Survey Deficiency Summary

38 Facilities Surveyed **Surveys Taken 9/5/13 - 10/30/13**

F151 Exercise of rights as a resident of the facility.

E Facility failed to honor patient rights to smoke for three of five patients.

F153 Right to access all records pertaining to himself or herself.

D Facility failed to allow the legal representative to purchase a copy of medical records for one patient.

F155 Right to refuse treatment/experimental research or to issue an advance directive.

D Facility failed to permit a patient to refuse treatment. The physician ordered an injection which the patient refused. The nurse gave it without the permission of the patient.

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

G Facility failed to notify the physician of a pressure ulcer for one patient.

G Facility failed to notify the physician of use of a multipodus boot and failed to notify the physician of pressure wound progression for one patient resulting in harm to the patient.

D Facility failed to notify the physician timely of significant changes in a patient's condition.

D Facility failed to notify the physician of a skin condition for one patient.

D Facility failed to notify the physician of a patient's refusal of medication.

D Facility failed to notify the responsible party of a change in condition of one patient.

D Facility failed to ensure family notification, related to a roommate change, for one patient.

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

E Facility failed to ensure patients had access to petty cash on an ongoing basis for five patient with a personal fund account.

D Facility failed to provide quarterly fund statement for one patient. It was mailed to a family member that was not the power of attorney.

F161 Assurance of financial security.

C Facility failed to provide a surety bond to at least equal the patients' personal funds balance.

F164 Right to privacy & confidentiality.

D Facility medication nurse failed to maintain the confidentiality of a patient's medical record during medication pass. The MAR was left open and unattended on the medication cart.

F170 Right to send/receive mail.

D Facility failed to deliver mail to the patients for one of six days mail was delivered to the facility.

C Facility failed to ensure patient's mail was promptly delivered on Saturdays for all patients in the facility.

F202 Documentation of transfer/discharge in resident's clinical record.

G Facility failed to ensure documentation by the physician in the clinical record to justify the involuntary discharge of one patient. This resulted in harm to the patient.

E Facility failed to ensure documentation was available for four patients. There were no discharge summaries in the medical record.

F203 Notice before transfer or discharge.

G Facility failed to ensure one patient was provided a 30-day involuntary discharge notice. This resulted in actual harm to the patient from mental and emotional distress.

F204 Orientation for transfer or discharge by facility to resident.

G Facility failed to provide sufficient preparation and orientation for an involuntary discharge of one patient. This resulted in harm to the patient from mental and emotional distress.

F221 Right to be free from physical restraints.

D Facility failed to ensure restraint assessments were completed for one patient.

D Facility failed to complete a restraint assessment and attempt restraint reduction for one patient.

F224 Mistreatment, neglect, misappropriation of resident property.

E Facility failed to prevent misappropriation of controlled substances for 13 patients. An LPN had been taking patient's discontinued medications and signing as needed medications as administered to patients but in actuality was keeping the medications. The facility did a through investigation but did not reimburse the affected patients for the controlled substances which were taken.

F225 Facility must not hire person with abuse history.

E Facility failed to ensure misappropriation of property from the removal of narcotic analgesic patches by a CNA which was reported immediately to the administrator.

D Facility failed to have evidence that an allegation of abuse was thoroughly investigated by failing to complete an incident/investigation report.

D Facility failed to ensure a patient's allegation of staff abuse was investigated. Facility failed to notify the family of a voiced allegation of abuse. This finding was related to a substantiated allegation in a complaint investigation initiated on Sept. 10, 2013.

D Facility failed to follow policy and procedures for a sexual abuse investigation for two patients and failed to investigate an attempted removal of a pain patch for one patient.

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

E Facility failed to ensure pre-employment reference checks were conducted for three staff members. Facility failed to provide abuse prohibition training prior to the staff having direct contact with the patients living in the facility.

D Facility failed to ensure staff immediately reported alleged abuse by another staff member for one patient.

D Facility failed to implement the abuse policy for one patient. The patient was administered an IM injection even though he refused, which was considered abuse.

D Facility failed to conduct an investigation of misappropriation of patient funds for one patient

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

E Facility failed to promote care for patients in a manner and in an environment that maintained or enhanced each patient's dignity as evidenced by one patient being placed at a dining room table that was not easily accessible for her height. Milk was also served in milk cartons. Staff stood to feed several patients during mealtime.

D Facility failed to provide an environment that maintains or enhances each patient's dignity and failed to respect the dignity with serving meals timely for one patient.

D Facility failed to maintain or enhance each patient's dignity and respect in three rooms. The rooms were entered by staff who did not knock or ask permission prior to entry.

D Facility failed to ensure two patients were treated with dignity and respect during dining when patients had to drink milk from a carton.

D Facility failed to promote care that maintained the patients' dignity, respect and quality of life by allowing a patient to remain suspended in the air in a sling of a lift with the hallway door open and the privacy curtain not pulled.

D Facility failed to provide an environment that maintains or enhances each patient's dignity. Staff entered a patient room without knocking or asking permission to enter.

D Facility failed to enhance dignity for one patient. The CNA was standing over the patient while assisting them with eating.

D Facility failed to maintain dignity and respect while administering medication during a meal for one patient. The LPN administered the medication in the dining room while the patient was eating.

D Facility failed to request and obtain permission prior to entering the patient's room for two patients.

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

D Facility failed to accommodate a patient's choice of breakfast for one patient. The patient wanted fried eggs instead of scrambled eggs.

D Facility failed to allow choices for one patient. The patient was not placed in the bed in a timely manner after requesting to go to bed.

D Facility failed to allow one patient to choose a shower schedule consistent with the patient's preferences. The patient wanted to be showered daily and not just twice a week.

F244 Facility follow-up on family group meetings.

