenty-four hours a day, seven days a week and reference to the previous corporate owner were inaccuracies in the letter that needed to be corrected. These findings were reviewed with E1 (ED) and E2 (HWD) on 1/20/16 at approximately	3225.5.0/3225.5.1 **All written information provided by the assisted living facility including the written application process shall be accurate, precise, easily understood and readable by a resident, and in compliance with all applicable laws. If an applicant is rejected the facility shall provide clear reasons for the rejection in writing upon request.** **I. Corrective Action** The Marketing Packet letter was revised on 1/19/16 to exclude 24 hour a day, 7 day a week RN Care information and updated with current ownership information. (Attachment A) **II .How to identify other residents** An audit of all current Marketing Packets was completed by the Executive Director /designee to verify that no other packets contained old information related to previous ownership, or references to inaccurate staffing claims. Old Packets have been removed and destroyed, updated packets are now present. **III. Systemic Changes** All Marketing Packet letters were changed to reflect above revisions on 1/19/16. The new letter has been saved for future utilization. The Sales and Marketing Director was re-educated by the Executive Director regarding the contents of the Marketing Packet. **IV. Monitoring/QA** To prevent recurrence, each individual Marketing letter will be signed the Executive Director before being	

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3225.5.5	2:40 PM. **The assisted living facility shall develop and adhere to policies and procedures to prevent residents with diagnosed memory impairment from wandering away from safe areas. However, residents may be permitted to wander safely within the perimeter of a secured unit.** **This requirement is not met as evidenced by:** Based on review of policies and procedures, observations and staff interviews, it was determined that the facility failed to develop and adhere to policies and procedures to prevent residents with diagnosed memory impairment from wandering away from safe areas. An unlocked, unalarmed exterior door was found by the surveyors on the initial tour of the facility on 1/12/16. Subsequent review of policies and procedures along with staff interviews failed to identify established policies and procedures related to door alarms for the facility's exterior doors outside of the facility's locked unit. Findings include: **1.** During the initial tour of the facility on 1/12/16 at 10:10 AM, the exterior door on the south side of the facility in the assisted living section was opened by the surveyor with no alarm sound heard. A small white box surrounded by dust webs was observed on the door frame above the door. E5 (Maintenance Director) was coming down the hall and when asked by the surveyor about the lack of a door alarm, E5 replied that the door was not required to be alarmed and that the battery alarm on the door frame was probably deactivated. Observations revealed a busy 5-lane road with traffic not far from the door along with a pink sign taped to the door indicating that effective October 29, 2010 the	distributed to potential residents, families, professional business referrals. **V. Completion Date** January , 19,2016 **3225.5.5** **The Assisted Living Facility shall develop and adhere to policies and procedures to prevent residents with diagnosed memory impairment from wandering away from safe area. However, residents may be permitted to wander safely within the perimeter of a secured unit.** **I. Corrective Action** 1. Alarms for the doors were ordered, obtained and activated on 1/14/16 by the Maintenance Director. Attachment B. 2. R1 was transferred to the Memory Care Unit on 1/14/16. **II. How to Identify Other Residents** 1.A Collaborative Care meeting was led by the ED on 2/24/16 and attended by the interdisciplinary team to review the elopement risk status of community residents to verify appropriate placement and to verify service plans are in place to meet needs. (See attendance record).	

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	door would be alarmed 24 hours a day for the safety of residents. At 1:40 PM, E2 (HWD) stated to the surveyor that she was uncertain whether the door should be alarmed, however E1 (ED), when asked, stated that the door should have a functioning alarm. Clinical record reviews beginning on 1/12/16 revealed that memory impaired residents, including but not limited to R1 and SS2, resided in the assisted living section of the facility. On 1/15/16 at 11:08 AM, the surveyor checked the door and an alarm sounded, however, the alarm shut off as soon as the door closed. E2 was nearby and stated that the alarm should have stayed on until deactivated by a staff member and that she would address this with E5. The surveyor then discussed the alarm with E1 who stated she would place an order for a new alarm device to be installed as soon as it was received. Staff interviews revealed that at times the front door to the facility was not locked, alarmed, or attended (within line of vision of concierge / receptionist). For example, on 1/17/16 at 4:29 PM, E11 (CNA /concierge) stated that her shift at the reception desk ended at 5:00 PM and the front door of the facility would be locked by the nurse around 9:00 PM. On 1/20/16 at approximately 1:15 PM, E2 explained to the surveyor that the front door was generally locked by the nurse around 7:00 PM or 8:00 PM and the concierge left at about 5:30 PM. E2 stated that the front door was not alarmed. When asked if any residents were at risk for elopement from the facility, E2 replied that generally speaking all of the residents were at risk. Specifically, survey record review and observations confirmed that R1 and SS2 were memory	**III. Systemic Changes** 1. Alarms on the doors will be inspected monthly by the Maintenance Director monthly and documented. Attachment C. 2. The facility will conduct monthly Collaborative Care Meetings to discuss residents who have the potential for elopement. The associates have been provided education on Brookdale's Missing Resident Policy and Procedure. In the event changes of condition are noted by any associate indicating exit-seeking is occurring, the associate will notify the ED or HWD immediately in order to adequately address the safety needs of the resident. Routine Missing Resident Drills will be conducted per policy and documented by Maintenance . The front door will be locked at 7pm each night prior to the residents who are on the day program in Clare Bridge return to their room in Assisted Living. **IV. Monitoring/QA** 1. Safety Inspection Checklist will be completed monthly, by the Maintenance Director the results will be reported to the Safety Committee. 2. The Collaborative Care notes will be reviewed during QA to determine trends. The ED will direct additional corrective action, based on findings. **V. Completion Date** 3/15/16	

