Survey Deficiency Summary

27 Facilities Surveyed **Surveys Taken 05/30/13-07/31/13**

F159 Management of resident's funds by facility upon written authorization.

C Facility failed to allow patients access to personal funds for 45 patients with a personal trust fund account managed by the facility. The patients complained that they could not access their money on the weekend.

F160 Conveyance of funds upon death.

D Facility failed to convey resident trust fund balance within 30 days of death or discharge for one patient. The patient expired in February, and the trust fund balance was not conveyed until April.

F164 Right to privacy & confidentiality.

E Facility failed to maintain visual privacy for multiple patients.

D Facility failed to maintain full visual privacy for three patient and failed to maintain confidentiality of patient's medical records by not closing the Medication Administration Record (MAR) during medication pass.

D Facility failed to ensure one nurse provided full visual privacy while providing care.

D Facility failed to maintain full visual privacy for patients in seven rooms.

F166 Right to have grievances resolved.

D Facility failed to resolve grievances for three patients and failed to replace a splint for one patient.

F176 Self-administration of drugs by resident.

D Facility failed to have an assessment or a physician's order for self-administration of medications. The patient was receiving a nebulizer treatment with no licensed personnel in attendance.

D Facility failed to determine safe self-administration of drugs for one patient. A nebulizer treatment was being administered without any licensed personnel in attendance.

F221 Right to be free from physical restraints.

D Facility failed to ensure patients are free from restraints for one patient.

D Facility failed to assess the use of bolsters as a potential restraint for one patient.

F224 Mistreatment, neglect, misappropriation of resident property.

D Facility failed to protect one patient from misappropriation of personal property by a facility employee. A CNA took a patient's rings and pawned them. She was reported, terminated, served jail time and made restitution to the patient.

F225 Facility must not hire person with abuse history.

D Facility failed to thoroughly investigate an allegation of neglect for one patient. The patient reported that an aide had told her on the previous shift that she did not have time to take her to the bathroom and to just use the incontinent brief the patient was wearing.

D Facility failed to implement the abuse prevention policy and procedure to perform a complete and thorough investigation of an injury of unknown origin or report the incident to the state survey agency within five working days of the injury for one patient.

D Facility failed to complete a thorough investigation and screening of a CNA prior to employment and prior to the CNA misappropriating one patient's personal property.

F226 Facility must have written policies in place to prevent abuse & neglect.

D Facility failed to implement the abuse prevention policy and procedure for performing a complete and thorough investigation of an injury of unknown origin for one patient.

F241 Dignity: Facility must allow residents to maintain his/her self-esteem & self-worth.

E Facility failed to provide an environment that enhanced the patient's dignity for one patient.

D Facility failed to promote services that maintained or enhanced dignity for one patient. The housekeeper did not knock nor ask permission prior to entering the patient's room.

D Facility failed to promote services that maintained or enhanced dignity for one patient. The nurse entered the room without knocking or asking permission to enter.

F242 Right to choose activities, schedules, & health care.

D Facility failed to allow one patient to choose the shower schedule of choice.

F246 Right to accommodations of individual needs & preferences.

D Facility failed to maintain a call light within reach for one patient.

D Facility failed to accommodate the needs of one patient. The patient could not push a regular call light and did not have accommodations made to resolve the issue.

D Facility failed to ensure a call light was within reach for one patient.

F250 Medically related social services.

D Facility failed to provide a social services admission assessment and discharge planning services for one patient.

D Facility failed to provide discharge planning for one patient.

D Facility failed to provide medically related social services for two patients.

F253 Housekeeping & maintenance services.

D Facility failed to ensure the facility was free from urine odors on one hall.

F272 Comprehensive assessment.

D Facility failed to completely assess for physical therapy (PT) for one patient.

D Facility failed to complete an assessment of a pressure ulcer for one patient and the use of a lap belt restraint for one patient.

D Facility failed to assess one patient receiving dialysis treatments.

F278 Assessment must be conducted with the appropriate participation of health professionals.