E Facility failed to act upon a grievance of the resident council related to the delay in receiving night-time medications.

F246 Right to accommodations of individual needs & preferences.

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

D Facility failed to accommodate the needs of one patient. The air conditioner in the patient room was not functioning.

D Facility failed to provide easy access to the nurse call system for two patients.

D Facility failed to accommodate the needs and choices of two patients. The staff left the patient room door open when he had requested it closed.

F247 Right to receive notice of change in resident's room.

D Facility failed to notify residents of a roommate change for two patients.

F248 Ongoing activities program to reflect resident's needs.

D Facility failed to provide an ongoing program of activities designed to meet the interests and physical, mental and psychosocial well-being of three patients.

F249 Criteria met to hire a qualified activities director.

E Facility failed to ensure there was a qualified professional responsible for directing the development, implementation, supervision and ongoing evaluation of an activities program.

D Facility failed to ensure the activities program was directed by a qualified professional. There was no documentation of qualification for the position.

F250 Medically related social services.

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

D Facility failed to provide social services for two patients.

F253 Housekeeping & maintenance services.

F Facility failed to provide necessary housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior as evidenced by loose cove base strips, chipped paint and dry wall, scratched furniture, chipped floor tile, loose door knobs, toilet vanities in disrepair, cracked sinks and loose night light covers on three halls.

E Facility failed to provide housekeeping and maintenance services to maintain the building in a sanitary, orderly and comfortable manner for three rooms.

D Facility failed to provide housekeeping and effective maintenance services for patient rooms to maintain a sanitary, orderly and comfortable environment as evidenced by floors dirty with wax build up, trash on the floors, smeared brown spots on the floors and dirty air conditioner vents. There was also cob webs on the walls, dust bathroom vents, urine odors in rooms, broken sink faucets, missing baseboards, tracks of privacy curtains hanging from the ceiling and broken tiles and dirty walls.

D Facility failed to ensure the environment was clean as evidenced by mold on the wall in one of the patient rooms.

D Facility failed to maintain a safe and sanitary shower stall for one out of two showers on one wing. There was some loose and cracked tile.

D Facility failed to maintain the temperature of the hot water at acceptable levels for three rooms.

D Facility failed to ensure a standing lift was clean as evidenced by the presence of dust and debris on one standing lift.

D Facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for one hallway and five patient rooms.

D Facility failed to ensure the environment was clean and sanitary as evidenced by a dirt buildup in the corners throughout the hallway and the doorway entrances to patient rooms; drippy faucets; stained sinks; dirty toilet tanks; dirty faucets; dirty over bed tables; and dirty floors.

D Facility failed to provide adequate and safe lighting levels for one patient.

D Facility failed to keep the facility free from odors. There was a presence of urine odor in the hallway.

F258 Comfortable sound levels.

D Facility failed to maintain calm and quiet noise levels in two patient rooms. There were complaints about the night shift staff hollering down the hallways.

F272 Comprehensive assessment.

G Facility failed to complete a comprehensive assessment for pressure ulcers for one patient resulting in harm to the patient. Facility failed to accurately assess dental status for one patient.

E Facility failed to complete a comprehensive assessment for eight patients with wandering behaviors.

D Facility failed to accurately document a significant weight loss for one patient.

D Facility failed to complete a quarterly MDS for two patients and failed to accurately assess a fall and weight loss and gain for one patient.

D Facility failed to complete the comprehensive assessment for one patient.

D Facility failed to assess one patient for chronic malpositioning of head and neck.

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

D Facility failed to accurately assess a patient for antidepressant medication for one patient.

D Facility failed to ensure the accuracy of a quarterly assessment for contractures for one patient.

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

G Facility failed to develop a comprehensive care plan for two patients which caused actual harm to one patient.

E Facility failed to develop care plans to ensure the necessary care and services were provided for six patients.

E Facility failed to develop a plan of care with measurable goals and interventions to address the care and treatment of dental and oral health concerns or impaired vision for four patients.

D Facility failed to ensure the care plan addressed activity needs of three patients.

D Facility failed to develop a care plan for the dental needs of one patient.

D Facility failed to have a care plan for ROM for one patient.

D Facility failed to develop a comprehensive care plan for one patient.

D Facility failed to develop a care plan to address impaired vision for one patient.

D Facility failed to develop a care plan to address a PICC line for one patient.

D Facility failed to develop a care plan to address urinary incontinence for one patient.

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

E Facility failed to update the care plan for two patients after a sexual altercation, and failed to revise the care plan to address the patients' changing needs for five patients.

D Facility failed to revise the care plan to address fall interventions for one patient.

D Facility failed to update care plans to reflect the changing needs of the patients.

D Facility failed to revise the care plan to reflect the current status of the patients related to the addition of new pressure ulcers, use of side rails and the use of Prevalon boots for three patients.

D Facility failed to revise the care plan to reflect the current status of a patient related to the use of hand rolls and nothing-by-mouth (NPO) status.

D Facility failed to revise a care plan to reflect safety devices for one patient.

D Facility failed to update the care plan to reflect a worsening pressure sore for one patient.

D Facility failed to revise the care plan to reflect the current status of patients related to dental and a nutritional supplement for two patients.

D Facility failed to update the care plan to include anticoagulation therapy and monitoring of adverse side effects from the therapy for one patient.

D Facility failed to update the care plan to include a splint provided by the facility to prevent further contracture for one patient.

D Facility failed to conduct a quarterly care plan review and involve the family in the care planning conference of one patient.

F281 Services must meet professional standards of quality.

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

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

D Facility failed to utilize professional standards in the performance of laboratory services for one patient.

D Facility failed to address the care area of hospice on the interim care plan for one patient.

