STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465158	A. BUILDING _____ B. WING _____	09/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE AND REHABILITATION CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 323 SS=B	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the resident environment did not remain as free of accident hazards as possible. Findings Include: Observation of the facility at various times from 9/11/06 to 9/14/06 were made. The utility closet in the main hallway and the laundry were unlocked at all times. The utility closet had six containers of chemicals used for cleaning to include: NABC Non-acid Disinfectant Bathroom Cleaner; Husky 1200 Furniture Polish; Ajax Chlorinated Scouring Powder; Pure and Natural Liquid Soap; 3200 Lemonshine Furniture Polish and Citrus Foaming Spray and Wipe Cleaner. There was an open container of liquid bleach in the laundry room. Material Safety Data Sheets were found for 4 of the 6 cleaners. In an interview with the administrator/acting maintenace coordinator on 9/13/06 they stated that it has not been their policy to keep these doors locked in the past.	F 323	The facility was purchased from previous owners on 5/1/06. The previous owners had been the subject of multiple and significant negative survey findings and had failed to put in place effective quality assessment and assurance programs (QA). At the time of the survey, and as noted in the survey findings, Majestic Care and Rehabilitation had already initiated a number of steps to correct problems that were identified by the surveyors and will continue to take a proactive approach to identifying non-compliance areas left by the previous owners. F 323 483.25(h)(1) ACCIDENTS The facility has installed a self-closing and self-locking mechanism on the main hallway utility closet and the laundry room doors. The maintenance personnel will review and document the condition of these doors, along will all other areas with hazardous chemicals, for continued optimal operation as part of the "Monthly Maintenance Inspection Checklist". F 323 483.25(h)(1) This Plan of Correction will be integrated in to the Quality Assurance Plan by 11/13/06.	11/13/06

10/17/06 POC acceptable Completion date 11/13/06 Quembenhr RN

Utah Department of Health
760612
OCT 17 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dallas Mark	ADMINISTRATOR	10-17-06

/ deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 's following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility did not store, prepare or serve food under sanitary conditions. Finding included: Initial observations of the kitchen area were conducted on 09/11/06 at 1:45 PM. Additional observations were conducted through 09/14/06. During the initial observation the following was observed: The dishwasher was observed to have a wash temperature of 145 degrees F (fahrenheit) and a rinse temperature of 178 degrees F. The dishwasher lists the minimum temperature for the wash cycle as 150 degrees F and 180-190 degrees F for the rinse. A Cuisenart food processor with the lid in place was observed to have moisture inside the processor bowl. Dried food particles were observed on the neck of a Kitchenaid mixer potentially cross contaminating food processed at a later date. An 80 ounce container of Stratford peanut butter that had been opened, had no open date.	F 371	F 371 483.35(i)(2) SANITARY CONDITIONS – FOOD PREP & SERVICE Physical plant non-compliance noted was corrected 10/3/06. Door threshold and screen were replaced. On-going quality assurance will be part of the "Monthly Maintenance Inspection Checklist" completed by the maintenance personnel. (See F 323.) An in-service was conducted with all fulltime kitchen staff on 10/3/06. Topics covered included proper use of gloves, dishwasher temperatures, sanitizing solution preparation, food temperatures and labeling/dating food as opened. A memo concerning these topics was prepared and distributed to weekend staff. On-going in-services will be conducted monthly during dietary staff meetings and will continue to address issues identified by the survey. The Dietary Manager will include the above memo in all new kitchen employee's orientation packet.	11/13/06

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F 371	Continued From page 2 An opened 1 pound package of mini marshmallows without date. An opened 2 pound package of powdered sugar without date. 22 opened containers of assorted spices without date opened. The kitchen refrigerators contained: 2 stacks of yellow cheese slices wrapped in plastic that were unlabled and not dated. 4 carafes of unlabled whitish liquid that were not dated. An opened 2 pound container of liquid egg product that was undated. An opened 1 gallon container of kosher dill relish that was undated. An opened 1 gallon container of maraschino cherries that was undated. An opened 1 gallon container of coleslaw dressing that was undated. An opened 1 gallon container of mustard that was not dated. An opened 24 ounce container of sweet relish that was not dated. An opened 16 ounce container of maraschino cherries that was not dated. 2 opened 5 pound containers of chicken base that were not dated An opened 1 pound container of ham base that was not dated. An opened 46 ounce container of Rejuv tomato paste soup that was not dated. An opened 1 gallon container of ranch dressing that was not dated. 2 opened 1 gallon containers of mayonaise that were not dated.	F 371	The Dietary Manager will conduct weekly observations of all kitchen staff and provide one-to-one education as required. Dishwasher Temperatures – Repairs to the existing facility dishwasher were completed during the survey on 9/13/06. The facility had received a replacement dishwasher on 9/12/06 resulting from a self identification of problems with temperatures. Installation was pending but was completed by GTCI-Ecolab on 10/5/06. Water temperatures are taken and recorded during each wash cycle per facility policy. The Dietary Manager will review temperature documentation daily as part of the facility's food services quality assurance. Undated, unlabeled opened containers – An inspection of food storage was completed on 10/3/06. All unlabeled, and/or undated food and food additives found i.e., spices, were disposed of.	

