Survey Deficiency Summary

22 Facilities Surveyed **Surveys Taken 8/7/13-9/15/13**

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

J Facility failed to notify the physician of a change in patient condition, failed to notify the physician of a delay in administering intravenous fluids and failed to notify the physician of not administering the ordered amount of intravenous fluids. Facility failed to notify the physician of uncompensated fluid loss and failed to notify the physician of the inability to safely swallow medications due to sedation for one patient. This failure resulted in immediate jeopardy for the patient who developed acute renal failure secondary to severe dehydration. The patient was transferred to the hospital emergency room and was admitted to the intensive care unit.

F164 Right to privacy & confidentiality.

D Facility failed to maintain confidentiality of medical information for one patient. Two nurses were discussing the medical record of a patient in the dining room with other patients in attendance.

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

D Facility failed to ensure the privacy of health information for four of six patient records.

F170 Right to send/receive mail.

C Facility failed to ensure patients' mail was promptly delivered on Saturdays for the patients.

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

D Facility failed to ensure the discharge documentation was available for two discharged patients.

F221 Right to be free from physical restraints.

D Facility failed to ensure a pre-restraint assessment was completed for one patient.

D Facility failed to ensure the correct application of a restraint for one patient.

D Facility failed to ensure restraint and side rail assessments were completed and accurate for three patients.

F224 Mistreatment, neglect, misappropriation of resident property.

J Facility failed to notify the physician of a change in condition, neglected to administer intravenous fluids as ordered by the physician, neglected to monitor and manage the intake and output and neglected to ensure training and competency of nursing staff for one patient. Facility failed to prevent misappropriation of narcotics for three patients. This negligence resulted in one patient developing acute renal failure secondary to severe dehydration and placed the patient in immediate jeopardy. This is also substandard quality of care.

F225 Facility must not hire person with abuse history.

D Facility failed to ensure the abuse registry was checked prior to employment for two newly hired employees and a criminal background check was checked for one newly hired employee.

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

E Facility failed to implement the abuse prevention policy and procedure for performing a complete and thorough investigation of injuries of unknown origin or falls for four patients.

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

E Facility failed to ensure each patient was treated with dignity and respect for for patients left in bed, uncovered with the door open and for 11 patients in the main dining room who were served milk in a carton instead of a glass.

D Facility failed to promote an environment to maintain and enhance dignity for six patients. The patients were eating their lunch in the hallway in front of the nurses station.

D Facility failed to maintain dignity for one patient. The patient's catheter bag was exposed.

D Facility failed to respect the dignity of one patient. The privacy curtain was not closed completely while a nurse was assessing the patient.

F244 Facility follow-up on family group meetings.

D Facility failed to address grievances made during the resident council meetings for six of the last seven months.

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

D Facility failed to notify one patient of changes in roommate assignments.

F252 Safe, clean, comfortable & homelike environment.

E Facility failed to maintain a homelike atmosphere during dining activities in one of the three dining areas. The staff members placed clothing protectors on 20 of the patients without asking the patients if they wanted to use them.

F272 Comprehensive assessment.

D Facility failed to assess for medication side effects for one patient.

D Facility failed to accurately assess significant weight loss for one patient and failed to accurately assess the bilateral lower extremity contractures for one patient.

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

E Facility failed to ensure the Minimum Data Set (MDS) was accurate for restraints for eight patients.

D Facility failed to accurately assess patients for urinary continence for one patient.

D Facility failed to provide an accurate assessment for weight loss of one patients.

D Facility failed to ensure the Minimum Data Set (MDS) was accurate for medical diagnoses of psychosis for one patient.

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

D Facility failed to develop a comprehensive care plan for two patients.

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

D Facility failed to develop a care plan for one patient admitted with a pressure ulcer of three patients reviewed with a pressure ulcer.

D Facility failed to revise the comprehensive care plans for two patients.

D Facility failed to revise the care plan for urinary incontinence for one patient.

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

D Facility failed to develop a comprehensive care plan for three patients.

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

E Facility failed to ensure staff revised and updated the care plans for new interventions after falls for four patients.

D Facility failed to ensure care plans were revised to include new fall interventions for two patients.

D Facility failed to revise the care plan to reflect new interventions after each fall for one patient.

D Facility failed to revise the care plan to address the use of hand splints and/or washcloths for one patient.

F281 Services must meet professional standards of quality.