D Facility failed to ensure an LPN was competent to administer medications and provide care with skill, safety and judgment for three patients. Medications were not administered nor documented properly. On investigation, it was found the nurse was tested positive for opiates.

D Facility failed to develop an initial care plan for one patient.

F282 Services must be provided by qualified persons.

D Facility failed to follow the care plan for padded side rails for one patient.

D Facility failed to provide services in accordance with the patient's plan of care for three patients.

D Facility failed to ensure care plan interventions were followed for range of motion (ROM) for two patients.

D Facility failed to follow the care plan interventions for a toileting schedule, fall mats or stop signs for one patient.

D Facility failed to follow care plan interventions related to falls, splinting devices and/or pressure ulcer relief.

D Facility failed to follow the comprehensive care plan for assistance with toileting for one patient.

F283 Discharge summary includes resident's stay.

D Facility failed to provide a completed discharge summary for four patients.

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

G Facility failed to follow physician orders for pain medications for one patient resulting in harm to that patient. Facility failed to maintain a contract, establish, and coordinate a plan of care with hospice for one patient.

D Facility failed to ensure a dialysis contract was maintained for one patient receiving dialysis.

D Facility failed to ensure physician orders were followed related to fluid restrictions for one patient receiving dialysis.

D Facility failed to address one patient's chronic malpositioning of the head and neck.

D Facility failed to administer medications as ordered for one patient. Rocephin was ordered IM for seven days, and it was only given six days.

D Facility failed to provide services for the care of a patient's PICC line. A dressing change every seven days as directed by facility policy had not been done.

D Facility failed to follow physician orders for blood sugar checks for one patient.

D Facility failed to follow the facility's pain management policy for one patient.

D Facility failed to ensure a medication was administered according to a physician's order for one patient.

F311 Appropriate treatment & services to maintain or improve ADLs.

D Facility failed to ensure one patient included in the bowel and bladder program received assistance as needed.

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

D Facility failed to provide assistance to maintain oral hygiene and fingernail grooming for one patient.

D Facility failed to provide adequate grooming assistance for one patient.

D Facility failed to shave facial hair for two patients.

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

D Facility failed to ensure proper treatment and assistive devices were obtained or maintained for vision ability for one patient.

D Facility failed to ensure proper treatment and assistive devices were obtained to maintain visual ability for one patient.

F314 Resident does not develop pressure sores.

G Facility failed to ensure nurses' weekly skin assessments were completed accurately to identify a pressure sore timely; obtain a physician's order for a treatment prior to starting the treatment; put preventative measures in place to prevent the development of a pressure ulcer; ensure physician orders and care plan interventions for Prevolon boots; and/or elevating the heels were followed. This caused actual harm to one patient.

G Facility failed to provide necessary treatment and services to prevent and treat pressure ulcers for one patient.

G Facility failed to prevent the development of avoidable pressure ulcers for two patients which resulted in harm for two patients.

F315 Incontinent resident receives appropriate treatment and services.

F Facility failed to evaluate the bladder status and failed to institute a bladder training program for one patient.

D Facility failed to have a justification for the use of an indwelling catheter for one patient.

D Facility failed to complete an assessment and develop an individualized toilet plan for one patient.

D Facility failed to assess bladder incontinence for one patient.

D Facility failed to ensure the Foley catheter bag and tubing were kept off the floor for two patients.

D Facility failed to provide treatment and services for incontinence for one patient.

D Facility failed to assess urinary function for one patient.

F318 Range of motion.

D Facility failed to ensure ROM were performed to prevent further decrease in range of motion for two patients.

D Facility failed to ensure treatment and services were provided to prevent further decline in range of motion for one patient with contractures.

F322 Tube feeding/prevention.

D Facility failed to ensure complications from the use of a percutaneous gastrostomy (PEG) tube were minimized by utilizing acceptable standards of practice for checking tube placement before administering medications through the PEG tube.

D Facility failed to label tube feeding solutions for two patients.

D Facility failed to ensure a patient fed by PEG tube received the appropriate treatment and services by not ensuring the feeding was labeled with the formula used and not changing the tube feeding bag every 24 hours for one patient.

F323 Accident hazards.

G Facility failed to prevent an accident which caused harm for one patient and failed to provide neurological checks for one patient. Facility failed to ensure hand rails were free of decorations.

G Facility failed to investigate and develop interventions to address falls for five patients resulting in harm for the patients.

E Facility failed to investigate falls for two patients; failed to protect a wandering patient; and failed to ensure equipment was safe for one patient.

E Facility failed to check placement and function of a wander guard for one patient and failed to identify one patient on admission with a history of pacing and wandering.

D Facility failed to ensure the environment was safe as evidenced by unsecured and accessible razors and nail clippers in three shower rooms.

D Facility failed to ensure the environment was free from accident hazards when alcohol was left on a shelf in one patient room.

D Facility failed to ensure that a patient at risk for falls had interventions implemented after each fall to prevent further falls.

D Facility failed to follow the care plan interventions for a toileting schedule, fall mats or stop signs for one patient.

D Facility failed to ensure fall interventions were in place for one patient with falls.

D Facility failed to ensure one patient was free of accidents. The care plan addressed interventions and goals for 19 falls. However, the resident fell and sustained a fractured a hip

F325 Facility must ensure acceptable parameters of nutritional status.

G Facility failed to ensure one patient received the required nutrition to maintain an acceptable body weight.

D Facility failed to adequately address and maintain the nutritional status of two patients

D Facility failed to prevent weight loss for two patients.

D Facility failed to record meal intakes for one patient with nutritional issues.

D Facility failed to follow physician's orders for therapeutic foods necessary to maintain the nutritional status of one patient.

F327 Sufficient fluid intake for proper hydration.

D Facility failed to ensure adequate fluids were provided for one patient at risk for dehydration.

