Survey Deficiency Summary

38 Facilities Surveyed **Surveys Taken 3/5/2014-7/30/2014**

Basic Services

Facility failed to maintain the physical environment.There were rodent droppings above the ceiling of the 1st and 2nd floor.

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

E Facility failed to provide two of three patients with the proper advanced beneficiary notices as required by law. The two notices sent were dated the same day that coverage ended.

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

J Facility failed to timely assess and notify the physician of edema of the right arm which resulted in a delay of treatment, actual harm, neglect and placed one patient in immediate jeopardy with a deep vein thrombosis (DVT).

J Facility failed to promptly notify the physician of a significant change in status for one patient. The facility failed to promptly notify the physician of the onset of seizure like activity and critical low blood sugar results which resulted in the patient being hospitalized.

G Facility failed to notify the physician or family of a significant unplanned weight loss for one patient. This resulted in actual harm to the patient.

D Facility failed to notify the physician of a significant weight loss for one patient.

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

C Facility failed to ensure patients had ready access to their personal funds for nine patients with trust accounts.

F164 Right to privacy & confidentiality.

E Facility failed to ensure three nurses provided privacy for patients during medication administration.

D Facility failed to ensure one patient's privacy was maintained during a treatment.

D Facility staff failed to maintain patient privacy as evidenced by staff talking about a patient in the main entry foyer on one day of survey.

D Facility nurse failed to maintain a patient's full visual privacy during medication administration.

F166 Right to have grievances resolved.

J Facility failed to thoroughly investigate grievances; and implement new, appropriate and measurable interventions to prevent psychological harm and potential resident to resident altercations resulting in immediate jeopardy. One patient stated that she was afraid of another patient and could not rest at night because he might come into her room. This was an immediate jeopardy.

D Facility failed to ensure patient grievances were resolved timely for two patients.

F223 Right to be free of physical/verbal abuse.

J Facility failed to thoroughly investigate incidents; and implement new, appropriate and measurable interventions to prevent psychological harm and potential patient to patient altercations for one patient who said she was afraid of another patient resulted in an immediate jeopardy.

F224 Mistreatment, neglect, misappropriation of resident property.

K Facility failed to appropriately assess and timely notify the physician of the swelling of the right arm resulting in a delay of treatment for one patient who was at high risk for DVT. The patient did have a DVT and it was cited as an IJ. The facility also had a failure to address one patient's behaviors of wandering, exit seeking and elopement from the facility resulting in an IJ.

F225 Facility must not hire person with abuse history.

J Facility failed to thoroughly investigate and/or report to administration allegations of abuse and neglect for one patient who was afraid and unable to rest at night and one patient who's behaviors of wandering, exit seeking and elopement from the facility resulting in immediate jeopardy.

D Facility failed to report allegations of abuse to the state survey agency for one patient.

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

J Facility staff failed to ensure allegations of abuse and elopement from the facility were thoroughly investigated and/or reported to administration for one patient. This resulted in an IJ.

D Facility failed to thoroughly investigate an allegation of abuse for one patient.

D Facility failed to follow it's own policies on abuse prohibition and prevention for one patient.

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

E Facility failed to promote care for a patient in a manner that maintained or enhanced his dignity. Meals were not served to the same table at the same time.

E Facility failed to provide care that enhanced a patient's dignity when a nurse exhibited an attitude and offensive body language and another nurse got smart with one patient who was interviewed concerning dignity. Facility failed to ensure three CNAs provided care that enhanced each patient's dignity when staff failed to assist patients with eating; referred to the patients as "feeders;" posted personal information about patients on the wall and failed to gain permission prior to entering a patient's room.

D Facility failed to promote care for patients in a manner that enhanced each patients dignity when four staff members stood to feed the patients during dining.

D Facility failed to ensure privacy was provided during a wheelchair to bed transfer for one patient.

D Facility failed to maintain patients' dignity during dining when one staff member stood while feeding a patient.

D Facility failed to ensure two CNAs maintained patients' dignity and respect when the staff referred to patients requiring assistance with feeding as "feeders."

D Facility failed to promote care for patients in a manner that enhanced each patient's dignity when one staff member stood to feed a patient in the dining room.

D Facility failed to ensure dignity was maintained for one patient walking in the D hallway.

D Facility failed to maintain dignity of patients when one nurse and one CNA stood to feed the patients in the dining room.

F244 Facility follow-up on family group meetings.

D Facility failed to follow up on the patients council's concerns for two patient council meeting minutes reviewed.

F246 Right to accommodations of individual needs & preferences.

D Facility failed to ensure a patient's individual needs and preferences were provided for one patient.

D Facility failed to place call lights within reach of two patients.

F248 Ongoing activities program to reflect resident's needs.

D Facility failed to provide individualized activities designed to meet the interests for two patients.

F252 Safe, clean, comfortable & homelike environment.

E Facility failed to provide a comfortable and homelike dining experience during two observations. Resident meals were served on trays and the plates were not removed from the tray for meal service.

F253 Housekeeping & maintenance services.

F Facility failed to provide housekeeping and effective maintenance services to maintain a sanitary, orderly and comfortable environment. There were dirty baseboards, scuff marks, torn baseboards, stains and dirt on the walls, peeling paint, and missing and cracked caulking around commodes.

F Facility failed to provide effective housekeeping and maintenance services to maintain a sanitary, orderly and comfortable environment as evidenced by wash basins and bedpans stored on the floor, closet doors in disrepair, multiple clothing items on the floor, odors, floors that were dirty and scuffed, walls with stains, peeling paint, dirty air conditioner units, broken vents, stained commodes and bathrooms and toilets in disrepair.

E The facility failed to ensure the residents' enviornment was clean and sanitary as evidenced by odors, dirty or stained floors, rusty door facings, dirty walls, chipped floor tiles, dark, black buildup around toliets, and a broken towel rack in resident bathrooms.

E Facility failed to provide effective maintenance and housekeeping services to maintain a sanitary, orderly and comfortable environment as evidenced by loose and hanging wallpaper, scuffed walls with sheetrock missing, and brown build-up around baseboards in patient rooms and bathrooms. There were knobs missing from night stands, dirty floors in patient rooms and bathrooms and sticky, dirty handrail. Some toilets were stained with a yellow substance and there was a strong urine smell in the facility.

E Facility failed to provide a clean environment as evidenced by scuffed walls, dirty floors along the baseboards, crumbling window sills, peeling paint over the air conditioning units, a large area of white putty-like material that was not finished beside the sink.

D Facility failed to provide effective housekeeping and maintenance services to maintain a sanitary environment as evidenced by odors in a patient's room.

D Facility failed to ensure the facility was clean and sanitary as evidenced by dirty commode area and urine odors in one patient room and bathroom.

F254 Clean bed & bath linens.

E Facility failed to provide sufficient linen to meet the needs of the patients.

F258 Comfortable sound levels.

E Facility failed to maintain comfortable sound levels as evidenced by loud laundry carts in the hallways.

F272 Comprehensive assessment.

D Facility failed to ensure the MDS was accurate for one patient.

