

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155621	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2011
NAME OF PROVIDER OR SUPPLIER  PINE HAVEN HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER DR EVANSVILLE, IN47720		
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 12, 13, 14, 15, 16, 19, 2011</p> <p>Facility number: 000442 Provider number : 155621 AIM number: 100266510</p> <p>Survey team: Amy Winger, RN TC 12/12-12/16/11 Diane Hancock, RN Vickie Ellis, RN 12/13-12/16/11, 12/19/11 Barb Fowler, RN</p> <p>Census bed type: SNF: 33 SNF/NF: 64 Total: 97</p> <p>Census payor type: Medicare: 13 Medicaid: 47 Other: 37 Total: 97</p> <p>Sample: 20 Supplemental sample: 6</p>	F0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that this plan of correction be considered our allegation of compliance, effective January 13, 2012 to the state findings of the Recertification and State Licensure survey conducted on December 12, 13, 14, 15, 16 and 19, 2011. The facility also respectfully requests a desk review of the plan of correction.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0221 SS=D	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 12/22/11 by Suzanne Williams, RN The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview, and record review, the facility failed to ensure 2 of 3 residents reviewed for restraints, in the sample of 20, were free of physical restraints, in that the residents lacked evidence of assessments for the use of the restraints, to include medical symptoms required for the use of the restraints. (Residents #77, #43)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #77 was reviewed on 12/13/11 at 10:00 A.M. The record indicated the diagnoses of Resident #77 included, but were not limited to, fracture-neck of femur and dementia.</p> <p>During initial tour on 12/12/11 at 10:30 A.M., RN #1 indicated Resident #77 used a self-release seatbelt restraint while in the wheelchair.</p> <p>On 12/12/11 at 1:00 P.M., Resident #77 was observed in the hallway sitting in a</p>	F0221	<p>F - 221</p> <p>The corrective action taken for those residents found to be affected by the deficient practice: The resident identified as Resident # 77 has been re-assessed for the use of a restraint.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice: The resident identified as Resident #43 has been re-assessed for the use of a restraint. Based on the results of the re-assessment, the resident no longer utilizes a restraint.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice:</i> All residents currently utilizing a restraint have been reassessed to ensure there is medical justification for the use of the restraint. The medical justification shall be included in the restraint order. In addition, the facility has implemented the practice that any resident utilizing a seatbelt who currently can release the device upon command will have this fact verified by the nurse each shift by documenting on the seatbelt flow sheet. Should the resident be incapable of self-releasing the seatbelt, the facility restraint policy and procedure will be implemented and followed.</p>	01/13/2012	

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	<p>wheelchair with a self release seatbelt intact across her lap.</p> <p>A Nursing note dated 11/02/11 at 12:00 P.M. indicated, "Res [resident] given seatbelt self-realese [sic]..."</p> <p>The Fall Care Plan included a handwritten notation, dated 11/02/11, which indicated, "res [resident] continues to require 1 on 1 supervision secondary to disease process-N/O [new order] received for SRB [self release seatbelt]."</p> <p>The Physical Restraint Consent Notification dated 11/02/11 indicated, "Type Of Restraint And Medical Reason For Use: seat belt alarm ... et [and] medical use is to protect res [resident] from physical harm from getting up et falling."</p> <p>A Physician's Telephone Order dated 11/02/11 indicated, "Self release seat belt alarm to w/c [wheelchair] d/t [due to] decrease safety awareness."</p> <p>During an interview with the ADoN [Assistant Director of Nursing] on 12/13/11 at 10:30 A.M., he indicated, "The diagnosis for the restraint is extremely poor safety awareness, requires one to one supervision, continual redirection, and dementia."</p>		<p>The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur: The facility has reviewed the restraint policy and procedure and has implemented the use of the seatbelt documentation form. A mandatory in-service has been provided for all nursing staff on the facility restraint policy and procedure, including the implementation of the new seatbelt flow sheet for documentation purposes. In addition, special emphasis was placed on the need for medical justification in the use of any physical restraint.</p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur:</i> A Quality Assurance tool has been developed and implemented to ensure the facility restraint policy and procedure is being followed by all nursing staff. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months, and then quarterly for three quarters. The information generated by completion of this Quality Assurance audit tool will be reviewed at the quarterly QA meeting to determine if any additional action is warranted.</p>				