D Facility failed to ensure a physician's order for fluid restriction was being maintained for one patient.

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

D Facility failed to ensure a patient's drug regimen was free from unnecessary drugs by not attempting a gradual dose reduction or documenting clinical contraindications for a gradual dose reduction of an antipsychotic drug for one patient.

D Facility failed to ensure a gradual dose reduction was implemented for one patient.

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

F332 Facility medication error rates of 5% or more.

E Facility failed to ensure licensed staff administered medications within appropriate time frames as ordered resulting in a 68 percent error rate. With an hour leeway, some medications were not administered for up to two hours after the time ordered.

D Facility failed to ensure two nurses administered medications with a medication error rate of less than 5 percent. The error rate was 6.25 percent.

D Facility failed to ensure a 5 percent or less medication error rate.

F333 Residents free of significant medication errors.

D Facility failed to administer one medication timely out of 26 medication opportunities.

D Facility failed to prevent significant medication errors for two patients. The Novolin insulin was administered two hours and 40 minutes after the time ordered.

D Facility failed to ensure one nurse administered medications free of a significant medication error. Insulin was not administered in the proper time frame.

F356 Nurse staffing data

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

D Facility failed to post nurse staffing information daily with the current date.

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

C Facility failed to post nurse staffing information on a daily basis at the beginning of each shif

F362 Dietary services employ sufficient staff.

D Facility failed to assist dining in a timely manner for one patient.

F364 Food preparation.

F Facility failed to serve hot food at or above 135 degrees Fahrenheit (F) and cold food at or less than 41 degrees F for two meal observations.

E Facility dietary department failed to serve food at the proper temperature. There was an approximate temperature drop of 30 degrees F in the hot food delivered to the floor versus the food temperature on the serving line.

D Facility failed to serve food that was palatable for three patients.

F367 Therapeutic diets.

D Facility failed to ensure a therapeutic diet was provided for one patient.

F369 Assistive devices for eating.

D Facility failed to provide the needed assistive device to enhance a patient's eating ability for two patients.

D Facility failed to provide eating equipment to address the visual impairment of one patient.

F371 Store, prepare, distribute, & serve food.

F Facility dietary department failed to maintain dietary equipment in a sanitary manner. There was an accumulation of blackened debris on the range top, backsplash, grill and can opener slot.

F Facility failed to provide sanitary storage of food and equipment used for preparation of food for patients.

F Facility dietary department failed to maintain and process dietary equipment in a sanitary manner. The can opener slot had an accumulation of blackened debris. There was also blackened debris on the tilt skillet, the walk-in refrigerator condenser fan grates and ceiling areas.

F Facility failed to ensure food was prepared, stored and served under sanitary conditions as evidenced by dirty kitchen equipment, dirty air vent in the dry storage area, dirty floor and ice machine, and hair not being completely covered in the kitchen.

F Facility failed to maintain a clean and sanitary kitchen. There were wet pans stacked together. A two-inch and four-inch pan were stored with clean pots and pans that both had a crusty substance on the inside.

F Facility failed to maintain a clean and sanitary kitchen and failed to store food under sanitary conditions in the dietary department.

F Facility failed to ensure food was protected from sources of contamination as evidenced by condensation in the freezer; pots and pans with a carbon build-up; food not covered or dated; and stove, food prep table and floor were dirty.

F Facility dietary department failed to maintain a clean hand sink area; failed to maintain sanitary food preparation equipment; failed to ensure pots and pans and utensils were appropriately sanitized in the three compartment sink. Facility failed to sanitize the food thermometer between food items; failed to serve food in a sanitary manner; failed to appropriately wash and sanitize serving utensils; and failed to maintain a sanitary dietary department.

E Facility failed to ensure food was served and delivered under sanitary conditions as evidenced by seven staff members serving and delivering meal trays with the dessert uncovered.

E Facility failed to ensure facility partners and/or visitors did not enter the kitchen without wearing a hair covering on two days of the survey. Facility failed to ensure an opened bag of chicken strips was dated when opened.

E Facility failed to ensure foods were prepared under sanitary conditions as evidenced by hairnets not covering the hair while food was being prepared, improper thawing of meat, and dirty dishes kept where thawed fruits and vegetables were washed.

D Facility failed to ensure the dish machine was sanitizing the dishes.

D Facility failed to ensure that food was stored, prepared and distributed under sanitary conditions as evidenced by staff coming into the kitchen without hair covers.

F372 Disposes of garbage & refuse.

F Facility failed to dispose of refuse properly. The doors were open on the dumpsters. The facility housekeeper was swinging two filled plastic refuse bags over her head in order to get the bagged refuse into the dumpster.

D Facility failed to dispose of garbage and refuse properly. The outside garbage receptacle was full and overflowing.

F411 Medicare patients must be provided with dental services.

D Facility failed to ensure dental services were provided for one patient.

F412 Medicaid patients must be provided with dental services.

D Facility failed to provide dental care for one patient.

D Facility failed to provide care and services related to the patient's dental/oral health in accordance with the assessment.

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

G Facility failed to provide pharmaceutical services for one patient resulting harm to the patient

D Facility failed to provide pharmacy services for three patients. The medications were not available for two days after admission.

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

D Facility failed to respond to the pharmacist's medication regimen review for one patient.

F431 Labeling of drugs & biologicals.

E Facility failed to correctly store medications in three of six medication carts and failed to ensure all medications were in date.

E Facility failed to ensure medications were stored properly in five medications carts.

E Facility failed to store medications properly in one medication cart. There were internal medications mixed with external medications in the drawer.

E Facility failed to manage controlled drugs for 13 patients receiving narcotics. Facility failed to dispose of controlled substances properly and failed to store medications properly.