D Facility failed to accurately assess a patient for falls for one patient.

D Facility failed to perform an accurate assessment of bladder continence for one patient.

D Facility failed to complete an accurate assessment of the use of side rails for one patient.

D Facility failed to accurately assess a restraint for one patient an the behavior status of one patient.

F279 Facility must develop a comprehensive care plan with objectives/timetables.

E Facility failed to develop a care plan for four patients.

D Facility failed to develop a comprehensive care plan addressing the patient's persistent refusal of care for one patient.

D Facility failed to update the care plan for one patient.

D Facility failed to develop a care plan for behaviors of sleep disturbances, dementia, poor safety awareness, and resistance of care for one patient. Facility failed to develop a care plan for the use of side rails for one patient. Facility failed to develop a care plan for the pressure ulcer for one patient.

D Facility failed to care plan for anticoagulant medication interventions for one patient.

F280 Care plans must be reviewed & revised by qualified persons.

E Facility failed to revise the care plan for two patients and failed to include two patients in care plan conferences.

D Facility failed to update a care plan for one patient.

D Facility failed to revise the care plan for falls for two patients.

D Facility failed to revise the care plan to reflect a left heel pressure ulcer for one patient.

D Facility failed to revise the care plan for a pressure ulcer or fall for two patients.

D Facility failed to update the care plan for one patient with a history of falls.

D Facility failed to ensure the care plan was complete for behaviors for one patient.

D Facility failed to revise the care plan for one patient and failed to include one patient in the care plan conferences.

D Facility failed to revise the care plan for two patients.

D Facility failed to include two patients in the patients care plan meetings.

F281 Services must meet professional standards of quality.

D Facility failed to document a pain assessment for one patient and failed to document complete and accurate behavior monitoring for one patient.

D Facility failed to ensure the use of the correct procedure to obtain an accurate blood pressure reading for one patient. The nurse put the cuff on the patient incorrectly.

D Facility failed to follow the physician's order for one patient.

D Facility failed to secure orders from the attending physician for hospital discharge medications per facility policy for one patient.

F282 Services must be provided by qualified persons.

F Facility failed to follow facility policy for administering intravenous (IV) medications for three patients. The facility had a policy that only RNs could administer IV medications, and an LPN had administered the medications thru the IV lines.

D Facility failed to ensure the care plan interventions for a fall were implemented for one patient.

D Facility failed to follow a care plan intervention implemented after a fall for one patient.

D Facility failed to follow the care plan interventions for padded side rails and assistance of staff with toileting for two patients.

F309 Each resident must receive care for highest well-being.

D Facility failed to follow physician's orders for one patient.

D Facility failed to monitor the fluid intake and maintain fluid restrictions to ensure compliance with the fluid restriction for one patient. Facility failed to administer medication timely for one patient.

D Facility failed to follow physician's orders for two patients.

D Facility failed to provide the necessary care for one patient. The patient had a wound vac that was making noise, and the patient could not sleep. The patient complained and the nurse told her there was nothing wrong with the wound vac. However, after another nurse changed the dressing and adjusted the vac the noise ceased.

F312 Resident receives services to maintain good nutrition/grooming/hygiene.

- D Facility failed to ensure toileting assistance was provided for one patient and failed to provide nail care for one patient.
- D Facility failed to maintain clean fingernails for one patient.
- D Facility failed to provide oral care for one patient with a tube feeding.
- D Facility failed to provide oral hygiene for one patient.
- D Facility failed to provide care for one dependent patient.
- D Facility failed to ensure two male patients received a shave and failed to ensure one patient received oral care.

F314 Resident does not develop pressure sores.

- D Facility failed to follow physician orders for treatment of pressure ulcers and failed to accurately identify pressure ulcers for one patient.
- D Facility failed to assess the skin condition for one patient.
- D Facility failed to timely and accurately assess the pressure ulcers of one patient.

F315 Incontinent resident receives appropriate treatment and services.

