Survey Deficiency Summary

18 Facilities Surveyed **Surveys Taken 11/8/12 -1/10/13**

F157 Notification of changes to designated individuals that affect resident well-being.

J Facility failed to follow facility policies to immediately notify the physician of one patient voicing suicidal ideations.

D Facility failed to notify the physician of laboratory results exceeding therapeutic range for one patient.

F164 Right to privacy & confidentiality.

D Facility failed to maintain the confidentiality of patient's medical records by not covering or closing the medication administration record during medication administration.

D Facility failed to provide privacy during treatment and protect the privacy and confidentiality of medical records for two patients.

D Facility failed to provide full visual privacy during care for one patient.

F172 Access & visitation rights.

C Facility failed to ensure the patients had knowledge of the ombudsman role in the facility and how to contact the office.

F176 Self-administration of drugs by resident.

D Facility failed to determine safety of self-administration of drugs for one patient. The patient was receiving a nebulizer treatment with no nurse in attendance.

D Facility failed to ensure one patient was assessed prior to self-administration of a medication for one patient.

F224 Mistreatment, neglect, misappropriation of resident property.

J Facility failed to follow and prevent neglect for one patient. The facility's failure to follow policies, provide mental health services, and prevent neglect resulted in one patient attempting suicide by attempting to stab himself in the chest with a table knife. This placed the patient in immediate jeopardy.

J Facility neglected to provide the necessary care to prevent an avoidable pressure sore for one patient. This failure resulted in an immediate jeopardy for the patient who developed a stage IV pressure ulcer with exposed bone, tendon or muscle to the sacrum.

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

D Facility failed to ensure an identified accused CNA was immediately removed from the facility until the completion of the investigation of alleged abuse. Facility failed to ensure the abuse policy included all required components and failed to ensure an allegation of abuse was reported to the state agency.

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

- D Facility failed to ensure a patient's dignity was maintained while being transported down the hallway for one patient.
- D Facility failed to ensure dignity was maintained for one patient when staff served the patient in a disposable food container for meals and placed red barrels for linens in the patient's room. The patient had isolation precautions being carried out and was not in isolation.
- D Facility failed to ensure patient's dignity was maintained by not addressing patients with a courtesy title for two patients.
- D Facility failed to maintain patient dignity during a meal service. The other patients at the table were eating lunch, and he did not have a meal.

F246 Right to accommodations of individual needs & preferences.

- D Facility failed to ensure the call light was within a patient's reach for one patient.

F250 Medically related social services.

- J Facility failed to follow facility policies and provide medically related social services for four patients. This failure resulted in the patient obtaining a dinner knife and attempting to stab himself in the chest. The patient was transferred to the hospital emergency room and admitted to a mental health unit for treatment. This placed the patient in immediate jeopardy.
- D Facility failed to provide social services adequate to meet the needs of one patient. The patient had asked the social worker to tell the physician that he was increasingly depressed. The social worker did not follow up.

F252 Safe, clean, comfortable & homelike environment.

- D Facility failed to ensure a homelike environment related to odors within the facility for one patient hallway observed.
- D Facility failed to provide a homelike environment by leaving meals on trays after being served to the patients.

F253 Housekeeping & maintenance services.

- D Facility failed to ensure patient equipment was clean and the environment was free from odors.
- D Facility failed to maintain a sanitary environment for one patient.

F272 Comprehensive assessment.

- D Facility failed to complete pain assessments for one; failed to update a bowel and bladder assessment with a change in condition for one; and failed to complete a care plan to address bowel and bladder status.
- D Facility failed to assess the bladder incontinence needs for one patient.

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

D Facility failed to accurately complete the MDS for falls for one patient.

D Facility failed to accurately complete the Minimum Data Set (MDS) for falls for two patients

D Facility failed to ensure the MDS was correctly coded to indicate the patient was receiving antipsychotics for one patient.

D Facility failed to ensure the MDS was accurately coded for behaviors for one patient.