D Facility failed to remove expired medications from one medication storage area.

D Facility failed to ensure multi-dose medication vials were properly stored on one medication cart.

D Facility failed to ensure medications were secured on one of five medication carts.

D Facility failed to store controlled medications in a safe and legal manner. The pharmacy delivered Tylenol #3 (a schedule II narcotic), and it was signed for by two nurses. However, the next day the medication was missing.

D Facility failed to ensure medications were not stored past their expiration date in one medication cart.

D Facility failed to ensure medications were stored safe and secured in one medication storage area.

D Facility failed to ensure all medications and biologicals were discarded prior to the expiration date for one medication cart.

D Facility failed to ensure medications and biologicals were stored properly in one medication storage area.

D Facility failed to destroy a controlled substance for one patient.

F441 Investigates, controls/prevents infections.

F Facility failed to maintain accepted infection control practices to eliminate possible sources of infection in the following areas: terminal room cleaning, ensuring clean suction machine equipment and providing clean water containers.

F Facility failed to follow infection control practices on one wing.

E Facility failed to follow guidelines to prevent the spread of infection for 13 patients. The ice scoop was stored in the ice cooler during meal service in the dining room.

E Facility failed to properly track and trend infections for three months.

E Facility failed to ensure proper infection control practices were followed to prevent the potential spread of infection when one nurse failed to change gloves, perform hand hygiene at the appropriate time, and turned the faucet off with bard hands during two dressing changes. One nurse failed to clean the accucheck machine with bleach wipe, and another touched medications with her bare hands while administering medications.

E Facility failed to ensure infection control practices were performed to prevent cross contamination in two of three clean linen rooms.

D Facility failed to wash and/or sanitize their hands while serving food trays to the patients.

D Facility failed to provide sanitary eating utensils for one patient.

D Facility failed to maintain standard infection control practices during the ice pass for one of six hallways.

D Facility failed to ensure staff maintained proper infection control practices when one medication nurse administered medications that were spit out by a patient and by one CNA touched food with her bare hands while passing meal trays on the east hall.

D Facility failed to ensure infection control was maintained in one dining room. The staff handed out lunch trays, and touched patient's trays and patients without wearing gloves or washing hands.

D Facility nurse failed to ensure proper infection control practices were followed to prevent the potential spread of infections when she did not clean or disinfect the stethoscope before or after auscultating a patient's bowel sounds. Another nurse also threw a soiled dressing into a patient's trash can.

D Facility nurses failed to ensure practices to prevent the potential spread of infection were maintained during medication administration.

D Facility failed to maintain a sanitary shower room for two showers.

D Facility failed to maintain a clean linen storage closet in a sanitary manner and failed to provide distribution of food trays and ice. Facility also failed to provide sanitary administration of oxygen by nasal cannula.

F456 Sufficient space & equipment maintenance.

D Facility failed to maintain essential equipment in proper working order in the laundry and in the kitchen.

F461 Have at least one window to the outside.

D Facility failed to provide private closet space for one patient.

F463 Resident call system.

D Facility failed to ensure a functional patient call system for two patients.

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

F Facility failed to ensure the environment was clean, safe and sanitary for patients, staff and the public.

E Facility failed to provide a clean and sanitary environment for patients and staff in five bathrooms and showers.

D Facility failed to maintain one bathroom shared by patients in a sanitary condition.

D Facility failed to ensure the environment was maintained in a functional capacity for two patients. The sliding bathroom door was stuck and could not be closed.

F468 Corridors equipped with hand rails.

F Facility failed to ensure handrails were securely fixed to the walls in three halls.

F469 Effective pest control.

D Facility failed to maintain an environment free of pests in the facility. There was a rat trap under the sink in the kitchen and a sticky trap behind the freezer. There was also live roaches crawling on the floor in a patient room.

F490 Administration.

F Facility failed to be administered in a manner that ensured the housekeeping and maintenance services maintained a clean, safe, sanitary environment for patients, staff, and the public. Administrator failed to maintain essential equipment in proper working order in the laundry area and the three compartment sink. Administrator also failed to ensure handrails were securely fixed to the walls in three of the halls. Quality of care issues had not been addressed related to the facility environment.

F494 Required training of nurse aides.

C Facility failed to ensure no nurse aide was charged for any portion of the nurse aide training program.

F502 Provide or obtain clinical laboratory services.

D Facility failed to ensure a laboratory test was completed for one patient.

D Facility failed to obtain laboratory tests as ordered for one patient.

D Facility failed to ensure laboratory tests were obtained for one patient.

F514 Criteria for clinical records.

D Facility failed to document administration of pain medication for one patient.

D Facility failed to have accurate medical records related to a weight for one patient.

D Facility failed to ensure the physician signed the discharge summaries for four patients and failed to sign a telephone order for one patient.

F520 Quality assessment & assurance.

G Facility failed to identify quality deficiencies and failed to develop and implement action plans to prevent the deficiencies from recurring.

F Facility administrative staff failed to identify and address quality of assurance issues to implement and develop plan of actions to provide necessary housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior on four halls, main dining room, conference room, activities and laundry.

D Facility failed to identify a problem with the administration of medications.

D Facility failed to ensure the required sign-in of the designated physician at the monthly QAA meetings for seven of nine monthly meetings to meet the regulatory quarterly requirements.

K012 Construction Type

E Facility failed to ensure four-hour-fire-rated construction is maintained. There were penetrations in the fire wall.

K018 Construction of Doors

F Facility failed to maintain the doors protecting the corridors.

F Facility failed to prevent the blocking of corridor patient room doors in the open position. The bathroom were blocking the patient room doors.

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

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

E Facility failed to maintain corridor separation. Some of the doors did not close and latch.

D Facility failed to ensure all fire doors closed and latched.

