STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 05/22/2014

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MANOR CARE HEALTH SERVICES	1315 S UNIVERSITY DR FARGO, ND 58103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey and complaint survey started on May 19, 2014, and completed on May 22, 2014, the sample included five (5) residents for complete review, twelve (12) residents for focused review, and three (3) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000	Fargo Plan of Correction for annual survey conducted on 5/22/14. The statements on this plan of correction are not admittances to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take action as set forth in the following plan of correction. The plan of correction constitutes the center's assertion of compliance. All alleged deficiencies cited have been or will be corrected by dates indicated.	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)	F 156		

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

Shannon Ellering 7-8-14

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

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F 156	Continued From page 1 (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	F156 ManorCare Fargo strives to provide Skilled Nursing Facility Denial Letters to patients when appropriate. Resident # 21 is no longer a patient at ManorCare Fargo. Residents who are Medicare Beneficiaries have the potential to be effected by this practice. Education on providing Skilled Nursing Facility Denial Letters as required was provided to licensed social workers by 6/30/14. Administrator or designee will conduct random audits weekly times six weeks, then monthly times two months, then quarterly times two quarters to ensure Skilled Nursing Facility Denial Letters were provided as required. Quality Assurance implemented 7/7/14.	

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F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of Medicare billing records and staff interview, the facility failed to provide a denial letter to 1 of 1 supplemental resident (Resident #21) discharged from Medicare services. Failure to provide an explanation of demand billing and submit demand bills is a violation of resident rights. This failure has the potential to affect all Medicare beneficiaries. Findings include: Review of the facility's Medicare billing records occurred on 05/20/14. The records identified Resident #21's Medicare coverage ended on 03/14/14. Resident #21's Medicare file lacked a Skilled Nursing Facility (SNF) Denial Letter, allowing the resident to request a demand bill, as the resident remained in the facility. This form asks the resident, or the responsible party, if they wish a demand bill (a review of the Medicare Part A	F 156	Audits will be forwarded to the QAPI committee for further recommendations and actions based on findings. Administrator or designee responsible for compliance by 7/11/14.	

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F 156	Continued From page 3 services). During an interview on the morning of 05/20/14, an administrative business office staff member (#5) and a social services staff member (#6) confirmed the facility failed to provide Resident #21 a SNF denial letter as required.	F 156		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide for an ongoing, individualized, and meaningful activity program to meet the needs of 1 of 1 sampled resident (Resident #6) with impaired cognition and on a one-to-one activity program. Failure to implement an individualized activity program to respond to the interests and current capabilities of the resident has the potential to negatively affect the resident's psychosocial well-being. Findings include: Review of the facility policy titled "Program Types and Guidelines" occurred on 05/22/14. This policy, dated January 2013, stated, "Program Modalities: Activity and recreation services are presented in various modes of delivery reflective of the interests and needs of the patients.	F 248	F248 ManorCare Fargo strives to meet the physical, mental, and psychosocial needs of each resident through an ongoing program of activities. Resident #6 was reassessed and her care plan updated to meet her past and current leisure interests on 6/22/14. She no longer resides in the facility. Residents with impaired cognition and on a one-to-one activity program have potential to be effected by this practice.	