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	impaired residents who spent days on the locked unit of the facility for their safety but continued to have rooms and spend evenings and nights in the assisted living section of the facility. The surveyors were informed at the exit conference on 1/20/16 at approximately 2:40 PM that the facility policy requiring alarmed doors only applied to the locked memory care unit. Consequently, the facility lacked a written policy and procedure to prevent all memory impaired residents from wandering away from safe areas. **2.** Facility reported information to the State Survey Agency revealed that on 10/9/15 at approximately 5:00 PM, R1 left the facility without staff knowledge and happened to be found by E12 (Concierge) and E13 (Activities Director) who had left work for the day and were on their way home. R1 was found down the road from the facility in the parking lot of a bank. On 1/20/16 at approximately 1:15 PM, E2 told the surveyor that the facility did not know what door R1 had left from. E2 stated that R1 immediately started spending waking hours on the locked unit in response to this elopement, however, no systemic change to ensure that all residents were prevented from wandering away from safe areas were identified by E2 or found in facility investigation documents of this incident. As of the time of the survey, over 3 months after R1 eloped, existing risks for resident elopement remained unidentified and unaddressed by facility staff for example unalarmed doors. These findings were reviewed with E1 and E2 on 1/20/16 at approximately 2:40 PM.		
3225.8.0	**Medication Management**		

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3225.8.1 3225.8.1.1	**An assisted living facility shall establish and adhere to written medication policies and procedures which shall address:** **Obtaining and refilling medication.** **This requirement is not met as evidenced by:** Based on record review, observation, and interview it was determined that the facility failed to establish and adhere to written medication policies and procedures for refilling pain medication for one (R7) out of 14 sampled residents. Findings include: Facility policy entitled "How to Order Medications" issued April 2011 with no revision date indicated that: - If the cycle refill is not available when the resident's medication supply reaches 7 days, fax a refill request to the pharmacy. - Contact the pharmacy by phone if the newly ordered/refilled medication does not arrive in a timely manner. 12/4/15 (1:40 PM) nurse's note documented that during a doctor's visit, R7 received a written prescription to refill pain medication patches. A copy of the prescription in the record indicated the facility faxed it to the pharmacy on 12/4/15 at 1:35 PM. 12/16/15 (11:00 PM) nurse's note documented a request for a "hold order" (a physician's order to withhold a medication temporarily) for R7's pain medication patch since the pharmacy required a prior authorization note from the physician. 12/17/15 (5:00 PM) nurse's note documented the need for a prior authorization, and that a follow up call was made to the physician who R7 received the prior authorization form on 12/4/15 but had not filled out the form, and also that a call was made to pharmacy.	**3225..8.1/3225.8.1.1** **An Assisted Living facility shall establish and adhere to written medication policies and procedures which shall address; Obtaining and refilling medication.** **I. Corrective Action** R7's medication was received 12/20/15. **II. How to Identify Other Residents** A medication cart audit was completed by a nurse to verify med availability for residents by comparing meds on hand to the current MAR All residents receiving medications that require prior authorization will be reviewed by the pharmacy and Health and Wellness Director to verify and complete additional action as required. **III. Systemic Changes** The pharmacy will provide a monthly report of these residents who will be requiring a prior authorization. A binder with Prior Authorizations will be kept in the Wellness Center, the nurses will review daily for follow up and notify the physician accordingly. Nurses will be re-inserviced by the HWD/Designee, on Availability of Medications Policy and Re-ordering of Medication Process. Attachment D. **IV. Monitoring/QA** Executive Director and Health and Wellness Director will audit the binder for completion monthly and will report trends and recommendations to the Quality Assurance Committee for review to verify identified areas have been addressed.	

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	12/17/15 (10:45 PM) nurse's note documented that the pharmacy called to report that the prior authorization was received; however R7's insurance company now needed a medical necessity form to be completed by the physician, which could possibly be a 3 – 5 day process. At that time R7 was showing signs and symptoms of withdrawal as evidenced by "R7 had complaints of chills and sweats" and a request was made for medication to treat the withdrawal symptoms. 12/18/15 (9:50 AM) physician order included a medication for withdrawal symptoms to be taken daily for seven days. 12/19/15 (4:12 PM) nurse's note documented that R7 obtained, and gave the facility, the completed medical necessity form to be faxed to the insurance company for approval of the medication patch. Review of R7's December, 2015 MAR indicated that the prescribed pain medication patch, ordered every other day, was not given on 12/16, 12/18, and 12/20, for a total of three missed administrations. On 12/18/15 a medication error was reported by the facility to the State Agency, which alleged the resident missed pain medication due to an incomplete prior authorization and needing insurance approval. 12/22/15 (8:45 PM) nurse's note documented that R7's pain medication patches were received. 1/20/16 (10:11 AM) during an interview with E2 (HWD), who stated on 12/4/15 when the prescription was faxed to the pharmacy R7 had 1 box of medication patches containing 5 patches, which would last ten days. E2 confirmed that the facility did not follow up on R7s prescription (after it was faxed to the pharmacy on 12/4/15) until 12/16/15 when	**V. Completion Date** 3//15/16	

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	there was no medication left. E2 also confirmed that the facility did not have a policy or system in place to prevent residents from missing medications if prescriptions were not filled in a timely fashion. The facility failed to follow-up with the pharmacy or physician regarding the prior authorization and/or insurance approval during the ten days when the resident still had pain patches available for use. This failure resulted in the resident experiencing withdrawal symptoms from the sudden discontinuation of this pain medication. These findings were reviewed with E1 (ED) and E2 on 1/20/16 at approximately 2:40 PM.		
3225.8.1.5 3225.8.1.5.3	**Provision for a quarterly pharmacy review conducted by a pharmacist which shall include:** **Review of each resident's medication regimen with written reports noting any identified irregularities or areas of concern.** **This requirement is NOT MET as evidenced by:** Based on record review and interview, it was determined that the facility failed to follow-up on concerns found during quarterly pharmacy reviews for two (R3 an R11) out of 14 sampled residents. Findings include: **1. Review of R3's clinical records revealed:** During the quarterly pharmacy reviews dated 3/21/15, 6/25/15, 9/24/15 and 12/23/15 completed for R3, the pharmacist identified areas of concern that PRN medications lacked a reason for when to administer the medications. There was no evidence in R3's clinical record	**3225.8.1.5/3225.8.1.5.3** **Provision for a quarterly pharmacy review conducted by a pharmacist which shall include;** **Review of each residents medication regimen with written reports noting any identified irregularities or areas of concern.** **I. Corrective Action** R3 and R11's pharmacy reviews and recommendations were re-examined by the HWD/Designee and recommendations were physician to obtain necessary documentation. This was completed on communicated to the 1/20/16. **II. How to Identify Other Residents** The Pharmacy review dated 12/23/15 has been reviewed by the Health and Wellness Director to determine necessary follow up. All follow up completed by 3/1/16.	