- D Facility failed to ensure there was a justifiable medical reason for the presence of a Foley catheter and failed to ensure a physician's order was followed for the size of the Foley catheter for one patient.
- D Facility failed to assess a patient's bladder status and implement a bladder training program to maintain/improve bladder function for the patient.
- D Facility failed to obtain a physician's order for a urinary catheter and failed to provide medical justification for the use of a urinary catheter for one patient.
- D Facility failed to assess bladder incontinence and implement a program to restore normal urinary function for one patient.
- D Facility failed to implement a program to restore urinary continence to one patient.
- D Facility failed to perform a bladder assessment and provide a toileting program for one patient.

F318 Range of motion.

- D Facility failed to ensure one patient had a wrist splint in place.

F322 Tube feeding/prevention.

- D Facility failed to ensure staff checked placement of a Percutaneous Endoscopy Gastrostomy (PEG) tube prior to the administration of medication through the tube.

F323 Accident hazards.

J Facility failed to ensure the environment was safe and free of accident hazards, failed to ensure assessment of each patient was complete and accurate and failed to implement appropriate and measurable interventions to prevent potential injuries for three patients with falls. This placed the patients in immediate jeopardy.

G Facility failed to ensure an alarm was in place and failed to supervise one patient. This failure resulted in actual harm to the patient.

D Facility failed to implement and/or update safety interventions for falls for one patient.

D Facility failed to follow the fall interventions for a low bed and hipsters for one patient.

D Facility failed to ensure a safety device was in place for one patient.

D Facility failed to implement interventions after a fall for one patient and failed to secure hazardous chemicals in the beauty shop.

D Facility failed to ensure interventions were implemented to prevent falls for two patients.

D Facility failed to provide an environment free of accident hazards by continuing to use bed bolster cushions causing the patient to exit at the foot of the bed for one patient.

F325 Facility must ensure acceptable parameters of nutritional status.

D Facility failed to assess the significant weight loss for one patient.

F327 Sufficient fluid intake for proper hydration.

D Facility failed to ensure routine hydration was provided for one patient. The patient stated that the facility only provided drinks if you asked for them.

F329 Each resident's drug regimen must be free from unnecessary drugs.

D Facility failed to consistently monitor for signs and symptoms for hypertensive medications for one patient reviewed for unnecessary medication usage.

D Facility failed to ensure medications were administered to patients according to physician's orders.

D Facility failed to ensure unnecessary medications were not administered for one patient.

F332 Facility medication error rates of 5% or more.

D Facility failed to ensure one nurse administered medications with a medication error rate of less than 5 percent. The error rate was 16 percent.

D Facility failed to ensure two nurses administered medications with a medication error rate of less than 5 percent. The error rate was 7.6 percent.

D Facility failed to prevent medication errors less than 5 percent resulting in three errors within 26 opportunities. The error rate was 11 percent.

F333 Residents free of significant medication errors.

D Facility failed to ensure pharmaceutical precautions were followed with the application of Exelon patches resulting in a significant medication error for two patients. The nurse failed to remove the old patch prior to the administration of the new patch.

F356 Nurse staffing data

D Facility failed to post accurate nurse staffing information as required.

D Facility failed to post the correct nurse staffing data.

C Facility failed to post the current nursing staff report.

F361 Dietary services staffing.

F Facility failed to ensure the food service director was a qualified food service manager.

F364 Food preparation.

F Facility dietary department failed to serve hot food at or above 135 degrees Fahrenheit (F) and cold food at or below 41 degrees F to the patients.

F Facility failed to serve hot and cold foods at the proper temperature.

D Facility failed to serve patient food at or above 135 degrees F in one dining room.

F371 Store, prepare, distribute, & serve food.

F Facility failed to ensure a sanitary and safe environment related to the storage of food in the three-compartment sink.

F Facility failed to provide sanitary storage of food and equipment. Multiple single serve containers of applesauce and pears in the walk-in cooler were uncovered and undated. A storage rack of multiple clean pots and pans were located under a leaking vent in the ceiling.