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F 248	Continued From page 4 Program modalities include group, one-to-one and self-initiated. . . . One-to-One Programming: A one-to-one program is provided for patients unable or unwilling to participate in large group setting, meeting some or all of the following criteria: *health and or disease status limits participation in group activities . . . *behavioral symptoms that limit tolerance and participation in group setting, *patient chooses not to participate in group activities offered or seldom initiates own activities. For some patients an individualized visit is intended as a brief intervention to help with orientation and adjustment. For patients with cognitive impairment, it could be a bridge to re-connect them to their interests. . . . Individualized visits are diverse to match the variety of patients receiving them depending on the patient's abilities, interests, and needs. . . . When offering individualized visit opportunities, consider the reduced ability of individualized visits to offer the full psychosocial benefit that comes from group involvement and spontaneous interaction with others. Individualized visit opportunities may be offered outside a patient's room in lounge areas, office areas, out of doors or in areas of the patient's choice. This strategy can potentially provide the psychosocial benefit of impromptu interaction with others and act as a bridge to participation in small and large group offerings. . . ." Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included dementia with behavior disturbance, anxiety, and depression. The current Minimum Data Set, dated 04/18/14, identified Resident #6 as severely impaired in cognition and required extensive assistance of one person for transfers	F 248	Administrator or designee educated activities staff members on providing an ongoing, individualized and meaningful activity program to meet the needs of residents on one-to-one activities programs and with impaired cognition by 7/1/14. Administrator or designee will conduct random audits weekly times six weeks, then monthly times two months, then quarterly times two quarters to ensure appropriate activities care plans for those on one-to-one activities programs and with impaired cognition. Quality Assurance implemented 7/7/14. Audits will be forwarded to the QAPI committee for further recommendations and actions based on findings. Administrator or designee responsible for compliance by 7/11/14.	

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F 248	Continued From page 5 and locomotion on unit. Resident #6's current care plan identified, "Focus: Prefers not to attend group activities due to resident choice, likes to stay in room most of day. Goals: Will participate in independent leisure activities of choice such as socializing with family, residents, & staff, and occasionally watching television. Will actively engage in room/1:1 activities such as socializing, listening to music, and working on jigsaw puzzles. Interventions: Assist in planning and/or encourage to plan own leisure time activities. Provide supplies/materials for leisure activities as needed/requested. Respect choice in regard to limited/not activity participation. Provide 1:1 (one-to-one) activity visits of potential interest 2 x [times] per week." The care plan also identified "Focus: Behavior symptoms (verbal aggression toward other) r/t [related to] dementia . . . Interventions: . . . likes to spend time reading - offer a book. . . . Focus: Indicators of depression/sadness . . . Dx [diagnosis] of major depressive d/o [disorder]. . . Interventions: Attempt to involve in activities respecting choice and preferences. Offer choices to enhance sense of control . . ." A nutritional assessment, dated 04/28/14, identified, "Pt [patient] has been usually eating in her room which is her preference . . ." Review of Recreational Services progress notes identified the following: *03/31/14 - ". . . Resident prefers not to attend group activities and is content working on independent activities. Resident socializes with other residents, watches television, and occasionally takes reading materials from leisure cart."	F 248		

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F 248	Continued From page 6 05/02/14 - "Resident is put on one on ones as of today due to lack of interest in group activities and little participation in independent activities." Review of Resident #6's "Daily Recreation/Activity Participation Documentation" identified the resident either refused, was unavailable, or did not participate in any group activities for the months of March, April and May 2014. The logs for these months identified "Independent - Socializing" and "Independent - Television" as Resident #6's activities. Observations of Resident #6 showed the following: 05/20/14 *8:00 a.m. - Resident sitting in room in wheelchair with the television on (resident's eyes closed). *9:15 a.m. - Resident eating breakfast in her room. A CNA (#3) stated the resident eats all of her meals in her room because she can become loud and disruptive in the dining room. *9:20 a.m. - A CNA (#3) provided toileting cares. Resident #6 stated she is afraid, asking the CNA to stay in the room with her as she does not want to be left alone. The CNA talked with the resident for approximately 5-10 minutes and then left the room. *10:30 a.m. - Resident sitting alone in her room in wheelchair. *11:15. Resident in wheelchair in room, looking out the door into the hallway. *12:15 p.m. - CNA (#3) provided toileting cares. Resident #6 stating she does not want to be alone. CNA (#3) called the resident's daughter, but there was no answer, so the resident left a message for the daughter to call her. After talking with the resident, the CNA left the room.	F 248		