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

J Facility failed to revise and update the plan of care to address refusal of care and failed to develop interventions for a Stage IV pressure ulcer for one patient. This failure resulted in immediate jeopardy for one patient who developed a stage IV pressure ulcer to the sacrum.

E Facility failed to develop a care plan for two patients for activities, one patient for smoking and three patients for discharge plans.

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

J Facility failed to follow facility policies and failed to revise the care plan with interventions t protect and prevent suicide attempts for one patient. This placed the patient in immediate jeopardy.

D Facility failed to revise care plans for hemodialysis or antibiotic use for two patients.

D Facility failed to allow care planning participation for patients and families for one patient.

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

D Facility failed to update the care plan for the use of side rails for one and failed to update the care plan related to a pressure ulcer for one.

F281 Services must meet professional standards of quality.

D Facility failed to develop a care plan to meet the needs for dialysis for patient and failed to administer a medication per physician order for one patient.

F283 Discharge summary includes resident's stay.

E Facility failed to ensure each patient discharged from the facility had a discharge summary that included a recapitulation discharge summary that included a recapitulation of the patient's stay for nine discharged patients.

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

J Facility failed to notify the physician of verbal statements of and plan for suicide, failed to prevent neglect by following facility policies for patient change in condition to protect and prevent suicide attempts and failed to provide social service counseling. Facility failed to revise the care plan with interventions to prevent suicide attempts and failed to provide mental health services for one patient. This failure placed the patient in immediate jeopardy.

- D Facility failed to follow physician's orders for the administration of medication for one
- D Facility failed to address verbalized complaints of pain for one patient with pain.

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

- D Facility failed to ensure that dependent patients were kept clean and dry for two patients.
- D Facility failed to carry out the necessary care and services needed to maintain grooming for one patient.

F313 Proper treatment & devices to maintain vision and hearing abilities.

- D Facility failed to ensure that patients received proper treatment and assistive devices to maintain vision ability for one patient.

F314 Resident does not develop pressure sores.

- J Facility failed to provide the necessary care to prevent an avoidable pressure sore for one patient. This failure resulted in an immediate jeopardy for one patient who developed a stage IV pressure ulcer to the sacrum.
- D Facility failed to assess a pressure ulcer for one patient.

F315 Incontinent resident receives appropriate treatment and services.

- D Facility failed to provide current physician's orders and justification for an indwelling Foley catheter for one patient.
- D Facility failed to complete an assessment and develop an individualized toileting plan for two patients.
- D Facility failed to ensure treatment and services were provided to prevent decline in bladder incontinence for one patient.

F319 Psychosocial adjustment difficulty.

- J Facility failed to follow facility policies and failed to provide mental health services for five patients. This failure placed one patient in immediate jeopardy.
- D Facility failed to provide the necessary mental health care and services to maintain the highest practicable mental and psychosocial well-being for one patient.

F323 Accident hazards.

- E Facility failed to follow the facility's smoking policy for one patient and to ensure the patients environment remained free of accident hazards on one hallway.
- D Facility failed to ensure that a patient at risk for falls had new interventions implemented after each fall to prevent further falls for one patient.
- D Facility failed to follow the facility smoking policy for one patient.

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

- D Facility failed to ensure three patients were free from unnecessary medications.
- D Facility failed to provide adequate indications for the use of medications for two patients.
- D Facility failed to ensure unnecessary medications were administered for one patient.

F332 Facility medication error rates of 5% or more.

- D Facility failed to ensure three medication nurses administered medications with a medication error rate of less than 5 percent. The error rate was 11.32 percent.

F333 Residents free of significant medication errors.

- G Facility failed to ensure patients were free of significant medication errors for one patient. This medication error resulted in an emergency hospitalization and harm for the patient. The patient received the roommates medication and not her own. This caused a sharp decrease in blood pressure and heart rate requiring a stay in the intensive care unit of the hospital for three days.
- D Facility failed to ensure a patient was free from significant medication errors when nursing staff failed to ensure ordered blood pressure was obtained prior to administration of an antihypertensive medication for one patient.
- D Facility failed to prevent a significant medication error for one patient.