D Facility failed to provide accurate comprehensive assessments for two patients.

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

- D Facility failed to ensure the patient's environment was maintained to be clean and sanitary as evidenced by odors, dirty or stained floors, rusty door facings, dirty walls, chipped floor tiles, dark, black buildup around toilets and a broken towel rack.
- D Facility failed to accurately assess dental status, ROM or falls for three patients.
- D Facility failed to complete the MDS to ensure each diagnoses assessed as being accurate for two patients.
- D Facility failed to ensure the MDS assessment was updated and accurate related to a urinary tract infection for one patient.
- D Facility failed to properly assess a patient with falls.
- D Facility failed to accurately assess patients with pressure ulcers and dysphasia for two patients.
- D Facility failed to include a diagnosis of congestive heart failure on the MDS.
- D Facility failed to accurately assess oxygen usage for one patient.
- D Facility failed to provide an accurate assessment for one patient.

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

- D Facility failed to develop a care plan related to anticoagulants for one patient.
- D Facility failed to develop a complete and accurate comprehensive care plan for anticoagulant therapy for one patient.
- D Facility failed to develop a care plan to reflect the presence of a urinary tract infection (UTI) for one patient.
- D Facility failed to have a care plan for ROM for one patient.
- D Facility failed to develop a comprehensive care plan for depression for one patient and failed to develop a care plan addressing weight and fluid status of one patient.
- D Facility failed to develop a care plan to address pain and narcotic use for three patients.
- D Facility failed to develop a complete and accurate care plan for contractures for one patient.

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

- G Facility failed to ensure care plans were revised to reflect the current status for unplanned weight loss or the risk for emergency bleeding care related to dialysis shunt site for three patients. This failure caused actual harm to one patient.
- D Facility failed to revise the care plans for falls for one patient reviewed with accidents.
- D Facility failed to revise the care plan for falls and contractures and failed to invite a patient to attend a care plan meeting for three patients.
- D Facility failed to revise the care plan for falls for two patients.

D Facility failed to revise the care plan to reflect the current status related to pressure ulcers for one patient.

D Facility failed to revise the care plan to reflect the development of an unstageable pressure ulcer for one patient.

D Facility failed to update the care plan with interventions for aftercare of a shoulder fracture and sling or for a fall for two patients.

D Facility failed to ensure the care plan included actual pressure ulcers for one patient.

D Facility failed to revise the care plan related to diagnoses, Foley catheters, activities of daily living and gastrostomy status for one patient.

D Facility failed to provide an accurate care plan for two patients.

D Facility failed to revise the care plan to reflect the patient's current status related to bathing and pressure ulcer interventions for two patients.

D Facility failed to honor the patient's right to participate in planning care for one patient.

F281 Services must meet professional standards of quality.

J Facility failed to ensure services provided to three patients met professional standards of quality. The facility failed to ensure the medication regimen was transcribed accurately on admission and failed to ensure diagnostic tests and administration of medication were ordered by the physician prior to being given to patient. The patient received the wrong medications and did not receive all of his prescribed medications for three days which resulted in the patient being hospitalized.

D Facility failed to ensure one medication nurse disposed of medications within an acceptable standard of practice.

F282 Services must be provided by qualified persons.

G Facility failed to follow the plan of care intervention of supplements for unplanned weight loss for two patients. This failure caused actual harm for one patient.

D Facility failed to ensure care plan interventions were followed for nutrition or a dialysis shunt for three patients.

D Facility failed to follow care plan interventions related to infection control for one patient.

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

D Facility failed to ensure care plan interventions were followed for oxygen therapy for one patient.

D Facility failed to ensure care plan interventions were followed for a dialysis shunt site for one patient.

D Facility failed to ensure a care plan intervention for a fall was followed for one patient.

D Facility failed to follow a plan of care for one patient who required a two person assist with the use of a sit-to-stand lift.

D Facility failed to provide activities according to the care plan for two patients.

D Facility failed to follow the care plan for placement of floor mats for one patient.

F282-Services provided by a qualified person

J Facility failed to follow the care plan intervention for monitoring a patient's arm and timely notification of condition changes to the physician resulting in a delay of treatment for one patient; to prevent one patient from eloping from the facility or entering a patient's room who was fearful of the patient and unable to rest. These failure resulted in immediate jeopardy.

F283 Discharge summary includes resident's stay.

D Facility failed to ensure discharge summaries were completed for two patients.

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

J Facility failed to appropriately assess and timely notify the physician of swelling of the right arm, for one patient who was at high risk for DVT, resulting in a delay of care when the patient did develop the DVT. This resulted in an IJ.

G Facility failed to ensure pain was controlled during a dressing change for one patient. Facility failed to manage the pain as evidenced by the patient grimacing and repeatedly crying "No, No" during the dressing changed which resulted in actual harm to the patient.

D Facility failed to ensure a dialysis access site was assessed for one patient.

D Facility failed to ensure that staff followed a physician order for administering pain medication no more than every six hours.

D Facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being when staff failed to complete patient assessments before and after returning from dialysis or monitoring the dialysis shunt site.

D Facility failed to follow the facility policy for monitoring the effectiveness of pain medication for two patients and failed to ensure the develop a contract with a dialysis clinic in one of four contracts reviewed.

D Facility failed to follow physician orders for a home health evaluation and treatment for one patient.

F310 ADLs do not diminish unless circumstances are unavoidable.

D Facility failed to prevent the decline in ADLs related to the development of a urinary tract infection (UTI).

F311 Appropriate treatment & services to maintain or improve ADLs.

D Facility failed to ensure oral care was done for one patient who required assistance with ADLs.

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

E Facility failed to ensure patients who were unable to carry out activities of daily living (ADLs) received the necessary assistance with tray set up or positioning during dining for six patients.

D Facility failed to ensure one patient who was unable to carry out all ADLs received assistance with oral hygiene.

D Facility failed to provide the necessary services for personal hygiene during bathing for one patient. The bed bath was done incorrectly. The CNA washed the patient's buttock area and did not change the water prior to washing other body parts.

D Facility failed to provide nail care for one patient.

F314 Resident does not develop pressure sores.

G Facility failed to identify a pressure ulcer/sore before it became unstageable and failed to provide pressure ulcer treatments as ordered by the physician for one patient.

E Facility failed to have a system in place to teach staff nurses consistent wound care to assure accurate assessments, interventions and monitoring of pressure ulcers for two patients.

E Facility failed to provide treatment as ordered by the physician for pressure ulcers for two patients with pressure ulcers.

D Facility failed to follow physician's orders and/or the care plan for the treatment of a suspected deep tissue injury for one patient.

D Facility failed to accurately assess and perform a skin assessment for one patient.

D Facility failed to follow physician's orders for wound care for one patient with a pressure ulcer.

D Facility failed to ensure treatment was provided for blood pressure ulcers for one patient with pressure ulcers.

F315 Incontinent resident receives appropriate treatment and services.

D Facility failed to provide timely treatment for a UTI for one patient.

D Facility failed to provide bladder retraining for one patient reviewed for urinary incontinence.