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F 371	Continued From page 3 A tin of thawing frozen diced carrots covered with aluminum foil that was not labeled or dated. 3 trays with 19 glasses of orange liquid, 4 glasses of red liquid, adn 24 glasses of white liquid that were covered, but not labled or dated. A plastic container marked pumpkin that was not dated. The kitchen freezers contained: 2 trays with 7 dishes of ice cream and 9 dishes of sherbert that were covered, but not labeled or dated. 3 bags of precooked chicken that were not labeled or dated. 1 package of sausage patties that were not labeled or dated. Exit door at back of dry storage area had light visible under the door, the weather strip did not appear adequate to prevent the entry of pests. The window screen for the window right of the kitchen exit door was missing. The sanitizing solution was tested by facility staff, and was greater than 200 ppm (parts per million). Solution should be approximately 50 ppm. Observation of the tray line occurred on 09/13/04 during the breakfast meal. A faciltiy cook was observed repeatedly handling trays, diet cards, and touching the counter with gloves on. The cook then picked up waffles, with the same gloves, and placed the waffles on the residents' plates. A facility cook was observed stirring a pot	F 371	All food opened will be dated with The date of opening by the person Opening them. If the food is Removed from the original package, The person repacking the item will Clearly label the contents and the original date of the opening at that time The Dietary Manager will review all food as it is received, will date it and place in storage. The Dietary Manager will monitor Monthly. Equipment cleanliness – All kitchen equipment was inspected for cleanliness by the Dietary Manager on 10/03/06. The Dietary Manager will monitor kitchen cleanliness daily utilizing the checklist provided by the consulting Dietician (RD). The RD will monitor the FSS checklists during regularly scheduled consulting visits and will document her findings. F 371 483.35(i)(2) This Plan of Correction will be integrated in to the Quality Assurance Plan by 11/13/06.	

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F 371	Continued From page 4 of food on the stove without hair covering. During kitchen observations on 09/13/04 the dishwasher was observed three times with wash temps at 133 degrees F, below the posted minimum of 150 degrees F. An interview with the facility dietary manager took place on 09/14/06 at 12:10 PM. The Dietary Manager stated that the dishwasher was in need of repair, and that a repairman had been contacted. Observation of the breakfast tray line occurred on 09/14/06. A facility cook was observed touching resident trays, diet cards, and the counter, then handling hardboiled eggs that had been shelled.	F 371	F 387 483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS A review of all current resident charts, including resident #8 and #10 will be completed by the ADON to ensure all residents have been seen and if not, physician visits will occur to bring the resident current.	11/13/06
F 387 SS=B	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that 1 of 10 residents in the facility were not seen at least once every 30 days for the first 90 days after admission and at least once every 60 thereafter. Resident Identifiers 8, 10	F 387	The DON will ensure all newly admitted residents will be seen by his/her physician at least once every 30 days for first 90 days after admission and at least every 60 days thereafter. A log system will be implemented that will contain all residents admit date, recert dates and other pertinent information to ensure that physicians see current and newly admitted residents are seen in a timely manner. The ADON will create a log system and the DON will monitor logs at least every 30 days.	