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	that these concerns were addressed by the ordering physician or that the facility nursing staff attempted to clarify the medication orders of concern. Medication orders were reviewed by facility nursing staff monthly and the orders consistently omitted the reasons for administration of some PRN medications. **2. Review of R11's clinical record revealed:** During the quarterly pharmacy reviews dated 3/21/15, 6/25/15, 9/24/15 and 12/23/15 completed for R11, the pharmacist identified areas of concern that PRN medications lacked a reason for when to administer the medications. There was no evidence in R11's clinical record that these concerns were addressed by the ordering physician or that the facility nursing staff attempted to clarify the medication orders of concern. Medication orders were reviewed by facility nursing staff monthly and the orders consistently omitted the reasons for administration of some PRN medications. Interview with E2 (HWD) on 1/19/16 at 10:00 AM confirmed that the facility had no policy or procedure for following up on medication concerns addressed during pharmacy reviews. These findings were reviewed with E1 (ED) and E2 on 1/20/16 at approximately 2:40 PM.	**III. Systemic Changes** All pharmacy reviews will be placed in a binder and reviewed daily by the nurse to maintain compliance. The nurses will be re- inserviced on the above process by the HWD/designee. **IV. Monitoring/QA** The Executive Director and or designee will audit the Pharmacy Review quarterly and report compliance to the Quality Assurance compliance meeting until substanital compliance has been met as determined by the QA Committee. **V. Completion Date** 3/8/16	
3225.12.0 3225.12.1 3225.12.1.3	**Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code.** **This requirement is not met as evidenced by:** Based on observation it was determined that the facility failed to comply with several areas	**3225.12.0** **3225.12.1** **3225.12.1.3** **3225.12.13** **The Assisted Living facility shall ensure that the residents service agreement is being properly implemented.**	

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	of the Delaware Food Code by: - storing food in a freezer without a package, cover or wrapping; and - using single use gloves for more than one task. Findings include: **1. Delaware Food Code 3-302.11 Packaged and Unpackaged Food – Separation, Packaging, and Segregation.** **(A) FOOD shall be protected from cross contamination by:** **(4) Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of this section, storing the FOOD in packages, covered containers, or wrappings;** An observation was made on 1/13/16 at 1:45 PM on the Claire Bridge Unit when one uncovered bowl of ice cream was found in the freezer. The facility stored food in a freezer without a package, cover or wrapping. **2. Delaware Food Code 3-304.15 ... single use gloves shall be used for only one task such as working with ready-to-eat food...and must be then discarded when damaged or soiled, or when interruptions occur.** 1/14/16 (12:19 PM) lunch observation on the Claire Bridge Unit revealed E9 (CNA) was observed wearing a pair of single use gloves. At 12:23 PM E9, wearing the same gloves, touched the back of a resident's chair to move the resident closer to the table. At 12:24 PM E9 picked up the telephone receiver wearing the same gloves. At 12:26 PM E9 removed a piece of cornbread from the serving container with the now contaminated gloves and placed the cornbread on R14's plate. E9 then served	**I. Corrective Action** 1. The ice cream was removed immediately by the Clare Bridge Director and discarded on 1/13/16. 2. Staff member was re- inserviced by the HWD that gloves are to be worn for single use only. 1/22/16. **II. How to Identify Other Residents** 1. The Clare Bridge kitchen was surveyed for non-compliance with standard by the Clare Bridge Director on 1/13/16. **III. Systemic Changes** 1. Daily inspection of the Clare Bridge kitchen and monitoring of staff wearing gloves will be completed by the Clare Bridge Director. 2. All staff will be in-serviced that gloves are to be worn for single use only. Attachment E. **IV. Monitoring/QA** Clare Bridge Director will report compliance to the QA Committee quarterly until substantial compliance is met and determined by the QA Committee. **V. Completion Date** 3/15/16	

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	R14's lunch plate with the contaminated cornbread. E9 then touched the lip (drinking surface) of R14's cup with the same contaminated gloves to reposition the cup on the table. The facility failed to serve food in a sanitary manner when E9 used a pair of single use gloves for multiple tasks, including touching ready-to-eat food and the drinking surface of R14's cup. These findings were reviewed with E1 (ED) and E2 (HWD) on 1/20/16 at approximately 2:40 PM.	**I. Corrective Action** R1, R8, and R10's Service Plans have been implemented. R1's hearing aid is in place on 1/20/16. R8's blood pressure was obtained by the nurse on 1/20/16. R10's weight was obtained by the nurse eon 1/20/16. **II. How to Identify Other Residents** An audit of current resident Medication Administration Records and Treatment Administration Records will be completed by the Executive Director and the Health and Wellness Director to verify orders are being followed and appropriately documented. Holes will be investigated by the HWD/Designee and documented accordingly. **III. Systemic Changes** The Nurses will be re- inserviced by the HWD on the current Brookdale Medication and Treatment Administration policy and the importance of recording weights, blood pressures, and hearing aids in the MAR and TAR. **IV. Monitoring / QA** The Executive Director and/ or designee will audit the MAR and TAR weekly to verify compliance. In the event non-compliance is noted, the ED will direct additional corrective action, up to and including termination, for repeated omissions or adverse findings. Findings will be reported to the QA Committee monthly until substantial compliance is met by the QA Committee **V. Completion** 3/31/16
3225.12.3	**The assisted living facility shall ensure that the resident's service agreement is being properly implemented.** **This requirement is not met as evidenced by:** Based on record review and interview it was determined that the facility failed to implement the service agreements for three (R10, R8 and R1) out of 14 sampled residents by failing to: - obtain weekly weights for R10; - obtain weekly blood pressure for R8; and - implement hearing aids for R1. Findings include: **1.** R10's 3/12/15 physician orders included obtaining the resident's weight weekly to monitor for weight loss. 10/5/15 Individualized Service Agreement included R10's weekly weights. Review of September through December, 2015 TARs found missing weights on 9/3/15, 10/1/15, 10/15/15 and 10/26/15. 1/19/16 interview at 10:00 AM revealed that E7 (LPN) stated the weights should be recorded on the TAR, but they could also be on the monthly weight sheet in E2's (HWD) office.		