F Facility failed to maintain proper kitchen sanitation as evidenced by the door to the dishwasher room and the door to the service hall were propped open. Also, raw beef patties were placed in a pan next to the prepared deli meat and partially covered corn bread and cold food was not served that the proper temperature. In addition, a visitor entered the kitchen without a hair cover with the potential to contaminate the food served to the patients.

F Facility failed to provide sanitary storage of food and equipment. There were open items in the cooler not sealed or labeled. There was also employee drinks in the cooler which had been opened.

F Facility failed to ensure the water in the steam table was free of debris between meal service. Facility failed to prevent the contamination between clan and dirty areas and to provide test strips for the sanitizer level used in the three compartment sink.

F Facility dietary department failed ensure thermometers were in refrigeration units, failed to maintain equipment in a sanitary manner and failed to maintain a clean and sanitary environment.

F Facility failed to sanitize dietary equipment per the manufacturer's recommendations. Equipment was not left in the solution for the recommended one minute.

F Facility failed to wash dishes in a sanitary manner and failed to maintain dietary equipment in a sanitary manner. The dishwasher was using the dirty rack of dishes to push the clean rack of dishes out of the dishwasher.

F Facility failed to cover hair to prevent food contamination. One of the dietary employees had a beard and was not wearing a beard cover.

E Facility failed to ensure food was prepared, stored or served under sanitary conditions when one CNA failed to practice hand hygiene and one cook failed to practice hand hygiene or allowed their sleeve to touch the food.

E Facility failed to ensure food was prepared, stored or served under sanitary conditions. There was a build-up of ice in the walk-in freezer. There were food items in the refrigerator which were not stored properly. Food particles were on the floor in front of the stove and on the stove top.

D Facility failed to ensure that meals were served under sanitary conditions when two staff members observed during dining failed to sanitize their hands after handling or touching patients, furniture or personal clothing or handling patients food with their bare hands.

F372 Disposes of garbage & refuse.

D Facility failed to dispose of garbage and refuse properly to maintain sanitary conditions. The garbage dumpster had a broken lid and was dented.

D Facility failed to dispose of garbage properly. There were two plastic bags of garbage on the concrete pad outside of the dumpster.

F386 Physician review resident's total program of care.

D Facility attending physician failed to verify and sign hospital discharge medications or give verbal orders for admission medications per facility policy.

F428 Drug regimen of resident must be reviewed by licensed pharmacist.

D Facility failed to ensure medications administered had an accurate physician's order for one patient.

F431 Labeling of drugs & biologicals.

F Facility failed to ensure accurate narcotic count records, ensure expired medications and supplies were discarded in a timely manner, and ensure medications were properly stored in the medication room and three medication carts.

F Facility failed to appropriately store internal and external medications and preparations for three of three medications carts observed.

E Facility failed to ensure expired medications were discarded in a timely manner, failed to ensure syringes were stored properly, and failed to store medications securely for three patients.

D Facility failed to remove expired medications from the shelf in one of two medication rooms.

D Facility failed to ensure medications were stored properly as evidenced by two boxes of medication unsecured on one day of the survey.

D Facility failed to ensure the medication carts remained free of loose pills and residue for three medication carts reviewed.

D Facility failed to ensure medication was stored properly by failing to discard medication within the accepted discard time in one medication cart.

D Facility failed to properly secure a controlled substance for one patient.

D Facility failed to label an intravenous (IV) bag for one patient.

F441 Investigates, controls/prevents infections.

F Facility failed to ensure proper infection control practices were followed to prevent the potential spread of infections in the terminal cleaning of rooms. The germicidal cleaner being used was not used in proper concentrations or correctly to kill C-diff.

F Facility failed to maintain infection control. The inside of the water container on the medication cart had a black ring around it.

E Facility failed to follow infection control practices during an ice pass for eight rooms. The aide filled the pitcher by holding it over the ice chest and placing the ice scoop inside the rim of the ice pitcher.

