Survey Deficiency Summary

20 Facilities Surveyed **Surveys Taken 6/21/13-8/7/13**

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

D Facility failed to assist three patients in securing an advance directive for end-of-life decision of five patients reviewed.

F156 Periodic notification of items/services for which resident may/may not be charged.

D Facility failed to ensure an Advanced Beneficiary Notice (ABN) was issued to one Medicare patient reviewed.

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

D Facility failed to notify the physician and obtain emergency medical services for greater than 60 minutes for one unresponsive patient with a critically low blood glucose value.

F164 Right to privacy & confidentiality.

E Facility failed to ensure full visual privacy for patients in 50 of 59 beds. The privacy curtains between the beds did not allow full visual privacy.

D Facility failed to provide and maintain privacy for one patient. The patient was exposed and visible from the hallway and was undressed.

D Facility failed to maintain the confidentiality of patient's health information when two of four nurses failed to close or cover the Medication Administration Record (MAR) during medication administration.

D Facility failed to ensure the confidentiality of medical information for two patients.

D Facility failed to provide dignity for one patient. The patient did not have full visual privacy and was exposed to viewing from the hallway.

F166 Right to have grievances resolved.

E Facility failed to provide resolution regarding call lights being answered timely for four patients and the shower rooms being cold.

F176 Self-administration of drugs by resident.

D Facility failed to have an assessment or a physician's order for self-administration of medications for one patient who was using a nebulizer without a nurse in attendance.

F221 Right to be free from physical restraints.

D Facility failed to assess for the use of restraints for two patients.

F225 Facility must not hire person with abuse history.

D Facility failed to ensure the abuse policy and procedures were followed for immediately reporting an allegation of alleged abuse to the administrator.

D Facility failed to report an allegation of abuse of one patient to the appropriate state agency.

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

D Facility failed to follow policy and procedure for investigating an allegation of abuse for one abuse investigation reviewed.

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

E Facility failed to maintain an environment that promoted the patient's dignity when staff failed to provide meals to all patients at a table at the same time. Staff failed to knock on the door or gain permission prior to entering a patient's rooms during two dining observations.

E Facility failed to ensure five staff members knocked on the door or gained permission prior to entering the patient's room.

D Facility failed to maintain the dignity of two patients and failed to ensure the dignity of patients in one dining room.

D Facility failed to maintain or enhance each patient's dignity and respect by calling patients "feeders" during dining observations.

D Facility failed to ensure dignity for one patient. The patient turned on the call light for assistance, an aide answered the light and turned it off but told the patient she would return to change a wet brief. The aide did not return, and 45 minutes later, the patient again rang the call light.

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

D Facility failed to provide showers for one patient. The alert and aware patient stated that they had not given him a shower because they said, "we don't have enough help."

F246 Right to accommodations of individual needs & preferences.

D Facility failed to accommodate the preferences of two patients. The two patients wanted to eat in the dining room, and they were told it was too late to go.

D Facility failed to provide care in a reasonable time to meet incontinent needs for one patient. The call light was not answered timely.

F250 Medically related social services.

D Facility failed to ensure medically related social services were provided to address concerns and issues related to a new amputee, new dialysis, depression and/or discharge planning.

D Facility failed to provide medically related social services to attain the highest practical physical, mental and psychosocial well being as evidenced by the lack of initial social service assessments and progress notes for seven patients.

F253 Housekeeping & maintenance services.

E Facility failed to maintain a clean environment in two of four shower rooms. There was a black substance on the floor and the walls in the shower area.

D The facility failed to ensure the environment was clean, sanitary and odor free in one shower room. There was a urine and foul odor in the shower rooms. There was missing caulking around the base of the commode.

D Facility failed to ensure a homelike environment related to odors for one of four hallways observed.

C Facility failed to maintain a clean comfortable environment. There was a continuous strong foul odor noticeable throughout the facility.

F272 Comprehensive assessment.

D Facility failed to accurately assess the fall status on one patient and failed to accurately identify the use of a restraint for one patient.

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

D Facility failed to accurately assess a patient for falls, vision, dialysis or terminal prognosis for four patients.