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	<p>2. The clinical record of Resident #43 was reviewed on 12/13/11 at 9:45 AM. The clinical record indicated the diagnoses included, but were not limited to, dementia.</p> <p>During initial tour on 12/12/11 at 10:37 AM, Resident #43 was lying in her bed. Upon interviewing LPN #1, and interview of resident, it was determined that Resident #43 was not interviewable.</p> <p>The MDS [Minimum Data Set Assessment], dated 11/14/11, also indicated that Resident #43 was not interviewable.</p> <p>The clinical record of Resident #43 indicated the resident had a physician's order dated 9/20/10 for a "SRSB [self-releasing seat belt] to W/C [wheelchair], check placement &amp; function Q [every] shift."</p> <p>The Care Plan reviewed on 12/14/11 at 1:30 PM, indicated on 11/2/11 the self-release belt was a Physical Restraint. The care plan listed that the self-release belt was related to "medical symptom for which restraint is used to treat: dementia, impaired cognition, inability to ambulate or reposition self at regular intervals" checked. The care plan indicated that the resident/family were aware of the risks</p>	F0221	<p>F - 221</p> <p>The corrective action taken for those residents found to be affected by the deficient practice: The resident identified as Resident # 77 has been re-assessed for the use of a restraint.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice: The resident identified as Resident #43 has been re-assessed for the use of a restraint. Based on the results of the re-assessment, the resident no longer utilizes a restraint.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice:</i> All residents currently utilizing a restraint have been reassessed to ensure there is medical justification for the use of the restraint. The medical justification shall be included in the restraint order. In addition, the facility has implemented the practice that any resident utilizing a seatbelt who currently can release the device upon command will have this fact verified by the nurse each shift by documenting on the seatbelt flow sheet. Should the resident be incapable of self-releasing the seatbelt, the facility restraint policy and procedure will be implemented and followed.</p> <p>The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur: The facility has reviewed the restraint policy and procedure and has implemented the use of the seatbelt documentation form. A mandatory in-service has been provided for all nursing staff on the facility restraint</p>	01/13/2012	

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	<p>associated with use of the device. Also, the care plan indicated that the staff was to monitor for the use of restraint as least restrictive device.</p> <p>A "Physical Restraint Consent Notification" reviewed on 12/14/11 at 2:50 PM, indicated that the consent was signed by Resident #43's Legal Representative on 11/2/11.</p> <p>Upon further review of the clinical records on 12/14/11 at 2:50 PM, the Tx [Treatment] Orders indicated that Resident #43 had an order for "SRSB to W/C, check placement &amp; function Q [every] shift" dated 9/20/10, that was initialed by the staff.</p> <p>It was also indicated on the Tx Orders, that beginning on 8/1/11, the "resident is able to remove SRB [self- release belt] on command, if not, notify nrsg [nursing] adm [administration] Q week assess ability [days]."</p> <p>The Restraint Record for the month of 11/11, reviewed on 12/15/11 at 10:15 AM, indicated "the restraint must be released for the purpose of exercise, toileting, ect (sic) [et cetera] at least every 2 hrs [hours]." The Restraint Record for the month of 11/11, also indicated "Restraint Order: SRB - unable to release</p>		<p>policy and procedure, including the implementation of the new seatbelt flow sheet for documentation purposes. In addition, special emphasis was placed on the need for medical justification in the use of any physical restraint.</p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur:</i></p> <p>A Quality Assurance tool has been developed and implemented to ensure the facility restraint policy and procedure is being followed by all nursing staff. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months, and then quarterly for three quarters. The information generated by completion of this Quality Assurance audit tool will be reviewed at the quarterly QA meeting to determine if any additional action is warranted.</p>				

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	<p>SRB on command with consistency.</p> <p>Upon further review, the Nurses Notes indicated that on 11/11/11 at 3:00 AM, resident #43 was alert to person and oriented only.</p> <p>The Nurses Notes indicated on 11/12/11 the resident was "propelled per staff in W/C," "SRB and sensor pad in W/C, sensor alarm pad in bed D/T [due to] decrease in safety awareness."</p> <p>On 11/13/11 at 1:53 PM, nurses notes indicated, "SRB in place and functioning, sensor alarm pad in W/C D/T decrease safety awareness, and the bed/chair sensor alarm pads in place and functioning," and on 11/13/11 at 5:19 PM, "the resident was propelled to the DR [dining room] by the staff, SRB in place and functioning sensor alarm pad in W/C and functioning."</p> <p>The Nurses Notes on 11/2/11 at 9:30 AM, indicated that Resident #43 "was unable to release the seat belt on command consistently." The clinical record also indicated the "ADoN notified, family notified; care plan, etc. updated" and on 11/2/11 at 2:30 PM the resident's "daughter here, consent signed for the restraint."</p> <p>Resident #43 was hospitalized from 12/4/11 to 12/11/11. No further documentation was indicated on the Care Plan or in the Nurses Notes regarding the assessment for the SRSB except on the</p>			

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	<p><b>Restraint Record.</b></p> <p>Upon observation on 12/14/11 at 12:00 PM, Resident #43 was placed into her W/C per Hoyer lift with assist of CNA #7 and LPN #1, and the self-release seat belt was applied by LPN #1.</p> <p>Upon interviewing of LPN #1 on 12/15/11 at 3:44 PM, she indicated Resident #43's family had requested a seat belt and that the diagnosis was probably dementia as the resident used to wheel herself around and would bend over while in her W/C to attempt to pick things up off of the floor. She indicated that the resident could release her seat belt at first but has now declined and was unable to release it. LPN #1 indicated that Resident #43's family wanted the SRB continued.</p> <p>During the interview of the ADoN [Assistant Director of Nursing] on 12/16/11 at 8:25 AM, the ADoN indicated the diagnosis for the SRB restraint was due to resident's decline in her condition.</p> <p>Upon further interviewing of the ADoN on 12/16/11 at 8:25 AM, the ADoN indicated he completed a restraint assessment on Resident #43 every Wednesday. The ADoN indicated that he would ask Resident #43 to release her self-releasing belt weekly and that she</p>				