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F 387	Continued From page 5 Findings Included: 1. Resident #8 was admitted to the facility on 7/24/06 with diagnoses that included late effects of acute polio, osteoporosis; schizoaffective disease and scolioses. R#8 was seen initially by her physician on 8/2/06. There is no documentation that the resident has seen the physician since that date. 2. Resident 10 was admitted to the facility on 04/17/06 with diagnoses that included diabetes mellitus. A review of resident 10's medical recor was conducted on 09/14/06. Resident 10 had no physician progress notes dated prior to 05/10/06, and no physician progress notes between 05/17/06 and 08/17/06 (90 days between visits).	F 387	The QA committee will meet and review the physician visit log system on or before 11/13/06 F 387.40(c)(1)-(2)This Plan of Correction will be integrated in to the Quality Assurance Plan by 11/13/06	11/13/06
F 444 SS=B	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation of the facility medication administration it was determined that the facility did not ensure that the facility nurses were washing or sanitizing their hands during the medication pass. Staff Identifiers: 1, 2, 3.	F 444	F 444 483.65(b)(3) PREVENTING SPREAD OF INFECTION DON/ADON will in-service all nursing personnel on proper infection control procedures during all resident care and during medication pass on or before 11/1/06. Gloves and hand sanitizer are available throughout the facility and personal hand sanitizer is available for nurses to carry with them to ensure availability. The DON/ADON will on a random basis (but at least weekly) observe nursing personnel to ensure they are practicing infection control procedures. The QA committee will review these procedures on or before 11/13/06.	

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F 444	Continued From page 6 Findings Included: Observations were made during medication passes on 9/12/06, 9/13/06 and 9/14/06. It was determined that facility nurses #1, #2, and #3 had passed both oral and injectable medications without washing or sanitizing their hands or wearing disposable gloves between residents. The nurses touched residents to administer insulin; handed souffle cups to the residents; assisted residents to place souffle cups to their mouths; and handed water glasses to residents.	F 444	F 465 483.70(h) OTHER ENVIORMENTAL CONDITIONS Water Temperatures – A new mixing valve has been installed. Water temperatures will be checked at least monthly and recorded on the "Monthly Maintenance Inspection Checklist."	
F 465 SS=B	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility did not provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. Findings include: Observations of the facility were conducted at various times from 9/11/06 to 9/14/06. Testing of water temperatures were made in 7 residents' rooms, the shower room and the womens' public restroom. Water temperatures checked on 9/11/06 showed the following: Room #15's	F 465	General Facility Repairs – On or before 10/13/06, the facility maintenance personnel will conduct an inspection of the physical environment and replace missing screens, missing down drain and arm rests on all dining room chairs. Maintenance personnel will review and document the condition of the physical environment for needed repairs as part of the "Monthly Maintenance Inspection Checklist". F 465 483.70(h) This Plan of Correction will be integrated in to the Quality Assurance Plan by 11/13/06	

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F 465	Continued From page 7 bathroom sink was 136.2F; Room #4's bathroom sink was 133.7F; Room #5's bathroom sink was 124.7F; Room #14's bathroom sink was 122.1F; Room #10's bathroom sink was 130F; Room #13's bathroom sink was 126F; Room #8's bathroom sink was 122.0F; the shower water temperature was 122.0F and in addition had a burned out light and noisy exhaust fan. The water temperature in the public womens' bathroom was 73.2F. General observations on the facility exterior showed window screens missing from the windows in rooms #7 and #3. There were two missing screens missing from the activities/dining room and one missing screen from a kitchen window. There was a missing down drain on the patio/smoking area and loose or missing armrests on two of the dining room chairs. In an interview with the facility administrator/acting maintenance manager on 9/11/06 the water temperatures were discussed and temperatures had been corrected to normal levels on 9/12/06. Other findings were discussed and it was determined that the building has been recently purchased and there are major renovations ongoing.	F 465		

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F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility did not maintain accurate medical records for 7 of 10 residents. Resident identifiers: 1, 2, 3, 4, 5, 6, 7. Findings included: 1. Resident #1 was admitted to the facility on 5/1/06 with diagnoses that included cerebral vascular accident, hypertension, congestive heart failure, and dementia. R#1's medical record was reviewed on 9/12/06. The Minimum Data Set (MDS) assessment dated 7/20/06 section I1 was marked indicating R#1 having a diagnosis of cerebral palsy. No information was found on the chart indicating R#1 had been diagnosed with cerebral palsy. An interview with the director of nursing (DON) occurred on 09/14/06 at 12:00 PM. The DON indicated that the noting of cerebral palsy on	F 514	F 514 483.75 (l)(1) CLINICAL RECORDS A review of all current resident charts (including residents 1, 2, 3, 4, 5, 6, and 7) will be completed by the ADON to ensure all resident physician orders and the MAR are accurate. The ADON will ensure all resident records accurately reflect the previous and current status of each resident. The ADON will ensure that the resident records are crossed checked for preadmission screening, plan of care, assessments, MAR, MDS and progress notes. This will be reviewed at least every 30 days for accuracy. Medical Records staff will create a system of check and balances to ensure accuracy of records at least every 30 days. This system will be completed on or before 11/13/06. The DON and ADON will in-service all nursing personnel on or before 11/1/06 on the procedure of cross checking medications, diagnosis,	11/13/06