E Facility failed to ensure staff washed or sanitized their hands while assisting patients with the meal service.

E Facility failed to ensure clean linen was stored in a sanitary manner on one of three linen carts, failed to ensure ice was distributed according to proper infection control practices on one of three halls and in one of four dining rooms. Facility also failed to ensure patient beverages were stored in a sanitary manner and failed to ensure patient trays were served in a sanitary manner in one of the dining rooms.

E Facility failed to sanitize a blood glucose meter between the use for patients. Facility CNA failed to wear gloves while removing dentures and failed to follow infection control practice for oxygen tubing since it was laying on the floor.

D Facility failed to show evidence employees were free from communicable diseases for two employee files.

D Facility nurses failed to take precautions in the disposal of disposable equipment. A lancet was not disposed of in a sharp's container as required.

D Facility nurse failed to ensure infection control practices were followed to prevent the spread of infection during medication administration. The nurse did not cleanse the skin prior to the administration of a Lidoderm patch.

D Facility failed to ensure practices to prevent the potential spread of infection were maintained during disposal of sharps by one nurse observed performing a finger stick for t blood glucose level.

D Facility failed to follow infection control techniques for two patients.

D Facility failed to maintain fans in a sanitary manner for two patients.

D Facility failed to maintain infection control and failed to follow practices to prevent the spread of infection.

D Facility failed to ensure staff handled and processed soiled linens in a manner to prevent the spread of infection. Soiled linen was lying on the floor of the patient's room, and the aide picked them up with bare hands when she put them in the dirty linen container.

D Facility failed to provide sanitary conditions for two patients. The LPN failed to remove her gloves and wash her hands prior to administering an injection. After donning the gloves, the nurse had rearranged several items in the room thus contaminating her hands and gloves.

F456 Sufficient space & equipment maintenance.

F Facility dietary department failed to maintain equipment in a safe operating manner. The large mixer bowl interior was rusted.

D Facility failed to maintain dietary equipment in a safe and operational manner. The hand sink was leaking into a bucket under the sink.

F460 Full visual privacy in room design.

E Facility failed to maintain full visual privacy for patients in 11 rooms. The privacy curtain did not provide full visual privacy.

F463 Resident call system.

D Facility failed to ensure that an emergency bathroom light was functional in one of four common shower rooms.

D Facility failed to maintain the emergency call lights in two of ten bathrooms in one hallway.

F464 Designated rooms for dining & activities.

D Facility failed to provide a dining room with sufficient space to accommodate the patients.

F490 Administration.

J Facility failed to be administered in a manner to ensure the environment was safe and free of accident hazards, failed to ensure each patient received complete and accurate assessments and failed to implement appropriate and measurable interventions to prevent potential injuries for two patients with falls. This failure placed the patients in immediate jeopardy.

F501 A physician must be designated as medical director.

J Facility failed to ensure the medical director assisted the facility with identifying, evaluating and addressing clinical concerns and failed to coordinate the medical care and provide clinical guidance and oversight regarding the implementation of patient care policies and procedures which reflect the current standards of practice for patients residing in the facility. The medical director failed to ensure the staff accurately and completely assessed patients with falls and implemented appropriate measurable interventions to prevent potential serious injuries for three patients with falls. This placed the patients in immediate jeopardy.

F505 Promptly notify physician of findings of lab results.

D Facility failed to notify the physician timely of laboratory results for one patient.

F514 Criteria for clinical records.

E Facility failed to ensure accurate documentation on the treatment record for one patient. Facility failed to ensure accurate documentation on the Medication Administration Records (MAR) for three patients.

D Facility failed to ensure the accuracy of the medical record for two patients.

D Facility failed to maintain a complete medical record for one patient. There was no documentation that a patient had received medication as ordered.

D Facility failed to ensure the medical record was complete and addressed all of the patient's behaviors for one patient.

D Facility failed to maintain a complete medical record for one patient.