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F0241 SS=E	<p>was no was longer able to release it due to the decline in her condition. The ADoN indicated that the only documentation that indicated that the resident was assessed by him was found on the Tx Order record and that it was indicated with a "Y" for yes or a "N" for no. There was no documentation for the date of 10/12/11 on the Tx Order record, indicating that Resident #43 was assessed for the week of 10/9/11 - 10/15/11. The ADoN indicated that he did not document on any other records other than the Treatment Order record regarding the assessment.</p> <p>3.1-3(w) 3.1-26(o)</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were cared for in a manner that maintained their dignity, for 5 of 5 supplemental sample residents reviewed for dignity, in the supplemental sample of 6, in that they were lined up in wheelchairs along the hallway outside the common bathroom, in order to get assistance with toileting. (Residents #101, #102, 103, #104, #105)</p>	F0241	<p>F -241</p> <p>The corrective action taken for those residents found to be affected by the deficient practice: The residents identified as Resident #s 101, 102, 103, 104 and 105 are now being toileted on a timely basis in accordance with their individual preferences.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice:</i> All residents requiring assistance with toileting are being assisted in a timely manner and in accordance with their</p>	01/13/2012			

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	<p>Findings include:</p> <p>An observation was made on 12/13/11 at 1:00 p.m., of 5 unidentified residents sitting in their wheelchairs in a line in the hallway outside the common restroom. CNA #4 was taking them inside the common restroom to assist them in toileting, one at a time.</p> <p>An observation, on 12/15/11 at 06:20 p.m., was made of Residents #101, Resident #102, Resident #103, Resident #104, and Resident #105, all sitting in their wheelchairs in the hallway outside the common restroom in a line. CNA #5 was observed assisting residents into the common restroom to assist with toileting. Resident #101 stated, "We have to take a number; we always wait in line like this."</p> <p>In an interview with CNA #5, on 12/15/11 at 06:25 p.m., CNA #5 indicated the residents were always toileted after meals one at a time in the common restroom.</p> <p>In an interview with the DoN [Director of Nurses], on 12/15/11 at 06:30 p.m., the DoN indicated the residents had always lined up outside the common restroom; she stated, "it's like they're trained."</p> <p>In an interview on 12/16/11 at 11:45 a.m., Resident #101 indicated she always</p>		<p>own personal preferences.</p> <p>The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur: A mandatory in-service has been conducted for all nursing employees concerning the facility practice of meeting the residents' individual needs in a dignified manner in accordance with their personal preferences and in a timely manner.</p> <p>The corrective action will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented to ensure that residents' needs are being met in a dignified and timely manner, and in accordance with their individual preferences. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months, and then quarterly for three quarters. The information generated by completion of this Quality Assurance tool will be reviewed at the quarterly QA meeting to determine if additional action is warranted.</p>		

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F0311 SS=D	<p>waited in line outside the common restroom after meals. Resident #101 indicated she does have her own restroom in her room, but that she gets assistance faster by waiting in line outside the common restroom. Resident #101 also indicated this had been the procedure since her admission to the facility.</p> <p>In an interview on 12/16/11 at 11:55 a.m. with Resident #103, Resident #103 indicated she had a restroom in her room, but was not supposed to use her own restroom to have a bowel movement. Resident #103 indicated RN #2 had told her not to use her own restroom, because she might fall.</p> <p>On 12/19/11 at 11:19 a.m., the Assistant Director of Nursing [ADoN] provided a document of resident privacy [no date], which indicated the facility's policy was "to uphold the resident's right to privacy and to maintain dignity through a homelike environment."</p> <p>3.1-3(t)</p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on interview and record review, the facility failed to ensure 1 of 4 residents</p>	F0311	F - 311 The corrective action taken for those residents found to be affected by the deficient	01/13/2012			

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	<p>reviewed for restorative care, in the sample of 20, received assistance with ambulation according to the restorative care plan, in that assistance with ambulation was not completed daily as planned. (Resident #62)</p> <p>Finding includes:</p> <p>Resident #62's clinical record was reviewed on 12/13/11 at 1:12 p.m. The resident's diagnoses included, but were not limited to, ischemic cardiomyopathy, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, peripheral vascular disease, and colostomy, and chronic kidney disease. The resident's most recent quarterly Minimum Data Set [MDS] assessment, dated 11/9/11, indicated the resident required extensive assistance of one person for ambulation. A care plan for restorative ambulation, dated 10/26/11, indicated the following goal: "Resident will be able to ambulate 50 feet 1 times a day in 1 shift with the following, rolling walker, gait belt, physical assist X 2." The approaches included, but were not limited to, the following: Provide assist of 2 with ambulation Use rolling walker Have resident stand up straight Resident will ambulate 50 feet 1 times a day in 1 shift</p>		<p>practice: The resident identified as Resident # 62 is now receiving restorative programs in accordance with their plan of care. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice:</i> All residents are now receiving their restorative programs in accordance with their plans of care. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur: The Staffing Coordinator has been directed not to pull restorative staff to work as floor staff unless deemed absolutely necessary by the Director of Nursing or the Assistant Director of Nursing. In addition, all certified nursing assistants have been trained on the restorative programs so that if an emergency does occur, any certified nursing assistant can provide the restorative programs in accordance with the applicable plans of care. The corrective action will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented to monitor the restorative programs to ensure that residents are receiving their restorative programs in accordance with their individual plan of care. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then</p>		

