Survey Deficiency Summary

39 Facilities Surveyed **Surveys Taken 02/05/2014-03/13/2014**

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

D Facility failed to notify the physician and the family of a decline in wound status for one patient.

D Facility failed to ensure family members or a physician were notified of a significant weight loss for two patients.

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

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

D Facility failed to ensure that upon death of a patient funds were disbursed within 30 days to the responsible party for one patient.

F164 Right to privacy & confidentiality.

D Facility failed to ensure the privacy of one patient during one of two medication administration passes observed.

F166 Right to have grievances resolved.

E Facility failed to resolve grievances for four patients.

F167 Right to examine survey results of the facility.

C Facility failed to ensure survey results were readily accessible to the patient residing in the facility.

F176 Self-administration of drugs by resident.

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

F221 Right to be free from physical restraints.

E Facility failed to assess or obtain consent for physical restraints for three patients.

F223 Right to be free of physical/verbal abuse.

D Facility failed to prevent involuntary seclusion for one patient.

F225 Facility must not hire person with abuse history.

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

- D Facility failed to report an injury of unknown origin for one patient.
- D Facility failed to report an allegation of possible abuse to the proper authorities for one patient.
- D Facility failed to report an allegation of abuse to local law enforcement for one patient.
- D Facility failed to report an alleged allegation of abuse in accordance with state law within five working days of the incident.

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

- D Facility failed to follow their policy by not reporting an allegation of abuse in accordance with state law, within five working days of the incident.

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

- E Facility failed to cover the catheter bag of one indwelling catheter of four catheter bags observed and failed to honor the dignity of the patients during the lunch meal.
- E Facility failed to ensure six CNAs observed during mealtime promoted the dignity of the patients by using the title "feeder" or standing to feed patients.
- E Facility failed to promote dignity of the patients by using the title "feeder" and talking over the patients while assisting with the meals during two dining observations.
- E Facility failed to provide dignity to eight patients during the dining observations. Clothing protectors were placed on all the patients without asking permission.
- D Facility failed to ensure one CNA maintained a patient's dignity and respect during dining when CNA call a patient "Honey" repeatedly during the dining observation.
- D Facility failed to maintain dignity of patients when staff stood while assisting in feeding patients.
- D Facility failed to provide a privacy bag for one patient with a urinary catheter.

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

- D Facility failed to accommodate preferences for one patient.

F244 Facility follow-up on family group meetings.

- D Facility failed to resolve grievances in a timely manner.
- D Facility failed to follow up on the resident council's concerns for two months.

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

- D Facility failed to notify family of patients of a room change for one patient.

F252 Safe, clean, comfortable & homelike environment.

- D Facility failed to maintain a fine dining experience by using disposable plastic tableware and not serving meals to the patients who were sitting together.

F253 Housekeeping & maintenance services.

D Facility failed to ensure the patient's environment was free from foul odors in one patient room.

D Facility failed to keep the hallways free of odors for two hallways.

F257 Comfortable & safe temperature levels.

D Facility failed to maintain comfortable temperatures in one shower room.

F258 Comfortable sound levels.

E Facility failed to maintain calm and quiet noise levels for residents according to the group interview and observations.

D Facility failed to ensure an acceptable noise level for three patients. The halls were very noisy with staff calling out to one another, therapy calling to staff regarding patient whereabouts, and nurses calling to one another about admissions. Patients were also wheeling up and down the halls calling out repeatedly.

F272 Comprehensive assessment.

D Facility failed to accurately assess dental status for one patient.

F274 Assessment after a significant change in resident's health status.

D Facility failed to complete a significant change of status MDS for a change in condition of one patient.

D Facility failed to complete a significant change minimum data set (MDS) in a timely fashion for one patient.

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

D Facility failed to accurately assess the urinary incontinence status on a MDS for one patient.

D Facility failed to accurately assess hospice care for one patient.

D Facility failed to accurately assess one patient for contractures.

D Facility failed to accurately assess range of motion (ROM) for one patient.

D Facility failed to ensure the MDS assessments were accurate for behaviors or falls for two patients.

D Facility failed to conduct an accurate assessment for one patient for dental status and one patient for urinary tract infection.