F318 Range of motion.

D Facility failed to provide range of motion care for two patients.

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

F319 Psychosocial adjustment difficulty.

J Facility failed to effectively implement new interventions for treating wandering behaviors, exit seeking behavior with an elopement and to prevent on patient from wandering into another patient's room resulted in an IJ.

F322 Tube feeding/prevention.

D Facility failed to ensure a patient who is fed through a percutaneous gastrostomy (PEG) tube received the proper treatment due to the nurse not flushing the tube prior to administering medication.

D Facility failed to properly administer medications via feeding tube, as evidenced by the nursing staff forced dissolved medications through the tube using a syringe plunger. The orders stated that the nurses administering medications were to use gravity to administer medications and flush tubing.

F323 Accident hazards.

J Facility failed to respond to a sounding alarm; and thoroughly investigate and implement new interventions for wandering and exit seeking behavior allowing a patient to elope from the facility, which resulted in an IJ.

F Facility failed to ensure the environment was free of accident hazards. There were unsecured razors and chemicals on one hall. This was a sub-standard quality of care.

E Facility failed to ensure the initiation of new interventions to protect from injury for two patient and failed to ensure the proper use of lift for transferring one patient.

D Facility failed to identify and implement an intervention to prevent accidents for one patient.

D Facility failed to ensure the environment was safe as evidenced by unsecured razors in three rooms.

D Facility failed to properly secure store chemicals on one hall.

D Facility failed to ensure the environment was free from accident hazards as evidenced by unsecured toxic substance in one bathroom.

D Facility failed to supervise the care of a urinary catheter for one patient.

D Facility failed to ensure that portable oxygen tanks were secured on two days of the survey.

D Facility failed to implement an intervention to prevent accidents.

D Facility failed to ensure the patients were free of accident hazards by failing to implement floor mats for one patient.

D Facility failed to ensure the correct safety device was in place for one patient of three patients.

F325 Facility must ensure acceptable parameters of nutritional status.

H Facility failed to adequately address and maintain the nutritional status for two patients who experienced unplanned weight loss. This caused actual harm and substandard quality of care to these two patients.

G Facility failed to timely implement interventions recommended by the registered dietitian and ordered by the nurse practitioner for six patients experiencing weight loss. This failure caused actual harm to one patient.

D Facility failed to ensure supplements were given as ordered or documented for two patients.

D Facility failed to implement interventions for a significant weight loss for one patient.

D Facility failed to ensure each patient received supplements as ordered by the physician to maintain acceptable nutritional status for one patient.

F328 Proper treatment & care for specialized services.

D Facility failed to ensure oxygen was administered at the physician's prescribed rate for one patient receiving oxygen therapy.

D Facility failed to ensure oxygen (O2) was administered at the physician's prescribed rate and failed to ensure unlicensed staff did not administer oxygen for one patient.

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

J Facility failed to ensure drug regimens were accurate and had adequate indications for use for two patients. This caused immediate jeopardy for one patient.

D Facility failed to follow a physician's order for a gradual dose reduction for an antianxiety medication for one patient.

D Facility failed to ensure two patients were free from unnecessary medication use. Both medications were antipsychotics.

D Facility failed to ensure one patient had a drug regimen that was free from unnecessary drugs as evidenced by inadequate indication for the use of the psychoactive medication (Seroquel).

D Facility failed to implement a gradual dose reduction ordered by the physician for one patient.

D Facility failed to follow a physician's order to discontinue the administration of a psychoactive medication for one.

F332 Facility medication error rates of 5% or more.

E Facility failed to ensure three administered medications with a medication error rate less than 5 percent. There were 13 medication errors out of 29 opportunities for error, which resulted in a medication error rate of 44.82 percent.

E Facility failed to ensure two nurses administered medications without a medication error rate of less than 5 percent. The error rate was 40 percent.

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

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

E Facility failed to ensure three nurses administered medications with a medication error rate of less than 5 percent. The error rate was 13.33 percent.

D Facility failed to ensure one nurse administered medications with an error rate of less than 5 percent. The error rate was 8 percent.

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

D Facility failed to administer medications without error resulting in a 10 percent medication error rate.

D Facility failed to ensure two nurses administered medications with an error rate of less than 5 percent. The error rate was 7.14 percent.

F333 Residents free of significant medication errors.

J Facility failed to ensure three patients were free of significant medication errors. This failure resulted in immediate jeopardy for one patient.

E Facility failed to ensure two nurses administered medications free of significant medication errors. Insulin was not given in the proper time frame in relation to meals.

E Facility nurse failed to administer medications without a significant medication error. The insulin was administered and no meal or food was given for more than 20 minutes.

E Facility failed to ensure three nurses administered medication without a significant medication error.

D Facility failed to ensure one medication nurse administered insulin timely in relation to meals which resulted in a significant medication error.

D Facility failed to ensure one nurse administered medications free of a significant medication error. The nurse did not administer sliding scale insulin as ordered.

F334 Flu Immunization

E Facility failed to provide the required components of the influenza and pneumococcal immunization program for six patients.

F354 Licensed nurse to serve as charge nurse.

E Facility failed to ensure there was a registered nursing that worked at least eight consecutive hours a day, seven days per week.

F356 Nurse staffing data

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

F364 Food preparation.

D Facility failed to serve cold food at or less than 40 degrees Fahrenheit (F) on the patient tray line; and failed to maintain food temperatures at a palatable level upon delivery to the patients.

D Facility failed to prepare and serve food that is palatable for three patients.

D Facility failed to ensure timely delivery of meals during one dining observation.

F365 Food meets individual needs.

D Facility failed to ensure a patient was provided with the diet prescribed by the physician for one patient.

F371 Store, prepare, distribute, & serve food.

- F Facility failed to ensure food was stored, prepared and distributed under sanitary conditions as evidenced by staff not wearing hair and beard covers, and dirty hand washing sink used for hand washing by dietary staff. There was also moisture and food particles on stacked plates, utility carts and inside microwave.
- F Facility dietary department failed to maintain sanitary grates on one of two walk-in refrigeration condenser units; failed to maintain sanitary grates in one of two reach-in refrigeration condenser units. Two of four dietary staff members failed to totally cover their hair with a hair restraint.
- F Facility failed to maintain a sanitary kitchen by not properly storing clean dishes, not monitoring for expired food, not properly storing food, not maintain thermometers in two refrigerators, and not maintaining safe milk temperatures.
- F Facility failed to maintain a sanitary kitchen by not properly storing food and monitoring expired food.
- E Facility failed to ensure proper sanitation and food handling practices were followed, as evidenced by failure of staff to wash hands between the handling of dirty and clean dishes, and by carbon build-up on the cookware.
- E Facility failed to ensure food was prepared and served under sanitary conditions as evidenced by pans with carbon build up and grease build up.
- E Facility failed to ensure that food was stored and protected from sources of contamination in the kitchen as evidenced by dietary staff not wearing hair covering, food stored past the expiration date and carbon build-up on the skillet.
- E Facility failed to ensure that opened food was dated when stored; ice scoops, thermal plates and covers were stored under sanitary conditions and hot food was served at 135 degrees F or above.
- E Facility failed to ensure food was stored in a sanitary manner when refrigerators did not have a thermometer present; contained an open and unlabeled drink or was in disrepair for two refrigerators. The facility failed to ensure that all persons entering the kitchen wore hair coverings.
- E Facility failed to ensure practices to prevent the potential spread of infection were maintained by five staff members.
- E Facility failed to ensure food was delivered under sanitary conditions when CNAs placed a meal tray on a bedside table in a patient room, and then retuned the meal tray back to the cart with meal trays not yet served during a meal service.
- E Facility failed to ensure kitchen equipment was cleaned after use, food was not left in the drain of the sink, there was proper sanitizer in the three compartment sink and the dish machine and frozen food was stored in an air tight container.
- E Facility staff failed to wash their hands and handled food with their bare hands during two dining observations. The facility failed to ensure food was protected from sources of contamination as evidenced by a dirty stove and oven, food not labeled and dated, staff not wearing beard covers and hair not completely covered.