D Facility failed to ensure the accuracy of completed assessments for range of motion for one and for a contracture for one patient.

D Facility failed to ensure a complete and accurate comprehensive assessment for vision, use of a Foley catheter, use of a prosthetic device, use of antidepressant and/or a diagnosis of dehydration for five patients.

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

E Facility failed to develop a comprehensive care plan to address the needs of the patients for three patients.

D Facility failed to ensure a comprehensive care plan was developed to address vision for one patient.

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

D Facility failed to ensure a comprehensive care plan was developed to address discharge planning, urinary catheter and/or vision for four patients.

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

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

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

D Facility failed to revise the care plan for range of motion (ROM), nutrition, discharge planning and/or behaviors for three patients.

D Facility failed to revise the care plan for emergency bleeding related to dialysis for one patient.

D Facility failed to revise the care plan for weight loss for one patient.

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

F281 Services must meet professional standards of quality.

E Facility failed to follow the falls prevention policy to reassess one patient after a fall and one patient after a hospital stay.

F282 Services must be provided by qualified persons.

D Facility failed to follow the care plan intervention of an alarm for a patient at risk of falls.

F284 Discharge summary includes post-discharge plan of care.

D Facility failed to complete a discharge summary for one patient.

D Facility failed to ensure that a post-discharge plan of care was developed for five patients.

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

E Facility failed to ensure medications were administered as ordered for pain management for three patients and failed to clarify physician orders to prevent duplicative therapy for one patient.

D Facility failed to follow physician's orders for one patient observed receiving medication patches. Old Exelon patches were not removed.

D Facility failed to follow physician's orders for placement of thromboembolic disease (TED) hose for one patient.

D Facility failed to ensure a physician's order to provide assistance with all meals was followed for one patient with nutritional risks.

D Facility failed to have the therapy department notify nursing when pain was discussed with the patient during therapy for one patient.

D Facility failed to recognize the life-threatening condition and obtain emergency transport for one unresponsive patient with a critical blood glucose.

D Facility failed to assess for positioning of one patient and failed to obtain a physician's order for dialysis for one patient.

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

D Facility failed to provide incontinence care timely for one patient.

D Facility failed to provide nail care for one patient.

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

D Facility failed to ensure patients received assistive devices to maintain vision ability for one patient with visual impairments.

F314 Resident does not develop pressure sores.

D Facility failed to ensure one patient reviewed with pressure sores received the care and services to promote healing and prevent new sores from developing.

D Facility failed to timely obtain a dietary consultation and to timely initiate and administer a vitamin as ordered for one patient.

F315 Incontinent resident receives appropriate treatment and services.

E Facility failed to ensure that pericare was performed according to policy and procedure of the facility for two patients.

D Facility failed to provide appropriate care by not obtaining an order for the use of a Foley catheter for one patient. Facility failed to change a Foley catheter every two weeks as ordered by the physician for one patient.

F318 Range of motion.

D Facility failed to provide treatment and services to prevent further decrease in ROM by not providing a splint or ROM for one patient.

D Facility failed to ensure patients with limitations in ROM received care and treatment to prevent further decline in ROM for one patient with contractures.

F322 Tube feeding/prevention.

D Facility failed to ensure tube feedings were in correct containers and labeled appropriately for one patient.

D Facility medication nurse left medication residual in the medication cup and did not follow the physician's orders for flushing the Percutaneous Endoscopy Gastrostomy (PEG) tube during the medication administration.

F323 Accident hazards.

K Facility failed to implement an effective falls prevention program for six patients. This placed one patient in immediate jeopardy and caused actual harm to another patient. The systematic failure to ensure any patient at risk for falls was provided effective interventions, failure to ensure alarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place an patient at risk for falls in immediate jeopardy.

D Facility failed to ensure interventions were in place related to falls for two patients.

F325 Facility must ensure acceptable parameters of nutritional status.

D Facility failed to ensure each patient received nutritional interventions for one patient.

D Facility failed to provide care to promote the nutritional status for one patient with weight loss.