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F0325 SS=D	<p>Document progress and any refusal on flowsheet</p> <p>Review of the restorative documentation for December, 2011 was reviewed during the record review. The following dates lacked documentation of any restorative ambulation: December 2, 3, 4, 5, 9, 10, 11, 12, 2011</p> <p>Resident #62 was interviewed on 12/14/11 at 9:20 a.m. He indicated he usually was assisted to ambulate 2 days a week, but never every day.</p> <p>3.1-38(a)(2)(B)</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview and record review, the facility failed to ensure 2 of 5 residents reviewed for nutritional deficits, in the sample of 20, were monitored for continued weight loss, in that weights were not monitored as care planned. (Residents #35, #41)</p>	F0325	<p>monthly for three months, and then quarterly for three quarters. The information obtained through completion of this Quality Assurance tool will be reviewed at the quarterly QA meeting to determine if additional action is warranted.</p> <p>F - 325</p> <p>The corrective action taken for those residents found to be affected by the deficient practice: The resident identified as Resident #35 is no longer a resident at the facility.</p> <p>The corrective action taken for those</p>	01/13/2012	

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	<p>Findings include:</p> <p>1. LPN #1 indicated, during the initial tour on 12/12/11 at 11:10 a.m., Resident #35 had diagnoses of spherocytosis [a disease of the red blood cells], renal failure, and pressure ulcers. She indicated he had a urinary catheter and required feeding by staff or his spouse. The resident was observed to be in bed on his back. His skin was yellowish in color [jaundiced].</p> <p>Resident #35's clinical record was reviewed on 12/12/11 at 2:50 p.m. Diagnoses included, but were not limited to, polymyalgia rheumatica [an inflammatory disorder involving pain in the shoulders and hips], spherocytosis, a history of kidney stones, and a history of a cerebrovascular accident [stroke]. The record indicated the resident was admitted to the facility on 10/1/11. The Nurses' Admission Record, dated 10/1/11 at 3:20 p.m., indicated the resident weighed 218 pounds. The resident's weight record was reviewed at that time and indicated the admission weight of 218 on 10/1/11, a weight of 179 on 10/4/11, and a weight of 172 on 11/2/11. There were no weights documented for December 2011.</p> <p>Resident #35 had a care plan, dated</p>		<p>residents found to be affected by the deficient practice: The resident identified as Resident # 41 is now being weighed weekly. Any significant weight loss is being reported to the physician. The care plan has been reviewed and updated to reflect appropriate interventions to meet the resident's nutritional needs.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice:</i> All residents in the facility have been re-weighed. The interdisciplinary team has reviewed the weights to determine which residents may be at nutritional risk. Any resident identified as being at nutritional risk will be placed on the nutritional risk program. A care plan will be developed and implemented to meet the resident's nutritional needs. These residents will be weighed weekly and reviewed weekly by the interdisciplinary team for additional interventions if warranted.</p> <p>The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur: A mandatory in-service has been provided for all nursing staff on the facility's nutritional risk program. In addition, special emphasis was placed on the importance of obtaining weights in accordance with the residents' individualized plans of care.</p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur:</i> A Quality Assurance tool has been developed and implemented to ensure that the facility's nutritional risk program is being followed and that weights are being obtained in accordance with each resident's individualized plan of care. This tool will be completed by the</p>		

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	<p>10/12/11, for poor appetite and dysphagia. The approaches included, but were not limited to, monitor weight weekly, inform doctor of weight loss of 5% or 5 pounds in one month, and nutritional shakes twice daily.</p> <p>LPN #1 was interviewed on 12/13/11 at 2:37 p.m. She indicated she didn't know about the December weights; she was off work the first week of the month when they routinely got the weights. She indicated she would have everyone weighed that day. She was interviewed again on 12/14/11 at 10:15 a.m. regarding weekly weights. She indicated she was unable to find any weekly weights documented on anyone on the unit since August, 2011.</p> <p>The resident was hospitalized 11/12 through 11/15/11 with diagnoses of congestive heart failure, atrial fibrillation, obstructive uropathy, hypothyroidism, bladder retention, chronic back pain, and polymyalgia rheumatica. The Nurses' Admission Record, dated 11/15/11 at 5:45 p.m., indicated a readmission weight of 218 pounds. The resident returned with a 3 centimeter [cm] by 3 cm stage I pressure area [intact skin with nonblanchable redness of a localized area, usually over a bony prominence] present on the left heel that had not been there prior to the</p>		Director of Nursing and/or her designee weekly for four weeks, then monthly for three months, and then quarterly for three quarters. The information obtained through the completion of this Quality Assurance tool will be reviewed at the quarterly QA meeting to determine if additional action is warranted.		