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

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

- D Facility failed to update the care plan for one patient with concerns of not getting out of bed; dialysis for one patient; insomnia for one; range of motion for a total of four patients.
- D Facility failed to develop a care plan to address depression, anxiety and urinary tract infection for one patient.
- D Facility failed to ensure there was a care plan for impaired vision for two patients.
- D Facility failed to develop a comprehensive care plan for three patients.
- D Facility failed to develop a complete and accurate comprehensive care plan for one patient.
- D Facility failed to develop a comprehensive care plan for urinary incontinence for one patient.
- D Facility failed to develop a care plan to reflect use of oxygen for one patient.
- D Facility failed to develop a care plan for one patient for depression and for one patient with Raynaud's disease.

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

- E Facility failed to revise care plans for falls, vision, nutrition, ROM, medication use and/or diagnoses for eight patients.
- E Facility failed to ensure staff revised the updated the care plans with new interventions for significant weight loss and/or falls for five patients.
- D Facility failed to update the care plan with new interventions following a fall for one patient.
- D facility failed to revise a care plan to reflect the removal of an indwelling urinary catheter for one patient.
- D Facility failed to revise the care plan to address behaviors for one patient.
- D Facility failed to update the care plan for one patient.
- D Facility failed to update the care plan for one patient.
- D Facility failed to revise the comprehensive care plan to reflect fall interventions for one patient.
- D Facility failed to revise the care plan for three patients.
- D Facility failed to update a care plan for one patient.
- D Facility failed to revise the care plan to include the correct technique to transfer for one patient.

F281 Services must meet professional standards of quality.

- D Facility failed to follow physician's orders for one patient.
- D Facility failed to provide the necessary assistance and supervision needed during a meal for one patient.
- D Facility failed to follow the physician's orders for oxygen for one patient.
- D Facility failed to complete an interim care plan for one patient.

F282 Services must be provided by qualified persons.

- D Facility failed to follow the care plan interventions of a bed alarm for one patient.
- D Facility failed to follow the care plan for two patients.
- D Facility failed to implement the care plan for one patient. The side rails were to be up/raised when the patient was in bed for positioning and mobility. This was not done.
- D Facility failed to provide activities for one patient.

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

- D Facility failed to administer oxygen per the physician's order for one patient and failed to obtain an order for the amount of oxygen to be administered for two patients.
- D Facility failed to ensure there was communication between the facility and the dialysis center for one patient.
- D Facility staff failed to provide appropriate care and services for safe transfers for one patient observed during transfer.
- D Facility failed to maintain proper body positioning for one patient.
- D Facility failed to arrange a dermatologist appointment for one patient and failed to provide safe transfer instructions to all care givers for one patient.

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

- D Facility failed to provide nail care for a dependent patient.
- D Facility failed to ensure fingernails were neat and clean for one patient.

F314 Resident does not develop pressure sores.

- G Facility failed to provide care and treatment to prevent the decline of one pressure ulcer for one patient with pressure ulcers. This resulted in harm to the patient.
- D Facility failed to ensure wound assessments were accurate for one patient reviewed with pressure ulcers.
- D Facility failed to ensure a pressure relieving device was in place for one patient.
- D Facility failed to provide appropriate care and treatment for pressure ulcers for one patient.
- D Facility failed to provide timely treatment of a pressure ulcer for one patient reviewed.

F315 Incontinent resident receives appropriate treatment and services.

- D Facility failed to ensure the staff appropriately cleaned one patient receiving incontinent peri-care.
- D Facility failed to complete a bladder assessment to determine if a patient was appropriate for a bladder retraining program.

F318 Range of motion.

- G Facility failed to perform range of motion (ROM) and apply orthotics resulting in a decrease in ROM (harm) for one patient.

F319 Psychosocial adjustment difficulty.

- D Facility failed to ensure appropriate treatment and services were provided to correct the assessed behaviors of crying, agitation and restlessness for one patient.
- D Facility failed to implement behavior monitoring forms for the months of December 2013-February 2014 for one patient.
- D Facility failed to follow a psychiatric drug recommendation to increase the antidepressant for one patient.

F320 Resident's clinical condition demonstrates pattern was unavoidable.

- D Facility failed to follow physician orders for behaviors for one patient.

F322 Tube feeding/prevention.

- D Facility failed to ensure tube feedings were properly labeled for one patient.
- D Facility failed to ensure staff provided care and services in accordance with their medication administration policy for a PEG tube and per physician orders for flushes for one patient.

F323 Accident hazards.