F Facility failed to follow physician orders for intravenous therapy for one patient and failed to ensure training and competency for negative pressure wound therapy for five patients. Facility failed to follow policies for medication administration.

D Facility failed to follow up on the effectiveness of the pain medication administered for one patient.

D Facility failed to provide services to meet professional standards of care during medication administration to ensure an accurate dosage of a medication was administered and reported accurately and timely for one patient.

D Facility failed to apply hand splints and/or washcloths to one patient's hands as ordered by the physician.

F282 Services must be provided by qualified persons.

G Facility failed to ensure staff followed the plan of care interventions put into place after falls for two patients. The facility failed to follow interventions that had been put into place, which resulted in actual harm to one patient who sustained a head injury with required medical intervention in the emergency room.

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

J Facility failed to notify the physician of a change in patient condition, failed to administer intravenous fluids as ordered by the physician, and failed to prevent neglect by not following facility policies for the patient change of condition. The facility failed to monitor the intake and output and did not ensure training of nursing staff for negative pressure wound therapy for one patient. This placed the patient in immediate jeopardy and the facility in substandard quality of care.

D Facility failed to ensure the physician's orders were followed for two patients.

D Facility failed to provide care as directed by the care plan for one patient.

D Facility failed to ensure physician's orders were followed for an orthotic device or medicatior for two patients.

D Facility failed to follow physician orders for obtaining intake and output and failed to obtain physician orders for dialysis or hospice care for three patients.

F314 Resident does not develop pressure sores.

G Facility failed to provide prompt treatment for a pressure ulcer for one patient. This resulted in actual harm for the patient.

D Facility failed to perform a comprehensive assessment to include staging, size and descriptior of a pressure ulcer for one patient.

F315 Incontinent resident receives appropriate treatment and services.

D Facility failed to demonstrate catheterization was necessary for one patient.

D Facility failed to implement a bladder retraining program for one patient.

D Facility failed to ensure that a patient who was only occasionally incontinent of bladder and always continent of bowel was revaluated after a decline in continence for one patient.

D Facility failed to ensure physician's orders and justification for the use of an indwelling catheter for one patient.

F323 Accident hazards.

G Facility failed to follow interventions put into place after falls, failed to implement new interventions after falls and failed to document follow-up after falls for four patients. The facility failed to put new interventions in place after falls and did not follow interventions tha had been put into place which resulted in actual harm to one patient who sustained a head injury which required medical intervention in the emergency room.

D Facility failed to implement interventions for falls for one patient.

D Facility failed to ensure appropriate interventions were put in place to prevent potential injuries from falls for one patient.

D Facility failed to implement new interventions after two falls for one patient.

D Facility failed to investigate a fall for one patient.

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

D Facility failed to follow interventions for transferring a patient to prevent accidents for one patient.

F325 Facility must ensure acceptable parameters of nutritional status.

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

F327 Sufficient fluid intake for proper hydration.

J Facility failed to follow policies and provide hydration, failed to administer intravenous fluids as ordered by the physician and failed to monitor the intake and output for one patient. This resulted in immediate jeopardy to the patient and substandard quality of care for the facility.

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

D Facility failed to prevent an unnecessary drug from being prescribed for one patient.

F332 Facility medication error rates of 5% or more.

E Facility failed to ensure two nurses administered medications with a medication error rate of less than five percent. The error rate was 24 percent.

D Facility failed to administer medication with a medication error rate of less than 5 percent. The error rate was 9 percent.

D Facility failed to ensure the medication error rate was less than 5 percent. The error rate was 11.5 percent.

F333 Residents free of significant medication errors.

D Facility failed to ensure two nurses administered medications free of significant medication errors. They failed to administer insulin within the proper time frame related to food consumption.

F356 Nurse staffing data

C Facility failed to ensure the total number and the actual hours worked were posted as required for three of three months reviewed.

F371 Store, prepare, distribute, & serve food.

F Facility failed to follow proper food storage and failed to maintain dietary equipment in a sanitary manner.

- F Facility failed to store plates in a sanitary manner, discard out of date milk and maintain the ice machine in a sanitary manner.
- F Facility failed to follow proper food storage in dietary department and in one of three dining rooms.
- F Facility failed to provide sanitary storage of food and equipment.
- E Facility failed to protect food from sources of contamination when staff failed to completely cover their hair while in the kitchen on three days of the survey. Facility failed to ensure the dish machine maintained the manufacturer's recommended 50 parts per million sanitizer for dish sanitation.
- D Facility failed to ensure the dietary manager prepared, stored and served food under sanitary conditions as evidenced by not covering his facial hair during the days of the survey. He did not cover his mustache while in the kitchen area.
- D Facility failed to ensure food was served under sanitary conditions as evidenced by two CNAs touching food with bare hands and failed to practice sanitary hand hygiene while serving meal trays during dining observations.