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	<p>hospitalization.</p> <p>The hospital history and physical, dated 11/13/11 at 12:55 p.m., indicated a weight of 153 pounds.</p> <p>A Nutrition Risk Assessment, dated 10/4/11 and completed by the Registered Dietitian, indicated the resident triggered at high nutritional risk status. Recommendations were made for liquid protein twice a day. A dietitian note dated 10/11/11 indicated the weight of 179 pounds, from 10/4/11. The dietitian indicated, "Nursing reporting 39 lb [pound] difference (decline) re-weight requested." "Continue to recommend diet change from 2000 cal [calorie] to cont. [consistent] CHO [carbohydrate] and also 30 ml [milliliters] Active Protein b.i.d. [twice a day] to address low albumin." A dietitian note dated 10/25/11 indicated the diet change had been made and the protein supplement added. The Dietitian continued to document the weight as 179, but did not indicate a re-weight had occurred. A Dietitian note dated 11/29/11 indicated, "(wt. inconsistent in wt. book or nursing adm. [admission] assessment.). Wt. remains w/i [within] target range, on-going wt. loss noted. Recommend b.i.d. SF [sugar free] shakes to address wt. loss." The Dietitian indicated the weight of 172 pounds at that time, which was</p>				

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	<p>taken prior to the hospitalization.</p> <p>A Nutrition Risk Assessment was completed by the Dietitian on 11/22/11. The Dietitian indicated the weights were inconsistent and the 218 wt. had been taken from the nursing admission form. The Dietitian's Summary indicated, "Resident sent out to hosp [hospital] 11/12/11, readmitted 11/15/11. resident remains at high nut [nutritional] risk status - receives cont. CHO, mech soft diet with protein supplement - will continue same at this time. Monitor wts, intakes, available." There was no indication she requested a re-weight or reviewed the weight from the hospital stay.</p> <p>Review of the Resident Weight Record, on 12/19/11 at 10:45 a.m., indicated the resident had been weighed on 12/13/11 and the weight was 164 pounds.</p> <p>2. During the initial tour, on 12/12/11 at 11:15 a.m., LPN #1 indicated Resident #41 was a fall risk, required oxygen therapy, and pressure wounds she was admitted with and one that was acquired in-house. She indicated the resident was not eating and was malnourished.</p> <p>Resident #41's clinical record was reviewed on 12/13/11 at 10:20 a.m. The</p>				

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	<p>resident's diagnoses included, but were not limited to, leukemia, anemia, chronic obstructive pulmonary disease, congestive heart failure and hypertension. The resident's admission Minimum Data Set [MDS] assessment, dated 11/4/11, indicated the resident's weight was 77 pounds and she had a stage II pressure ulcer [partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister].</p> <p>The resident had a care plan, dated 11/4/11, for Potential Altered Nutrition. Problems identified were poor appetite and chewing difficulties at times. Approaches included, but were not limited to, mechanical soft diet, monitor weights weekly, food in bowls, and Mighty Shake [nutritional supplement] three times a day with meals.</p> <p>The Dietitian did a Nutrition Risk Assessment, dated 11/8/11. The assessment indicated, "...very thin and frail. resident is edentulous [without teeth], tolerates mech [mechanical] soft diet adequately. Recommend adding mighty shakes at all meals due to low wt. status, and daily MVI [multivitamin]." She documented the resident's weight as 77 pounds. On 11/22/11, the Dietitian's</p>			

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	<p>nutritional assessment indicated the following: "Shakes t.i.d. started 11/9/11..." "Started on Megace [appetite stimulant] 11/16. Resident feeds self w/ [with] set-up, appetite poor. Monitor wts weekly, encourage optimal intakes." She documented the resident's weight as 77 pounds. A Dietitian Progress Note, dated 11/29/11, indicated, "Nursing reports skin issues - new Stage II area on coccyx. Nutritional provisions include t.i.d. house shakes, MVI and mech soft diet. Resident also receives Megace. Current provisions adequate encourage optimal intakes."</p> <p>The Resident Weight Record was reviewed on 12/13/11 at 11:00 a.m. The resident's admission date on the document indicated 10/28/11. The Admission weight was documented as 77.4 pounds. There were no other weights documented for Resident #41.</p> <p>On 12/14/11 at 10:15 a.m., LPN #1 indicated she was unable to find any weekly weights for the resident, or any residents since August, 2011.</p> <p>CNA #7 and LPN #1 were observed to weigh Resident #41. The resident weighed 69.2 pounds, indicating a 10% weight loss since admission.</p> <p>3.1-46(a)(1)</p>				