F356 Nurse staffing data

- D Facility failed to post nurse staffing information on a daily basis at the beginning of each shif on two days of the survey.
- D Facility failed to post the required staffing information related to the actual hours worked by licensed and unlicensed staff.

F366 Food substitutes offered.

- D Facility failed to ensure one patient received a substitute after refusing food served.

F371 Store, prepare, distribute, & serve food.

- F Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by dirty kitchen equipment, including dry-food-storage containers; dietary staff not wearing hair covers; and cooler temperature not maintained at 41 degrees Fahrenheit (F) or below.
- F Facility failed to maintain a sanitary dietary department and failed to serve food at or greater than 135 degrees F in one dining room.
- D Facility failed to ensure practices to prevent the spread of infection were maintained when one CNA failed to practice hand washing during meal tray pass on one hall.
- D Facility failed to ensure supplements were stored at the proper temperature by not having a thermometer in the refrigerator for one nourishment refrigerator.

F425 Provide routine and emergency medications; allow unlicensed personnel to administer drugs per law under supervision.

- E Facility failed to ensure two patients received medications as ordered, and failed to ensure accuracy of a physician order sheet for one patient.
- D Facility failed to provide pharmaceutical services in a timely manner for one patient.

F431 Labeling of drugs & biologicals.

- E Facility failed to ensure that medications and biologicals were stored in locked compartments when unattended.
- D Facility failed to ensure medications were stored under proper refrigerator temperatures in one medication refrigerator.

F441 Investigates, controls/prevents infections.

- E Facility failed to ensure practices to prevent the potential spread of infection was maintained when two nurses failed to disinfect the glucometer machines between patients. The nurse cleaned with an alcohol pad rather than the sani-wipes that are approved.
- D Facility failed to ensure three nurses followed the hand washing/hand hygiene policy or properly disposed of sharps in accordance with the facility policy.
- D Facility failed to maintain contact precautions for one patient in contact isolation.
- D Facility failed to maintain standard infection control practice related to failure to wash or sanitize the hands during ice pass for two patient rooms. The facility failed to ensure standard infection cleaning of the ice cart. Facility failed to remove contaminated breakfast foods from the dining area prior to the lunch dining observation and failed to maintain a clean environment in the shower room on the 100 wing hallway for one of two shower
- D Facility treatment nurse failed to maintain proper infection control practices by failing to obtain clean gloves during one dressing change.
- D Facility failed to prevent/minimize the transmission of potential airborne contamination for one patient during a random observation at mealtime.
- D Facility failed to ensure infection-control practices were maintained for one patient.

F460 Full visual privacy in room design.

- D Facility failed to provide full visual privacy for two patients.

F463 Resident call system.

- D Facility failed to maintain a nursing call system for two.

F465 Facility must provide a safe, functional, sanitary, & comfortable environment for residents, staff and the public

- E Facility failed to maintain a safe environment in multiple rooms. There was torn and loose hard plastic covering on the door facings.

F490 Administration.

J Facility failed to be administered in a manner to ensure processes were in place to train and educate all staff on suicide prevention. Facility failed to prevent neglect by not following facility policies for patient change in condition to protect and prevent suicide attempts and failed to notify the physician of verbal statements of and plan for suicide. Facility failed to revise the care plan with interventions to prevent suicide attempts, and failed to provide the necessary care and services to maintain the highest practicable mental and psychosocial well-being for one patient. Facility failed to provide mental health services for five patients. This placed the patients in immediate jeopardy.

J Facility failed to be administered in a manner to monitor and ensure turning and positioning of patients. The facility failed to update care plans and develop interventions regarding a patient's refusal of care and failed to investigate the disappearance of a sliding board. The facility failed to provide the necessary care to prevent the development of a stage IV pressure ulcer.

F514 Criteria for clinical records.

