STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355095	A. BUILDING _____ B. WING _____	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OAKES	213 N 9TH ST OAKES, ND 58474

(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, started on 07/22/13 and completed on 07/24/13, the sample included 4 residents for complete review, 10 residents for focused review, and 3 closed records for review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, and staff interview, the facility failed to ensure staff fed residents in a manner which enhances each resident's dignity for 2 of 3 days (July 22 -24, 2013) of meal observations for Resident #4 and #6. Findings include: Review of the facility policy titled "Dining Room Service" occurred on the afternoon of 07/24/13. The policy, dated November 2009, stated, ". . . If dining assistance is needed by a resident, staff are to sit next to the resident; do not stand and feed resident. . . ." It's Tough to Swallow: Nutrition and Dining for Dysphagia by Becky Dorner & Associates, a division of Nutrition Consulting Services, Inc,	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	8-12-13

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 241	Continued From page 1 copyright 2002, page 70, indicated: "General Feeding Tips: . . . Sit next to the person and feed from eye level (not from above) . . ." - Observation 07/23/13 at 11:30 a.m. showed Resident #6 seated in a wheelchair at the East nurses' station. Observation showed a Certified Nursing Assistant (CNA) (#1) standing and bending over Resident #6 to feed her the noon meal. Review of Resident #6's medical record occurred on July 22-24, 2013. Resident #6's medical diagnoses included dementia and anxiety. Resident #6's quarterly Minimum Data Set (MDS), dated 06/28/13, identified extensive assistance with eating. - Observation on 07/23/13 at 11:45 a.m. showed Resident #4 seated in a reclining chair at the East nurses' station. Observation showed a CNA (#1) standing and bending over Resident #4 to feed her the noon meal. - Observation on 07/24/13 at 11:00 a.m. showed Resident #4 seated in a reclining chair at the East nurses' station. A CNA (#1) prepared Resident #4's tray and began to feed her while standing. An administrative staff nurse (#2) informed the CNA she "needs to sit down beside the resident whenever she feeds [Resident #4's name]." Review of Resident #4's medical record occurred on July 22-24, 2013. Resident #4's medical diagnoses included dementia, and anxiety. Resident #4's significant change MDS, dated 06/12/13, identified extensive assistance with eating.	F 241	F-241 1. The Facility will ensure when resident #6 is being assisted with dining that the person who is assisting is sitting at eye level. Resident #4 has expired. 2. All residents who are assisted to eat have the potential to be affected by this same deficient practice. 3. Education will be given to the staff that helps with dining on August 27th about the correct procedure that they should be using. They should be seated when assisting residents. 4. An audit will be developed to show compliance with the procedure of sitting when feeding. Audits will be done by the QA Coordinator or designee weekly for 1 month, monthly for 3 months, and as deemed necessary by the QA committee. 5. The Corrective action will be complete by August 28, 2013	

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F 241	Continued From page 2 During an interview on 07/23/13 at 9:15 a.m., an administrative nursing staff member (#2) confirmed staff should not stand when feeding residents as is "overbearing."	F 241		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment and services to promote healing for 1 of 2 sampled residents (Resident #10) with a current pressure ulcer. Failure to develop a care plan, notify the dietary department, and monitor the pressure ulcer may result in delayed healing of the ulcer. Findings include: Review of the facility policy "Pressure Ulcers: Skin Assessment and Prevention" occurred on 07/23/13. The policy, revised January 2011, stated: "Purpose: . . . * To accurately document observation and assessments of residents * To appropriately use prevention techniques and	F 314		