F372 Disposes of garbage & refuse.

- E Facility failed to provide intact dumpsters to dispose of garbage appropriately for two dumpsters.

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

- D Facility failed to provide accurate dosage of medication for one patient.
- D Facility failed to provide pharmaceutical services for one patient.

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

- D Facility failed to ensure a pharmacy review was acted upon timely for one patient.

F431 Labeling of drugs & biologicals.

- D Facility failed to ensure medications were stored securely in two of 21 medication storage areas. One medication cart was unlocked, unattended and out of the nurse's sight.
- D Facility failed to maintain accurate narcotic medication reconciliation counts and documentation of narcotic reconciliation for one of four refrigerator narcotic storage boxes. Facility failed to secure an emergency medication box and failed to maintain sanitary conditions and had expired laboratory blood tubes available for patient use in one medication storage rooms. Facility failed to secure opened needle syringes in the staff development room
- D Facility failed to ensure medications were not stored past their expiration date in three medication storage areas.
- D Facility failed to secure medications for one medication cart. The cart was left unlocked and unattended.

F441 Investigates, controls/prevents infections.

- E Facility failed to prevent cross contamination through infection control practices for hand hygiene, medication preparation and the distribution of ice in an unsanitary manner.
- E Facility failed to perform hand hygiene during medication pass for two patients.
- E Facility failed to maintain a sanitary shower room for one of two showers.
- D Facility failed to provide hand sanitation while assisting patients with meals in two of four dining rooms.
- D Facility failed to ensure hands were washed appropriately. A CNA serving breakfast trays touched the patients trays and face without wearing gloves or washing the hands.
- D Facility nurses failed to ensure practices to prevent the potential spread of infection were maintained during medication administration.
- D Facility failed to ensure infection control was maintained for one patient. A nurse administered an insulin injection without gloves and without washing her hands.
- D Facility failed to assess the need to continue isolation for one patient. Facility failed to provide sanitary storage of linens in two of two linen storage closets.
- D Facility failed to follow infection control practices for of three sit to stand lifts. The lift was dirty.

F456 Sufficient space & equipment maintenance.

- F Facility failed to properly maintain the hot water temperature probe of the dishwasher in the dietary department.
- D Facility failed to ensure care alarms were in proper working order for one patient.

F460 Full visual privacy in room design.

- D Facility failed to provide full visual privacy for patients in six rooms.

F502 Provide or obtain clinical laboratory services.

- D Facility failed to obtain a laboratory test as ordered by the physician for one patient.
- D Facility failed to obtain laboratory specimens as ordered for one patient.

F514 Criteria for clinical records.

- D Facility failed to obtain accurate weights for one patient reviewed for significant weight loss.

K018 Construction of Doors

- E Facility failed to maintain the doors protecting the corridor openings.
- D Facility failed to ensure corridor doors closed to a positive latch.
- D Facility failed to ensure corridor doors would resist the passage of smoke. Some of the doors did not close to a positive latch.

K020 Sleeping Room Egress

E Facility failed to ensure the elevator shaft construction was maintained. There were two unsealed penetrations in the concrete shaft wall that is visible from the first floor.

D Facility failed to have vertical openings fire rated. There were unsealed penetrations in the fire wall.

K021 Automatic Closing Doors

E Facility failed to ensure the corridor fire doors would close to a positive latch.

K022 Enclosure Doors Serving Exits

E Facility failed to provide an exit with an approved readily visible exit sign.

D Facility failed to install directional exit signs in areas where the exit was not apparent.

D Facility failed to install directional exit signs in areas where the exit is not apparent. The path of egress was not evident when the fire alarm was activated or the hallway doors were closed at one patient room.

K025 Smoke Partition Construction

F Facility failed to maintain the smoke barriers. There were penetrations in the fire wall.

D Facility failed to maintain the smoke barriers. There were penetrations in the walls.

K029 Hazardous Areas Separated By Construction

E Facility failed to maintain the hazardous areas. There were doors that did not latch to a positive latch.

D Facility failed to ensure hazardous area's one hour fire rated construction is maintained. There were penetrations in the ceiling of the back hot water heater room.