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	1/19/16 during an interview at 11:40 AM, E2 confirmed the missing weights on the TAR and reviewed the monthly weight records. Since there were no dates recorded for when the monthly weights were obtained, it could not be determined if any of the monthly weights corresponded with the missing weights on the TAR. The facility failed to obtain R10's weekly weights on 4 out of 13 occasions (30.7%) from September through December, 2015. **2.** R8's 12/15/15 physician orders included obtaining a blood pressure weekly. chart review revealed: * December, 2015 TAR was missing a blood pressure on 12/26/15. Both of the January, 2016 BPs were recorded. * Nursing notes did not include a recorded blood pressure around the date of the 26th. * Individualized Service Agreement from November, 2015 was not in the resident's record. 1/19/16 during an interview at 10:20 AM, E8 (LPN) stated the BP should be written on the MAR when asked about the missing BP. 1/19/15 during an interview at 11:50 AM, E2 (HWD) confirmed the missing BP and stated if it was not written in a nursing note then it was not obtained. 1/20/16 at 11:58 AM – E2 presented the surveyor with a copy of the service agreement (dated 11/30/15) that was awaiting POA signature. E2 confirmed this service agreement was not revised to include the weekly BP checks ordered 12/15/15. E2 commented that she does not revise service agreements for minor things like that. The facility failed to obtain a BP for R8 on 1 out of 4 occurrences (25%) in December,		

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	2015 and January, 2016. **3.** R1 had a physician's order originating on 1/25/15 for bilateral hearing aids to be put in by staff in the morning and removed at bedtime and to be stored in the medication cart at night. A UAI dated 5/4/15 documented that R1 was hard of hearing and had bilateral hearing aids which the nurse would store in the medication cart at night. This UAI documented that R1 was forgetful with intermittent confusion. A service agreement dated 5/4/15 contained conflicting information by stating in one place that R1 used her hearing aids independently (without staff assistance) while also including a notation that effective 11/4/15 staff would provide assistance with the hearing aids. Review of TARs revealed that from June, 2015 through November, 2015 staff circled their initials to indicate that R1's hearing aids were not in use. In December, 2015 the section on the TAR for R1's hearing aid use was yellowed out with a highlighter meaning cancelled. The January, 2016 physician's orders, however, continued to include an order for bilateral hearing aids daily. Multiple nursing notes documented the missing hearing aids including 5/4/15 (10:45 AM), 7/6/15 (9:40 PM), and 8/9/15 (9:41 PM). The clinical record lacked evidence of efforts to locate the hearing aids at the time they were first lost; communication with R1's family about options to replace the hearing aids; or instructions for staff on how to best communicate with R1 who required hearing aids but no longer had them. The service agreement in effect at the time of the survey (along with a physician's order) was not being implemented due to the loss of R1's hearing		

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	aids at least 7 months earlier. These findings were reviewed with E1 (ED) and E2 on 1/20/16 at approximately 2:40 PM.		
3225.12.6	**In accordance with the service agreement, the assisted living facility shall be responsible for facilitating access to appropriate health care and social services for the resident.** **This requirement is not met as evidenced by:** Based on record review, staff interviews, and other interviews as indicated, it was determined that for one (R4) out of 14 sampled residents, the facility failed to facilitate access to appropriate social services. As of the time of the survey in January, 2016, R4, with advanced dementia, was residing on the locked memory care unit. There was no emergency contact, responsible party, or legal guardian identified in R4's clinical record. R4 signed admission papers in 2013 for the assisted living facility, however, when R4's condition declined due to progressive dementia, the facility failed to provide appropriate social services to identify a legal guardian or responsible party for R4. Findings include: According to the last annual UAI for R4 dated 4/13/15, R4 had impaired cognition and was unable to sign. A service agreement dated 10/1/15 for R4 included documentation that R4 had no Power-of-Attorney or Guardian. The name of a financial manager was found in the clinical record and during an interview on 1/15/16 at 1:15 PM, E20 (Financial Manager Volunteer) stated to the surveyor that she was a volunteer in a money management program for seniors and she ensured that R4's bills were paid. E20 explained that she had no other role in R4's	**3225.12.6** **In accordance with the Service Agreement the Assisted Living facility will be responsible for facilitating access to appropriate health care and social services for the resident.** **I. Corrective Action** R4's application for a Public Guardian has been submitted. 2/1/16 . Attachment F. The Executive Director/Designee will be responsible for ongoing communication and follow-up with the appropriate entities, agents and agencies until guardianship is in place. **II. How to identify other residents** An audit by the ED/Business Office Manager was conducted on all current residents to verify there is a Power of Attorney, Guardian, and or Health Care Surrogate of some sort assigned for any resident who is memory impaired and has no current responsible party designation 2/16/16. **III. Systemic Changes** The Sales and Marketing Manager and Business Office Manager have been re-educated by the ED regarding the need to verify and document information regarding responsible parties, Healthcare Representatives, Powers of Attorney and/or guardianship designation prior to move-in. The ED/Designee will be responsible for reviewing move-in paperwork at the time of move-in. Residents will be reviewed at least monthly in Collaborative Care meeting to review for changes in condition that may indicate the need to implement a POA or guardian and the ED will be responsible for directing this process.	