D Facility failed to ensure the medical record was complete for pain assessments for one patient and a physician's order was obtained for the use of a BiPAP machine for one patient.

D Facility failed to maintain an accurate clinical record for one patient.

F520 Quality assessment & assurance.

J Facility quality assurance and assessment committee failed to ensure the environment was safe and free of accident hazards, failed to ensure each patient received complete and accurate assessments, and failed to implement appropriate and measurable interventions to prevent potential injuries for two patients with falls. This failure placed the patients in immediate jeopardy.

K015 Interior Finish - Rooms

D Facility did not ensure wall finishes in offices did not have a flame spread rating of class A, B or C.

K017 Corridors Separated With Fire Walls

D Facility failed to maintain the fire rated walls.

K018 Construction of Doors

F Facility failed to prevent blocking of corridor patient room doors in the open position. Several rooms were blocked in the open position by patient bathroom doors.

E Facility failed to maintain the corridor openings. One patient room door revealed the upper portion of the entry door had a three quarter inch gap when the door was in the closed position.

D Facility failed to ensure corridor doors closed to a positive latch.

D Facility failed to have corridor doors resist the passage of smoke. Several of the locations had louvered doors.

K021 Automatic Closing Doors

D Facility failed to ensure corridor fire door in one hall closed to a positive latch.

D Facility failed to ensure the fire doors closed to a positive latch when the closure was deactivated.

K025 Smoke Partition Construction

E Facility failed to protect the fire and smoke barriers. There were penetrations in the fire wall.

E Facility failed to ensure smoke barrier walls were maintained. There were penetrations in the fire wall.

D Facility failed to ensure the two-hour fire wall's fire rated construction is maintained. There were penetrations in the fire wall.

K027 Doors In Smoke Barriers

F Facility failed to have four doors positively latch.

K029 Hazardous Areas Separated By Construction

D Facility failed to ensure one hour fire rated construction is maintained. There were penetrations in the storage room wall.

D Facility failed to ensure rooms larger than 50 square feet, used to store combustible materials, were provided with door closures.

D Facility failed to ensure rooms protected as hazardous were provided with door closers.

K038 Exit Accessible At All Times

E Facility failed to ensure eight of 12 delayed egress doors would release upon activation of the fire alarm.

D Facility failed to ensure one exit door in the kitchen was accessible at all times.

D Facility delayed egress exit door by one room did not alarm when tested.

D Facility failed to maintain all the exits. The exit door by the bookkeeping office was dead-bolted and was not secure and able to close within the frame.

D Facility failed to ensure all magnetically locked doors released upon fire alarm activation. One of the eight doors did not release when the fire alarm activated. The delayed egress functioned properly, and all staff interviewed knew the code to unlock the door.

D Facility failed to ensure delayed egress doors had appropriate signage. All exterior exit doors did not have delayed egress signage.

D Facility failed to ensure that exits are readily available at all times. One exit door required more than 15 lbs. of force to open it.

K045 Exit Lighting

F Facility failed to have exit paths lighted so the area would not be in total darkness. Two side exit discharge was not arranged so that the failure of any single lighting fixture will not leave the area in total darkness.

E Facility failed to have exit paths lighted so the area would not be in total darkness. Two side exit discharge was not arranged so that the failure of any single lighting fixture will not leave the area in total darkness.

E Facility failed to illuminate exit paths that were also on emergency lighting to the public way

D Facility failed to provide lighting for exit discharge. The exit discharge from the 500 hall to the public way, failed to provide enough emergency egress lighting in the event of failure of normal lighting.

D Facility failed to ensure exit paths were lighted. The outside courtyard lights failed to illuminate the means of egress to exit the courtyard and the wall mounted light was burnt out.

K050 Fire Drills

F Facility failed to ensure staff members are familiar with proper fire drill procedures.

D Facility failed to conduct two of 12 required fire drills.

K051 Fire Alarm System

D Facility failed to ensure all exits were provided with manual pull stations.