E Facility failed to ensure food was prepared under sanitary conditions as evidenced by a mixer with peeling paint and carbon build-up on cooking utensils.

E Facility failed to ensure food was protected from sources of contamination when one CNA and two dietary workers failed to wash hands or failed to ensure hair was covered during the food service.

E Facility failed to ensure foods were stored and served under sanitary conditions as evidenced by a dirty meat slicer, expired foods, foods stored without dates, carbon build-up on cookware, and staff without proper hair coverings in the kitchen.

D Facility failed to ensure practices to prevent the potential spread of infection were maintained by four CNAs during dining observations.

D Facility failed to ensure food was prepared and served in a sanitary manner when one dietary staff in the skilled unit kitchen touched inanimate objects then touched food without performing hand hygiene and failed to ensure the kitchen floor was clean.

D Facility failed to ensure food was prepared in a sanitary manner when one dietary staff member prepared food with facial hair uncovered. There was also a pink substance on the ice guard. Two nurses touched patients' food with bare hands.

D Facility failed to ensure food was prepared, distributed or served under sanitary conditions when one staff member failed to wash hands during meal service and a delivery man failed to wear a hair net in the kitchen.

D Facility failed to ensure foods were served under sanitary conditions by desserts being uncovered and one CNA handling the food with bare hands without performing hand hygiene.

D Facility failed to ensure food was distributed or served under sanitary conditions when two nurses failed to wash their hands during meal service.

F372 Disposes of garbage & refuse.

F Facility failed to ensure proper garbage disposal as evidenced by garbage on the ground around the outside of the storage receptacles.

E Facility failed to properly store garbage in a covered dumpster for two days of the survey.

F386 Physician review resident's total program of care.

J Facility failed to ensure physician's signed orders timely and documented the date of their signature to verify the orders for one patient. The admission orders and five telephone orders were not signed timely. The facility failed to verify the medication orders with the physician, which resulted in an immediate jeopardy.

F406 Facility must provide or obtain specialized rehabilitative services.

G Facility failed to timely implement the person at risk meeting recommendation and physician orders for a speech therapy evaluation for one patient. This caused actual harm to the patient.

F411 Medicare patients must be provided with dental services.

D Facility failed to obtain dental services for one patient.

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

D Facility failed to address a drug order irregularity during a monthly medication reconciliation for one patient.

F431 Labeling of drugs & biologicals.

F Facility failed to ensure all medications and biological were labeled when opened, medications were not stored past their expiration date, and internal and external medications were not stored together in six medication rooms.

E Facility failed to ensure that medications were not stored past their expiration date; internal and external drugs were not stored together and chemicals were stored separately from medications in three medication rooms.

E Facility failed to ensure medications were not stored past their expiration date, internal and external medications were not stored together, and that chemicals were not stored with medications in three medication carts.

E Facility failed to ensure medications were dated when opened and failed to ensure external and internal medications and supplements were stored separately. Facility also failed to ensure the medication storage area was kept securely locked when not in use.

E Facility failed to ensure medications were stored properly and not stored past their expiration dates.

E Facility failed to provide locked storage of patients' medications on two medication carts.

D Facility failed to ensure one nurse observed administering medications did not leave medications at the bedside unattended.

D Facility failed to ensure all medications and biological were properly labeled when opened and stored in one medication storage area.

D Facility failed to ensure one medication nurse did not leave medication or the medication cart unlocked, unattended and out of the line of sight during medication administration.

D Facility failed to ensure two medication nurses did not leave medication unattended and out of their sight.

D Facility failed to provide proper medication storage as evidenced by medications being left on bedside table unattended and out of the nurses view, medication stored uncapped and opened and undated inhalers stored in two medication storage units.

D Facility failed to ensure one medication nurse did not leave medications unattended and out of their sight and/or failed to accurately monitor refrigerator temperatures or ensure medications were not stored past their expiration date in one medication room.

D Facility failed to dispose of expired medications in one medication storage room. There were 11 expired heparin syringes that had past their expiration date in the medication room.

D Facility failed to ensure proper storage of medication in one of four medication carts.

F441 Investigates, controls/prevents infections.

F Facility failed to ensure staff practices were consistent with current infection control principles to prevent cross contamination as evidenced by a resident in isolation being out in a common area. There were wash cloths and potty chair buckets sitting on the floor, clean linen on top of dirty linen barrels, standing dirty mop water in mop buckets in common showers, and an opened Foley catheter and a condom catheter hanging from the top of the closet.

F Facility failed to ensure that staff who have direct contact with the patients are free from communicable disease for five personnel files reviewed.

E Facility failed to ensure practices to prevent the potential spread of infection were maintained as evidenced by bed pans, wash basins, and towels on the floor in seven patient rooms.

E Facility failed to ensure practices to prevent the potential spread of infection were maintained by five staff members. They turned off the water with their bare hands.

E Facility failed to ensure practices to prevent the potential spread of infection and cross contamination were maintained when one dietary aide failed to perform hand hygiene and one nurse failed to disinfect a glucometer or a stethoscope prior to patient use.

E Facility failed to show evidence employees were free from communicable diseases for one personnel file. Facility failed to ensure practices to prevent the potential spread of infection were maintained when one staff member did not wash her hands while serving meals and one medication nurse placed a used glucometer in the
medication cart without proper sanitation.

E Facility failed to ensure staff prevent the potential spread on infection and cross contamination when two nurses failed to clean stethoscopes prior to checking feeding tube placement. One nurse also stored ointment without a cap. Oxygen tubing was left laying on the floor.

E Facility failed to ensure practices to prevent the spread of infection and cross contamination were maintained when laundry failed to use the proper detergent on three days of the survey and a CNA failed to practice good hygiene during personal care for one patient.

E Facility failed to ensure three nurses followed appropriate infection control practices to prevent cross contamination between patients during medication administration. One nurse failed to ensure soiled dressings were disposed of properly following a dressing change.