D Facility failed to follow facility policies and maintain accurate records for one patient.

D Facility failed to ensure the accuracy of documentation in the medical record for one patient. The patient had an amputation of the left great toe, but it was charted in the nursing notes as the right great toe.

F516 Clinical record information loss, destruction or unauthorized use.

D Facility failed to follow facility policies and safeguard protected health information for one patient. A staff member made a copy of the social services notes on the patient and gave them to a family member working in the business office of the facility. The family member was not the power of attorney or responsible party.

F520 Quality assessment & assurance.

J Facility failed to ensure an effective system was in place to train and educate all staff on suicide prevention and failed to ensure an effective system to prevent neglect by following facility policies for patient change in condition to protect and prevent suicide attempts. Facility failed to ensure an effective system to notify the physician of verbal statements of and plan for suicide, failed to ensure an effective system to provide social service counseling, and failed to ensure an effective system to revise the care plan with interventions to prevent suicide attempts. Facility failed to ensure an effective system to provide the necessary care and services to maintain the highest practicable mental and psychosocial well-being for one patient. Facility failed to ensure an effective system to provide mental health services for five patients. This place the patients in immediate jeopardy.

D Facility failed to ensure the required sign-in of the designated physician at the monthly quality assurance meetings for one of the months.

K017 Corridors Separated With Fire Walls

D Facility failed to ensure all fire wall construction is maintained. There were penetrations in the fire walls.

K018 Construction of Doors

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

D Facility failed to maintain the conference room door to resist the passage of smoke. The door would not close and latch.

D Facility failed to maintain all doors to resist the passage of smoke.

D Facility failed to maintain all fire doors. The double fire doors in the corridor at the laundry failed to latch when closed.

K029 Hazardous Areas Separated By Construction

D Facility failed to separate hazardous areas from other spaces. There was an accordion door covering an area filled with the activities department decorations, clothes and other items.

D Facility failed to maintain the rated construction in hazardous areas.

K038 Exit Accessible At All Times

D Facility failed to ensure exit discharge is readily accessible.

D Facility failed to maintain readily accessible exits at all times.

D Facility failed to ensure exit access is readily accessible at all times.

K050 Fire Drills

D Facility failed to conduct the required fire drills.

K054 Smoke Detector Maintenance

D Facility failed to ensure the smoke detector in the medication room did not have the required clearance from the air supply diffusers.

K056 Auto Sprinkle Sys. Of Standard Approved Type

D Facility failed to ensure the sprinkler system and components were installed per NFPA 13. There was wiring attached to, or supported by, the sprinkler piping.

D Facility failed to ensure the automatic sprinkler system was being maintained.

K062 Automatic Sprinkler - Maintenance

D Facility failed to maintain multiple sprinkler heads in the facility. There was paint on the pendants.

- D Facility failed to maintain the sprinkler system in reliable operating condition.

K064 Portable Fire Extinguishers

- D Facility failed to maintain access and visibility to one fire extinguisher. There was a chair blocking access.

K066 Smoking Regulations

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

K067 Ventilating Equipment

- F Facility failed to ensure the fire dampers were maintained in accordance with NFPA 90A.
- F Facility failed to maintain their heating, venting and air conditioning (HVAC). There was no four-year fire and smoke damper maintenance performed.
- D Facility failed to provide constant air circulation in three patient rooms.
- D Facility failed to maintain negative air pressure in required areas.
- B Facility failed to provide constant air circulation in multiple rooms. The only source of air exchanges were the heating and air conditioning units. The fan function of the units had been turned off in multiple patient rooms.

K069 Commercial Cooking Equip. Meets Requirements

- D Facility failed to protect the cooking facilities. There was a grease build-up on the hood.

K072 Furnishings and Decorations

- D Facility failed to maintain the path of egress from the west wing corridor. There were items in the hallway in the path of egress.

K073 Flammable Furnishings

- D Facility failed to prohibit the use of decorations of highly flammable character. Some of the corridor doors were covered with wrapping paper.