D Facility failed to ensure each patient received nutritional interventions to prevent weight loss for one patient.

F328 Proper treatment & care for specialized services.

D Facility failed to follow a physician's order for administration of oxygen for one patient.

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

G Facility failed to prevent the unnecessary use of antipsychotic drugs for one patient. This failure resulted in toxicity marked by varying degrees of impairment of speech, cognition, orientation and arousal and causing actual harm to the patient.

D Facility failed to ensure each patient was free of unnecessary medication usage when two patients failed to have a diagnosis for the use of the medication they were receiving.

F332 Facility medication error rates of 5% or more.

E Facility failed to ensure there was a medication error rate of less than 5 percent. The error rate was 28.571 percent.

E Facility failed to ensure three medication nurses administered medications with a medication error rate of less than 5 percent. The error rate was 65.3846 percent.

D Facility failed to ensure one nurse administered medications with a medication error rate of less than 5 percent. The error rate was 11.54 percent.

D Facility failed to ensure two nurses administered medications with a medication error rate of less than 5 percent. The error rate was 8 percent.

F333 Residents free of significant medication errors.

D Facility failed to prevent a significant medication error. The patient was administered the incorrect dosage of Coumadin.

D Facility failed to ensure two patients receiving insulin were free of significant medication errors.

D Facility failed to ensure one nurse administered medications without a significant medication error. The nurse failed to dilute enteral tube medication as ordered with 10-30 ml. of warm water prior to administration.

D Facility failed to ensure one patient receiving insulin was free of a significant medication error. The patient did not receive her meal in a timely manner after the insulin injection.

F356 Nurse staffing data

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

D Facility failed to post nurse staffing information on a daily basis at the beginning of each shif on three days of the survey.

F364 Food preparation.

D Facility failed to ensure food was maintained at appropriate temperatures on one hallway. The food cart arrived on the hallway at 8:40 a.m. and the last tray was delivered at 9:15 a.m., The eggs were not warm.

F371 Store, prepare, distribute, & serve food.

F Facility failed to provide sanitary storage of food and equipment.

F Facility failed to store food under sanitary conditions. There were out of date tortilla chips, a dented can improperly stored, napkins on the floor, and open popsicles were not labeled or dated.

F Facility dietary department failed to maintain dietary equipment in a sanitary manner.

E Facility failed to ensure that food was prepared, stored and served under sanitary conditions when one dietary staff member failed to cover facial hair and one failed to clean the thermometer after taking the food temperature of each food. Staff failed to thoroughly clean the meat slicer, and four staff members failed to wash their hands after touching the patients' environment and then preparing meal trays.

E Facility failed to ensure patient food trays were delivered under sanitary conditions as evidenced by food and beverages delivered uncovered down the halls and lack of hand hygiene by staff members during tray delivery.

E Facility failed to ensure patient food trays were delivered down the halls under sanitary conditions during two dining observations. There was also a lack of hair coverings by staff in the kitchen.

E Facility failed to ensure patient food trays were delivered down the halls under sanitary conditions during the delivery of meal trays during two dining observations and lack of hair coverings by staff in the kitchen.

D Facility failed to store thermal plate covers to prevent wet nesting for one day of the survey.

D Facility failed to ensure food was safe for consumption by having expired and open food items in the patient nourishment kitchens on two floors. Facility failed to prevent cross contamination of food by failing to ensure appropriate hand washing was followed during two meals observed.

F372 Disposes of garbage & refuse.

D Facility failed to dispose of garbage and refuse to maintain sanitary conditions. One dumpster was leaking fluid.

D Facility failed to store and dispose of refuse properly.

F386 Physician review resident's total program of care.

D Facility failed to ensure the physician signed and dated the physician orders for one patient.

F411 Medicare patients must be provided with dental services.

D Facility failed to obtain a dental consult for one patient even though it was care planned.

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

D Facility failed to provide narcotic medications timely for one patient. When the patient requested the pain medication, there was none in the facility. It was ordered from the pharmacy, and a staff member retrieved it. It was more than an hour from the time of the patient request until the medication was actually administered.