K052 Testing of Fire Alarm

F Facility failed to ensure fire-alarm strobes were synchronized where more than two were in the field of view.

K054 Smoke Detector Maintenance

D Facility failed to ensure the smoke detectors were installed at least three feet from the air returns.

K056 Auto Sprinkle Sys. Of Standard Approved Type

D Facility failed to have all areas of the building sprinklered.

D Facility failed to have all areas of the building sprinklered.

K061 Automatic Sprinkler - Main Control Valve

D Facility failed to provide a listed indicating valve for the automatic sprinkler system in an accessible location, so located as to control all automatic sources of water supply.

K062 Automatic Sprinkler - Maintenance

F Facility failed to have a heat source for the automatic sprinkler system.

F Facility failed to install and maintain the automatic sprinkler system.

E Facility failed to maintain all components of the sprinkler system. The post indicator valve (PIV) near the service entrance was missing a window glass.

D Facility failed to maintain all sprinkler heads. One of two sprinkler heads in the restroom did not have an escutcheon ring.

D Sprinkler was not maintained in operating condition. Excessive storage was blocking the sprinkler in the riser room.

K066 Smoking Regulations

D Facility smoking areas were not provided with metal containers with self-closing cover devices.

D Facility failed to provide appropriate ashtray containers in the designated smoking areas.

D Facility failed to provide metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted.

D Facility failed to provide the smoking area with self-closing cover devices.

K067 Ventilating Equipment

F Facility fire dampers were not maintained at last every four years. (Fusible links shall be removed; all dampers shall be operated to verify that they fully close. The latch, if provided, shall be checked and moving parts lubricated as necessary).

E Facility failed to maintain the ventilation system. The dryer room exhaust vent was obstructed with lint.

K069 Commercial Cooking Equip. Meets Requirements

E Facility failed to protect the cooking facilities. The suppression head over the deep fryer was missing the protective cap and there was a grease build up on the head and the piping over the grill was loose.

D Facility commercial cooking stove and the deep fryer were not separated by at least 16 inches.

K072 Furnishings and Decorations

E Facility failed to maintain the means of egress. One exit was blocked by a laundry rack.

D Facility failed to ensure all exits were readily accessible and free from obstructions.

K076 Nonflammable Medical Gas Systems

D Facility failed to keep all oxygen bottles in a secure condition to prevent damage. One bottle of oxygen in one nurse's station was not secure.

D Facility failed to keep oxygen bottles in a secure condition to prevent damage.

K104 Penetration of Smoke Barriers

D Facility failed to maintain the fire walls.

K130 Other LSC Deficiency Not On 2786

D Facility failed to provide ventilation and outside exhaust to all patient toilets and support areas.

D Facility failed to maintain the fire dampers. A nurse call cable was installed through the fire damper on one of the units.

K144 Generators

E Facility failed to maintain the emergency generator and transfer switch locations in accordance with NFPA 99 and NFPA 110.

D Facility failed to maintain all generator equipment.

D Facility failed to provide a remote alarm for the emergency generator. There was no annunciator panel.

D Facility failed to ensure the automatic transfer switch location was provided with battery-powered emergency lighting.

K147 Electrical Wiring and Equipment

E Facility failed to maintain the electrical wiring. The ground fault circuit interrupter (GFCI) failed in one room.

D Facility failed to maintain the electrical equipment. Extension cords were being used in some rooms.

D Facility failed to maintain electrical equipment. There were some broken covers on the light fixtures.

D Facility failed to ensure the electrical wiring and equipment is in accordance with NFPA 70. There were oxygen concentrators plugged into power strips.

D Facility failed to prohibit multiple outlet adapters for use with medical devices. There were several power strips being used in the facility.

D Facility failed to prohibit the use of extension cords.

D Facility failed to ensure electrical wiring and equipment is in accordance with the National Electric Code. There were no ground fault circuit interrupter outlets adjacent to the sinks in the bathrooms of two patient rooms.