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

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

D Facility failed to have all hazardous areas smoke resistant and doors to be self-closing.

K038 Exit Accessible At All Times

F Facility failed to maintain the exit access.

D Facility failed to ensure magnetically locked doors released with fire activation.

D Facility failed to provide the proper signage for exit doors.

K042 At Least Two Exits

- D Facility failed to provide areas greater than 2,500 square feet with at least two exits. The sidewalk in the courtyard was leading away from the building, ending at a dead end at a fence.

K045 Exit Lighting

- E Facility failed to ensure exits paths to the public way was provided with lighting.
- D Facility failed to provide egress lighting at all exit discharges from the building.

K047 Exit Signs

- E Facility failed to maintain the exit signs. The exit sign located above the kitchen door was not illuminated.
- D Facility failed to provide signage for all exits.

K050 Fire Drills

- F Facility failed to train staff members on fire drills procedures.
- F Facility failed to conduct the required quarterly fire drills.
- D Facility failed to conduct two of 12 fire drills from Nov. 14 2012 until Aug. 20. 2013.

K051 Fire Alarm System

- F Facility failed to have the air conditioning shut down during the fire drills.
- D Facility failed to ensure smoke detectors were located at least three feet from air flow.

K052 Testing of Fire Alarm

- F Facility failed to ensure smoke detectors were located at least 3 feet from an air supply.
- D Facility failed to have two duct detectors annually tested.

K054 Smoke Detector Maintenance

- D Facility failed to ensure one smoke detector had the required clearance from the air supply diffusers.

K056 Auto Sprinkle Sys. Of Standard Approved Type

- D Facility failed to provide sprinkler coverage in all areas of the facility.

K062 Automatic Sprinkler - Maintenance

- F Facility failed to maintain the sprinkler system. There was storage located within 18 inches of the sprinklers in some areas.
- F Facility failed to keep sprinkler heads free from corrosion or foreign material.

E Facility failed to ensure sprinkler heads were free of foreign material.

E Facility failed to ensure the sprinkler system was maintained.

E Facility failed to maintain and test a complete automatic sprinkler system. Four gauges on the sprinkler riser were over five years old and in need of recalibrating or replacing.

D Facility failed to have the sprinkler system inspected and tested periodically. There was no quarterly sprinkler inspection for the second quarter of 2013.

D Facility failed to maintain all sprinkler systems. There was a build-up of lint on some of the sprinkler heads.

D Facility failed to ensure the sprinkler system was maintained. Two of four sprinkler heads under the front canopy were corroded.

D Facility failed to maintain all sprinkler heads. There was a lint build-up on the sprinkler heads in the laundry room.

D Facility failed to maintain components of the automatic sprinkler system.

D Facility failed to maintain the automatic sprinkler system to ensure that it is reliable operating condition.

K064 Portable Fire Extinguishers

F Facility failed to properly inspect all fire extinguishers. All of the extinguishers had not been checked monthly.

D Facility failed to maintain clearance to all fire extinguishers.

K066 Smoking Regulations

D Facility failed to maintain smoking to designated smoking areas only. There were 11 cigarette butts located at the kitchen door.

D Facility failed to provide the required equipment in the smoking area. There was no metal container with self-closing cover device into which ashtrays could be emptied readily available to the area where smoking was permitted.

K067 Ventilating Equipment

F Facility failed to maintain all fused link fire dampers. The facility had not had the fused link fire dampers inspected every four years as required.

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

F Facility failed to have all fused link fire dampers inspected every four years as required.

E Facility failed to ensure fire dampers were maintained in accordance with NFPA 90A. All of the fire dampers had been serviced with required maintenance in the four-year time period.

E Facility failed to maintain the heating, ventilating and air conditioning systems. (HVAC). Several of the ventilating fans were not working.

D Facility failed to maintain the heating, ventilating and air condition (HVAC) system. The dining room has excessive paint overspray on the fusible links.

K069 Commercial Cooking Equip. Meets Requirements

F Facility failed to protect the cooking facilities. There was a damaged filter in the kitchen's hood system. The stove and the deep fryer were not centered under the kitchen's hood extinguishing system nozzles.

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 clear egress in four exit corridors and a clear passage from the exit discharge to a public way.

D Facility failed to maintain exits free of all obstructions. There was storage outside of the exit door adjacent to the laundry area.

D Facility failed to ensure the corridors in the means of egress were maintained clear of all obstructions.