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	care but was able to provide the surveyor with the name of a "case manager". At the exit conference on 1/20/16 at approximately 2:40 PM, E1 (ED) stated that it was the facility's understanding that a Public Guardian was not an option for R4 due to the fact that she had a living, although uninvolved, daughter. A series of phone calls made by the surveyor to State social service agencies to inquire about R4 following the exit conference determined that the State Office of the Public Guardian had accepted R4 in July of 2013 to begin the guardianship process, however, there had been no follow-up contact by the facility or any other State agency and no guardianship action was taken. Consequently, R4 had been without any responsible party, emergency contact, or legal guardian despite advanced dementia. The facility failed to ensure that social services were provided to R4 when she was no longer able to participate in her care and decision making to identify a responsible party or guardian. These findings were reviewed with E1 and E2 on 1/20/16 at approximately 2:40 PM.	**IV. Monitoring/ QA** The results of the Collaborative Care Review in regards to the need for Public Guardianship of current residents will be reported by the Executive Director to the QA Committee. **V. Completion Date** 3/15/16	
3225.13.0	**Service Agreements**	**3225.13.0/3225.13.2/3225.13.2.2/3225.13.5 Service Agreements**	
3225.13.2	**The service agreement or contract shall address the physical, medical, and psychosocial services that the resident requires as follows:**		
3225.13.2.2	**Services provided by licensed nurses.** Based on record review, staff interviews, and observations, it was determined that for one (R4) out of 14 sampled residents reviewed the facility failed to address in the service agreement the services to be provided by licensed nurses to address R4's contracture		

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	of the right hand. R4 received rehabilitation services in 2015 to address her right hand contracture. No services, however, were identified in her service agreement for the facility nursing staff to provide between therapy sessions. A palm protector (a splint like device to hold the hand in a normal position and protect the palm from bent fingers making contact) was ordered in May of 2015, however, use of the palm guard was not added to the service agreement and the device was lost at an unknown time by August, 2015. On 1/11/16, rehabilitation services to address R4's contracted right hand were again initiated, seven months after the palm protector ordered for a hand contracture was lost in the facility. No nursing services to address the contracture or palm protection were included by the facility in the service agreement for R4 so that all staff was aware of what care to provide and to ensure that the contracture did not worsen. Findings include: Review of the clinical record revealed R4 resided in the facility since 2013. Observations on 1/15/16 at 1:11 PM revealed that R4's right hand appeared abnormal with three fingers curled into her palm (nearly making contact with the palm surface), her right index finger appearing fixed and raised while her thumb was extended straight. According to rehabilitation documentation not found in the clinical record but obtained for the surveyor by E2 (HWD) upon request, OT services were provided to R4 in early 2015 to address her right hand contracture. In addition, email communication between E2 and the rehabilitation services provider were provided to the surveyor for review. The following documentation regarding R4's right hand contracture and need for services related to her right hand contracture was	**I. Corrective Action** 1. R4's palm protector was discontinued on 1/20/16 and Service Agreement updated to reflect current orders. 2. R11 was seen by the psychiatrist on 2/4/16. Medication changes were made. **II. How to Identify other Residents** A Collaborative Care Meeting was conducted by the ED on 2/24/16 and the appropriate interdisciplinary team members were in attendance. Residents were reviewed for adaptive equipment needs or other changes in condition that would indicate the need to update the Service Agreement. Residents exhibiting behavioral expressions were reviewed. **III. Systemic Changes** Staff will be re- inserviced on the policy on Managing Resident Behaviors. Attachment G. Service Agreements will be reviewed by the HWD/designee and updated every six (6) months and as needed for change of condition. Therapy notes will be available in the Wellness Center for review by the Health and Wellness Director ,and progress will be reviewed at least monthly in Collaborative Care meeting. **IV. Monitoring/QA** Executive Director or designee will audit records of residents with adaptive devices and residents with hoarding and disruptive behaviors quarterly and review with therapy and psychiatric services until substantial compliance is met as determined by the QA Committee. **V. Completion Date** 3/25/16	

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	found: - 3/12/15 email discussion between E2 and rehabilitation staff related to pre-medicating R4 before therapy sessions to address pain, using a warm washcloth and massage to loosen her hand, and use of a hand roll to stretch the hand such as a washcloth; - 3/17/15 Difficult and painful for R4 to open right hand, requires passive range of motion (assistance with moving and stretching hand); - 3/24/15 Trial of washcloth rolled in hand to keep hand open but hand so tight that a smaller cloth would have to be used, slow prolonged stretching of hand needed; - 4/2/15 Possible splint or rolled up washcloth needed in hand to prevent further contracture; - 4/2/15 email to E2 from rehabilitation provider indicating that a rolled washcloth did not fit in R4's hand due to the contracture and only a small piece of a washcloth would fit; - 4/21/15 Able to tolerate slow stretch of right hand but will holler in pain at times; - 4/23/15 R4 and staff trained to keep rolled washcloth in hand as long as possible, staff told of importance of keeping ¼ of rolled washcloth in palm; - 5/15/15 R4 now has a palm protector on order to keep right hand open to prevent further contracture; - 5/22/15 email to E2 from rehabilitation provider indicating that R4's tolerance of the palm protector was being worked on and was up to an hour to an hour and a half; and - 6/16/15 OT services to be discontinued, palm protector tolerance by R4 at 4 hours of use, PT to continue and address any issues. A review of TARs for R4 revealed that in August, 2015 the palm guard was used sporadically with most entries consisting of circled initials meaning it was not used. In September, 2015, the palm guard was rarely used with entries made that it was not		

