Survey Deficiency Summary

15 Facilities Surveyed **Surveys Taken 1/28/2015 - 3/27/2015**

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

E Facility failed to provide the appropriate liability and appeal notices to two patients.

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

K Facility failed to immediately notify the attending physician of significant changes in the patient's condition after the patient exhibited assaultive behaviors towards staff and failed to immediately notify the physician of a related patient-versus-patient assault for two patients reviewed. One patient assaulted another patient and caused the patient to receive emergency medical treatment for acute injuries with bites on tops of both shoulders, hands and forearms and bruises with edema to both hands. This placed all patients in immediate jeopardy.

G Facility failed to notify the physician of a decline in a pressure ulcer for one patient. This caused actual harm when one patient's pressure ulcer got worse.

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

D Facility failed to ensure patients had access to petty cash on an ongoing basis for two patients with a personal fund account.

F223 Right to be free of physical/verbal abuse.

K Facility failed to provide adequate supervision or implement any interventions to prevent abuse on the secure unit for one patient. This failure resulted in physical assault of another patient causing emergency medical intervention with bites on the tops of both shoulders, hands and forearms. This resulted in immediate jeopardy for all the patients in the facility.

F224 Mistreatment, neglect, misappropriation of resident property.

K Facility failed to implement written policies to prevent patient abuse or neglect for two patients. This failure resulted in a physical assault of one patient and required medical intervention. This placed all patients in immediate jeopardy.

G Facility failed to prevent neglect when staff failed to follow up on dental orders and failed to notify the attending physician of a dental procedure while the patient was on anticoagulation medications. The facility failed to follow the facility Coumadin therapy protocol for one patient. The facility neglected to notify the physician of a dentist's desire to hold Coumadin for a dental procedure, and the facility failed to notify the physician of a PT/INR result. The patient received actual harm when he was hospitalized after a tooth extraction due to excessive bleeding.

G Facility neglected to provide services necessary to avoid physical harm and mental anguish for incontinence and/or rehabilitation care for three patients. By failing to provide incontinence care, actual harm occurred due to the patient smelling strongly of urine. Facility neglected to provide range of motion (ROM) which resulted in actual harm when one patient developed limitations in functional ROM of the upper extremities. The facility rehabilitation department neglected to educate the nursing staff on the care of a patient with an immobilizer which resulted in the patient not being bathed, and his clothes were not changed. This resulted in actual harm when the patient was found to have a body odor.

F225 Facility must not hire person with abuse history.

K Facility failed to report allegations of patient neglect to the administrator and/or governing body immediately upon their discovery and failed to thoroughly investigate allegations of neglect and report findings of the investigations to the facility administrator for two patients. This placed all the patients in immediate jeopardy.

G Facility failed to thoroughly investigate and report incidents with injuries of unknown origin for two patient reviewed for accidents. The facility failed to report injuries of unknown origin to the state survey agency. The facility failure to thoroughly investigate wandering and injuries of unknown origin resulted in actual harm when one patient sustained a laceration and fractured ribs.

D Facility failed to perform a complete and thorough investigation of an allegation of misappropriation of patient property and failed to report the incident to the state survey and certification agency within five working days of the reported incident.

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

K Facility failed to ensure staff were trained in policies and procedures to protect patients from abuse and neglect. This failure resulted in an assault of one patient by another, and caused immediate jeopardy to all the patients in the facility. This was a substandard quality of care citation.

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

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

G Facility failed to ensure patients were treated with dignity and respect when staff failed to provide incontinence care and bathing assistance for two patients.

F246 Right to accommodations of individual needs & preferences.

G Facility failed to ensure services were provided to accommodate a patient's individual needs and preferences for bathing and dressing assistance for patients reviewed for activity of daily living care. This resulted in actual harm.

F250 Medically related social services.

E Facility social worker failed to ensure referrals for psychiatric services were obtained for three patients.

F253 Housekeeping & maintenance services.

F Facility failed to ensure the environment was clean, sanitary and free of odors, and furniture was in good repair for four floors of the facility. This failure resulted in substandard quality of care.

D Facility failed to provide housekeeping services to maintain a sanitary, orderly and comfortable environment as evidenced by an odor in one patient bathroom.

F272 Comprehensive assessment.

G Facility failed to accurately assess a pressure ulcer for one patient. This resulted in actual harm to one patient.

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

D Facility failed to complete a significant change MDS assessment for one patient.

D Facility failed to complete a significant change MDS assessment for two patients.

D Facility failed to complete a significant change in MDS assessment for hospice care for one patient.

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

E Facility failed to accurately assess an active diagnosis for four patients.

D Facility failed to accurately assess a patient receiving hospice care. The MDS did not reflect hospice.

D Facility failed to accurately assess patients for falls and/or behaviors for five patients.

D Facility failed to accurately assess patients receiving an antidepressant.

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

G Facility failed to develop a comprehensive care plan for one patient. This resulted in actual harm to the patient.

E Facility failed to develop a care plan to include care for anticoagulant therapy and deep venous thrombosis (DVT), risk of developing pressure ulcer and/or actual pressure ulcer, and ROM for three patients.

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

G Facility failed to revise the care plan to reflect the current status related to risk of falls, fall prevention, behaviors, incontinence with bowel and bladder training and/or vision for 10 patients. This failure resulted in actual harm when one patient sustained a laceration and abrasion and another sustained a contusion to the right hip and a sprained elbow.

G Facility failed to revise the care plan to reflect the current status of urinary incontinence, actual pressure ulcer, behaviors, and/or new interventions for accidents for five patients.

D Facility failed to ensure interventions implemented after a fall were placed on the care plan for one patient.

F281 Services must meet professional standards of quality.