E Facility failed to ensure practices to prevent the potential spread of infection were maintained when four staff members failed to practice sanitary hand hygiene during dining and dressing change observations.

E Facility failed to ensure one staff member served food under sanitary conditions during dining. Four nurses failed to wash their hands and there was no evidence that the facility employees were free of communicable diseases.

E Facility failed to disinfect the accucheck machine with a Super Sani wipe to prevent the potential spread of infection.

E Facility failed to ensure practices to prevent the potential spread of infection were maintained when staff failed to wash their hands and/or placed a used meal tray back on the cart with a meal tray that had not been served.

D Facility failed to ensure one nurse disinfected the glucometer before and after performing an accucheck.

D Facility failed to maintain infection control practices to prevent the possibility of cross-contamination as evidenced by one nurse failing to empty and clean the nebulizer chamber and mouthpiece after use.

D Facility failed to ensure practices to prevent the potential spread of infection were maintained by four CNAs during dining and two nurses during medication administration.

D Facility failed to ensure one nurse observed administering medications properly disposed of biohazard material and/or failed to cleanse or rinse a used feeding syringe after use.

D Facility failed to ensure infection control practices for contact isolation were maintained during a dressing change for one patient.

D Facility failed to ensure food was served in a sanitary manner when two facility staff members touched inanimate objects, then touched food with bare hands without performing hand hygiene.

D Facility failed to provide evidence employees were free from communicable disease for one staff member hired. Facility failed to ensure practices to prevent the spread of infection and cross contamination were maintained when one CNA handled food with bare hands without performing hand hygiene.

D Facility failed to administer medications in a sanitary manner for one of four nurses observed for medication administration, failed to prevent contamination of catheter tubing while ambulating for one of three patients with a catheter, and failed to provide sanitary catheter care for one patient.

D Facility failed to ensure one nurse disinfected the glucometer before and after performing an accucheck.

D Facility failed to ensure staff maintained standard precautions to prevent the spread of infection and failed to follow facility policy for proper hand-washing and clean dressing change of a feeding tube insertion site for one patient.

F456 Sufficient space & equipment maintenance.

D Facility failed to maintain patient care equipment in safe working order. There was electrical tape holding the shower chairs together.

F460 Full visual privacy in room design.

E Facility failed to ensure full visual privacy could be maintained in 15 rooms. There were missing hooks on the privacy curtains.

D Facility failed to maintain full visual privacy for patients.

F463 Resident call system.

D Facility failed to ensure the call system was functioning in one whirlpool room.

D Facility failed to ensure there was an operational patient call light system in one patient room. The call light was not working.

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

F Facility failed to maintain a clean and sanitary environment for patients and staff in four shower rooms.

E Facility failed to ensure the environment was clean, sanitary and/or free of odors in one shower room and three halls.

E Facility failed to ensure common areas in the facility were safe, clean and sanitary as evidenced by odors on two halls, dirty base boards, dirty window sills, dirty cabinets and missing knobs. There were cracked tiles, a beside table with nail clippers present, clothing in the bath tub, bowl of oatmeal on the table, missing floor tiles, peeling paint in one shower room.

E Facility failed to ensure the environment was clean, sanitary and free of odors on four halls and the main entrance.

D Facility failed to ensure one shower room was safe, sanitary and in good repair. There were chipped and cracked shower tiles in the stall.

D Facility failed to ensure the common areas were clean and sanitary on one halls and one bathroom on the second floor of the building.

D Facility failed to maintain a clean and sanitary environment at the front entrance. There was a presence of stale urine odor.

F468 Corridors equipped with hand rails.

E Facility failed to provide firmly secured handrails on two halls.

D Facility failed to ensure that handrails were firmly secured on one hall.

F469 Effective pest control.

E Facility failed to ensure it was free of pests as evidenced by flies on three halls.

D Facility failed to ensure the environment was free of insects in one short hall bathroom across from the activity common bathrooms.

D Facility failed to provide an environment free of insects as evidenced by ants in patient rooms.

D Facility failed to ensure the facility was free from pests as evidenced by flies in three patient rooms.

F490 Administration.

K Facility failed to consistently follow a systematic process to thoroughly investigate and/or report to administration allegations of abuse and neglect for three patients resulting in an IJ.

F497 Regular in-service education.

D Facility failed to ensure performance evaluations were done annually for one CNA.

F498 Proficiency of nurse aides.

D Facility failed to ensure one CNA demonstrated competency in bathing of one patient.

F500 Use of outside resources.

D Facility failed to obtain a written agreement with the outside dialysis facility to ensure the dialysis facility met professional standards, principles and timeliness of dialysis services for one patient.

F501 A physician must be designated as medical director.

J Facility medical director failed to coordinate medical care in the facility, provide clinical guidance and oversight, and assist in identifying and addressing medical and clinical concerns of patient care. The medical director also failed to assist in the development, implementation, and evaluation of resident care policies and procedures to address medication or transcription errors.

F502 Provide or obtain clinical laboratory services.

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

D Facility failed to perform laboratory testing as ordered by the physician for one patient.

F505 Promptly notify physician of findings of lab results.

J Facility failed to promptly notify the physician of abnormal, critically low, and critically high laboratory results for two patients. This failure resulted in immediate jeopardy for one patient with a critically low blood sugar result.

D Facility failed to promptly notify the physician of an abnormal urinalysis laboratory test result for one patient identified with abnormal lab results.

F507 Filing results of lab tests.

J Facility failed to ensure laboratory test results of a basic metabolic panel was available for clinical management for one patient. This resulted in immediate jeopardy for one patient.

F514 Criteria for clinical records.

J Facility failed to maintain a complete and accurate medical record resulting in a delay of care and immediate jeopardy.

J Facility failed to maintain clinical records on each patient in accordance with accepted professional standards and practices to ensure the record was complete and accurate for three patients. This failure resulted in immediate jeopardy for the patients.

D Facility failed to maintain an accurate medical record for two patients.

D Facility failed to ensure behavior records were complete for monitoring behaviors for one patient.

D Facility failed to ensure the accuracy of documentation in the medical record for three patients.

D Facility failed to document a shower or bath for the month of June for one patient.

D Facility failed to ensure a medical record had accurate documentation of a right elbow wound for one patient.

F517 Emergency/disaster plans.

F Facility failed to ensure emergency food supplies were on hand at all times as evidenced by expired foods in the emergency food supply.

F518 Emergency training.

K Facility failed to ensure staff were knowledgeable of the requirements of what to do when a patients was discovered missing nor were they aware of the facility's elopement code which resulted in an IJ.

F519 Transfer agreements.

F Facility failed to obtain a transfer agreement with a hospital to ensure timely admission to the hospital if/when the transfer is medically appropriate.

F520 Quality assessment & assurance.

K Facility quality improvement committee failed to identify and address identified concerns for three patients resulting in an IJ.

J Facility quality assurance committee failed to establish and implement a method of identifying concerns, identified and implement plans of actions to correct identified concerns of medication and transcription errors, and ensure patients were not administered unnecessary medications.