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F 314	Continued From page 3 pressure redistribution surfaces on those residents at risk for pressure ulcers . . . Procedure: . . . 4. A comprehensive assessment, which includes the Resident Assessment Instrument (RAI), will be completed by the RN evaluating the resident's risk factors, the resident's skin condition, and the nature of the pressure to which the resident may be subjected. . . . Risk factors are those factors that increase a resident's susceptibility to develop or impact healing times of pressure ulcers. They include, but are not limited to: * Impaired/decreased mobility and decreased functional ability * Co-morbid conditions, such as . . . diabetes mellitus . . . * Cognitive impairments . . . 5. A systematic skin inspection will be made daily by the nursing assistant assigned to those residents at risk for skin breakdown . . . The nursing assistant responsible for this will report any abnormal findings or signs of skin impairment to the licensed nurse. . . 7. If a pressure ulcer is identified . . . The licensed nurse records the location of the area, the measurements and the ulcer/wound characteristics. Document the information on the Wound Flow Sheet . . . 10. Notify dietary of the pressure ulcer using the Nutrition Risk Notification . . . 11. The interdisciplinary teams should determine any modification that are necessary to the resident's plan of care. . . . 14. The pressure ulcer should be assessed/evaluated at least weekly and documented on the Wound Flow Sheet . . . should include at least the following: * Measurements - length, width, depth * Characteristics of the ulcer . . ."	F 314		

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F 314	Continued From page 4 On 07/22/13 at 3:30 p.m., a certified nursing assistant (CNA) (14) transferred Resident #10 from the bathroom to her recliner using a sit-to-stand lift. Observation showed a pressure relieving boot on the resident's left foot. The CNA (#14) stated Resident #10 did not have an open area, but had a "dark heel." The CNA removed the boot. Observation showed a crescent shaped area approximately 6 centimeters (cm) long by 2.5 cm wide on the resident's lateral left heel covered with black eschar (dead tissue). Resident #10's medical record, reviewed on all days of survey, identified diagnoses including cerebral vascular accident with left hemiparesis (weakness), diabetes mellitus, and dementia. An annual Minimum Data Set (MDS), dated 07/16/13, identified the resident had short and long term memory problems, severely impaired decision making skills, and required extensive assistance with bed mobility, transfers, dressing, eating, and toilet use, and total assistance with personal hygiene. The MDS also identified the resident not at risk for pressure ulcers and had no unhealed pressure ulcers. Interdisciplinary Progress Notes (IDP notes) identified the following: * 07/09/13 at 6:45 a.m.: "Resident has a 5 cm x [by] 2.5 cm on her left heel (blister). She also has [increased] edema in her left foot and ankle. No edema noted in Rt [right] foot ankle. No verbal or non verbal indication of pain noted. Soft protective brace and foot pedal will be applied to protect foot/ankel [sic] (left) from injuries . . ." * 07/15/13 (no time recorded): ". . . Blister intact to bottom of heel . . ." The record indicated staff notified the physician of	F 314		

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F 314	Continued From page 5 the blister. A physician's progress note, dated 07/09/13, stated, "Patient is being seen today for recertification for nursing care facility. Nursing staff indicates that for the past couple of days patient's left foot and ankle have been swollen, There is redness in the area and patient also has a blister in the area of the left heel. . . ." The record showed the physician ordered an antibiotic for a diagnosis of cellulitis of the left ankle. Observations of Resident #10's pressure ulcer occurred on 07/23/13 at 10:15 a.m. with the two administrative nurses (#5 and #6) and a CNA (#11). The nurses confirmed Resident #10 had an unstageable pressure ulcer covered with black eschar on her left heel. Resident #10's care plan, dated 07/09/13, identified interventions including the pressure relieving boot for the cellulitis of the left ankle, but failed to identify interventions for the left heel pressure ulcer. Resident #10's medical record lacked further documentation regarding the ulcer to the resident's left heel, including weekly documentation on a Wound Sheet with measurements and characteristics of the ulcer. During an interview on 07/13/13 at 9:45 a.m., a supervisory/MDS nurse (#6) and an administrative nurse (#5) stated they were aware of the left ankle cellulitis, but unaware of the resident's left heel pressure ulcer. An interview with a dietary supervisor (#13) occurred on 07/23/13 at 10:00 a.m. The staff member stated she was not aware of Resident #10's pressure ulcer and confirmed the resident	F 314	F 314 1. The Facility has ensured all the accurate document observation, assessments and a notification to dietary had been done for resident #10. 2. All Residents who have the potential for forming pressure ulcers have the potential to be affected by this same deficient practice. 3. Nursing staff will be educated on August 27th about the proper procedure about communicating, documentation and prevention techniques of the formation of pressure ulcers. 4. An audit will be developed to show compliance of these procedures. Audits will be done by the QA Coordinator or designee weekly for 1 month, monthly for 3 months, and as deemed necessary by the QA committee. 5. The Corrective action will be complete by August 28, 2013	

