Survey Deficiency Summary

13 Facilities Surveyed **Surveys Taken 03/11/2014-05/31/2014**

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

D Facility failed to provide the appropriate liability and appeal notice for two patients for the termination of Part A skilled services from Medicare.

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

J Facility failed to immediately notify the physician of the incorrect placement of a pressure prevention device that resulted in a deep tissue injury (DTI). Facility failed to immediately notify the physician of a change in the patient's condition, failed to notify the physician of a delay in the placement of a peripherally inserted central catheter line and failed to immediately notify the physician of oral and intravenous antibiotics not administered as ordered. This failure resulted in one patient with a diagnosis of peripheral vascular disease developing a stage IV pressure ulcer and placed the patient in immediate jeopardy.

E Facility failed to notify the physician of falls for three patients with falls.

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

E Facility failed to ensure patients receiving Medicaid, trust fund balances did not exceed the Supplemental Security Income (SSI) limit for seven patients.

F203 Notice before transfer or discharge.

D Facility failed to issue a 30-day discharge notice prior to discharge for one patient.

F205 Notice of bed-hold policy & readmission.

D Facility failed to issue the facility's bed hold policy upon hospital transfer to one patient.

F225 Facility must not hire person with abuse history.

E Facility failed to ensure allegations of abuse were reported timely to the facility administration and/or state licensure and certification agency for two patients.

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

E Facility failed to implement it's policy for immediately reporting allegations of abuse to the administration of the facility and failed to report an allegation abuse to the state licensure and certification agency for two patients.

D Facility failed to follow their abuse policy by not having obtained an abuse registry check at hire for two licensed practical nurses (LPNs).

D Facility failed to implement the abuse policy for one patient. A full investigation had not been completed when a patient alleged abuse.

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

D Facility failed to ensure dignity during lunch dining for one patient and failed to maintain the dignity of one patient with an indwelling urinary catheter. The first patient's meal was interrupted during lunch to administer medications. The catheter bag had not been covered for the second patient.

D Facility failed to maintain dignity during meals for one patient. The staff member was standing over the patient feeding them, rather than sitting next to them.

D Facility failed to promote care in a manner and environment that maintained dignity for one patient. The patient had a urinary catheter bag exposed and visible from the hallway with no privacy cover in place.

D Facility failed to maintain dignity during dining for one patient. The dietary manager placed a clothing protector on the patient while speaking to another patient.

D Facility failed to ensure dignity was maintained by a staff member who was standing, not sitting beside, while assisting the patient to eat.

F246 Right to accommodations of individual needs & preferences.

D Facility failed to accommodate the needs of patients by ensuring the water temperatures were comfortable for three of the patients. The hot water temperatures were 95 degrees F or less.

F253 Housekeeping & maintenance services.

F Facility failed to accommodate the needs of patients by assuring the water temperatures were comfortable for three of the patients. The hot water temperatures were 95 degrees F or less.

F256 Adequate & comfortable lighting levels.

E Facility failed to ensure there was adequate lighting in five patient bathrooms. Several of the light bulbs were burned out.

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

D Facility failed to accurately assess an active diagnosis and medications for one patient. The MDS did not identify that the patient had a psychotic disorder and was receiving antidepressant medications.

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

D Facility failed to develop a care plan to reflect measurable and appropriate fall interventions and/or limitations in range of motion (ROM).

D Facility failed to develop a care plan to address pneumonia and a urinary tract infection for one patient.

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

D Facility failed to develop a care plan to address the fluid restriction for one patient.

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

E Facility failed to revise the care plan with measurable and appropriate interventions for falls for three patients.

D Facility failed to revise the care plan for one patient. The patient had been diagnosed and was being treated for a urinary tract infection (UTI) and it had not been care planned.

D Facility failed to revise the care plan for one patient. The patient was receiving two blood thinners but the care plan stated that the blood thinners had been discontinued.

F281 Services must meet professional standards of quality.