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F0371 SS=F	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure food was stored under sanitary conditions, in one of one walk-in freezer in the kitchen, in that temperatures were recorded above zero degrees Fahrenheit for 15 of 15 days of December, 2011. This had the potential to affect 95 of 95 residents residing in the facility who ate meals from the kitchen.</p> <p>Finding includes:</p> <p>On 12/15/11 at 9:40 a.m., the walk-in freezer temperature was observed to be 8 degrees Fahrenheit [F]. The Refrigerator/Freezer Temperature Worksheet, dated December, 2011, was observed posted on the freezer door. The temperatures were recorded as follows:</p> <p>December 1, 4 [degrees F] December 2, 6 [degrees F] December 3, 6 December 4, 4 December 5, 8 December 6, 10</p>	F0371	<p>F 371</p> <p>The corrective action taken for those residents found to be affected by the deficient practice: No specific residents were identified as having been directly affected during the survey.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice:</i> All residents have the potential to be affected by the deficiency cited; however, there were no negative outcomes as a result of the issue identified. The freezer was repaired on Friday December 16, 2011, (i.e., prior to the end of the survey). In addition, a new temperature log was developed. A new practice was implemented related to the immediate reporting of any abnormal temperatures to the Dietary Manager and to the Maintenance Director.</p> <p>The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur: A mandatory in-service was provided for all dietary employees related to the new temperature log and the new practice of recording the temperature twice each day and reporting any abnormal temperatures immediately to the Dietary Manager and the Maintenance Director.</p>	01/13/2012	

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	<p>December 7, 6 December 8, 6 December 9, 10 December 10, 10 December 11, 8 December 12, 4 December 13, 8 December 14, 8 December 15, 6</p> <p>Cook #1 was interviewed, on 12/15/11 at 9:45 a.m. She indicated she checked the temperature first thing in the morning. She indicated she read the gauge on the outside of the freezer and documented that temperature. The Dietary Service Manager [DSM] indicated to the cook that she should use the thermometers inside the freezer to get a more accurate reading.</p> <p>The freezer was checked again, on 12/15/11 at 11:33 a.m. At that time the thermometers inside the freezer indicated 24 degrees Fahrenheit. The DSM indicated it appeared to be in defrost mode.</p> <p>The DSM indicated, on 12/16/11 at 9:30 a.m., a refrigeration company representative had looked at the freezer and was making repairs.</p> <p>3.1-21(i)(3)</p>		<p>The corrective action will be monitored to ensure the deficient practice will not recur: <i>A Quality Assurance tool has been developed and implemented to monitor the temperature logging system to ensure temperatures are being recorded as directed and that any abnormal temperatures have been immediately reported in accordance with the new practice. This tool shall be completed by the Dietary Manager and/or her designee weekly for four week, then monthly for three months, then quarterly for three quarters. The information generated through the completion of this Quality Assurance audit tool will be reviewed at the quarterly QA meeting to determine if any additional action is warranted.</i></p>		

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F0441 SS=E	<p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure</p>	F0441	F - 441  The corrective action taken for those	01/13/2012

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	<p>infection control procedures were followed to help prevent the transmission of infections, for 3 of 3 sampled residents reviewed for infection control procedures, in the sample of 20, and for 2 of 2 supplemental sample residents reviewed for infection control procedures, in the supplemental sample of 6, in that gloves were not changed and/or hands not washed between soiled and clean activities and/or between residents. (Residents #16, #106, #59, #46, #52)</p> <p>Findings include:</p> <p>1. An observation was made on 12/13/11 at 1:00 p.m., of RN #2 and CNA #6 doing incontinent care on Resident #16. Prior to incontinent care, neither RN #2 or CNA #6 were observed to wash hands. Both RN #2 and CNA #6 put on gloves and proceeded to apply another pair of gloves over the top of the first pair of gloves. After incontinent care, both RN #2 and CNA #6 removed the top layer of gloves and proceeded with care without washing hands. RN #2 continued with care in the form of a dressing change to the buttocks area and CNA #6 assisted with resident positioning.</p> <p>In an interview with the Director of Nursing [DoN] during an exit conference on 12/14/11 at 4:05 p.m., the DoN stated,</p>		<p>residents found to be affected by the deficient practice: The resident identified as Resident #16 is now receiving personal care, including treatments, in accordance with acceptable standards of infection control practices. Staff members identified as RN #2 and CNA #6 have participated in a "teach and train" session on acceptable standards of infection control practices, including hand washing.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice: The resident identified as Resident #106 is now receiving personal care in accordance with acceptable standards of infection control practices. The staff member identified as CNA # 2 has also participated in a "teach and train" session regarding acceptable standards of infection control practices, including hand washing</p> <p>The corrective action taken for those residents found to be affected by the deficient practice: The resident identified as Resident #59 is now receiving personal care in accordance with acceptable standards of infection control practices. Her linens are being handled in accordance with acceptable standards of infection control practices. The resident's Bipap machine is now having the water emptied each morning in accordance with the current physician's orders. As noted earlier, the staff member identified as CNA #2 received a "teach and train" session related to acceptable standards of infection control practices, including hand washing between tasks and residents. (Resident #46)</p> <p>The corrective action taken for those residents found to be affected by the deficient practice: The resident</p>		