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

D Facility failed to ensure appropriate medication doses were given to a patient based on pharmacy recommendations for one patient reviewed for unnecessary medication use.

F431 Labeling of drugs & biologicals.

E Facility failed to ensure medications were stored properly as evidenced by loose tables and dirty drawers in seven of the medication carts and medication rooms.

E Facility failed to store medications and chemicals and to monitor the temperature refrigerator storage area for one of two medication storage rooms.

D Facility failed to store medications according to manufacturer's instructions and in a sanitary manner in three refrigerators.

D Facility failed to remove expired medications and supplies from stock and failed to ensure internal and external medications were stored separately in three medication carts and one medication storage room. The facility failed to ensure a non-licensed person did not have access to medications.

D Facility failed to ensure that one nurse did not leave medications unattended and in her sight.

D Facility failed to ensure safe and secure storage of medication in three medication carts.

D Facility failed to label and store medications correctly on one of seven medication carts.

F441 Investigates, controls/prevents infections.

F Facility failed to follow guidelines to prevent the spread of infection.

E Facility failed to ensure that pericare was performed according to policy and procedure of the facility for two patients.

E Facility failed to follow their policy on hand washing.

D Facility failed to ensure one nurse administering medications washed her hands prior to preparing medications.

D Facility failed to ensure the staff washed their hands before touching or serving food during two dining observations.

D Facility failed to ensure the nurse performed hand washing prior to instilling eye drop medication for one patient.

D Facility failed to ensure that consistent infection control principles were maintained to prevent cross contamination during medication administration for one patient and failed to maintain standard infection practices during the ice pass.

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

D Facility failed to provide a sanitary, odor free environment for one patient. One patient room had a strong urine odor and a sticky floor.

F490 Administration.

K Facility administration failed to provide an effective system to ensure supervision and an environment free of accident hazards. This failure place the patients in immediate jeopardy.

F493 Governing body.

K Facility failed to have a governing body to effectively establish and implement policies regarding patient falls.

F501 A physician must be designated as medical director.

D Facility failed to ensure the medical director participated in the development and implementation of patient care policies to ensure an effective program for fall prevention. This placed six patients in immediate jeopardy.

F514 Criteria for clinical records.

D Facility failed to provide care for one patient.

D Facility failed to ensure the care plans were accurate after transferring the records from paper to electronic records for two patients.

D Facility failed to complete an admission assessment for one patient.

D Facility failed to accurately document the discharge date and failed to maintain a complete medication administration record for one patient.

F518 Emergency training.

D Facility failed to ensure a staff member's competency in emergency procedures for the discovery of a fire, earthquake and a bomb threat was received for one CNA.

F520 Quality assessment & assurance.

K Facility quality assessment and assurance committee failed to develop a plan of action related to patient accidents/falls. The facility was cited with immediate jeopardy.

D Facility quality assessment and assurance committee failed to identify issues related to quality of care issues for patients and failed to develop and implement appropriate plans to correctly identify quality of care deficiencies.

K018 Construction of Doors

F Facility failed to maintain all fire doors. Some fire doors failed to close to a positive latch.

E Facility failed to maintain all doors to resist the passage of fire and smoke. Some of the fire doors did not close to a positive latch.

D Facility failed to maintain corridor smoke doors. The corridor doors adjacent to room four would not close within the door frame.

D Facility failed to prevent the blocking of corridor doors in the open position.

D Facility failed to ensure there were no impediments to closing patient room doors and corridor doors closed to a positive latch.

K021 Automatic Closing Doors

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

K029 Hazardous Areas Separated By Construction

D Facility failed to maintain smoke resistant partitions. A storage room door was held open with a plastic coat hanger attached to the door knob and hooked into a metal rack.

D Facility failed to ensure rooms larger than 50 square feet used to store combustible materials were provided self-closing doors.

K038 Exit Accessible At All Times

D Facility failed to maintain egress in corridors. There were four empty chairs stored outside the therapy department in front of the nurses station.