K104 Penetration of Smoke Barriers

- D Facility failed to maintain two rated fire and smoke walls. There were penetrations in the walls.
- D Facility failed to maintain all rated assemblies. There was a penetration in the ceiling tile in one area of the hallway.
- B Facility failed to maintain all rated walls. There were penetrations in the fire wall.

K130 Other LSC Deficiency Not On 2786

- D Facility failed to conduct the semi-annual emergency preparedness drills.

K144 Generators

D Facility failed to provide a remote annunciator from the generator to a continuously occupied area.

K147 Electrical Wiring and Equipment

F Facility failed to maintain all electrical wiring and components. There were electrical receptacles with open grounds in multiple locations.

D Facility failed to maintain all electrical components in the west shower room and the therapy department.

D Facility failed to ensure electrical extension cords were not in use.

D Facility failed to maintain the electrical wiring in accordance with NFPA 70.

K211 Alcohol Based Hand Rub Dispensers

D Facility failed to install alcohol based hand rub dispensers in the correct locations.

N1216 Resident Rights

Facility failed to maintain the confidentiality of patient's medical records by not covering or closing the medication administration record during medication administration. This was a type C pending penalty.

Facility failed to submit plans and specifications to the Tennessee Department of Health engineering department prior to renovations of the facility. A side porch had been converted to physical therapy offices, individual treatment room and a storage room.

N1227

Facility failed to ensure dignity was maintained for one patient when staff served the patient in disposable food containers and placed red barrels in the patient's room. The patient was not on isolation precautions.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

Facility failed to provide documentation of a flood drill conducted for staff on all shifts.

Facility failed to conduct disaster drills for all staff.

Facility failed to conduct the required tornado, flood and earthquake drills.

Facility has not exercised its annual tornado and earthquake disaster drill.

N1411 Disaster Preparedness; Fire Safety Drills

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

Facility failed to conduct the required disaster drills.

Facility failed to perform its annual bomb threat drill.

N201 Licensing Procedures

Facility failed to post conspicuously the nursing home license.

N433

Facility failed to post the charity care statement in an area easily accessible for public viewin

N629 Infection Control; Disinfect Contaminated Items

Facility failed to ensure two nurses cleaned the glucometer machine correctly between uses for different patients. This was a type C pending penalty.

N645 Nursing Services

Facility failed to ensure patient equipment was clean and the environment was free from odors. This was a type C pending penalty.

N729 Pharmaceutical Services

Facility failed to ensure that medications and biologicals were stored in locked compartments when unattended. This was a type C pending penalty.

N767 Food and Dietetic Services; Written Policies and Procedures

Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by dirty kitchen equipment, including dry-food-storage containers; dietary staff not wearing hair covers; and cooler temperature not maintained at 41 degrees Fahrenheit (F) or below.

N769 Social Work Services; Resident History

Facility failed to ensure hot foods were kept at 140 degrees F. The fish was 122 degrees F. This was a type C pending penalty.

N776 Refrigerator Temperature

Facility failed to ensure the cooler temperatures did not exceed 45 degrees F. The cooler temperature was 54 degrees F. This was a type C pending penalty.

N831 Building Standards

Facility failed to maintain the condition of the ceilings. A layer of paint on the ceiling had separated and was peeling.

Facility failed to ensure the automatic sprinkler system is installed properly. The piping is penetrating through a four hour fire wall in one hall.

Facility failed to maintain the overall nursing home environment in such a manner that the safety and well-being of the patients are ensured. There were stained ceiling tiles in the hallways.

N835 Building Standards; Approval of New Construction

Facility failed to submit plans and specifications to the Tennessee Department of Health engineering department prior to renovations of the facility. A side porch had been converted to physical therapy offices, individual treatment room and a storage room.

N848 Building Standards; Exhaust & Air Pressure

Facility failed to maintain a negative air pressure in all toilet rooms.

Facility failed to ensure a negative air pressure is maintained in all soiled areas.