F Facility quality assurance committee failed to identify issues related to quality of life for patients and to develop and implement appropriate plans of action to correct identified quality of life for patients and to develop and implement appropriate plan of action to correct identified quality of life deficiencies. The facility failed to provide housekeeping and effective maintenance services to maintain a sanitary, orderly and comfortable environment.

K017 Corridors Separated With Fire Walls

D Facility failed to prohibit the passage of smoke. One floor linen closet door did not close within the frame and door knob was loose.

K018 Construction of Doors

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

E Facility had installed devices on doors which prevented the closing of the doors.

E Facility failed to maintain the corridor openings. One patient room door required more than 15 pounds of force to open the door.

D Facility failed to maintain all doors to resist the passage of smoke. The oxygen storage room door would not latch.

D Facility failed to maintain all doors to resist the passage of smoke. Several doors did not latch when closed.

D Facility failed to maintain corridor door openings in accordance with NFPA 101. The housekeeping closet door mechanism had tape across it preventing the door from closing and latching.

D Facility failed to ensure the medical records room door closed tightly in the frame.

D Facility failed to maintain the corridor openings in the laundry area and two patient rooms.

K021 Automatic Closing Doors

D Facility failed to maintain self-closing doors. The employee dining room exit door did not close within the door frame.

K025 Smoke Partition Construction

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

E Facility failed to maintain the smoke barriers NFPA 101. There was a penetration around a copper pipe in the sheet rock.

K027 Doors In Smoke Barriers

D Facility failed to maintain clearance at all automatic self-closing doors.

D Facility failed to maintain smoke barriers doors on one corridor. The hall door was held open with wooden wedges.

D Facility failed to install self-clsoing devices on all smoke barrier doors.

K029 Hazardous Areas Separated By Construction

D Facility failed to maintain one hour fire walls in hazardous areas.

D Facility failed to install self-closing devices on all smoke barrier doors per NFPA. There was no closure on the housekeeping storage room.

K033 Exit Partitions - Fire Walls

E Facility failed to enclose five exit stairways with a one hour fire wall construction.

K038 Exit Accessible At All Times

D Facility failed to maintain one door equipped with a magnetic locking device to unlock in 15 seconds.

D Facility failed to maintain the exits. The exit door did not have the correct signage to explain the 15 second delay.

D Facility failed to provide an exit access that was readily accessible at all times. One exit door required considerable force to open due to the door dragging on the threshold.

D Facility failed to maintain exit access. The exit door in the main dining area was locked.

K045 Exit Lighting

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

D Facility failed to provide required illumination at all exit discharges.

K046 Emergency Lighting

D Facility failed to maintain two of three battery back up emergency lights in the kitchen.

K047 Exit Signs

E Facility failed to provide exit signs to indicate the direction of egress.

K050 Fire Drills

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

K051 Fire Alarm System

E Facility failed to install and arrange the fire alarm system components in accordance with NFPA 72.

K052 Testing of Fire Alarm

E Facility failed to maintain all smoke detectors in the upstairs ceiling and failed to install a smoke detector in the central supply room on hall one as required.

D Facility failed to maintain all fire alarm components according to National Fire Protection Association 72,1-5.4.6. When one of the phone lines was disconnected the trouble signal was not received at the remote annunciator at the nurses station.

D Facility fire alarm system was not installed according to NFPA 72. Smoke detectors had been installed within 36 inches of the air vent.

K054 Smoke Detector Maintenance

D Facility failed to provide sensitivity testing on the smoke detectors.

K062 Automatic Sprinkler - Maintenance

- F Facility failed to maintain and test a complete automatic sprinkler system. The obstruction investigation which is required every five years was not done.
- F Facility failed to have the 10-year dry sprinkler testing/replacement performed in accordance NFPA 25.
- E Facility failed to maintain all sprinkler systems components.
- E Facility failed to maintain all components of the sprinkler system.
- E Facility failed to maintain all sprinkler components. There was a build-up of dirt and lint.
- D Facility failed to maintain the required number of spare sprinkler heads inside the sprinkler head box. (Never fewer than six dependent on the total number of sprinkler heads in the building.)
- D Facility failed to maintain all sprinkler heads in the kitchen. There was a heavy build-up of lint on the sprinkler heads.
- D Facility failed to maintain fire suppression sprinkler heads in the laundry dryer room.
- D Facility failed to maintain clearance below all sprinkler heads in two rooms.
- D Facility failed to conduct the required inspections on the sprinkler system.

K064 Portable Fire Extinguishers

- E Facility failed to do monthly inspections on portable fire extinguishers.
- D Facility failed to have the fire extinguishers inspected monthly.
- D Facility failed to maintain one fire extinguisher in one hall.

K066 Smoking Regulations

- D Facility failed to provide a metal container with self-closing lid in the smoking area.
- D Facility failed to provide the required equipment in smoking areas.

K067 Ventilating Equipment

- F Facility failed to maintain all fused link fire dampers.
- E Facility failed to provide constant air circulation to maintain ventilation in five patient rooms.
- E Facility failed to maintain building service equipment. The patient bathroom exhaust fans were not all operational.
- E Facility failed to maintain the HVAC system. There was no negative air unit in the area.
- E Facility failed to install fire dampers in fire rated assemblies. This was evident in the exhaust in physical therapy, the return air in a mechanical room, and the supply air in the dry storage area and kitchen.

D Facility failed to provide ventilation in all required areas.

D Facility failed to provide constant air circulation in three patient rooms.

D Facility failed to provide constant air circulation in three patient rooms. The HVAC system was turned off and that was the only source of air exchange in the room.

D Facility failed to provide inspection and maintenance for the fire dampers every four years as required.

D Facility failed to provide inspection and maintenance to fire dampers every four years as required.

D Facility failed to maintain the HVAC. The exhaust fans in some rooms were not functioning.

C Facility failed to provide constant air circulation in 36 of 37 patient rooms. The fan function was turned off on the HVAC systems.

K069 Commercial Cooking Equip. Meets Requirements

F Facility failed to conduct inspections of the kitchen suppression system every six months.

D Facility failed to provide the upblast fan for the kitchen exhaust system with the required safety components and cleaning access requirements.

K070 Space Heaters

D Facility failed to prohibit the use of portable space heaters.

K072 Furnishings and Decorations

D Facility failed to maintain a means of egress free of impediments.

D Facility failed to maintain egress free of all furnishings.

K074 Combustible Curtains

D Facility failed to limit decorations. In one room there was excessive combustible materials attached to the walls.

K076 Nonflammable Medical Gas Systems

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

K104 Penetration of Smoke Barriers

E Facility failed to maintain all smoke barrier walls.

D Facility failed to maintain all rated assemblies. There were open junction boxes.

D Facility failed to label medical gas lines in two stairways.

D Facility failed to maintain the smoke barriers.

K130 Other LSC Deficiency Not On 2786

D Facility failed to maintain the fire barriers. There were penetrations around the conduit.

D Facility failed to secure all oxygen cylinders.

D Facility failed to provide constant air circulation in four patient rooms.

D Facility failed to maintain the fire barrier. There was a penetration in the fire wall of the sprinkler riser room.