D Facility failed to ensure no more than one delayed egress door in any path of the egress. The door leading into the Alzheimer's wing is labeled as an exit and is magnetically locked by a delayed egress lock. Once you enter the Alzheimer's wing through the delayed egress door, the exit access takes you to the end of the hall to the next exit door that is magnetically locked with delayed egress that leads outside to the public way.

K039 Width Of Aisles Or Corridors

D Facility failed to maintain a clear passage to the exit door. A rolling bread cart was blocking the kitchen egress.

K045 Exit Lighting

E Facility failed to ensure exits and outside egress paths were provided with egress lighting (must be on emergency power).

D Facility failed to provide lighting at the exit discharge so that failure of any single lighting fixture (bulb) would not leave the area in darkness.

D Facility failed to provide adequate exit discharge lighting. Two exit discharge lighting units did not have at least a two-bulb light fixture on emergency power.

D Facility failed to provide lighting at six exits so that failure of any single lighting fixture (bulb) would not leave the area in darkness.

K046 Emergency Lighting

E Facility failed to ensure exit paths were provided with egress lighting with emergency power. The outside lights at the rear sidewalk were not provided with egress lighting.

D Facility failed to maintain two battery back up emergency lights.

K050 Fire Drills

D Facility staff failed to perform their assigned duties during the fire drill.

K051 Fire Alarm System

D Facility failed to provide a manual pull station at all exits.

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

K052 Testing of Fire Alarm

D The facility failed to maintain the fire alarm system.

D Facility failed to protect one of the manual fire alarm boxes from obstruction and accessibility.

D Facility failed to maintain all components of the fire alarm system. One of the strobe lights did not flash during a fire alarm test.

D Facility failed to maintain all fire alarm equipment. It was found the sprinkler pit will accumulate water or become wet and cause the tamper switches to short circuit and not function properly.

K054 Smoke Detector Maintenance

D Facility failed to maintain smoke detectors in accordance with manufacturer's specifications.

K062 Automatic Sprinkler - Maintenance

E Facility failed to maintain and test a complete automatic sprinkler system. Five gauges on the sprinkler risers were more than 5 years old in need of recalibrating or replacement. One sprinkler head behind the laundry dryers was covered in lint and in need of cleaning.

D Facility failed to maintain sprinkler heads in accordance with NFPA 13. One sprinkler head had paint on it.

K066 Smoking Regulations

D Facility failed to provide ashtrays for patient use.

K067 Ventilating Equipment

F Facility failed to maintain their heating, ventilating and air conditioning. The facility had not inspected or tested the fire dampers in the facility for more than four years.

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

K072 Furnishings and Decorations

D Facility failed to maintain egress in exit corridors.

K076 Nonflammable Medical Gas Systems

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

D Facility failed to identify full and empty oxygen canisters. There were more than 100 canisters that were not marked as empty or full.

K104 Penetration of Smoke Barriers

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

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

D Facility failed to maintain all fire and smoke separations. There was a penetration around a receptacle cover in the ceiling in front of the vent hood.

K130 Other LSC Deficiency Not On 2786

D Facility failed to implement safe practices for the safety of all patients and staff by not securing oxygen cylinders to prevent damage.

K144 Generators

F Facility failed to properly test the emergency generator power supply. Weekly checks on the battery water level were not done prior to February 2013. One of the documented minute load test did not have a begin time and end time or an hour meter reading to verify the generator was tested for 30 minutes.

F Facility failed to inspect the emergency power supply batteries.

K147 Electrical Wiring and Equipment

E Facility failed to install and use electrical equipment properly.

D Facility failed to maintain electrical equipment as required.

D Facility failed to install ground fault interrupting circuits (GFIC) in all wet areas with electrical devices.

K160 Elevator Use during Emergencies

F Facility failed to maintain elevator's in accordance with NFPA 101. The elevator did not stop level with the exit doors.

K211 Alcohol Based Hand Rub Dispensers

D Facility failed to ensure alcohol based hand rub (ABHR) dispensers were not installed over or adjacent to an ignition source.

N1102 Record and Reports; Recording of Unusual Incidents

Facility failed to report an allegation of abuse of one patient to the appropriate state agency as required.