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F 248	Continued From page 7 Observation showed no recreational items in the room, such as books, puzzles, etc., and the television was not on. *3:00 p.m. - Resident sitting in her room in her wheelchair looking out the door into the hallway. *4:30 p.m. - Resident sitting in her room in her wheelchair, looking out the door. 05/21/14 *10:10 a.m. - Resident sitting in room. An unidentified staff member was talking to the resident and stated Resident #6 "just wants someone to sit with her" *10:55 - CNA (#7) provided toileting cares. Resident again stating she does not want to be alone. After the interaction, the CNA left the room. *1:45 p.m. - Resident sitting in her room in her wheelchair by herself. The television was not on. *3:00 p.m. - Resident sleeping in bed on her back. *3:50 p.m. - Resident remains asleep in bed *4:30 p.m. - Resident awake in bed, stating "I am so scared, I don't want to be alone." A staff member (#16) offered the resident a cookie, sat with her for approximately 5-10 minutes, placed the call light in reach, and left the room. Random observations throughout the morning on 05/22/14 showed Resident #6 in her room, sitting in her wheelchair. Resident #6 ate all of her meals in her room during the survey. Although the care plan identified Resident #6 enjoyed socializing, listening to music, jigsaw puzzles and reading books, observations on June 20-21 showed the resident in her room sitting in her wheelchair, without any books or puzzles and with limited social interaction. Observations showed Resident #6 asking for staff to sit with her	F 248		

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F 248	Continued From page 8 and talk with her. During an interview the morning of 05/22/14, an administrative activity staff member (#17) confirmed activity staff should increase the number of 1:1 visits with Resident #6 to provide more social interaction.	F 248		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy/procedure review, and staff interview, the facility failed to ensure that each resident received adequate supervision to prevent accidents for 1 of 1 sampled resident (Resident #6) left alone in the bathroom. Failure to provide adequate supervision to prevent accidents has the potential to result in a fall and/or injury. Findings include: Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included vascular dementia, anxiety, kyphosis, muscle weakness, and difficulty walking. The current Minimum Data Set, dated 04/18/14, identified Resident #6 as severely impaired in cognition and	F 323	F323 ManorCare Fargo strives to provide adequate supervision to prevent accidents. CNA (#3) was educated regarding reading the Point of Care Task List and leaving patients alone in the bathroom when tasked to stay with the resident. Resident # 6 no longer resides in the facility. Patients with a Point of Care Task to not leave the patient unattended in the bathroom have potential to be affected by this practice.	

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F 323	Continued From page 9 required extensive assistance of one person for transfers and toilet use. Resident #6's current care plan identified "At risk for falls due to impaired balance/poor coordination . . . Interventions: . . . Staff to stay with pt [patient] when pt in bathroom. . . ." The "Point of Care Task List" for certified nursing assistants (CNA) identified "special need (FYI) [for your information] do not leave patient unattended in bathroom." Review of General Progress Notes identified the following: 04/14/14 at 1:29 p.m. - ". . . Is confused/forgetful most of the time. . . . Does ambulate per self. Remind pt [patient] to ask for assistance. Is incontinet (sic) of bladder at times. Does toilet self. Does not use call light appropriately, will yell for assistance. . . ." Nurses notes from January 1, 2014 to May 22, 2014 identified staff found Resident #6 on the floor six (6) times, attempting to self transfer/walk. Observation at 10:55 a.m. on 05/21/14 showed a CNA (#3) assisted Resident #6 to transfer from the wheelchair to the toilet. The CNA placed the call light in the resident's hand, closed the bathroom door, walked out of the room, and closed the room door. The call light immediately started to ring and the CNA returned to the bathroom. Resident #6 did not appear to be aware of putting the call light on. The CNA (#3) again left the resident, closed the bathroom door, walked out of the room, and closed the room door. Once outside of the room, the surveyor asked the CNA (#3) if Resident #6 could be left alone in the bathroom. The CNA (#3) stated that	F 323	Licensed nursing staff was educated regarding the importance of not leaving individuals alone in the bathroom if they are Point of Care Tasked accordingly by 7/8/14. Those yet to be educated will not be permitted to work until education is complete. Random audits weekly times six weeks, then monthly times two months, then quarterly times two quarters will be conducted by the ADNS or designee to ensure no patients with Point of Care Task Plans to not be left unattended in the bathroom are left alone. Quality Assurance implemented 7/7/14. Audits will be forwarded to the QAPI committee for further recommendations and actions based on findings. ADNS or designee responsible for compliance by 7/11/14.	