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	<p>"double gloving is a no and I have not seen that in years."</p> <p>On 12/19/11 at 11:19 a.m., the Assistant Director of Nursing [ADoN] provided a document, Non-Sterile Gloving Technique [no date], which indicated in order to reduce the risk of transmission of infection a key point was to only wear 1 pair of gloves at a time.</p> <p>2. An observation was made of Resident #106 on 12/14/11 at 10:15 a.m., being assisted with toileting. CNA #2 assisted Resident #106 with peri-care and removed gloves. CNA #2 then continued by assisting Resident #106 into her wheelchair to her room, touching the wheelchair and the doorknob. Further observation was made of CNA #2 continuing with work duties and no handwashing was done.</p> <p>3. On 12/12/11 at 3:25 p.m., Resident</p>		<p>identified as Resident #52 is now receiving personal care in accordance with acceptable standards of infection control practices.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice: All residents have the potential to be affected by this deficient practice. All residents are now receiving care and services in accordance with acceptable standards of infection control practices.</p> <p>The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur: A mandatory in-service has been provided for all nursing staff on the facility's standards of infection control practices, including hand washing. The topics reviewed at the in-service were hand washing practices, handling of linen, glove usage, care of a Bipap machine, and general infection control practice.</p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur:</i> A Quality Assurance tool has been developed and implemented to monitor consistent adherence to the facility's infection control policies and procedures. This tool will monitor personal care, hand washing, linen handling, treatments and care of the bipap machine in accordance with physician's orders. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months, and then quarterly for three quarters. The information obtained through completion of this Quality Assurance tool will be reviewed at the quarterly QA meeting to determine if additional action is warranted.</p>		

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	<p>#59's overbed table was observed in her room. It appeared to have sprinkles of white powder on the top surface. The resident indicated it was from her morning care, when they used powder after bathing her and hadn't been cleaned off. She further indicated she required a bi-pap machine to assist her breathing at night. She indicated the water was supposed to be emptied out of the device every morning and refilled at night. The device was observed on her bedside cabinet and had water in it.</p> <p>On 12/13/11 at 9:30 a.m., Resident #59 was observed being provided morning care by CNA #2. The CNA was observed to place a soiled wash cloth and towel on the overbed table. The CNA then provided perineal care to the resident, cleansing the front and the back of the periarea. The soiled wash cloths were placed on the overbed table. The CNA wore gloves during the cleansing. She did not change gloves and proceeded to get a bottle of powder and powder the resident's skin. She then assisted the resident to get clean clothes on and assisted her to the wheelchair. She wadded up the soiled linens, placed some of them in a plastic bag, then took her gloves off. She made the bed and put clothes away. Additional soiled linens were carried, along with the bagged linens, to the soiled utility room.</p>				

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	<p>CNA #2 disposed of the linens, then proceeded to the dining/activity area of the unit. Resident #46 was seated in a wheelchair in the room. She touched the resident's shoulders and face, then went to Resident #52's room and began helping him with morning care. No handwashing or hand sanitizing was observed. No sanitizing was done of the overbed table where the soiled linens had been. The bi-pap device was observed on the bedside cabinet and had water in the reservoir.</p> <p>Resident #59's room was observed on 12/16/11 at 10:30 a.m. The resident was in bed. The bi-pap device on the bedside cabinet had water in the reservoir. The resident indicated it had not been emptied all week.</p> <p>Resident #59's clinical record was reviewed on 12/13/11 at 1:42 p.m. The record indicated a physician's order, dated 9/1/11, "Nsg [nursing] to empty H2O [water] chamber every a.m. [morning], refill every p.m. [evening] distilled H2O."</p> <p>The policy and procedure for Handwashing, dated 9/08, was provided by the Director of Nurses [DoN] on 12/16/11 at 11:45 a.m. The policy and procedure included, but was not limited</p>			

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	<p>to, the following: "Before and after each resident contact, staff will wash their hands under running water with soap at the nearest sink. If an employee cannot get to a sink to wash their hands between resident contact, a no-rinse product may be utilized up to three times before going to a sink to wash their hands at a sink..."</p> <p>3-1-18(l)</p>				

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F0494 SS=D	<p>A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of § 483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b).</p> <p>A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e) (2)(i) and (ii) of this section.</p> <p>Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.</p> <p>Based on interview and record review, the facility failed to ensure 1 of 4 CNAs reviewed from out of state obtained Indiana CNA certificates within the 4 months required, in that the CNA continued to work past the 4 month deadline without having a competency evaluation for the state of Indiana. (CNA #3)</p> <p>Finding includes:</p> <p>Review of CNA certificates, on 12/15/11 at 3:00 p.m., indicated CNA #3 had a</p>	F0494	<p>F - 494</p> <p>The corrective action taken for those residents found to be affected by the deficient practice: No specific residents were identified as having been directly affected during the survey. The certified nursing assistant that was identified as CNA #3 has now taken and passed her Indiana certification test.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice:</i> All residents have the potential to be affected by the deficiency cited. The facility has conducted a house-wide audit of all the files of employee s currently working as nursing assistants</p>	01/13/2012