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F 514	Continued From page 9 Resident 1's MDS was done in error. 2. Resident 2 was readmitted to the facility on 08/29/06 with diagnoses that included congestive heart failure, hypertension, esophogeal reflux, chronic kidney disease stage one, diabetes mellitus type 2. A review of resident 2's medical record was conducted from 09/11/06-09/13/06. Resident 2's current MAR (medication administration record) included the following orders: Ambien 10mg (milligrams) po (by mouth) qhs (at bedtime), Ambien 10 mg tablet take 1 by mouth at bedtime as needed (included a handwritten note "scheduled qpm" (each evening)) and Seroquel 25mg po qd (daily). Resident 2's recertification orders dated 08/30/06 for 09/01-09/30/06 stated Ambien 10mg tab take 1 tab by mouth at bedtime as needed. No order for routine dosing of Ambien was found. An interview with the facility's DON (director of nursing) and ADON (assistant director of nursing) took place on 09/12/06 at 5:10 PM. The DON and ADON indicated that they were unsure as to why the Ambien order had been transcribed as both routine and PRN (as needed) on the resident's MAR. Additionally, the DON was asked about the use of Seroquel as no diagnosis was found to support the use of the medication. The DON produced a copy of a an undated order, that was not signed by the physician, from Resident	F 514	F 514 (con't) MAR and physicians orders to ensure the accuracy of the current status of the residents. Lab reports will be made part of the resident's medical records. Nursing staff will ensure upon receiving lab results, will note the result and fax the lab results to the physician. A nursing note will be completed. The physician will be immediately called to report any abnormal results. The DON and Medical Record staff will implement a log system to ensure all labs have been performed and results reported and filed in the residents record. All nursing personnel will be inserviced on or before 11/01/06. All newly hired nursing orientation will include information on the facility practices regarding medical records. All current resident records are being reviewed which will be completed on or before 11/01/06. The ADON, will monitor at least every 30 days for accuracy. The QA Committee	

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F 514	Continued From page 10 2's discharge chart indicating: "Clarify dx (diagnosis) to be dem (dementia) (with) dep (depression) & psych (psychotic) features m/b (manifested by) down arrow (decreased) activity of interest and delusional thought." Resident 2's initial MDS (Minimum Data Set) assessment dated 08/19/06 section I (1.) (s.) was marked indicating the resident had a disease diagnosis of cerebral palsy. No information was found on the chart indicating resident had been diagnosed with cerebral palsy. An interview with the DON occurred on 09/14/06 at 12:00 PM. The DON indicated that the noting of cerebral palsy on Resident 2's MDS was done in error. 3. Resident #3 was admitted to the facility on 3/27/06 with diagnoses that included chronic obstructive pulmonary disease, dementia and congestive heart failure. R#3's medical record was reviewed on 9/12/06. In the Minimum Data Set (MDS) assessment dated 7/4/06 section J1 was marked indicating R#1 having edema. No information was found on the chart indicating R#1 had a problem condition of edema. An interview with the director of nursing (DON) occurred on 09/14/06 at 12:00 PM. The DON indicated that the noting of edema on Resident 3's MDS was done in error. 4. Resident #4, admitted to the facility on 6/30/04 with diagnoses that included Type II diabetes,	F 514	F 514 (con't) will review the procedures on or before 11/13/06.	