N1216 Resident Rights

Facility failed to maintain the confidentiality of patient's health information when two of four nurses failed to close or cover the Medication Administration Record (MAR) during medication administration.

Facility failed to ensure the confidentiality of medical information for two patients. This was a type C pending penalty.

N1349 Universal Do Not Resuscitate Order; POST Form

Facility failed to ensure Physician Orders for Scope and Treatment (POST) on admission were followed up on and completed for end-of-life decisions of three patients.

N1404 Disaster Preparedness; Emergency Electrical Power

Facility failed to maintain records on generator testing. The facility was unable to provide documentation or record of the weekly and monthly testing of the generator.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

Facility was unable to provide documentation of conducting flood and earthquake disaster drills.

Facility failed to provide documentation that an earthquake and flood drill had been conducted for all staff.

Facility failed to conduct disaster drills for all staff.

Facility failed to ensure an earthquake drill was exercised annually.

N424 Administration; Filed Documentation of Abuse Registries

Facility administration failed to provide an effective system to ensure supervision and an environment free of accident hazards. This failure place the patients in immediate jeopardy.

N601 Performance Improvement Program

Facility quality assessment and assurance committee failed to develop a plan of action related to patient accidents/falls. The facility was cited with immediate jeopardy.

N613 Medical Director Responsibilities

Facility failed to ensure the medical director participated in the development and implementation of patient care policies to ensure an effective program for fall prevention. This placed six patients in immediate jeopardy.

N645 Nursing Services

The facility failed to ensure the environment was clean, sanitary and odor free in one shower room. There was a urine and foul odor in the shower rooms. There was missing caulking around the base of the commode. This was a type C pending penalty.

N681 Nursing Services; RN Supervision

Facility failed to implement an effective falls prevention program for six patients. This placed one patient in an environment which was detrimental to their health, safety and welfare.

N727 Pharmaceutical Services

Facility failed to ensure internals and externals medications were stored separately in one medication storage area. This was a type C pending penalty.

Facility failed to ensure that one nurse did not leave medications unattended and in her sight. This was a type C pending penalty.

Facility failed to ensure safe and secure storage of medication in three medication carts. This was a type C pending penalty.

N767 Food and Dietetic Services; Written Policies and Procedures

Facility failed to ensure that food was prepared, stored and served under sanitary conditions when one dietary staff member failed to cover facial hair and one failed to clean the thermometer after taking the food temperature of each food. Staff failed to thoroughly clean the meat slicer, and four staff members failed to wash their hands after touching the patients' environment and then preparing meal trays. This was a type C pending penalty.

Facility failed to ensure patient food trays were delivered under sanitary conditions as evidenced by food and beverages delivered uncovered down the halls and lack of hand hygiene by staff members during tray delivery. This was a type C pending penalty.

Facility failed to store thermal plate covers to prevent wet nesting for one day of the survey. This was a type C pending penalty.

Facility failed to ensure patient food trays were delivered down the halls under sanitary conditions during two dining observations. There was also a lack of hair coverings by staff in the kitchen. This was a type C pending penalty.

Facility failed to ensure patient food trays were delivered down the halls under sanitary conditions during the delivery of meal trays during two dining observations and lack of hair coverings by staff in the kitchen. This was a type C pending penalty.

Facility failed to ensure food was safe for consumption by having expired and open food items in the patient nourishment kitchens on two floors. Facility failed to prevent cross contamination of food by failing to ensure appropriate hand washing was followed during two meals observed. This was a type C pending penalty.

N831 Building Standards

Facility failed to maintain walls and receptacle covers in the facility.

Facility failed to maintain the overall physical environment of the facility. The outside sprinkler riser room wall is dry rotted and falling out.

Facility failed to maintain building plumbing. There were plumbing leaks in all the shower room walls.

N848 Building Standards; Exhaust & Air Pressure

Facility failed to maintain a negative air pressure in all soiled utility rooms, janitor's closets and toilet rooms.

Facility failed to maintain a positive air pressure in all the clean rooms.