D Facility failed to ensure corridor doors had no impediments to closing the doors and that they closed to a positive latch.

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

D Facility failed to ensure all patient room doors closed to a positive latch.

K021 Automatic Closing Doors

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

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

K022 Enclosure Doors Serving Exits

D Facility failed to have a directional exit sign to direct staff to an exit in the tunnel.

D Facility failed to ensure areas were marked with approved exit signage.

K027 Doors In Smoke Barriers

F Facility failed to maintain smoke barrier doors with required door labels. The fire resistive labeling rating labels were missing.

E Facility failed to maintain the smoke barrier doors. There was a penetration above the panic bar.

D Facility failed to maintain all smoke doors. The doors did not close to a positive latch.

K029 Hazardous Areas Separated By Construction

F Facility failed to maintain the hazardous area. The fire door's facing was damaged.

E Facility failed to ensure hazardous areas were maintained.

D Facility failed to have hazardous areas equipped with self-closing doors.

D Facility failed to protect hazardous areas. The activity office contained combustibles and was not provided with a door closer.

D Facility failed to provide hazardous areas with self-closing doors.

K038 Exit Accessible At All Times

F Facility failed to inform all staff the code to unlock the six stairwell doors on the second and third floors. Only 25 of 80 staff members knew the code.

D Facility failed to provide exit access that was readily accessible at all times for four designated exit doors and failed to provide departmental doors with locking hardware that meets the NFPA 101 requirements.

D Facility failed to have exits accessible at all times.

D Facility failed to ensure that exits were marked with proper signage.

K045 Exit Lighting

E Facility failed to ensure outside egress paths were provided with egress lighting on emergency power to the public way.

E Facility failed to provide lighting at the rear exit sidewalk.

D Facility failed to ensure exits were lighted.

D Facility failed to provide lighting for all exit discharges.

D Facility failed to provide lighting for the exit discharge. Two of the exits did not have general night lighting and lights that are on emergency power leading to a public way.

D Facility failed to ensure outside egress paths to the public way were provided with egress lighting.

K046 Emergency Lighting

E Facility failed to maintain the emergency lighting.

D Facility failed to provide and maintain emergency lights. The battery back up light over the exit door would not illuminate when the test button was pushed.

D Facility failed to install emergency lighting from the exit discharge to a public way.

K047 Exit Signs

E Facility failed to provide general and emergency lighting at the exit discharges.

K048 Evacuation Plan

D Facility failed to provide an emergency alternate route of egress and evacuation for exits under construction.

K050 Fire Drills

F Facility failed to conduct the required fire drills.

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

D Facility staff failed to perform their assigned duties according to the policies and procedures manual during the fire drill.

D Facility failed to conduct the required fire drills.

K052 Testing of Fire Alarm

F Facility failed to maintain the fire alarm system.

D Facility failed to provide a smoke detector in the facility's day room.

K054 Smoke Detector Maintenance

F Facility failed to ensure smoke detectors were tested for sensitivity every two years.

D Facility failed to have smoke detectors at least three feet away from air flow.

D Facility failed to ensure smoke detectors were located at least three feet from an air supply.

D Facility failed to maintain one of 40 fire alarm components. A smoke detector cover was damaged.

K056 Auto Sprinkle Sys. Of Standard Approved Type

D Facility failed to ensure all areas of the facility were provided with sprinkler coverage. The walk-in cooler and freezer were not sprinklered.

K062 Automatic Sprinkler - Maintenance

F Facility failed to maintain the sprinkler system. Some of the sprinkler heads were corroded.

E Facility failed to continuously maintain the sprinkler system. There were only five extra sprinklers instead of six.

E Facility failed to maintain all parts of the sprinkler system. The compressor in the maintenance shop for the sprinkler system ran excessively.

D Facility failed to provide certified personnel to perform quarterly sprinkler system inspections

D Facility failed to ensure sprinkler heads in each compartment were of the same type.

D Facility failed to maintain the sprinkler system in accordance with NFPA 101. There was paint noted on three sprinkler heads.

D Facility failed to maintain the automatic sprinkler system components. The sprinkler heads under the front entrance canopy are either corroded or have a build-up of dirt and debris.

D Facility failed to maintain the automatic sprinkler system.

D Facility failed to maintain the automatic sprinkler system and its components. No five year internal obstruction investigation test has been conducted.

D Facility failed to ensure the sprinkler system piping was not to be used to support non-system components.

D Facility failed to maintain all sprinkler heads. One sprinkler head was covered with lint.

D Facility failed to maintain the automatic sprinkler system. There had been no five year obstruction investigation test conducted.

K064 Portable Fire Extinguishers

F Facility failed to maintain all fire extinguishers. All fire extinguishers are not being inspected on a monthly basis and documented by either the fire extinguisher tag or a log book.

K066 Smoking Regulations

D Facility failed to provide metal containers with self-closing devices into which ashtrays can be emptied.

D Facility failed to provide metal containers with self-closing devices into which ashtrays can be emptied into.

D Facility failed to provide metal containers with self-closing devices into which ashtrays can be emptied.

K067 Ventilating Equipment

F Facility failed to maintain the heating, ventilation and air conditioning (HVAC) system. There were two fire damper access doors that were not secured to the ducts.

F Facility failed to ensure fire dampers were maintained in accordance with NFPA 90A.

F Facility failed to maintain all fused link fire dampers.

D Facility failed to maintain the heating, ventilation and the air-conditioning system. The exhaust fans in all the patient bathrooms did not function.

D Facility failed to maintain the heating, ventilation, and the air-conditioning system.

D Facility failed to provide constant air circulation in 19 patient rooms. The only source of air exchanges were the heating and air conditioning units and the fan function was turned off in 19 rooms.