- G Facility failed to provide a two person transfer resulting in a fall with fracture (harm) for one patient, failed to apply proper foot wear for one patient and failed to apply a pressure alarm for one patient.
- E Facility failed to maintain a safe environment on one hall of four halls and failed to ensure aspiration prevention of one patient.
- E Facility failed to ensure the patients' environment remained free from accident hazards as evidenced by unsecured chemicals in two janitor closets. There were also unsecured razors, nail clippers, manicure sticks and chemical hazards in two central baths and a damaged wheelchair and trash in one central bath.
- D Facility failed to update the care plan with new interventions following a fall for one patient.
- D Facility failed to provide supervision to prevent falls for one patient reviewed for accidents.
- D Facility failed to ensure a bed alarm intervention to prevent accidents/falls was implemented for one patient.
- D Facility failed to ensure staff implemented new appropriate interventions after each fall for two patients who had falls.
- D Facility failed to ensure safety devices were in place and functioning to prevent falls and failed to implement recommended new interventions to prevent falls for one patient. Facility failed to secure one facility supply closet.

- D Facility failed to ensure a safety device was functional for one patient. A mobility alarm was not functioning.
- D Facility failed to ensure a safety device to prevent falls was in place for one patient. The chair alarm was not functional.
- D Facility failed to ensure safety devices were in place for one patient. The ordered pressure alarm was not in place.

F325 Facility must ensure acceptable parameters of nutritional status.

- D Facility failed to follow the policy for weight loss for one patient. There was a 13-pound documented weight loss in one month with no follow-up.

F328 Proper treatment & care for specialized services.

- D Facility filed to ensure oxygen was administered at the rate prescribed by the physician for two patients receiving oxygen therapy.

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

- D Facility failed to ensure a patients' drug regimen was free from unnecessary drugs by no completing the behavior/intervention monthly flow record for one patient.
- D Facility failed to ensure one patient did not receive an unnecessary medication. The patient had Seroquel ordered without documentation of a specific diagnosis.

F333 Residents free of significant medication errors.

- D Facility failed to prevent a significant medication error for one patient.

F353 Adequate nursing staff to provide nursing & related services..

- E Facility failed to provide sufficient nursing staffing for one of two wings.

F356 Nurse staffing data

- D Facility failed to post nurse staffing information.
- D Facility failed to ensure the daily census was posted along with the nursing staffing information for three months of staffing posting sheets reviewed.
- C Facility failed to post the current facility staff hours. The posted staffing report was five days old.
- C Facility failed to post nurse staffing information as required.
- C Facility failed to post nurse staffing information.

F362 Dietary services employ sufficient staff.

- D Facility failed to have enough staff in order to serve food at palatable temperatures for one patient.

F364 Food preparation.

F Facility dietary department failed to maintain cold food at or less than 41 degrees F.

D Facility failed to serve food at a palatable temperature for one patient.

F371 Store, prepare, distribute, & serve food.

F Facility failed to dispose of outdated leftovers; failed to maintain a sanitary walk-in refrigerator; and failed to maintain the dietary equipment in a sanitary manner in the dietary department.

F Facility failed to maintain proper food temperatures in the lunch service tray line in the dietary department.

F Facility failed to store food under sanitary conditions and failed to maintain a clean and sanitary kitchen.

F Facility failed to ensure food was prepared and stored under sanitary conditions as evidenced by dirty drip pans on the stove, dietary staff with exposed hair in the kitchen, dietary staff with no evidence of kitchen sanitation training upon hire and food storage in a refrigerator with temperatures greater than 41 degrees (F).

F Facility failed to maintain the sanitizer level and the sanitizer emersion time in the three compartment sink as recommended by the manufacturer.

F Facility failed to obtain temperatures of the foods on the serving line prior to the food being plated. Facility failed to clean the fryers each week and failed to perform weekly cleaning behind the food preparation area.

F Facility failed to maintain sanitary conditions during the process of obtaining food temperatures in the food preparation area.

F Facility failed to ensure outdated food were not available for patients, and failed to ensure dirty food carts were not stored in clean areas of the kitchen.

F Facility dietary department failed to maintain the manufacturer's recommended level of sanitizer solution in the three compartment sink.