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	available or unable to be located. For October, 2015 through December, 2015 the palm guard was not used due to being missing. On 1/5/16 a physician's order was written for OT to evaluate R4's right hand. According to the OT evaluation completed on 1/11/16, R4's right hand was fully flexed, her thumb was hyperextended (stretched) due to "prolonged pressure" with staff reporting that they had been able to extend all of her fingers two weeks prior to complete hand washing. OT documented that R4's right hand contracture was worsened making it very difficult for staff to wash her hand and that OT was consulted for contracture management and education strategies to reduce contracture and restore hand use. The OT wrote that the worsened contracture was new for R4. A post-exit interview conducted with E6 (Memory Care Unit Program Director) on 1/26/16 at 9:00 AM revealed that the palm protectors for R4 had arrived In May or June, 2015 as a package of 3 or 4 and that she still had one in her office. E6 explained that she was not a nurse and she was not aware of why the palm protector use had stopped and that no one had asked her if she had a palm protector available. Interview with E19 (OT) on 1/26/16 at 9:25 AM revealed that the purpose of the palm protector was to keep R4's hand open and to prevent the contracture from getting worse. The facility failed to ensure that R4's service agreement identified what nursing services, including palm protector use as ordered, would be provided to R4 to address her identified hand contracture. These findings were reviewed with E1 (ED)		

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	and E2 on 1/20/16 at approximately 2:40 PM.		
3225.13.5	**The service agreement shall be developed and followed for each resident consistent with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.** **This requirement is not met as evidenced by:** Based on record review and interview it was determined that for one (R11) out of 14 sampled residents, the facility failed to develop and follow an individualized service agreement which addressed R11's unique psychosocial needs. Findings include: Review of R11's record revealed the resident was admitted on 6/8/2008 with diagnoses including Traumatic Brain Injury, Stroke after a ruptured brain blood vessel, Mood Swings, Anger, Anxiety, OCD, Episodic Agitation and a history of drug and alcohol abuse. R11's personal service plan (updated 12/17/15) included behavior concerns related to anger outbursts, tearfulness, yelling, hoarding objects/food in apartment. Management of these behaviors included, but are not limited to, approach resident with a gentle voice and expression to tell the resident that he/she is safe and cared for; redirect resident to their most familiar and comfortable area of the community if disruptive to others; use a positive physical approach (for example go slow, make eye contact, get down low). This service plan did not identify behavior plans that were in place to address R11's behavior and disruption to other residents in the facility. Review of the Behavior Plan originally dated 12/11/12 and reviewed 12/17/15 included the concern of R11's anger outbursts, tearfulness		

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	and yelling which were possibly triggered by R11's communication difficulties. The Behavior Plan's interventions included: encourage resident to use electronic communication device; encourage resident to slow down when trying to communicate; listen to resident and allow her to express feelings in appropriate manner; do not disturb 9pm-7am. The Behavior Plan was reviewed on 12/17/15 and revealed that R11 continues to have anger outbursts, tearfulness and yelling at staff because they can't understand; refuses to use communication device; throws things at times and stated R11 was followed by psych [psychiatry]. The facility failed to identify other interventions after the resident refused to use a communication device. Review of an additional Behavior Plan originally dated 12/16/13 and reviewed 12/17/15 included the concern of R11's hoarding objects and food in her apartment. The goal of this plan was that R11 would maintain socially acceptable apartment appearance. Interventions included: educate resident on socially acceptable standards; educate resident on fall risks related to clutter; educate resident on health risks related to keeping food for extended periods of time; educate resident on proper food storage practices; and return items to the appropriate places whenever possible (such as dishes & napkins to kitchen). Reviews of Behavior Plan dated 12/15/14, 6/17/15 and 12/17/15 revealed R11 continued to hoard objects in her apartment and resident refused assistance with cleaning apartment. The facility failed to identify new approaches to manage resident's hoarding behavior. All documentation was initialed and signed by E2 (HWD). Review of psychiatric notes by E10 (Psychiatric NP) revealed at least monthly visits (6/20/15, 7/26/15, 8/19/15, 8/31/15,		

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	9/10/15, 10/8/15, 12/17/15, 12/31/15) to R11. Documentation was lacking evidence that E10 addressed R11's behavior issues which continued in spite of monthly visits to E10. Interview with E10 on 1/14/15 at 2:30 PM confirmed that R11 had behavior issues that can disrupt other residents and staff. E10 reported that during her visits with R11, R11 displays agitation and will use nonverbal gestures as a way to dismiss the conversation. There was no evidence in the record that a psychiatrist was asked to evaluate R11's psychosocial needs or that new interventions were initiated. The facility failed to develop individualized interventions to address R11's disruptive and hoarding behaviors. These findings were reviewed with E1 (ED) and E2 on 1/20/16 at approximately 2:40 PM.	**3225.16.0/3225.16.2 Staffing** **I. Corrective Action** One Certified Nursing Assistant has been hired for the 3pm-11pm shift. Attachment H. **II. How to Identify Others** All Clare Bridge residents are affected. **III. Systemic Changes** Staffing will be monitored daily by the Executive Director utilizing the Service Alignment Program. This program assists in monitoring acuity levels of each resident. Staffing will be adjusted according to acuity level and census. **IV. Monitoring/QA** Executive Director will report to the QA meeting to determine appropriate staffing levels quarterly. **V. Completion Date** 3/31/16	
3225.16.0 3225.16.2	**Staffing** **A staff of persons sufficient in number and adequately trained, certified or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations.** **This requirement is not met as evidenced by:** Based on review of staffing records, staff interviews, review of clinical records, and observations, it was determined that the facility failed to have a staff sufficient in number to meet the requirements of the residents. The facility had a secured (locked) memory care unit (Claire Bridge Unit) occupied by cognitively impaired residents. Information provided to the surveyors revealed that approximately half of these residents had moderate to advanced		