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F 314	Continued From page 6 was not on the facility's nutrition risk list. The staff member (#13) stated she is usually notified of skin issues at the daily stand-up meeting. An interview with the MDS nurse (#6) occurred on 07/23/13 at 10:20 a.m. The nurse verified the 07/16/13 MDS did not identify the pressure ulcer and she would correct it. The nurse confirmed the lack of a care plan and weekly wound documentation of the pressure ulcer and stated it was her expectation that staff complete both. Facility staff's failure to notify administrative nursing and dietary staff, develop a care plan, and complete weekly monitoring of Resident #10's pressure ulcer may have delayed healing of the ulcer.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329		

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F 329	Continued From page 7 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, policy and procedure review, review of professional literature, and staff interview, the facility failed to ensure a drug regimen free of unnecessary medications for 1 of 2 sampled residents (Resident #4) with orders for as needed (PRN) Ativan (an anti-anxiety medication) and Tylenol (a pain medication). Findings include: The 2013 Nursing Drug Handbook, page 843-844, identified adverse reactions to Ativan (Lorazepam) as drowsiness, sedation, amnesia, insomnia, agitation, dizziness, weakness, unsteadiness, disorientation, depression, and headache. The Handbook stated, "Use cautiously in elderly, acutely ill, or debilitated patients. . . ." Review of the facility policy titled "Psychoactives" occurred on the afternoon of 07/24/13. The policy, dated January 2006, stated, ". . . While the use of prn psychoactive medications is not encouraged, if a prn Physicians' order is received, ensure that the order has clear parameters, i.e. severe agitation that does not respond to other care plan interventions. It is important to initiate other care plan interventions prior to the use of prn psychoactive medications. . . ."	F 329		

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F 329	Continued From page 8 Review of Resident #4's medical record occurred on July 22-24, 2013. Diagnoses included shoulder pain, dementia, anxiety, Parkinson's disease, weakness, and depression. The resident's significant change Minimum Data Set (MDS), dated 06/12/13, identified short term and long term memory problems, verbal and other behaviors occurring 1 to 3 days, and no pain present. Resident #4's Physician Orders, signed 07/18/13, identified the following: 06/27/13 - Tylenol #3 [300 mg Tylenol and 30 mg Codeine] one by mouth at hour of sleep and every six hours prn pain 06/27/13 - Ativan (Lorazepam) 0.5 mg one by mouth prn twice a day for anxiety Review of Resident #4's Medication Administration Records (MARs) for June and July revealed administration of prn Tylenol #3 and Ativan simultaneously on 15 occasions during the evening and night shifts. The medical record lacked evidence that staff consistently implemented non-pharmacological interventions prior to administering the anti-anxiety medication. Review of the June and July MARs revealed Tylenol #3 and Ativan administered with the following reasons of restless, moaning, hollering, crying out, and agitation. Facility staff failed to assess the effectiveness of one medication before attempting another medication. During an interview on the afternoon of 07/24/13, an administrative nursing staff member (#2) confirmed staff failed to consistently implement non-pharmacological interventions and provide adequate rationale for the simultaneous	F 329	F329 1. Resident #4 has expired on 8-7-13. 2. All Residents who receive PRN anti-anxiety medication and pain medication have the potential to be affected by this deficient practice. 3. Nursing staff will be educated on August 27th about the proper procedure of consistently implementing non-pharmaco-logical intervention and provide adequate rationale for the use of giving PRN medications. 4. An audit will be developed to show compliance of these procedures. Audits will be done by the QA Coordinator or designee weekly for 1 month, monthly for 3 months, and as deemed necessary by the QA committee. 5. The Corrective action will be complete by August 28, 2013	