E Facility failed to ensure food was stored, prepared and served in a sanitary manner as evidenced when five staff members were observed touching food bare handed. There was also a lack of hand washing while serving prepared trays, and a prepared food tray was placed back on the food cart with other trays waiting to be served. Kitchen food was stored without having an expiration date on it, hair was not completely covered by hairnets and dirty equipment was observed during two days of the survey.

E Facility failed to ensure food was served under sanitary conditions as evidenced by one CNA touched food bare handed. The facility failed to ensure food was stored, prepared, and distributed under sanitary conditions as evidenced by hair not completely covered, facial hair not covered, food storage with no dates, the reach in refrigerator not at the proper temperature. A mop was left in the water bucket in the janitors closet and two dirty grease trays were on the stove.

D Facility failed to ensure appropriate storage and cleaning of containers and food used for medication administration in one of two medication rooms and one of four medication carts.

D Facility failed to ensure food was dated when stored and staff followed hand hygiene while cleaning dishes in the kitchen.

D Facility failed to adhere to sanitary requirements when in the kitchen, when thawing meats and while preparing meal trays for patients.

F372 Disposes of garbage & refuse.

C Facility failed to ensure garbage and refuse was properly disposed of.

C Facility failed to maintain the dumpster area appropriately.

F412 Medicaid patients must be provided with dental services.

D Facility failed to obtain routine dental services for one patient.

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

D Facility failed to promptly notify the physician of pharmacy consultant reports for two patients.

D Facility failed to timely notify the physician of pharmacy communication for one patient. A recommendation to discontinue a medication was not relayed to the physician for several weeks.

F431 Labeling of drugs & biologicals.

E Facility failed to ensure medications were stored properly as evidenced by one Advair diskus not used within 30 days of being removed from the foil pouch, loose pills, unlabeled medication, chemicals stored with medications and dirty drawers in three of 4 medication carts.

D Facility failed to store medication in a locked area for one patient.

D Facility failed to ensure medications were stored properly as evidenced by one container of gerimucil and one container of super sanicloth wipes were stored together and a bottle of sterile eye drops was stored without a label in two medication storage areas.

D Facility failed to ensure medications were properly disposed of for one of two medication rooms observed.

D Facility failed to ensure all the medications available for patient use were not expired on the medication carts.

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

D Facility failed to ensure medications were stored properly when two medication nurses left medications unsecured.

F441 Investigates, controls/prevents infections.

F Facility failed to ensure hand hygiene and standard infection control precautions were practiced for 18 patients during a lunch dining service. Facility failed to prevent the use of shared items between patients and keeping the shower clean of dirty linen in one of two showers.

E Facility failed to ensure proper infection control practices were maintained to prevent the potential spread of infection when two medication nurses did not clean or disinfect the stethoscope before of after auscultating bowel sounds or contaminated a clean barrier during medication administration.

E Facility failed to ensure that infection control practices were maintained as evidenced by a potty chair bucket on the floor under the checker table. There was an oxygen cannula on the floor in one dining room and a mop sitting in dirty mop water in one janitor's closet.

E Facility failed to maintain a clean and sanitary ice/water dispenser machine for one of two ice/water dispenser machines.

D Facility failed to ensure one CNA practiced hand hygiene to prevent the potential spread of infection.

D Facility failed to follow their policy on hand hygiene during dining.

D Facility failed to ensure practices to prevent the potential spread of infection or cross contamination were maintained when one nurse failed to wash hands or use different tissue between instilling eye drops or clean the stethoscope prior to checking placement of a PEG tube.

D Facility failed to change the soiled clothing for one patient and failed to prevent cross-contamination during ice pass for two patients.

D Facility failed to ensure two nurses observed administering medications maintained infection control practices to prevent the possibility of cross-contamination by discarding a used lancet into a regular trash can in a patients room and failing to empty and rinse a nebulizer chamber and mouthpiece after use.

D Facility failed to ensure practices to prevent the spread of infection and cross contamination were maintained when two nurses failed to disinfect the stethoscope and one CNA touched food with her bare hands.

D Facility failed to ensure staff performed hand hygiene for one of three nurses observed during medication pass.

D Facility failed to maintain hand hygiene during the meal pass on one of two wings observed.

D Facility failed to follow standards for the prevention and spread of infections by not disinfecting the hands after the removal of gloves for one patient having intravenous medication administration.

D Facility failed to perform hand hygiene during incontinence care for one patient.