K068 Combustion and Ventilation Air

D Facility failed to ensure combustion air was taken from outside air for gas-fired dryers.

K069 Commercial Cooking Equip. Meets Requirements

D Facility failed to conduct semi-annual hood inspections for the fire suppression system.

D Facility failed to provide documentation the kitchen hood fire suppression system was professionally tested semi-annually.

K072 Furnishings and Decorations

D Facility failed to maintain egress from the exit discharge in two exit egress paths to a public way.

D Facility failed to keep the means of egress freely clean and unobstructed.

D Facility failed to ensure the path of egress was free from obstructions for two of 10 means of egress.

K104 Penetration of Smoke Barriers

E Facility failed to maintain the penetrations around the ducts in the smoke barriers. There were penetrations in the fire wall.

D Facility failed to maintain all rated walls. There were penetrations in the fire wall.

D Facility failed to maintain all rated assemblies. The fire wall in the attic had an unsealed penetration.

D Facility failed to maintain all rated assemblies. There were penetrations in the fire wall.

K130 Other LSC Deficiency Not On 2786

E Facility failed to comply with the Life Safety Code. There were penetrations in some of the stairwell walls.

D Facility failed to maintain fire lanes free of all obstructions. Cars were parked in the fire lane.

D Facility failed to maintain the fire barriers. There was a penetration in the fire walls.

D Facility failed to post signage to alert that oxygen was stored in the room.

K144 Generators

F Facility failed to maintain the emergency generator power supply. The facility did not have an annunciator system to indicate when the generator system was in trouble status.

F Facility failed to ensure the emergency generator was provided with a remote annunciator in a continuously occupied area.

D Facility failed to exercise the generator under load for 30 minutes per month in five of 12 months.

D Facility failed to maintain a readily accessible workspace around the generator.

K147 Electrical Wiring and Equipment

F Facility failed to maintain all electrical equipment and failed to prohibit the use of unapproved electrical equipment.

E Facility failed to maintain the electrical system. The electric cord to the hair dryer in the beauty shop was overly stretched.

E Facility failed to ensure electrical outlets were maintained. There were several outlets that were loose from the wall.

E Facility failed to maintain the electrical system. Two electrical panels were blocked with a box and cart.

E Facility failed to ensure power strips were maintained, not piggybacked with extension cords and not used for medical devices.

E Facility failed to maintain the electrical system. There was an electrical junction box without any cover plate.

E Facility failed to ensure electrical panels had the required three-feet space in front of them.

E Facility failed to maintain the electrical equipment. There was equipment plugged into power strips.

D Facility failed to maintain the electrical equipment. One of the ground fault circuit interrupter (GFCI) did not trip when tested.

D Facility failed to maintain the electrical system. There was a light gauge wire that was not in conduit.

D Facility failed to provide clearance in front of electrical panels and to prohibit the use of extension cords as a substitute for fixed wiring to provide power to medical equipment.

D Facility failed to maintain the electrical equipment. Two GFCI outlets did not trip when tested.

D Facility failed to maintain the electrical equipment. There was a tool cart in front of the electrical panel.

D Facility failed to maintain all electrical components. The GFIC receptacle would not reset after the test button was pushed.

D Facility failed to maintain the electrical equipment. The electric panel front cover plate was loose in the kitchen.

K211 Alcohol Based Hand Rub Dispensers

D Facility had installed ABHR dispensers over ignition sources.

D Facility had installed alcohol based hand rub (ABHR) dispensers above an ignition source.

N003 Special Circumstances

Facility failed to maintain a wait list that included the name of the applicant, name of the contact person or designated representative, address of the applicant and contact person, telephone number and other required information.

Facility failed to maintain a waiting list that included the name of the applicant, name of the contact person or designated representative, and all other required information to comply with Linton law.

N1102 Record and Reports; Recording of Unusual Incidents

Facility failed to have evidence that an allegation of abuse was thoroughly investigated by failing to complete an incident/investigation report for one patient.

N1216 Resident Rights

Facility medication nurse failed to maintain the confidentiality of a patient's medical record during medication pass. The MAR was left open and unattended on the medication cart.

N1227 Resident Rights; Resident Dignity

Facility failed to promote care for patients in a manner and in an environment that maintained or enhanced each patient's dignity as evidenced by one patient being placed at a dining room table that was not easily accessible for her height. Milk was also served in milk cartons. Staff stood to feed several patients during mealtime. This was a type C pending penalty.

N1405 Disaster Preparedness; Physical Facility and Community Emergency Plans

Facility failed to provide documentation of a current emergency disaster plan.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

Facility failed to conduct disaster drills for all staff.

Facility failed to conduct annual disaster drills for all staff.

Facility failed to provide documentation that an annual tornado or earthquake drill had been conducted on any shift since May 2012.

Facility failed to conduct annual disaster drills for all staff prior to March 2013.

N1411 Disaster Preparedness; Fire Safety Drills

Facility failed to conduct annual bomb threat drills.

N1418 Disaster Preparedness; Emergency Plans

Facility failed to participate in county wide emergency disaster response plans.

N410 Administration; Personal Property

Facility failed to maintain a copy of a patient's personal property for one patient.

N411 Administration; Surety Bonds

Facility failed to carry a surety bond to cover the patient's personal funds account.

N419 Administration; Criminal Background Check

Facility failed to perform a criminal background check for one staff member file reviewed.

N433 Administration; Charity Care Policies

Facility failed to develop and post a charity care policy accessible to the public.

N611 Physician Services; Dental Services

Facility failed to provide care and services related to the patient's dental/oral health in accordance with the assessment.

N629 Infection Control; Disinfect Contaminated Items

Facility failed to ensure a standing lift was clean as evidenced by the presence of dust and debris on one standing lift. This was a type C pending penalty.