D Facility installed an unapproved lock on the egress door on hall one.

K144 Generators

F Facility failed to maintain a complete emergency generator power supply with battery back-up task illumination.

E Facility failed to maintain the emergency generator power supply.

D Facility failed to maintain the emergency generator in accordance with NFPA 110. There was no generator annunciator.

D Facility failed to test all generator components.

D Facility failed to test all generator components. The specific gravity for the generator batteries is not being tested and documented monthly.

K147 Electrical Wiring and Equipment

F Facility failed to maintain all electrical wiring and components.

F Facility failed to maintain all electrical wiring and components. The hot and neutral wires were reversed.

F Facility failed to maintain all electrical wiring and components. There were multiple electrical boxes that were missing covers.

E Facility failed to maintain the electrical system. The circuit breaker unit was found to be non- operational in the beauty shop.

D Facility failed to maintain all electrical components in the conference room, two patient rooms and the clean linen room.

D Facility failed to prohibit the use of electrical adapters as a substitute for fixed wiring to provide power to medical equipment or other appliances for permanent use in two patient rooms.

D Facility failed to prohibit the use of electrical adapters as a substitute for fixed wiring to provide power to medical equipment or other appliances for permanent use.

D Facility failed to install GFIC interrupters within six feet of water sources.

D Facility failed to prohibit the use of extension cords in one room.

D Facility failed to install ground fault circuit interrupters (GFCI) within six feet of all sinks.

D Facility failed to maintain the electrical equipment. There were daisy chained power strips being used.

D Facility failed to maintain the electrical equipment. There was a daisy-chain in the central supply room and one junction box was missing in a storage room.

D Facility failed to prohibit the use of electrical adapters as a substitute for fixed wiring to provide power for medical equipment in three patient rooms.

D Facility failed to maintain the electrical equipment NFPA 70. There was a ceiling light fixture with a broken cover.

D Facility failed to maintain the electrical equipment in two halls and one patient room. There was no cover for the junction box.

K211 Alcohol Based Hand Rub Dispensers

D Facility installed alcohol hand rub dispensers adjacent to an ignition source.

N1207 Resident Rights

Facility staff failed to ensure allegations of abuse and elopement from the facility were thoroughly investigated and/or reported to administration for one patient. This resulted in an IJ.

N1405 Disaster Preparedness; Physical Facility and Community Emergency Plans

Facility had no written disaster plans.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

Facility failed to provide documentation of an earthquake drill conducted for all staff.

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

Facility failed to conduct and evaluate tornado, flood, and earthquake drills for all staff and all shifts for 2014.

Facility failed to conduct annual tornado, flood or earthquake drills.

Facility failed to conduct external disaster drills. The facility was unable to provide documentation of annual tornado, flood and earthquake drills.

N1411 Disaster Preparedness; Fire Safety Drills

Facility failed to conduct annual bomb threat drills.

Facility failed to conduct internal disaster drills. There was no documentation of an annual bomb threat.

N401 Administration

Facility failed to consistently follow a systematic process to thoroughly investigate and/or report to administration allegations of abuse and neglect for three patients resulting in an IJ. This was a type A suspension of admissions.

N424 Administration; Filed Documentation of Abuse Registries

Facility failed to consistently follow a systematic process to thoroughly investigate and/or report to administration allegations of abuse and neglect for three patients resulting in an IJ.

N601 Performance Improvement Program

Facility quality improvement committee failed to identify and address identified concerns for three patients resulting in an IJ.

Facility quality assurance committee failed to establish and implement a method of identifying concerns, identified and implement plans of actions to correct identified concerns of medication and transcription errors, and ensure patients were not administered unnecessary medications.

N611 Physician Services; Dental Services

Facility failed to obtain dental services for one patient.

N616 Physician Services; Medical Director

Facility medical director failed to coordinate medical care in the facility, provide clinical guidance and oversight, assist in identifying and addressing medical and clinical concerns of patient care. The medical director also failed to assist in the development, implementation, and evaluation of resident care policies and procedures to address medication or transcription errors.

N629 Infection Control; Disinfect Contaminated Items

Facility failed to ensure one nurse disinfected the glucometer before and after performing an accucheck. This was type C pending penalty.

Facility failed to maintain infection control practices to prevent the possibility of cross-contamination as evidenced by one nurse failing to empty and clean the nebulizer chamber and mouthpiece after use.

Facility failed to ensure practices to prevent the potential spread of infection and cross contamination were maintained when one dietary aide failed to perform hand hygiene and one nurse failed to disinfect a glucometer or a stethoscope prior to patient use.

Facility failed to ensure one of four nurses disinfected a stethoscope prior to checking a feeding placement tube. This was a type C pending penalty.

Facility failed to ensure one nurse disinfected a stethoscope before and after use.

Facility failed to disinfect the accucheck machine with a Super Sani wipe to prevent the potential spread on infection. This was a type C pending penalty.

N645 Nursing Services

Facility failed to ensure the patient's environment was clean and sanitary as evidenced by odors, dirty or stained floors, rusty door facings, dirty walls, chipped floor tiles, dark, black buildup around toliets, and a broken towel rack in resident bathrooms.

Facility failed to ensure the environment was free of accident hazards. There were unsecured razors and chemicals on one hall. This was a sub-standard quality of care. This was a type C pending penalty.

Facility failed to ensure common areas in the facility were safe, clean and sanitary as evidenced by odors on two halls, dirty base boards, dirty window sills, dirty cabinets and missing knobs. There were cracked tiles, a beside table with nail clippers present, clothing in the bath tub, bowl of oatmeal on the table, missing floor tiles, peeling paint in one shower room.

Facility failed to properly secure stored chemicals on one hall.

Facility failed to provide effective housekeeping and maintenance services to maintain a sanitary environment as evidenced by odors in some patient rooms.

Facility failed to ensure one shower rooms was safe, sanitary and in good repair. There were chipped and cracked shower tiles in the stall.

Facility failed to provide a clean environment as evidenced by scuffed walls, dirty floors along the baseboards, crumbling window sills, peeling paint over the air conditioning units, a large area of white putty-like material that was not finished beside the sink.

Facility failed to ensure the facility was clean and sanitary as evidenced by dirty commode area and urine odors in one patient room and bathroom. This was a type C pending penalty.

Facility failed to ensure the environment was free from accident hazards as evidenced by unsecured toxic substance in one bathroom.

N653 Nursing Services; Coordination of Nursing Services

Facility failed to provide sufficient linen to meet the needs of the patients. This was a type C pending penalty.

N669 Nursing Services; Physician Notification

Facility failed to timely assess and notify the physician of edema of the right arm which resulted in a delay of treatment, actual harm, neglect and placed one patient in immediate jeopardy with a deep vein thrombosis (DVT).

Facility failed to notify the physician or family of a significant unplanned weight loss for one patient. This resulted in actual harm to the patient. This was a type C pending penalty.

Facility failed to notify the physician of a significant weight loss for one patient.