D Facility failed to maintain a sanitary environment related to the storage of dirty water pitchers and a dirty dish bush, stored underneath a sink in one medication room.

D Facility failed to maintain infection control protocol by not wearing gloves during medication administration for one patient.

F456 Sufficient space & equipment maintenance.

D Facility failed to maintain a microwave and the floors in the walk-in freezer and walk-in refrigerator in safe operational condition in the dietary department. The floors were worn with areas of rust. The microwave interior wall was cracked.

F460 Full visual privacy in room design.

D Facility failed to maintain full visual privacy for two patient rooms.

F463 Resident call system.

E Facility failed to ensure there was an operational resident call light system in four common restrooms used by patients.

D Facility failed to ensure the call lights were in working order for three rooms.

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

E Facility failed to provide a safe and sanitary patient environment as evidenced by unsecured razors, nail clippers, manicure sticks, and equipment; trash on the floor; a garbage can running over with trash; and a potty chair bucket sitting on the floor in two central baths.

F468 Corridors equipped with hand rails.

E Facility failed to ensure handrails were securely fixed to walls on two halls of the facility.

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 lab work was obtained as ordered for one patient.

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

F514 Criteria for clinical records.

F Facility failed to maintain patient records in a systematically organized, complete, accurate, and readily accessible format for four patients.

E Facility failed to complete behavioral management documents, pain flow sheets and medication administration records for three patient.

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

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

- D Facility failed to maintain accurate clinical information on one patient.
- D Facility failed to update the medication administration record to reflect the change in the physician order for one patient.

K014 Interior Finish - Corridors

- F Facility failed to have interior finishes in corridors and exit ways of a class A or class B flame spread.

K015 Interior Finish - Rooms

- F Facility failed to have interior finishes for rooms and spaces not used for corridors or exit ways of a flame spread rating of at least a class A, class B, or class C.
- D Facility failed to have flame spread information on interior finishes.

K018 Construction of Doors

- E Facility failed to maintain the corridor openings. Some patient room doors required more than 15 pounds of pressure to open and close.
- E Facility failed to have fire doors latch within their frame.
- E Facility failed to ensure corridor doors closed to a positive latch.
- D Facility failed to maintain the corridor opening. One door did not close within the frame.
- D Facility failed to ensure fire doors will close to a positive latch.
- D Facility failed to maintain all doors. Some doors would not close to a positive latch.

K021 Automatic Closing Doors

- D Facility failed to maintain two corridor fire doors to close properly.

K022 Enclosure Doors Serving Exits

- D Facility failed to properly mark the exits.

K025 Smoke Partition Construction

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

K027 Doors In Smoke Barriers

- D Facility failed to maintain smoke resistant partitions.

K029 Hazardous Areas Separated By Construction

- D Facility failed to maintain the fire doors. Several doors to laundry and storage rooms that were over 50 square feet with combustible materials were not self-closing.
- D Facility failed to ensure doors to rooms used to store combustibles were provided with door closers.
- D Facility failed to have self-closing doors in hazardous areas.

K038 Exit Accessible At All Times

- E Facility failed to ensure all exits were accessible. The staff did not know the code for the back up door locks on the exit. Doors did unlock during the fire alarm activation.
- E Facility failed to provide the required signage for delayed-egress signage.
- D Facility failed to provide exits readily accessible at all times.
- D Facility failed to maintain exit egress from the building.

K050 Fire Drills

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

K052 Testing of Fire Alarm

- F Facility failed to maintain the fire alarm system and its components.
- F Facility failed to maintain the magnetic delayed egress doors.
- E Facility failed to ensure fire alarm strobes were synchronized.
- D Facility failed to properly install smoke detectors.

K054 Smoke Detector Maintenance

- E Facility failed to have fire extinguishers clearly visible and identifiable.
- D Facility failed to provide smoke detection in all rated areas. There was no smoke detector inside the electrical room.

K062 Automatic Sprinkler - Maintenance

- F Facility failed to maintain the automatic sprinkler system per NFPA 25. The sprinkler heads are mis-matched.
- F Facility failed to maintain the water storage tank per the NFPA 25 standard for the inspection, testing and maintenance of water-based fire protection systems for water tanks.
- F Facility failed to maintain the automatic sprinkler system and its components.
- E Facility failed to maintain the sprinkler system.