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F 329	Continued From page 9 administration of Tylenol #3 and Ativan.	F 329		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, record review, and staff interview, the facility failed to prepare pureed food using methods to enhance attractiveness on 3 of 3 days (July 22-23, 2013). Failure to ensure foods served to residents are prepared to promote palatability may impact food intake of residents. Findings include: Review of facility's policy titled "Texture Altered Diets" occurred on the afternoon of 07/24/13. The policy, dated August 2012, stated, ". . . The pureed diets should be prepared and plated to maximize the visual impact and dining experience. . . . Pureed foods will hold a "mashed potato" consistency . . . Pureed food will not be combined, or stirred together, on the plate during dining unless it is requested by the resident and documented in the care plan. . . ." - Observation of the evening meal on 07/22/13 at 5:40 p.m. showed a certified nursing assistant (CNA) (#4) assisted Resident #10 to eat. Observation showed light brown, yellow, and red	F 364		

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F 364	Continued From page 10 pureed foods on the resident's plate, which the CNA identified as Polish sausage, macaroni and cheese, and beets. Observation showed the three items had a very soft consistency and, due to that consistency, ran together on the plate. Observation of the noon meal on 07/23/13 at 11:50 a.m. showed a CNA (#1) assisted Resident #10 to eat. Observation showed pureed meatloaf, peas, and mashed potatoes on the resident's plate. The meatloaf and peas were of a very soft consistency and ran into the mashed potatoes. Observation on 07/23/13 at 11:45 a.m. showed Resident #4 seated in a reclining chair at the East Nurses' Station. Observation showed a CNA (#1) mixing mashed potatoes from the resident's plate into her cup of milk and encouraging the resident to drink. Observation during the noon meal served in the dining room on 07/23/13 showed a CNA (#7) assisted Resident #12 to eat. Observation showed pureed meatloaf, peas, and mashed potatoes on the resident's plate. The meat loaf and peas were of very soft consistency and ran together on the plate. Observation showed staff mixed together the meatloaf, mashed potatoes, and peas and fed the mixture to the resident. Review of Resident #4, #10, and #12's care plans, on the afternoon of 07/24/13, failed to identify preferences for combining foods. Observation of pureed food preparation occurred on 07/23/13 at 3:15 p.m. The cook (#8) measured six servings of ham salad and bread into a blender. The cook then poured milk from a carton into the blender and mixed until it became	F 364	F 364 1. The facility will ensure that Residents' #4, #10 and #12 food is not mixed when fed to them and pureed food is the consistency of mashed potatoes and promote palatability. Resident #4 expired on 8/7/13. 2. All Residents that have pureed food orders have the potential to be affected by this deficient practice. 3. Staff that assist in feeding will be educated on August 27th about the proper procedure of not mixing food together and the dietary staff will be educated on August 26th about how to properly puree food. 4. An audit will be developed to show compliance of these procedures. Audits will be done by the QA Coordinator or designee weekly for 1 month, monthly for 3 months, and as deemed necessary by the QA committee. 5. The Corrective action will be complete by August 28, 2013	

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F 364	Continued From page 11 smooth. When interviewed regarding the amount of milk used, the cook stated it depends on the consistency of the sandwich. Observation showed the pureed sandwiches did not have the consistency of mashed potatoes. The cook served the sandwiches in bowls. The cook failed to refer to the pureed recipes posted inside a cabinet near the food preparation area. Observation of the noon meal service on 07/24/13 showed staff served pureed barbecue chicken and mashed potatoes. The food items were very soft in consistency and ran together on the plate. During an interview on 07/24/13 at 12:00 p.m., a cook (#9) stated she added enough milk to the pureed foods to achieve a mashed potatoes consistency. The cook confirmed the consistency of the barbecue chicken was thin. During an interview on 07/23/13 at 9:15 a.m. and on the afternoon of 07/24/13, an administrative nursing staff member (#2) and a licensed registered dietitian (#10) confirmed staff should not mix foods when feeding residents.	F 364		
F 454 SS=D	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference and staff interview, the facility failed to store oxygen according to current Life Safety Code requirements in 1 of 2 oxygen storage closets (West unit). Failure to store oxygen tanks	F 454		