Facility failed to promptly notify the physician of a significant change in status for one patient. The facility failed to promptly notify the physician of the onset of seizure like activity and critical low blood sugar results which resulted in the patient being hospitalized.

N682 Pharmaceutical Services; Storage of Medications

Facility failed to follow the care plan interventions for monitoring a patient's skin and reporting change of conditions to the physician, complete wander guard checks and ensure a bed alarm for three patients. This resulted in immediate jeopardy.

N689 Nursing Services; Physical Restraints

Facility failed to appropriately assess and timely notify the physician of swelling of the right arm, for one patient who was at high risk for DVT, resulting in a delay of care when the patient did develop the DVT. This resulted in an IJ.

N727 Pharmaceutical Services

Facility failed to ensure that medications were not stored past their expiration date; internal and external drugs were not stored together and chemicals were stored separately from medications in three medication rooms. This was a type C pending penalty.

Facility failed to ensure one nurse observed administering medications did not leave medications at the bedside unattended.

Facility failed to ensure medications were not stored past their expiration date, internal and external medications were not stored together, and that chemicals were not stored with medications in three medication carts. This was a type C pending penalty.

Facility failed to ensure medications were dated when opened and failed to ensure external and internal medications and supplements were stored separately. Facility also failed to ensure the medication storage area was kept securely locked when not in use.

Facility failed to ensure internal and external medications were not stored together in one medication storage area.

Facility failed to provide proper medication storage as evidenced by the medications being left on bedside table unattended and out of the nurses view, medication stored uncapped and opened and undated inhalers stored in two medication storage areas.

Facility failed to ensure one medication nurse did not leave medications unattended and out of her sight.

N728 Basic Services; Pharmaceutical Services

Facility failed to ensure the medication storage area was kept securely locked when not in use. This was a type C pending penalty.

Facility failed to ensure one medication nurse did not leave medications or the medication cart unlocked, unattended and out of the line of sight during medication administration. This was a type C pending penalty.

Facility failed to ensure two medication nurses did not leave medication unattended and out of their sight. This was a type C pending penalty.

N765 Food and Dietetic Services; Freezer Temperature

Facility failed to ensure proper sanitation and food handling practices were followed, as evidenced by failure of staff to wash hands between the handling of dirty and clean dishes, and by carbon build-up on the cookware. This was a type C pending penalty.

Facility failed to ensure that food was stored and protected from sources of contamination in the kitchen as evidenced by dietary staff not wearing hair covering, food stored past the expiration date and carbon build-up on the skillet. This is type C pending penalty.

Facility failed to ensure that opened food was dated when stored; ice scoops, thermal plates and covers were stored under sanitary conditions and hot food was served at 135 degrees F or above.

Facility failed to ensure food was stored in a sanitary manner when refrigerators did not have a thermometer present; contained an open and unlabeled drink or was in disrepair for two refrigerators.

Facility failed to ensure food was stored, prepared and distributed under sanitary conditions as evidenced by staff not wearing hair and beard covers, and dirty hand washing sink used for hand washing by dietary staff. There was also moisture and food particles on stacked plates, utility carts and inside microwave.

Facility failed to ensure food was prepared and served in a sanitary manner when one dietary staff member in the skilled kitchen touched and inanimate object and then touched food without performing hand hygiene.

Facility failed to ensure food was prepared in a sanitary manner when one dietary staff member prepared food with facial hair uncovered. There was also a pink substance on the ice guard. Two nurses touched patients' food with bare hands. This was a type C pending penalty.

Facility failed to ensure food was prepared, distributed or served under sanitary conditions when one staff member failed to wash hands during meal service and a delivery man failed to wear a hair net in the kitchen. This was a type C pending penalty.

Facility failed to ensure food was delivered under sanitary conditions when CNAs placed a meal tray on a bedside table in a patient room, and then retuned the meal tray back to the cart with meal trays not yet served during a meal service. This was a type C pending penalty.

Facility failed to protect the patients' food from possible contamination as evidenced by a dirty stove and oven, food not labeled and dated, staff not wearing beard covers and hair not completely covered.

Facility failed to ensure food was prepared under sanitary conditions as evidenced by a mixer with peeling paint and carbon build-up on cooking utensils.

Facility failed to ensure food was protected from sources of contamination when one CNA and two dietary workers failed to wash hands or failed to ensure hair was covered during the food service.

N767 Food and Dietetic Services; Written Policies and Procedures

Facility failed to ensure food was prepared and served under sanitary conditions as evidenced by pans with carbon build up and grease build up.

Facility failed to ensure that opened food was dated when stored; ice scoops, thermal plates and covers were stored under sanitary conditions and hot food was served at 135 degrees F or above.

N770 Food and Dietetic Services; Dish Sanitation

Facility failed to ensure kitchen equipment was cleaned after use, food was not left in the drain of the sink, there was proper sanitizer in the three compartment sink and the dish machine and frozen food was stored in an air tight container.

N773 Food and Dietetic Services; Refridgerator/Freezer Thermometers

Facility failed to ensure food was stored in a sanitary manner when refrigerators did not have a thermometer present; contained an open and unlabeled drink or was in disrepair for two refrigerators.

N780 Social Work Services

Facility failed to effectively implement new interventions for treating wandering behaviors, exit seeking behavior with an elopement and to prevent on patient from wandering into another patient's room resulted in an IJ.

N831 Building Standards

Facility failed to prohibit all bolt action slide locks in patient areas. On bathroom door in a patient room had a slide action bolt lock installed to prevent entry from the bathroom into his room.

Facility failed to follow all safety policies for the protection of the facility and the patients.

Facility failed to ensure the night lights were working on two halls and the bathroom vent fans were not operative in two halls.

Facility failed to maintain the overall nursing home environment assuring the well-being of the patients. There were several areas in the facility that required housekeeping interventions.

Facility failed to maintain the overall nursing home environment. The hand railing throughout the facility was loose. There was a water faucet that was loose.

Facility failed to provide constant air circulation in all patient rooms.

Facility failed to maintain the overall nursing home environment. There was a hole in the fire wall.

Facility failed to maintain the condition of the physical plant and the overall nursing home environment in the laundry room.

Facility failed to ensure air return ducts were maintained in accordance with NFPA 90A.

N843 Building Standards; New Construction and Renovation

Facility failed to ensure the call system was functioning in one whirlpool room.

Facility failed to comply with applicable codes. There was a multi-plug adaptor in use and a broke ground plug on the hair dryer in the beauty shop.

N848 Building Standards; Exhaust & Air Pressure

Facility failed to maintain negative air pressure in dirty areas and positive air pressure in clean areas.

Facility failed to maintain negative pressure in designated areas. The kitchen mop closet has positive pressure.

Facility failed to maintain negative air pressure. The housekeeping closet door will not close within the door frame.

Facility failed to maintain negative pressure where required. The biohazard room had positive pressure.

N901 New Code Compliance

Facility failed to comply with the life safety codes as required. The bulb was burned out of the exit sign at the service ramp.

Facility failed to maintain applicable building and fire safety codes. There was an electrical outlet that was loose from the wall.