- D Facility failed to maintain the sprinkler system. The five-year sprinkler investigation had not been done.
- D Facility failed to maintain the automatic sprinkler system. There were some corroded sprinkler heads and three sprinkler heads had not been updated to quick response sprinkler heads.
- D Facility failed to provide qualified technicians to perform quarterly inspections on the fire sprinkler protection system, failed to maintain 18 inches of clearance for sprinkler heads and failed to ensure sprinkler heads were free from an accumulation of a foreign matter.
- D Facility failed to maintain clearance below all sprinkler heads.
- D Facility failed to ensure sprinkler system was not used to support non-system components.

K062 Sprinkler Maintenance

- D Facility failed to maintain clearance between all sprinkler heads and obstructions.

K064 Portable Fire Extinguishers

- F Facility failed to have the six-year maintenance performed on the fire extinguishers.
- D Facility failed to maintain the portable fire extinguishers. They had not been inspected monthly.

K066 Smoking Regulations

- D Facility failed to provide the required equipment in smoking areas.
- D Facility failed to provide smoking areas with metal containers with a self-closing lid.
- D Facility failed to provide metal containers with self-closing lids to all smoking areas.
- D Facility failed to provide metal containers with self-closing lids to all smoking areas for ashtrays to be emptied into.

K067 Ventilating Equipment

- F Facility failed to conduct their four-year damper maintenance.
- F Facility failed to have fire dampers serviced every four years as required by NFPA 90A.
- F Facility failed to ensure fire dampers are maintained in accordance with NFPA 90A. The fire dampers had not been serviced.
- F Facility failed to maintain the heating, ventilation, and air conditioning (HVAC) in accordance with NFPA 90 A.
- E Facility failed to maintain the HVAC system. Several individual units were not functioning.
- E Facility failed to maintain the HVAC. Some units were not working.
- E Facility failed to maintain the HVAC system. The exhaust fans in some patient rooms were not working.

D Facility failed to provide constant air circulation in seven rooms. The fan function of the individual HVAC systems was turned off. This was the only source of air exchanges.

D Facility failed to install fire dampers in fire rated wall assemblies.

K069 Commercial Cooking Equip. Meets Requirements

D Facility failed to protect the cooking facilities. The kitchen fire suppression system was not centered over the cooking equipment.

K072 Furnishings and Decorations

D Facility failed to maintain egress in exit corridors. There were four potted plants in front of one exit door.

K076 Nonflammable Medical Gas Systems

D Facility failed to ensure medical gasses were properly stored. There were unsecured oxygen cylinders in the outside oxygen storage area.

K077 Piped-In Oxygen System

D Facility failed to install and maintain the medical gas system.

K104 Penetration of Smoke Barriers

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

K130 Other LSC Deficiency Not On 2786

D Facility failed to have labels on the doors identifying them as fire doors.

D Facility failed to have fire doors close and latch within their frame.

K144 Generators

F Facility failed to properly maintain and test the emergency generator power supply.

D Facility failed to maintain battery operated task lighting inside the electrical transfer switch room.

D Facility failed to have a remote annunciator for the generator that is in a continuously monitored location.

K147 Electrical Wiring and Equipment

E Facility failed to protect the electrical system from overloading. There were multi-plug adapters in use.

E Facility failed to maintain the electrical system.

E Facility failed to maintain the electrical outlets.

E Facility failed to prevent the use of power strips as a substitute for fixed wiring to provide power for medical equipment and maintain electrical equipment.

- D Facility did not maintain electrical wiring and equipment. There were oxygen concentrators plugged into power strips.
- D Facility failed to prevent the use of power strips as a substitute for fixed wiring to provide power for medical equipment.
- D Facility failed to maintain ground fault circuit interrupters (GFCI) outlets in wet areas.
- D Facility failed to maintain the electrical components. There were loose sockets in the walls.
- D Facility failed to maintain electrical receptacles.
- D Facility failed to prohibit the use of power strips as a substitute for fixed wiring to provide power to medical equipment.
- D Facility failed to plug medical devices directly into an outlet.

K211 Alcohol Based Hand Rub Dispensers

- D Facility failed to install an alcohol based hand rub dispenser away from an ignition source.

N1102 Record and Reports; Recording of Unusual Incidents

Facility failed to implement the abuse policy and procedure to perform a complete and thorough investigation of an injury of unknown origin or report the incident to the state survey agency. This was a type C pending penalty.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

Facility failed to conduct an earthquake disaster exercise in previous year.