Facility nurse failed to ensure proper infection control practices were followed to prevent the potential spread of infections when she did not clean or disinfect the stethoscope before or after auscultating a patient's bowel sounds. Another nurse also threw a soiled dressing into a patient's trash can. This was a type C pending penalty.

Facility failed to ensure one nurse cleaned the accucheck machine with bleach wipes after usage. This was a type C pending penalty.

N645 Nursing Services

Facility failed to provide housekeeping and effective maintenance services for patient rooms to maintain a sanitary, orderly and comfortable environment as evidenced by floors dirty with wax build-up; trash on the floors; smeared brown spots on the floors; dirty air conditioner vent;, urine odors in rooms; a broken sink faucet; missing baseboards; tracks for privacy curtains hanging from the ceiling; torn, missing wall coverings; unfinished paint on the walls; call lights in patient bathrooms covered with bowel movement; door frames missing paint and rusty, missing and broken tiles and dirty walls in rooms and hallways.

Facility failed to ensure the environment was free from accident hazards when alcohol was left on a shelf in one patient room. This was a type C pending penalty.

Facility failed to ensure the environment was clean as evidenced by mold on the wall in one of the patient rooms. This was a type C pending penalty.

Facility failed to ensure the environment was clean and sanitary as evidenced by a dirt buildup in the corners throughout the hallway and the doorway entrances to patient rooms; drippy faucets; stained sinks; dirty toilet tanks; dirty faucets; dirty over bed tables; and dirty floors. This was a type C pending penalty.

Facility failed to provide necessary housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior as evidenced by loose cove base strips, chipped paint and dry wall, scratched furniture, chipped floor tile, loose door knobs, toilet vanities in disrepair, cracked sinks and loose night light covers on three halls. This was a type C pending penalty.

N727 Pharmaceutical Services

Facility failed to ensure medications were not stored past their expiration date in one medication cart. This was a type C pending penalty.

N728 Basic Services; Pharmaceutical Services

Facility failed to ensure medications were stored safe and secured in one medication storage areas. This was a type C pending penalty.

N767 Food and Dietetic Services; Written Policies and Procedures

Facility failed to ensure food was served and delivered under sanitary conditions as evidenced by seven staff members serving and delivering meal trays with the dessert uncovered.

Facility failed to ensure that food was stored, prepared and distributed under sanitary conditions as evidenced by staff coming into the kitchen without hair covers. This was a type C pending penalty.

Facility failed to ensure food was prepared, stored and served under sanitary conditions as evidenced by dirty kitchen equipment, dirty air vent in the dry storage area, dirty floor and ice machine, and hair not being completely covered in the kitchen. Type C pending penalty.

Facility failed to ensure foods were prepared under sanitary conditions as evidenced by hairnets not covering the hair while food was being prepared, improper thawing of meat, and dirty dishes kept where thawed fruits and vegetables were washed. This was a type C pending penalty.

Facility failed to ensure food was protected from sources of contamination as evidenced by condensation in the freezer; pots and pans with a carbon build-up; food not covered or dated; and stove, food prep table and floor were dirty. This is a Type C pending penalty.

N831 Building Standards

Facility failed to maintain the condition of the building. There were holes in walls. Water was seeping from under some of the window air conditioning units. There were water stains on the tile in the hallway.

Facility failed to maintain the condition of the physical plant for safety of both patients and staff members. A door hold-open device was loose in the wall.

Facility failed to maintain the conditions of the overall nursing home environment. The roof gutter was broken, and the water had created a puddle next to the building.

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 was assured. There were water stains on some of the ceiling tiles.

Facility failed to ensure a reliable sprinkler system water supply for each "building". The facility is divided into three fire zones by three four-hour rated fire walls. One dry pipe sprinkler riser branch provides sprinkler protection to all three fire compartments. (This issue is on the agenda for the Board of Licensing Health Care Facilities in January 2014).

Facility failed to ensure it did not exceed the maximum allowable square footage and that sprinkler piping did not penetrate a four-hour fire wall.

Facility failed to maintain the condition of the physical plant in such a manner that the safety and well-being of the patients is assured. The sewer clean out covers in the corridors were loose which created a trip hazard.

Facility failed to keep combustible materials away from the gas fired furnace/boiler. There was a cardboard box filled with paper in the furnace room.

Facility failed to maintain cove base in 11 of 46 resident rooms.

Facility failed to have a reliable sprinkler system water supply for each building. The building has five fire compartments with one dry sprinkler system that penetrates each of the four-hour walls; servicing all fire compartments. The four-hour fire walls are not permitted to be penetrated by sprinkler piping. (This issue is on the Board for Licensing Health Care Facilities agenda for January.)

Facility failed to maintain the condition of the physical plant for the safety of both staff and patients. There was no plug to the plumbing drain. Instead, a piece of rag was used to plug the drain.

N835 Building Standards; Approval of New Construction

Facility failed to obtain approval from the Tennessee Department of Health Engineering Department for the installation of magnetic locking devices installed on the two A wing courtyard gates.

N847 Building Standards; Hot Water Temperature

Facility failed to provide the minimum hot water temperature to patient areas.

N848 Building Standards; Exhaust & Air Pressure

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

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

N901 New Code Compliance

Facility failed to comply with the applicable building and fire safety regulations. The lights in several rooms were not functioning.

Facility failed to comply with the Life Safety Code. There was no illuminated EXIT signs leading into the two stairway exits.

Facility failed to comply with the applicable building and fire safety regulations. The night lights in some patient rooms were not functioning.

Facility failed to comply with the applicable building and fire safety regulations. Some of the night lights were out.

Facility failed to comply with the applicable building and fire safety regulations. The fire door magnetic door-open device was loose in the wall.