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	cognitive impairment. A Programming Skills Evaluation Summary completed by facility staff on 1/9/16, and provided to the surveyor upon request, revealed that of 21 residents on this unit, eleven (52%) had moderate to advanced dementia symptoms. Staffing on the locked unit was routinely two CNAs for approximately 24 residents on the 3:00 PM to 11:00 PM shift. Record review, staff interviews, and observations revealed that two CNAs were not sufficient to meet the care and safety needs of the residents. Findings include: **1.** Upon surveyor request on 1/19/16, the surveyors were provided with a list of which residents on the Claire Bridge Unit, required staff assistance with toileting and feeding. A list of 24 permanent residents of the locked unit was provided by E2 (HWD) who noted on the form that 15 of 24 (63%) of the residents required staff assistance with toileting and 21 of 24 (88%) required cueing (verbal instruction or encouragement) or assistance with feeding. Review of Daily Assignment Sheets for 1/6/16 through 1/17/16 revealed that routine staffing on the Claire Bridge Unit for the 3:00 PM to 11:00 PM sheet was two CNAs. Each CNA had a half hour meal break according to the staffing sheet meaning that for one hour each evening (generally 6:30 PM to 7:30 PM) there would be one CNA for all 24 cognitively impaired residents. **2.** On 1/17/16 at 3:40 PM, E14 (CNA) was observed to be the only staff member on the Claire Bridge Unit with 24 residents. When asked about this, E14 explained that the other assigned CNA (E15) had not yet arrived for the 3:00 PM to 11:00 PM shift. E14 further explained that there was no dietary or kitchen staff assigned so the two CNAs assigned to the locked unit performed all		

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	duties related to plating, serving, and cleaning up from the evening meal, along with a third CNA who was pulled from the assisted living section of the facility to assist for about an hour. Review of Daily Assignment Sheets for 1/6/16 through 1/17/16 revealed that there were two CNAs assigned to the assisted living section of the facility (approximately 60 residents) so when one CNA went to the Claire Bridge Unit for an hour, that would leave just one CNA for the 60 assisted living residents. **3.** Observations beginning at 4:50 PM on the Claire Bridge Unit on 1/17/16 prior to, and during, the dinner meal revealed that staff was insufficient: - E14 (CNA), E15 (CNA), and E16 (CNA) were observed performing all kitchen activities required for plating and serving the dinner meal to the residents who were seated at seven tables in the dining areas. The serving of drinks and soup was performed by E15 and E16 while E14 was primarily in the kitchen (behind a closed door). At times, all three CNAs were in the kitchen or at the kitchen serving window opening (which is out of the visual field of the dining area) resulting in no staff members being with the residents to observe, cue, or assist. - SS4 and SS5 were observed frequently leaving their seats at their tables and wandering around the dining room with SS4 walking over to the surveyor at 4:56 PM carrying a cup and spoon and looking for assistance; - SS6 was given a cup of Ensure, a nutritional supplement drink, at 5:02 PM by a nurse and SS6 was then observed using her spoon to try to consume the Ensure which was spilling from the spoon onto her shirt. Other residents at the table with SS6 were using a spoon to		

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	eat soup at the time. No staff members were present to cue SS6 to pick up the cup to more easily consume the Ensure. 4. Interview with E1 (ED) on 1/15/16 at 2:00 PM revealed that for the past several years, the staffing on the Claire Bridge Unit on the 3:00 PM to 11:00 PM shift had been two CNAs for approximately 24 residents with cognitive impairment. E1 stated that the facility agreed that more staff was needed on this unit to meet the needs of the residents. On 1/20/16 at 9:25 AM, E17 (Corporate Nurse) stated to the surveyor that she (E17) had identified in June, 2015 (seven months before the survey) when she began working with this facility that another CNA was needed on the 3:00 PM to 11:00 PM shift and the plan was to have the third CNA start as soon as one was hired. These findings were reviewed with E1 and E2 [illegible] At the exit conference E18 (Corporate Representative) stated that the usual staffing would be 1 CNA per 8 residents on the day and evening shifts. When asked about the current ratio of one CNA to 12 residents on the 3:00 PM to 11:00 PM shift, E17 replied that 3 CNAs were needed going forward starting today (1/20/16).		
3225.17.0 3225.17.2 3225.17.2.2	**Environment and Physical Plant** **Assisted living facilities shall:** **Be clean.** **This requirement is NOT MET as evidenced by:** Based on observation it was determined that the facility failed to be clean by having stained carpet in 5 (Rooms 9, 14, 18, 25 and 46) out of 10 rooms entered during the	**3225.17.0/3225.17.2/3225.17.2.2 Environment and Physical Plant Be Clean**	

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	survey. Findings include: 1.1/15/16 observations found during the initial tour and between 12:10 PM – 12:30 PM: - Room 9 (occupied by SS1) – numerous dark and colored staining on the carpeting around room. - Room 14 (occupied by R13) – numerous areas of dark staining of the carpet between the door to the room and the bathroom door. - Room 25 (occupied by R14) – small greenish stain at foot of bed by the window and staining at the entrance into the room. - Room 46 (occupied by R1 until 1/20/16) – staining along length of the bed next to the window and two stains between the entry and the bed by the door. 2.1/17/16 at 3:20 PM observation - Room 18 (occupied by SS7) - heavy soiling and staining of the carpet throughout the whole room. The facility failed to maintain a clean environment in 5 out of 10 rooms entered during the survey. These findings were reviewed with E1 (ED) and E2 (HWD) on 1/20/16 at approximately 2:40 PM.	I. Corrective Action The carpet in room 9 and 46 were replaced on 2/22/16 by Sherwin Williams. The carpet in room 14, 18, and 25 will be replaced on 3/3/16 by Sherwin Williams. II. How to identify others A physical plant survey was completed for carpet replacement on 1/29/16 by the Maintenance Director. III. Systemic Changes The Maintenance Director will conduct physical plant inspections monthly utilizing the Monthly Safety inspection form to determine carpet replacement needs. Attachment C. IV. Monitoring/QA The results of the monthly inspections will be reported to the Safety Committee. V. Completion Date 3/31/16	
3225.17.5.3	**Bedrooms and all bathrooms used by residents in assisted living facilities, except in specialized care units for memory impairment, shall be equipped with an intercom or other mechanical means of communication for resident emergencies. For specialized care units for memory impairment, staff must be equipped to communicate resident emergencies immediately.** **This requirement is not met as evidenced by:** Based on observation during the initial tour and interview it was determined that the	3225.17.5.3 **Bedrooms and all bathrooms used by residents in assisted living facilities, except specialized care units for memory impairment, shall be equipped with and intercom or other mechanical means of communication for resident emergencies. For specialized care units for memory impairment, staff must be equipped to communicate resident emergencies immediately.**	