Facility failed to conduct annual disaster drills for all staff.

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

N1411 Disaster Preparedness; Fire Safety Drills

Facility failed to conduct and evaluate bomb threat drills for all staff and all shifts.

N1501 Nurse Aide Training

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

N629 Infection Control; Disinfect Contaminated Items

Facility failed to ensure proper infection control practices were maintained to prevent the potential spread of infection when two medication nurses did not clean or disinfect the stethoscope before of after auscultating bowel sounds or contaminated a clean barrier during medication administration. This was a type C pending penalty.

Facility failed to ensure practices to prevent the spread of infection and cross contamination were maintained when two nurses failed to disinfect the stethoscope. This was a type C pending penalty.

N645 Nursing Services

Facility failed to ensure the patient's environment was free from foul odors in one patient room. This was a type C pending penalty.

Facility failed to ensure the patients' environment remained free from accident hazards as evidenced by unsecured chemicals in two janitor closets. There were also unsecured razors, nail clippers, manicure sticks and chemical hazards in two central baths and a damaged wheelchair, trash in one central bath. This was a type C pending penalty.

N727 Pharmaceutical Services

Facility failed to store medication in a locked area for one patient. There was an inhaler of Proventil on the patient's nightstand. This was a type C pending penalty.

Facility failed to ensure internal and external medications were stored properly in one medication storage area. This was a type C pending penalty.

N729 Pharmaceutical Services

Facility failed to ensure medications were stored properly as evidenced by one container of gerimucil and one container of super sanicloth wipes were stored together and a bottle of sterile eye drops was stored without a label in two medication storage areas. This was a type C pending penalty.

Facility failed to ensure medications were stored properly as evidenced by one Advair diskus not used within 30 days of being removed from the foil pouch, loose pills, unlabeled medication, chemicals stored with medications and dirty drawers in three of 4 medication carts. This was a type C pending penalty.

N767 Food and Dietetic Services; Written Policies and Procedures

Facility failed to ensure food was stored, prepared and served in a sanitary manner as evidenced when five staff members were observed touching food bare handed, lack of hand washing while serving prepared trays and a prepared food tray placed back on the food cart with other trays waiting to be served. Kitchen food was stored without having an expiration date on it, hair not completely covered by hairnets and dirty equipment during two days of the survey. This was a type C pending penalty.

Facility failed to ensure food was served under sanitary conditions as evidenced by one CNA touched food bare handed. The facility failed to ensure food was stored, prepared, and distributed under sanitary conditions as evidenced by hair not completely covered, facial hair not covered, food storage with no dates, the reach in refrigerator not at the proper temperature. A mop was left in the water bucket in the janitors closet and two dirty grease trays were on the stove. This was a type C pending penalty.

Facility failed to ensure food was prepared and stored under sanitary conditions as evidenced by dirty drip pans on the stove, dietary staff with exposed hair in the kitchen, dietary staff with no evidence of kitchen sanitation training upon hire and food storage in a refrigerator with temperatures greater than 41 degrees (F). This was a type C pending penalty.

Facility failed to ensure food was dated when stored and staff followed hand hygiene while cleaning dishes in the kitchen. This was a type C pending penalty.

N776 Refrigerator Temperature

Facility failed to ensure the refrigerator temperature shall be kept at a temperature not to exceed 45 degrees (F). This was a type C pending penalty.

N831 Building Standards

Facility failed to maintain the condition of the nursing home environment. There were some doors that did not close to a positive latch.

Facility failed to maintain the physical plant and the overall condition of the nursing home environment. The parapet wall above the roof line was showing signs of deterioration with cracks and flaking.

Facility failed to ensure there was an operational resident call light system in four common restrooms used by patients. This was a type C pending penalty.

N832 Building Standards

Facility failed to provide the physical therapy area at a negative air pressure at least 6 air changes per hour.

N848 Building Standards; Exhaust & Air Pressure

Facility failed to maintain negative and positive air pressure in designated.

Facility failed to maintain negative air pressure in a soiled utility room.

Facility failed to maintain a negative air pressure in dirty areas.

N901 New Code Compliance

Facility failed to comply with the applicable building and fire safety regulations. Some night lights were not working.

Facility failed to comply with the applicable building and fire safety regulations.

Facility failed to maintain the automatic sprinkler system and its components.