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F 323	Continued From page 10 she did not know, as she did not usually work on this unit. The CNA asked a nurse (#7) who also stated she does not usually work on this unit and was not sure if the resident could be left alone. The nurse (#7) then told the CNA (#3) to go check on the resident and to not leave her alone. The CNA (#3) returned to the room and stayed with the resident in the bathroom. During an interview the afternoon of 05/22/14, an administrative staff member (#9) confirmed staff should not leave Resident #6 alone in the bathroom.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide fluids to maintain adequate hydration for 3 of 8 sampled residents (Resident #5, #6, and #8) observed during personal cares. Failure to offer fluids to residents who are unable to access them independently placed these residents at risk for dehydration, constipation, and urinary tract infections (UTIs). Findings include: - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, hemiplegia, dysphasia, and a	F 327	F327 ManorCare Fargo strives to ensure each resident is provided with sufficient fluid intake to maintain proper hydration and health. Hydration evaluations were completed for Residents #5 and #8 on 6/18/14 and 5/28/14, respectively. Resident #6 no longer resides in the facility.	

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F 327	Continued From page 11 history of UTIs. The current care plan stated, ". . . ADL [activities of daily living] Self care deficit related to physical limitations: CVA [cerebrovascular accident] with left sided hemiplegia, dementia, and generalized weakness. . . . Interventions . . . Hands on assist with . . . eating . . . Risk for alteration in hydration related to cognitive state with STM [short term memory] & LTM [long term memory] deficits . . . Interventions . . . Encourage and assist as needed to consume all fluids offered at and between meals . . . Thickened liquids per MD[medical doctor]/mid-level order . . ." Resident #5's dietary tray card identified two glasses of nectar thick milk at each meal. Observations on 05/20/14 at 9:51 a.m. and 11:42 a.m. showed Resident #5 in bed, and certified nursing assistants (CNAs) (#14 and #15) checked and changed the resident's brief and repositioned her. The CNAs failed to offer/encourage fluids. Observations on 05/20/14 from approximately 2:45 p.m. until 4:41 p.m. showed Resident #5 in bed. At 4:41 p.m., two CNAs (#10 and #11) assisted the resident out of bed and failed to offer/encourage fluids. Observation also showed two unopened containers of thickened water on the bedside table. Observations on 05/20/14 at 5:51 p.m. and on 05/21/14 at 8:08 a.m. showed Resident #5 in the dining room eating her meals. Observation showed one 8 ounce glass of milk at each meal, not two glasses as identified on her tray card. Observations on 05/21/14 at 8:51 a.m. and 11:41	F 327	Staff members will be educated on the importance of offering/encouraging fluids, opening containers of liquids for patients when appropriate, and matching the fluid preferences on meal cards by 7/11/14. Residents Care Planned to be at a hydration risk as based on an IDT assessment, have potential to be affected by this practice. Random audits weekly times six weeks, then monthly times two months, then quarterly times two quarters will be conducted by the ADNS or designee to ensure that staff is offering/encouraging fluids when appropriate, opening containers of fluids when appropriate, and offering residents fluids listed on their meal cards. Quality Assurance implemented ~~7/7/14~~ 7/11/14 per TC DON 7/9/14 KH Audits will be forwarded to the QAPI committee for further recommendations and actions based on findings. ADNS or designee responsible for compliance by 7/11/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 327	Continued From page 12 a.m. showed CNAs (#12 and #13) assisted Resident #5 with cares but failed to offer/encourage fluids. During an interview on the morning of 05/22/14, a supervisory nurse (#9) stated staff are educated to offer fluids between meals and with cares. - Review of Resident #8's medical record occurred on all days of survey and diagnoses included myotonic muscular dystrophy and mild intellectual disabilities. The quarterly Minimum Data Set (MDS), dated 05/05/14, identified extensive assistance for eating and weight loss. The current care plan stated, ". . . Focus: Risk for alteration in hydration related to abnormal labs, decreased appetite, needing assistance with eating and drinking, disease process/conditions . . . times of dry mouth . . . Interventions . . . Encourage and assist patient with fluids at and between meals as needed and as she allows." Review of a nutrition/weight progress note dated 02/18/14 stated, ". . . she [Resident #8] does need assistance with drinking her fluids . . ." Observations on 05/20/14 at 11:10 a.m. and 3:50 p.m. showed Resident #8 toileted by CNAs (#2 and #3). The CNAs failed to offer/encourage fluids. Observation on 05/21/14 at 9:30 a.m. showed the CNA (#2) washed Resident #8's eyes and failed to offer/encourage fluids. - Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included dementia, hypertension, and edema.	F 327		