K211 Alcohol Based Hand Rub Dispensers

D Facility failed to install alcohol based hand rub dispenser away from an electrical switch.

D Facility failed to ensure alcohol based hand rub dispensers were not installed over an ignition source.

N1102 Record and Reports; Recording of Unusual Incidents

Facility failed to implement the abuse prevention policy and procedure to perform a complete and thorough investigation of an injury of unknown origin or report the incident to the state survey agency within five working days of the injury for one patient.

N1216 Resident Rights

Facility failed to maintain full visual privacy for three patient and failed to maintain confidentiality of patient's medical records by not closing the Medication Administration Record (MAR) during medication pass.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

Facility failed to conduct disaster drills for a tornado, flood and earthquake as required.

Facility failed to provide documentation of a tornado, earthquake and flood drill for all staff.

Facility failed to exercise external disaster drills. There was no documentation available to show an annual earthquake drill had been done.

N1411 Disaster Preparedness; Fire Safety Drills

Facility failed to conduct the required disaster drills. There was no bomb threat drill conducted.

Facility failed to conduct a bomb threat drill for all staff.

Facility failed to provide documentation that a bomb threat exercise had been done in the previous year.

N1418 Disaster Preparedness; Emergency Plans

Facility failed to establish communications with the county emergency management agency.

N629 Infection Control; Disinfect Contaminated Items

Facility failed to ensure proper infection control practices were followed to prevent the potential spread of infections in the terminal cleaning of rooms. The germicidal cleaner being used was not used in proper concentrations or correctly to kill C-diff.

N727 Pharmaceutical Services

Facility failed to ensure medications were stored properly as evidenced by two boxes of medication unsecured.

N767 Food and Dietetic Services; Written Policies and Procedures

Facility failed to ensure food was prepared, stored or served under sanitary conditions when one CNA failed to practice hand hygiene and one cook failed to practice hand hygiene or allowed their sleeve to touch the food.

Facility failed to ensure food was prepared, stored or served under sanitary conditions. There was a build-up of ice in the walk-in freezer. There were food items in the refrigerator which were not stored properly. Food particles were on the floor in front of the stove and on the stove top. This was a type C pending penalty.

Facility failed to maintain proper kitchen sanitation as evidenced by the door to the dishwasher room and the door to the service hall were propped open. Also, raw beef patties were placed in a pan next to the prepared deli meat and partially covered corn bread and cold food was not served that the proper temperature. In addition, a visitor entered the kitchen without a hair cover with the potential to contaminate the food served to the patients.

N769 Social Work Services; Resident History

Facility failed to ensure cold food was served at 45 degrees F or below.

N831 Building Standards

Facility failed to maintain the ventilation system. The dryer room exhaust vent was obstructed with lint.

Facility failed to maintain the condition of the physical plant and the overall nursing home environment in such a manner that the safety and well-being of the patients are assured. There were stained ceiling tiles in several areas of the building.

Facility failed to maintain the building fire safety components. One halls fire-rated doors had been replaced with smoke doors and have been altered from the original approved design.

N835 Building Standards; Approval of New Construction

Facility failed to ensure alterations to the facility are made with prior approval from the Department of Health. A new emergency generator was installed without submitting plans or obtaining approval for the generator.

N848 Building Standards; Exhaust & Air Pressure

Facility failed to maintain the soiled linen storage area under a relative negative air pressure.

Facility failed to have proper airflow in the clean and dirty areas.

Facility failed to maintain the exhaust system. The entire unit on one wing was not working.

Facility failed to ensure clean linen areas were well ventilated and maintained under a relative positive air pressure.

Facility failed to assure the therapy gym was maintained under a relative negative air

Facility failed to maintain negative and positive air pressure in the required areas.

Facility failed to ensure soiled linen storage areas maintained under a relative negative air pressure.

Facility failed to provide proper air supply to the clean and dirty laundry areas.

N902 Elimination of Fire Hazards

Facility failed to eliminate fire hazards. There was a build up of lint on the lint traps of the dryers.