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	<p>Kentucky CNA certification, but did not have a current Indiana CNA certification.</p> <p>Further record review indicated CNA #3 had a hire date of 8/11/11.</p> <p>The facility receptionist provided a document that indicated CNA #3 was scheduled to take the Indiana CNA certification test on 12/14/11, but due to identification denial, CNA #3 had been rescheduled for testing on 12/19/2011.</p> <p>In an interview with the Director of Nursing [DoN] on 12/16/11 at 10:10 a.m., the DoN indicated in order to work as a CNA in Indiana, CNA #3 would had to have taken the CNA certification test within 120 days of the hire date.</p> <p>The DoN provided a timecard report document of CNA #3's time on 12/16/11 at 10:35 a.m., which indicated CNA #3 had worked on 12/10/11, 12/11/11 and 12/12/11.</p> <p>The DoN provided a 2 week schedule on 12/16/11 at 11:30 a.m., which indicated CNA #3 was scheduled to work on the following dates: 12/10/11, 12/11/11, 12/12/11, 12/14/11, 12/15/11, and 12/16/11, all of which were past the 120 day deadline for CNA #3 to obtain her Indiana CNA certification.</p>		<p>to ensure proper certification. Any nursing assistant who has not taken their certification test has been scheduled to take the test prior to their 120 th day of employment. The one employee who had passed the 120 th day of employment was removed from the schedule until successfully passing the certification test.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur: The Staffing Coordinator has been given a "teach and train" counseling session, and has been instructed that upon hiring of any non-certified nursing assistant, the certification test is to be scheduled within thirty days of hire to secure a test date within the first 120 days of employment. The Staffing Coordinator was also instructed that if any employee has not successfully passed the certification test by their 120 th day of employment, they are to be removed from the schedule.</p> <p>The corrective action will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented to monitor employee files to ensure all required certifications have been obtained in accordance with all State and Federal requirements. This tool will be completed by the Director of Nursing and/or her designee. The tool will be completed weekly for four weeks, then monthly for three months, and then quarterly for three quarters. The information obtained through the</p>				

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F9999	<p>3.1-14(b)(2)</p> <p>STATE RULES</p> <p>3.1-13 Administration and management (m) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under a written agreement. Such agreements pertaining to services furnished by outside resources must specify, in writing, that the facility assumes responsibility for the following:</p> <p>(3) Orientation to pertinent facility policies and residents to whom they are responsible.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure Agency staff knew what to do in the event of an emergency, in that 6 of 6 Agency staff were not</p>	F9999	<p>completion of this Quality Assurance tool will be reviewed at the quarterly QA meeting to determine if any additional action is warranted.</p> <p>State Finding</p> <p>The corrective action taken for those residents found to be affected by the deficient practice: No residents were identified as having been directly affected by this deficiency during the survey. Agency staff identified as RN #s 1, 2, 3, and 4, as well as CNA #s 1 and 2 have all been oriented to the facility with special focus on residents' rights, abuse, and fire/disaster preparedness, along with a review of the floor plan and physical tour of the unit in which the agency personnel has been assigned.</p> <p>The corrective action taken for the other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice. In the future, all new agency staff will be oriented to the facility prior to providing any direct resident care.</p> <p>The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur: The Staffing Coordinator has developed and implemented a specific orientation program for all agency staff new to the Pine Haven facility to ensure that they are properly oriented prior to providing any direct resident care. This</p>	01/13/2012	

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	<p>trained on fire policy and procedure. (Agency RN #1, Agency RN #2, Agency RN #3, Agency RN #4, Agency CNA #1, and Agency CNA #2) This had the potential to affect 97 of 97 residents who resided in the facility.</p> <p>Findings include:</p> <p>During the entrance conference on 12/12/11 at 11:15 A.M., the Health Facilities Administrator [HFA] indicated the facility utilized agency staff.</p> <p>In an interview with CNA [Certified Nursing Assistant] #1 on 12/14/11 at 10:20 A.M., she indicated she was in charge of nursing staff scheduling and in the past 30 days agency staff had been utilized on eight days.</p> <p>The daily nursing schedule was provided by CNA #1 on 12/14/11 at 10:25 and was reviewed at that time. The schedule indicated the following:</p> <p>Agency RN #1 was on duty 11/26/11 on evening shift Agency RN #2 was on duty 11/27/11 on evening shift Agency CNA #2 was on duty 11/27/11 on night shift Agency CNA #1 was on duty 12/06/11 on day shift</p>		<p>orientation program includes residents' rights, abuse, and fire/disaster preparedness, along with a review of the facility's floor plan and a physical tour of their assigned unit.</p> <p>The corrective action will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented to monitor utilization of agency personnel to ensure that the required facility orientation has been completed prior to the provision of any direct resident care. This tool will be completed by the Director of Nursing and/or her designee. The tool will be completed weekly for four weeks, then monthly for three months, and then quarterly for three quarters. The information generated through the completion of this Quality Assurance tool will be reviewed at the quarterly QA meeting to determine if any additional action is warranted.</p>		

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	<p>Agency CNA #2 was on duty 12/06/11 on night shift            Agency RN #3 was on duty 12/09/11 on evening shift            Agency RN #3 was on duty 12/10/11 on evening shift            Agency CNA #2 was on duty 12/10/11 on night shift            Agency RN #3 was on duty 12/11/11 on evening shift            Agency CNA #2 was on duty 12.11 on night shift            Agency CNA#2 was on duty 12/12/11 on night shift            Agency RN #4 was on duty 12/13/11 on evening shift.</p> <p>In an interview with the ADoN [Assistant Director of Nursing] on 12/14/11 at 11:15 A.M., he indicated "Agency staff is not formally inserviced on fire..." He indicated they had no procedure in place to orient agency staff to the facility.</p> <p>3.1-13(m)(3)</p>				