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F 327	Continued From page 13 Resident #6's current medications included furosemide (a diuretic medication) 20 milligrams twice a day. The current Minimum Data Set, dated 04/18/14, identified Resident #6 as severely impaired in cognition and required supervision and setup help for eating. Resident #6's current care plan stated, "Risk for alteration in hydration related to abnoraml (sic) labs, diuretic medication, cognitive deficits, disease process/conditions: (dementia with paranoia & [and] behavioral disturbance, depression, anxiety, . . .), times of pain, times of refusing meals and cares, times of behaviors, times of constipation. . . . Interventions: . . . Encourage and assist patient with fluids at and between meals as needed and as she accepts. . . " Observations on 05/20/14 at 9:20 a.m. and 12:15 p.m. showed Resident #6 toileted by a CNA (#8). The CNA failed to offer/encourage Resident #6 to drink fluids. Observation on 05/21/14 at 10:55 a.m. showed Resident #6 toileted by a CNA (#3). The staff member (#3) failed to offer or encourage Resident #6 to drink fluids. During an interview on 05/22/14 at 10:43 a.m., an administrative staff member (#4) stated offering fluids with cares is a standard of practice.	F 327		
F 494 SS=B	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY 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	F 494		

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F 494	Continued From page 14 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). 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. 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. This REQUIREMENT is not met as evidenced by: Based on review of state nurse aide registry files, facility record review, policy and procedure review, and staff interview, the facility failed to ensure 1 of 1 nursing assistant (staff member A) whose certification had expired remained certified. Staff member A provided hours of nursing related services without verifying competency through certification. Failure to ensure certification of caregivers has the potential to affect resident care. Findings include: Review of the facility policy titled	F 494	F494 ManorCare Fargo strives to ensure that certified nursing assistants are competent and able to provide care while working. (Staff member A) is now appropriately licensed and competent. The employee responsible for ensuring licensed staff members are licensed and competent at the time of the expired certification is no longer employed at ManorCare Fargo. Current human resources staff were educated on ensuring licensure is current on 6/27/14. Administrator or designee will conduct random audits weekly times six weeks, then monthly times two months, then quarterly times two quarters to ensure staff are licensed as appropriate. Quality Assurance implemented 7/7/14.	

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F 494	Continued From page 15 "License/Certification Vertification" occurred on the morning of 05/21/14. The policy, dated 06/15/11, stated ". . . The human resources designee or other designee (e.g. nursing) shall maintain a system to track all license/certification expiration dates and will take steps to ensure no employee works with an expired license. . . ." - Staff member A contacted the state nurse aide registry on 07/09/13 to renew the employee's certification. The state nurse aide registry file review identified staff member A's certification expired on 06/17/13. Review of the employee's hours on the morning of 05/20/14 verified staff member A worked between 06/17/13 and 07/09/13 for 99. 6 hours (13 shifts) with an expired certification.	F 494	Audits will be forwarded to the QAPI committee for further recommendations and actions based on findings. Administrator or designee responsible for compliance by 7/11/14.	