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F 514	Continued From page 11 hypertension, and vascular dementia. A review of R#4's medical record was done on 9/12/06. The physician's order form for 9/1/06 -9/30/06 was reviewed. An order for Novolin R 100U/1ml- give 8 units subcutaneously twice daily was listed among other orders for insulin. The order date for this insulin was noted to be 8/21/06. No documentation was found in the physician's orders section of R#4's medical record. This order for insulin was not transcribed onto the 9/06 medication administration record. (MAR). An interview with the director of nursing (DON) occurred on 09/14/06 at 12:00 PM. The DON indicated that the pharmacy supplying the insulin to the facility had made a transcription error when printing the 9/06 physicians' orders. The medication was not delivered nor given to R#4. 5. A review of Resident 5's medical record was completed on 09/13/06. R#5 was admitted to the facility on 5/22/06 with diagnoses that included esophogeal reflux, chronic airway obstruction, mononeuritis and recurrent depression with psychosis moderate. Resident 5's current MAR listed Lidoderm 700mg (50mg/gm (gram) adhsv (adhesive)) 5% (700mg) adh. (adhesive) patch apply 1/2 patch to back and 1/2 patch to groin every 12 hours. The Lidoderm order on the MAR had been yellowed out, and was not signed as having been given since 07/22/06. Documentation on the MARs indicated that the resident had been	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465158	A. BUILDING _____ B. WING _____	09/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 12 refusing the medication prior to being discontinued. No order to discontinue the Lidoderm was found. An interview with the DON was conducted on 09/13/06 at 3:50 PM. The DON stated that the previous physician recertification orders stated that medication should be discontinued for non-use after 30 days, but the current recertification orders do not state that. The DON stated that it appeared that there had been no T.O. (telephone order) written to cover discontinuation of the medication. 6.. Resident 6 was admitted to the facility 08/25/06 with diagnoses that included: Alcohol amnestic disorder, alcohol dependant convulsions, arthropathy, and hypertension. A review of Resident 6's medical record was completed on 09/13/06. Resident 6's current MAR listed Accupril 10mg po qday (daily) d/c (discontinue) when ortho (orthostatic) BP (blood pressure) remains to low. A physician's order dated 08/29/06 indicated Accupril 5mg po qd. No order for Accupril 10mg was found. An interview with the DON and a facility RN was conducted on 09/13/06 at 10:55 AM. RN 1 stated that she did not know why she had transcribed the Accupril order to the MAR as 10mg instead of 5mg as ordered.	F 514		

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F 514	Continued From page 13 7. Resident 7 was admitted to the facility on 04/28/05 with diagnoses that included hypertension, peripheral vascular disease, and cerebral degeneration. A review of Resident 7's medical record took place on 09/14/06. Resident 7 had a physician's order dated 05/10/06 to obtain a urinalysis. No documentation of the lab being completed was available on the medical record. An interview was conducted with the ADON on 09/14/06 at 10:30 AM. The ADON stated she was unable to find an original copy of the lab results, or identify if the results had been sent to the physician upon receipt. The ADON did request and received a copy of the results from the lab, when the missing lab was brought to her attention, indicating that the urinalysis had been done.	F 514		
F 518 SS=B	483.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview and observation it was determined that the facility did not train all employees in emergency procedures when they began working in the facility, periodically reviewed	F 518	Utah Department of Health OCT 17 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment	

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F 518	Continued From page 14 the procedures with the existing staff or carry out unannounced staff drills using those procedures. Findings Included: Interviews were conducted with 6 employees between 9/11/06 and 9/14/06. 2 charge nurses, 3 certified nursing assistants and the activities director were interviewed. 3 employees including the charge nurse did not know how to use a fire extinguisher. 4 employees including the charge nurse did not know how to respond if the fire alarm sounded. 2 employees including the charge nurse were not sure where the fire alarms and fire extinguishers were located in the facility. 2 employees including the charge nurse were not sure what the procedure was if they discovered a resident missing. An interview with the administrator, director of nursing and staff development nurse was conducted on 9/13/06. The facilitity is under new ownership and many of the staff members are newly employed there. There are inservices, new employee orientations and fire drills being planned.	F 518	F 518 483.75(m)(2) Disaster and Emergency Preparedness An in-service will be conducted on or before 11/13/06 of all staff employed in the facility. Topics covered include use of fire extinguishers, responding to the fire alarm, locations of fire alarm and extinguishers, and missing residents. The administrator has posted signage indicating emergency evacuation routes throughout the building. The facility administrator will conduct random interviews of current staff until 11/13/06 to ensure staff knowledge. New employee orientation program will be developed by 11/13/06 and will include use of fire extinguishers, responding to the fire alarm, locations of fire alarm and extinguishers, and missing residents. F 518 483.75(m)(2)This Plan of Correction will be integrated in to the Quality Assurance Plan by 11/13/06	11/13/06