K076 Nonflammable Medical Gas Systems

D Facility failed to properly store medical gas. There were unsecured oxygen cylinders in the storage closet.

D Facility failed to secure oxygen cylinders during storage.

K077 Piped-In Oxygen System

D Facility failed to install electrical devices properly in oxygen storage locations. The oxygen storage room for portable oxygen and piped in oxygen has an electrical outlet and a light switch below 5 feet off the floor.

D Facility failed to install piped in medical gas systems and components properly. The vacuum lag pump was not wired into the mast alarm and the oxygen storage room for the piped in medical gas system does not have the light switch at least 5 feet off the floor.

K104 Penetration of Smoke Barriers

E Facility failed to maintain the penetrations around the ducts in the smoke barriers. There were penetrations in the ceiling around the heating and cooling air duct.

D Facility failed to maintain the fire walls. There was a penetration in the fire wall in several locations.

K130 Other LSC Deficiency Not On 2786

E Facility failed to comply with the Life Safety Code. There were penetrations in the fire wall and there were some doors that were damaged.

D Facility failed to install the correct signage on three of five delayed egress exit doors.

D Facility failed to maintain the fire barriers. There were penetrations in the fire wall.

D Facility failed to maintain the fire barriers. There were penetrations in the fire wall.

K144 Generators

- F Facility failed to insect the emergency power supply batteries.
- F Facility failed to properly maintain the generator records.

K147 Electrical Wiring and Equipment

- F Facility failed to maintain the electrical wiring and equipment.
- D Facility failed to maintain the electrical wiring and equipment in accordance with NFPA 70. There were oxygen concentrators plugged into power strips in some patient rooms.
- D Facility failed to ensure low voltage wires were supported by structure.
- D Facility failed to install ground fault interrupting circuits (GFIC) within 6 feet of all sinks.
- D Facility failed to maintain the electrical system. There was back to back power strips in the administrators office.
- D Facility failed to ensure electrical panels have a three feet clearance in front of them.

K211 Alcohol Based Hand Rub Dispensers

- D Facility installed an alcohol based hand rub dispenser over an ignition source which is not in compliance with the regulations.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

Facility failed to conduct disaster drills for all staff for 2013.

Facility failed to conduct annual tornado, flood and earthquake drills for all shifts.

Facility failed to conduct the required annual disaster drills.

N411 Administration; Surety Bonds

Facility failed to maintain a surety bond sufficient to cover the full amount of the patient funds in the resident trust fund account.

N416 Administration; Background Check

Facility failed to perform a nationwide criminal background check on two nurses. (This deficiency was removed when the administrator pointed out there was not a requirement for a nationwide test, and the facility was in compliance with the current law.)

N433 Administration; Charity Care Policies

Facility failed to post a concise statement of its charity care policies in a place accessible to the public.

N629 Infection Control; Disinfect Contaminated Items

Facility nurses failed to ensure practices to prevent the potential spread of infection were maintained during medication administration. The nurse did not clean the patient's glucometer after using it.

N728 Basic Services; Pharmaceutical Services

Facility failed to ensure medications were stored securely in two of 21 medication storage areas. One medication cart was unlocked, unattended and out of the nurse's sight. This was a type C pending penalty.

N767 Food and Dietetic Services; Written Policies and Procedures

Facility failed to ensure the dietary manager prepared, stored and served food under sanitary conditions as evidenced by not covering his facial hair during the days of the survey. He did not cover his mustache while in the kitchen area. This was a type C pending penalty.

Facility failed to protect food from sources of contamination when staff failed to completely cover their hair while in the kitchen on three days of the survey. Facility failed to ensure the dish machine maintained the manufacturer's recommended 50 parts per million sanitizer for dish sanitation. This was a type C pending penalty.

N771 Food and Dietetic Services; Dishwashing Standards

Facility failed to ensure the dish machine maintained the manufacturer's recommended 50 parts per million sanitizer for dish sanitation.

N831 Building Standards

Facility failed to maintain the rear outside entrance to the kitchen in a clean and sanitary condition.

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 multiple water stained ceiling tiles.

Facility failed to maintain the overall physical environment of the facility. There was a large hole in the ceiling of the classroom.

N835 Building Standards; Approval of New Construction

Facility failed to submit plans for upgrading the fire alarm control panel.

N848 Building Standards; Exhaust & Air Pressure

Facility failed to install and maintain a positive and negative pressure in clean and soiled rooms.

Facility failed to have correct positive and negative air flow in rooms.