D Facility failed to provide necessary equipment in a timely manner for one patient; failed to provide medications in a timely manner for two patients; and failed to correctly document medication administration for one patient.

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

F282 Services must be provided by qualified persons.

J Facility failed to follow the care plan interventions for Coumadin therapy or sheep skin to chair arms for two patients. The failure of the facility to follow the care plan interventions by not obtaining a PT/INR laboratory test for monitoring a bleeding study as ordered placed one patient in immediate jeopardy.

J Facility failed to ensure all nursing staff were trained and competent in the correct use of a pressure preventative device in accordance with the patient's care plan for one patient. This failure resulted in one patient being placed incorrectly in an offloading heel elevator. It was under the patient and the development of a stage IV pressure ulcer occurred causing immediate jeopardy to that patient.

D Facility failed to follow the care plan to facilitate dialysis communication for one patient. The intervention for the problem of lack of communication between the dialysis center and the facility was to send a communication sheet with each visit to allow communication between the staff and the clinic. This had not been done.

D Facility failed to follow the care plan for one patient. The patient's nails had not been cleaned and she was feeding herself.

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

K Facility failed to educate the staff on Coumadin; failed to document the parameters of the desired therapeutic range of the PT/INR with instructions on when to hold the dose on the physician orders per the policy; and failed to appropriately obtain and monitor the PT/INR laboratory test used to determine therapeutic levels for blood thinning medication. Facility failed to obtain a PT/INR laboratory result as ordered by the physician and the pharmacy failed to identify and notify the facility for potential drug interactions related to Coumadin therapy. This failure placed the patients in the facility in immediate jeopardy.

J Facility failed to place peripherally inserted central catheter line (PICC) timely and failed to administer oral and intravenous antibiotics as ordered for one patient. This failure placed the patient in immediate jeopardy.

D Facility failed to document a daily blood pressure for three days when ordered.

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

D Facility failed to provide nail care for one patient. The patient had long jagged fingernails.

D Facility failed to ensure showers were provided for two patients.

D Facility failed to provide nail care for one patient. The patient's nails were dirty.

F314 Resident does not develop pressure sores.

J Facility failed to ensure training and competency of nursing staff in the correct placement of a pressure prevention device, failed to assess and monitor the new development of a stage I pressure ulcer, and failed to place a PICC timely. The facility failed to administer oral and IV antibiotics as ordered for one patient and failed to ensure accurate assessments and pressure ulcer staging for one patient. These failures resulted in immediate jeopardy to the patient.

F315 Incontinent resident receives appropriate treatment and services.

D Facility failed to complete a bladder assessment for one patient.

F318 Range of motion.

D Facility failed to ensure measures were implemented to prevent further decrease in range of motion (ROM) for one patient.

F322 Tube feeding/prevention.

D Facility failed to check placement of a feeding tube for one patient and failed to flush a feeding tube prior to administering medication for one patient.

F323 Accident hazards.

L Facility failed to ensure the environment was free from accident hazards when hot water temperatures were measured between 120 to 132.8 degrees Fahrenheit (F) in 26 patient rooms. This failure placed the patients in immediate jeopardy and sub-standard quality of care.

K Facility failed to ensure the environment was safe and free of accident hazards by failing to implement new, appropriate and measurable interventions after falls, failing to document neurological checks after falls, failing to complete post fall assessment/investigations and failing to notify physicians of falls for four patients. This failure placed the patients in immediate jeopardy.

E Facility failed to ensure potentially hazardous chemicals were stored in a safe, secure manner and failed to ensure equipment was safe for one patient. The door was unlocked to the biohazard room and a can of spray buff was available for patients to reach. One of the patient wheelchairs had the arm rest duct taped to the chair with a loose sharp edge.

D Facility failed to ensure a safety device was in place to protect the skin for one patient. Geri-sleeves were not in place as ordered.

D Facility failed to adequately provide supervision to prevent elopement for one patient.

F332 Facility medication error rates of 5% or more.

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

F333 Residents free of significant medication errors.