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(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 454	Continued From page 12 in a secure manner has the potential for the tanks to fall and become a projectile missile potentially causing injury to residents, visitors, and staff. Findings include: Life Safety Code requirements state, "Nonflammable medical gas systems and equipment used for the administration of inhalation therapy and for resuscitative purposes comply with NFPA 99, 13-5.1, 7-1.2, NFPA 70." Standard for the Storage, Use, and Handling of Compressed Gases and Cryogenic Fluids in Portable and Stationary Containers, Cylinders, and Tanks, NFPA 55, 7.1.4.4 states "Securing Compressed Gas Containers Cylinders, and Tanks. Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling (collect/gather) them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.4.4.1 and 7.1.4.2.7." Observations of oxygen storage occurred on 07/24/13 at 9:25 a.m. with a licensed nurse (#12) and identified racks filled with oxygen tanks and two unsecured tanks in the West unit oxygen storage closet. The nurse (#12) confirmed staff are to secure oxygen tanks in the racks provided in the closet. Observation on 07/24/13 at 1:15 p.m. with two administrative nurses (#5 and #6) showed the oxygen tanks remained unsecured in the West unit oxygen closet.	F 454	F 454 1. No Residents were directly affected by this deficient practice. 2. All Residents, Staff and Visitors have the potential to be affected by this deficient practice. 3. All staff will be educated on August 27th about how to and the importance of the storage of oxygen. 4. An audit will be developed to show compliance of the procedure of oxygen storage. Audits will be done by the QA Coordinator or designee weekly for 1 month, monthly for 3 months, and as deemed necessary by the QA committee. 5. The Corrective action will be complete by August 28, 2013	
F 494	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO -	F 494		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355095	A. BUILDING _____ B. WING _____	07/24/2013

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F 494 SS=D	Continued From page 13 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 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, and staff interview, the facility failed to ensure a nurse aide (Individual A) working with residents in the facility remained certified. Individual 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.	F 494		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 494	Continued From page 14 Findings include: Review of state nurse aide registry files identified a facility's staff member contacted the North Dakota Department of Health (NDDoH) Nurse Aide Registry to check on Individual A's current certification as a certified nurse aide (CNA) on 03/11/13. NDDoH State Registry information identified Individual A's certification expired on 01/11/13 (two months prior). A check of the NDDoH Nurse Aide Registry identified Individual A renewed her certification on 03/20/13. During interview on 07/24/13 at 8:00 a.m., a staff development nurse (#3) stated she tracks employee license and certification expiration dates on a spreadsheet. This nurse stated she checks the report every couple of months, updates expiration dates as she receives a copy of an employee's certificate or license, and discovered in March 2013 Individual A failed to renew her certification. Review of facility payroll records on 07/23/13 identified Individual A worked at the facility from January 11-March 20, 2013, providing nursing related care to residents for 386.7 hours (69 shifts) with an expired certificate.	F 494	F 494 1. No Residents were directly affected by this deficient practice. 2. All Residents have the potential to be affected by this deficient practice. 3. All licensed and certified staff will be educated on August 27th about making sure they have all of their licenses and certifications up to date. A database will be created and maintained to ensure all licenses are up to date and checked monthly. 4. An audit will be developed to show compliance of the licenses and certification of all staff needing such. Audits will be done by the D.N.S. or designee weekly for 1 month, monthly for 3 months, and as deemed necessary by the QA committee. 5. The Corrective action will be complete by August 28, 2013	