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	facility failed to ensure the bathroom emergency call bell was in working order for two (Rooms 9 and 51) out of nine (9) rooms tested on the initial tour. **1.** 1/12/16 at 9:18 AM – Bathroom emergency call bell in room 9 (used by SS1 who uses a cane to ambulate) did not activate when the cord was pulled several times by the surveyor. 1/12/16 at 9:45 AM - E5 (Maintenance Director) was informed that the wall-mounted bathroom emergency call bell did not activate in room 9. E5 stated he would "check it out". 1/12/16 at 10:00 AM - E5 stated the battery inside the call bell had loosened and needed to be reinserted which fixed the issue. The bathroom emergency call bell was now working. **2.**1/12/16 between 10:30 AM – 11:30 AM, the bathroom emergency call bell in room 51 (used by SS3) did not activate and the device came off of the wall when the cord was pulled. This was immediately taken to E5 by the surveyor for repair and reattachment to the wall. E5 reported that the battery in the call light was misplaced (in backwards) and the call bell was reattached onto the wall in the bathroom. The facility failed to ensure two bathroom emergency call lights were in working order. These findings were reviewed with E1 (ED) and E2 (HWD) on 1/20/16 at approximately 2:40 PM.	**I. Corrective Action** The emergency call bell in room 9 and room 51 were repaired on 1/20/16 by the Maintenance Director. **II. How to identify others** All bathroom emergency call bells will be evaluated by the Maintenance Director. **III. Systemic Changes** The Maintenance Director will conduct monthly audits of all emergency call bell systems. Attachment C. **IV. Monitoring/QA** The finding of the monthly audit will be reported to the Safety Committee monthly until substantial compliance is met. **V. Completion Date** 3/7/16	
3225.17.6	**Resident kitchens shall be available to residents either in their individual living unit or in an area readily accessible to each resident. Residents shall have access to a microwave or stove/ conventional oven, refrigerator, and sink. The assisted living facility shall establish**	**3225.17.6** **Resident kitchens shall be available in their individual living unit or in an area readily accessible to each resident. Residents shall have access to a microwave oven, refrigerator, and sink. The assisted living facility shall establish and adhere to policy and procedures to ensure that common kitchens are used and maintained in such a way as to provide:** **A clean sanitary environment.**	

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3225.17.6.1	**and adhere to policies and procedures to ensure that common kitchens are used and maintained in such a way as to provide:** **A clean and sanitary environment.** **This requirement is not met as evidenced by:** Based on observation it was determined that the facility failed to keep the resident common kitchen clean. Findings include: The common kitchen was not clean and orderly. The common kitchen shares space with the activity department. Observations made on 1/12/16 at 9:10 AM, 1/13/16 at 9:15 AM and 1/15/16 at 3:00 PM found two small wood end tables sitting on top of the larger (dining) tables and the stainless steel sink had a grey/white coating, creating a haze on the metal. These findings were reviewed with E1 (ED) and E2 (HWD) on 1/20/16 at approximately 2:40 PM.	**I. Corrective Action** 1. The tables on top of the larger tables were part of a men's activity group. These were removed on 1/20/16 by the Concierge. 2. The sink was cleaned with stainless steel cleaner. 2/20/16 by housekeeping. **II. How to Identify Others** All residents were affected. **III. Systemic Changes** 1. The Resident Programs Coordinator will be in-serviced by the Executive Director to verify daily activities are removed from the dining tables at the completion of the activity. 2. The sink in the common kitchen will be cleaned by the housekeeper as part of the routine weekly cleaning of the area. **IV. Monitoring/QA** 1.The Resident Programs Coordinator will monitor the common kitchen area daily for compliance. 2. The Maintenance Director will monitor the cleaning of the common kitchen area sink weekly. **V. Completion Date** 3/15/16	
3225.18.0 3225.18.6 3225.18.6.2	**Emergency Preparedness** **Each facility shall submit with an application for a license and annual renewal of a license:** **Copies of the FEMA certificate of achievement which demonstrate that at least two active, full-time employees have completed FEMA training in ICS-100 and NIMS-700a in the past 24 months.** **This requirement is not met as evidenced by:** Based on interview and review of facility documents it was determined that the facility failed to have documentation that two full-time employees completed the two required FEMA courses within the past 24 months.	**3225.18.0/3225.18.6/3225.18.6.2 Emergency Preparedness**	

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	Both of these courses include disaster management. Findings include: 1/12/16 at 9:40 AM– Surveyors gave E7 (LPN) the Entrance Conference Worksheet (Facility Copy) listing information to be presented to the survey team. Documentation of two specific FEMA disaster training courses completed within the past 24 months by two full-time employees was included on the Entrance Conference Worksheet. 1/14/16 interview at 1:00 PM with E1 (ED) who stated she would get back to the surveyor when asked for documentation of the required FEMA online training courses. - Introduction to Incident Command System (ICS-100) - National Incident Management System (NIMS-700a) 1/20/15 at 1:00 PM – The facility had not provided the survey team documentation about the FEMA training completion. The facility did not have two full-time employees with specific FEMA disaster management training within the past 24 months. These findings were reviewed with E1 and E2 (HWD) on 1/20/15 at approximately 2:40 PM. During the exit conference E1 stated she would check with E5 (Maintenance Director) and forward the training information to the survey team. Email received from E1 on 1/22/15 after exit from the facility, contained documentation that E5 completed ICS-100 on 1/14/16 and NIMS-700a on 1/15/16. Evidence that a second full-time employee completed these training courses within the past 24-months was not provided. At the time of the survey entrance the facility failed to have two full-	**I. Corrective Action** Executive Director will complete the ICS-100 and NIMS700a. **II. How to Identify Others** No other affected **III. Systemic Changes** Executive Director and Maintenance Director will complete the ICS-100 and NIMS700a training every 24 months. **IV. Monitoring/ QA** Business Office Director will maintain copies of the certification and notify Executive Director and Maintenance Director when certifications are due. **V. Completion Date** 3/11/16	

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	time employees who successfully completed the designated FEMA disaster training within the previous 24 months.		