J Facility failed to ensure oral and IV antibiotics were administered as ordered for one patient. This caused immediate jeopardy for the patient.

D Facility failed to prevent the administration of an anticoagulant after the medication had been discontinued for one patient.

F371 Store, prepare, distribute, & serve food.

F Facility failed to ensure that food was protected from sources of contamination in the kitchen as evidenced by carbon build-up, expired foods in the refrigerator, beard not fully restrained and lack of sanitation in the three compartment sink and dish machine.

F Facility failed to provide sanitary conditions in the reach-in cooler and dry storage room of the dietary department. There were opened and unlabeled food items as well as supplement products which had expired.

F Facility failed to provide sanitary conditions in one of two dry food storage areas of the dietary department and in the refrigerator of one patient pantry.

F Facility failed to ensure employees in the food preparation area wore hairnets to prevent contamination of the patients food. One employee's bangs were not secured in the net and two male employees had beards that were not covered.

F Facility failed to contain the hair of one of seven staff members preparing meals. Facility failed to maintain the sanitary equipment in the food preparation area and failed to label food in one walk-in coolers in the dietary department. Facility failed to cover food during tray service for four wings.

F372 Disposes of garbage & refuse.

C Facility failed to maintain sanitary conditions for two of two dumpsters in the garbage area. There was multiple items of debris scattered around the base of both dumpsters.

F385 Physician services.

J Facility failed to ensure the physician monitored for changes in the medical condition of a patient by obtaining and monitoring the PT/INR laboratory test used to determine therapeutic levels for a blood thinning medication for one patient. This failure placed the patient in immediate jeopardy.

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

J Facility failed to ensure the pharmacy consultant identified and notified the facility for potential drug interactions for one patient receiving Coumadin. This failure placed the patient in immediate jeopardy.

F431 Labeling of drugs & biologicals.

F Facility failed to ensure medications were dated when opened, not stored past their expiration date, stored in their proper containers and stored securely in five medication storage areas.

D Facility failed to ensure all medications and biologicals were labeled when opened and not stored past their expiration date in one medication storage room.

F441 Investigates, controls/prevents infections.

F Facility failed to ensure practices to prevent the potential spread of infections were maintained during disposal of sharps by two nurses performing blood glucose checks by finger sticks. The facility failed to ensure the infection control program identified, investigated and prevented the spread of infections for six months.

F Facility failed to sanitize the hands while passing the meal trays for three hallways. Facility failed to ensure isolation procedures were followed for one room with two patient and failed to properly store clean linen on four halls. Facility failed to provide sanitary storage of linens in one linen closet and failed to ensure one bed scale was clean. Facility failed to ensure one ice chest was not contaminated in the main dining room.

D Facility failed to ensure containers containing biohazard waste were securely closed/sealed in biohazard room.

D Facility failed to maintain an environment to prevent cross contamination. The housekeeper was cleaning a room with the patient out of the room, however, the oxygen mask and cannula were both exposed to the dust rather than being covered and stored in the drawers as policy required.

D Facility failed to follow the infection control policy for contact isolation for one patient and failed to follow standard universal precautions for one patient.

D Facility failed to maintain infection control during meal service for one patient. The CNA touched the patient's bread with bare hands to put butter on it.

D Facility failed to serve food in a sanitary manner for two of three meals. The CNA held bread with her bare hands to butter it for the patient.

D Facility failed to provide signage for isolation for one patient.

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

F Facility failed to maintain tiles in a safe and sanitary manner for three of four shower rooms observed.

D Facility failed to provide maintenance services for deteriorating walls in one patient room. The wallpaper in one room was hanging off the wall and black debris was observed on the sheetrock behind the wallpaper.

F490 Administration.

L Facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to maintain the highest practicable physical and psychosocial well-being by failing to educate the staff on Coumadin; failing to document the parameters of the desired therapeutic range of PT/INR and failing to obtain and monitor the PT/INR. There was also a failure to ensure the pharmacy consultant notified the facility of drug interactions. These failure resulted in immediate jeopardy for the residents. The facility also failed to ensure that hot water temperatures in the patient rooms were within safe parameters.

K Facility failed to be administered to ensure the environment was safe and free of accident hazards by failing to implement new, appropriate and measurable interventions after falls, failing to document neurological checks after falls, failing to complete post fall assessment/investigations and failing to notify physicians of falls for four patients. This failure placed the patients in immediate jeopardy.

F498 Proficiency of nurse aides.

J Facility failed to ensure training and competency of CNAs in the correct placement of a pressure prevention device for one patient. This resulted in an immediate jeopardy situation for the patient.

F514 Criteria for clinical records.

D Facility failed to maintain a complete and accurate medical record for two patients. The patients were to have vital signs daily and nursing assessment of drainage tubes. This was not documented as done.

D Facility failed to accurately transcribe a medication order and failed to document as needed medication administration and effectiveness on the MAR as per policy for one patient.

D Facility failed to ensure a complete medical record was maintained for one patient. The patient was admitted and was to be placed on hospice care for terminal cancer. There was no care plan for the hospice service.

D Facility failed to ensure a clinical record was accurately documented for medication administration.

F515 Retention of clinical records.

D Facility failed to maintain a medical electronic record for one patient.

F520 Quality assessment & assurance.

K Facility's quality assurance committee failed to identify issues, and develop and implement plans of action to correct quality deficiencies related to managing patients receiving anticoagulant therapy. This failure place the patients in immediate jeopardy.

J Facility quality assurance committee failed to ensure training and competency of nursing staff in the correct placement of a pressure prevention device, failed to assess and monitor the new development of a stage I pressure ulcer, and failed to place a PICC timely. The facility failed to administer oral and IV antibiotics as ordered for one patient and failed to ensure accurate assessments and pressure ulcer staging for one patient. These failures resulted in immediate jeopardy to the patient.

K029 Hazardous Areas Separated By Construction

E Facility failed to have hazardous areas separated by smoke resistant partitions and self-closing doors.

E Facility failed to have one-hour-fire-rated construction doors on hazardous areas.

D Facility failed to maintain hazardous areas. The dry storage area was over 50 square feet and has combustible storage. The door was not self-closing and not smoke resistant due to louvers installed in the door.

K038 Exit Accessible At All Times

D Facility failed to maintain exit access readily accessible at all times on one exit. It was labeled as a delayed egress and did not function when engaged.

K050 Fire Drills

F Facility staff members were not familiar with the fire drill procedures. The patient room doors were not closed until instructed by the maintenance director.

K052 Testing of Fire Alarm

D Facility failed to maintain the dialer component of the fire alarm system. The disconnecting phone line would not activate the audible or visual trouble signal within 120 seconds.

K062 Automatic Sprinkler - Maintenance

E Facility failed to ensure the sprinkler heads were in reliable operating condition. The sprinkler heads were painted with overspray.

E Facility failed to correct the sprinkler deficiencies determined by the inspection company earlier in the month. There were more than 50 dry sprinklers greater than 10 years old which had not been tested or replaced.

D Facility failed to maintain all fire sprinkler components. There was a build-up of lint on multiple sprinkler heads.

K067 Ventilating Equipment

F Facility failed to maintain all fused link fire dampers.

D Facility failed to maintain ventilation in resident toilet rooms. The exhaust fans were not circulating the air to the outside.

K072 Furnishings and Decorations

F Facility failed to maintain a clear path from the exit discharge to the public way in four exits.

K073 Flammable Furnishings

E Facility failed to ensure combustible decorations were treated with fire retardant.

K076 Nonflammable Medical Gas Systems

D Facility failed to store medical gas in accordance with NFPA 99 and NFPA 70. There were oxygen cylinders stored in an area that had electrical outlets and switches less than five feet above the floor.

K130 Other LSC Deficiency Not On 2786

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

K144 Generators

F Facility failed to inspect the emergency power supply batteries.

K147 Electrical Wiring and Equipment

F Facility failed to maintain all electrical wiring and components. There were missing circuit breakers in the panels.

E Facility failed to maintain the electrical wiring and equipment in accordance with NFPA 70.

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 provide ground fault circuit interrupters (GFCI) in wet areas.

K211 Alcohol Based Hand Rub Dispensers

F Facility failed to install alcohol base hand sanitizer dispensers correctly. They were installed over an ignition source.

N1111 Record and Reports; Maintenance Records

Facility failed to maintain inspection, testing, and maintenance reports for building safety equipment in a manner allowing review during business hours. There were no sprinkler system records for review for the third and fourth quarter of 2013.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

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

Facility failed to exercise an earthquake drill annually.

N1411 Disaster Preparedness; Fire Safety Drills

Facility failed to conduct a bomb threat drill for all staff and all shifts.

N1419 Disaster Preparedness; Physical Facility and Community Emergency Plans

Facility failed to conduct required disaster drills prior to March.

N401 Administration

Facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to maintain the highest practicable physical and psychosocial well-being by failing to education the staff on Coumadin; failing to document the parameters of the desired therapeutic range of PT/INR and failing to obtain and monitor the PT/INR. There was also a failure to ensure the pharmacy consultant notified the facility of drug interactions. These failure resulted in immediate jeopardy for the residents. The facility also failed to ensure that hot water temperatures in the patient rooms were within safe parameters.

Facility failed to be administered to ensure the environment was safe and free of accident hazards by failing to implement new, appropriate and measurable interventions after falls, failing to document neurological checks after falls, failing to complete post fall assessment/investigations and failing to notify physicians of falls for four patients. This failure placed the patients in immediate jeopardy.

N421 Administration; Verification of Personnel Licensure

Facility failed to ensure proper respiratory care for three patients. The facility had no documentation regarding maintenance of the respiratory equipment for the ventilator patients.

N424 Administration; Filed Documentation of Abuse Registries

Facility failed to ensure the environment was free from accident hazards when hot water temperatures were measured between 120 to 132.8 degrees Fahrenheit (F) in 26 patient rooms. This failure placed the patients in immediate jeopardy and sub-standard quality of care.

Facility failed to ensure assessments of each patient was complete and accurate, and failed to complete neurological checks post head injuries for one patient. The facility failed to complete a fall risk assessment for the fall and failed to implement appropriate and measurable interventions to prevent potential injuries for four patients with falls. These failures resulted in immediate jeopardy and a type A penalty suspension of admissions.

N601 Performance Improvement Program

Facility's quality assurance committee failed to identify issues, and develop and implement plans of action to correct quality deficiencies related to managing patients receiving anticoagulant therapy. This failure place the patients in immediate jeopardy.

N682 Pharmaceutical Services; Storage of Medications

Facility failed to ensure the pharmacy consultant identified and notified the facility for potential drug interactions for one patient receiving Coumadin. This failure placed the patient in immediate jeopardy.

N689 Nursing Services; Physical Restraints

Facility failed to educate the staff on Coumadin; failed to document the parameters of the desired therapeutic range of the PT/INR with instructions on when to hold the dose on the physician orders per the policy; and failed to appropriately obtain and monitor the PT/INR laboratory test used to determine therapeutic levels for blood thinning medication. Facility failed to obtain a PT/INR laboratory result as ordered by the physician and the pharmacy failed to identify and notify the facility for potential drug interactions related to Coumadin therapy. This failure placed the patients in the facility in immediate jeopardy.

N831 Building Standards

Facility failed to provide cooking equipment under the hood. The double convection oven on the baker's side had been moved to where the convection oven was not under the hood.

Facility failed to maintain the physical plant to ensure the safety and well-being of the patients. There were broken tiles in the shower room.

N832 Building Standards

Facility failed to submit building construction plans to the department for a renovation and alteration to the building.

N848 Building Standards; Exhaust & Air Pressure

Facility failed to ensure soiled storage areas were maintained under a negative air pressure.