D Facility failed to administer medications as directed by the physician for seven patients. The patients had Synthroid ordered every morning at 6 a.m., and it was not administered.

F282 Services must be provided by qualified persons.

K Facility failed to ensure the care plan interventions were followed related to monitoring laboratory tests for patients receiving anticoagulants, failed to administer anticoagulants with orders, and failed to ensure weekly skin assessments were done for patients at risk of impaired skin integrity. Facility failed to ensure activities of daily living (ADLs) were performed for patients that were unable to perform the activities independently, failed to ensure psychiatric services were obtained for patients with behaviors, and/or failed to ensure catheter care was provided for 13 patients. The facility failed to ensure blood levels were monitored per orders and facility protocol placing patients in immediate jeopardy. Facility staff failed to complete weekly skin assessment on patient who were a high risk for developing pressure ulcers, failed to identify a pressure ulcer before patients developed Stage II pressure ulcers, and failed to provide treatments as ordered resulting in actual harm.

D Facility failed to follow the care plan to implement incontinence care to prevent future falls for one patient.

D Facility failed to follow the care plan intervention for monitoring behaviors for two patients.

D Facility failed to ensure the care plan was followed for one patient.

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

K Facility failed to provide services to attain the highest as practical physical, mental and psychosocial well-being in accordance with the plan of care when medication regimens were not transcribed on admission, laboratory tests were not done as ordered, labs were done without an order, and medications were administered without an order. The nurse practitioner (NP) and/or physician failed to sign and date orders for 21 patients. The facility failed to administer anticoagulants as ordered, failed to monitor blood levels, and failed to notify the physician or NP of critical or subtherapeutic lab results. This place the patients in immediate jeopardy.

G Facility staff failed to follow up on dental orders and failed to notify the attending physician of a dental procedure while the patient was on anticoagulation medications. Facility failed to follow the facility Coumadin therapy protocol for one patient. Facility failed to ensure one nurse followed the facility policy for transdermal drug delivery system application by failing to clean the site of the old Exelon patch.

D Facility failed to obtain physician orders for dialysis care for one patient.

D Facility failed to follow physician orders for medications for one patient.

D Facility failed to ensure one patient's long fingernails were trimmed to prevent scratches.

D Facility failed to ensure communication between the facility and the dialysis center for one patient.

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

G Facility failed to ensure ADLs was provided to maintain good personal hygiene for two patients. The facility failed to provide incontinent care which resulted in actual harm when one patient smelled strongly of urine. The facility failed to bathe and change one patient's clothes resulting in actual harm.

D Facility failed to provide necessary services to maintain hygiene for one patient. According to the patient record, the patient had not had a bath in seven days and was care planned to received three showers a week.

F314 Resident does not develop pressure sores.

H Facility failed to ensure nurses completed weekly skin assessments and identified pressure sores timely. Facility failed to provide treatments as ordered resulting in actual harm for one patient. This was substandard quality of care.

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

F315 Incontinent resident receives appropriate treatment and services.

E Facility failed to provide services to improve normal bladder function to the extent possible by not implementing a bowel and bladder training program and failed to implement incontinence care to prevent future falls for two patients with incontinence.

E Facility failed to have physician's orders for indwelling urinary catheter and/or failed to provide Foley catheter care for three patients.

D Facility failed to ensure a bladder rehabilitative program was implemented to improve urinary continence and restore as much bladder function as possible for one patient.

D Facility failed to complete a bladder assessment and develop an individualized toileting plan for one patient.

F317 No reduction in range of motion.

G Facility failed to provide range of motion exercises for one patient reviewed. This resulted in actual harm to the patient.

F319 Psychosocial adjustment difficulty.

G Facility failed to identity behaviors of climbing out of bed, implement pertinent interventions and identify the cause of behaviors for one patient. The facility failed to identify causes of behaviors and implement appropriate interventions for behaviors resulting in actual harm when one patient fell sustaining a contusion to the right hip and a sprained elbow.

E Facility failed to ensure referrals for psychiatric services were obtained for three patients.

F323 Accident hazards.

K Facility failed to provide adequate supervision to prevent altercations on the secure unit for two patients. This failure placed the patients in the facility in immediate jeopardy. This was a substandard quality of care citation.

G Facility failed to provide supervision to prevent falls and failed to investigate falls per the facility policy for 10 patients. Three of the patients sustained actual harm from this failure.

E Facility failed to ensure the environment was safe and free of accident hazards by filing to implement new, appropriate measurable interventions after falls for two patients.

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

F328 Proper treatment & care for specialized services.

K Facility failed to ensure subcutaneous injections of an anticoagulant medication were not administered without a signed physician's order for four patients. Facility failed to ensure oxygen was administered with a physician's order for one patient and failed to ensure tracheostomy care was provided under sanitary conditions for two patients. The facility failed to consistently follow a systemic process to ensure medications administered were ordered by the physician or NP which resulted in immediate jeopardy and substandard quality of care.

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

K Facility failed to demonstrate a process that monitored and addressed the potential for adverse consequences related to anticoagulant therapy when the facility failed to ensure physician/NP orders were obtained for anticoagulant medications prior to administering the medication. Facility failed to ensure medication orders were signed and dated, failed to ensure anticoagulant medications were administered as ordered, failed to perform ordered lab monitoring tests, and failed to obtain a clarification order for correct doses of anticoagulant medication to be given. Facility failed to notify the physician/NP of critical and subtherapeutic lab results. These failures placed the patients in immediate jeopardy.

D Facility failed to provide behavior and side effect monitoring for psychoactive medications for two patients.

F332 Facility medication error rates of 5% or more.

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

F333 Residents free of significant medication errors.

L Facility failed to ensure patients were free of significant medication errors. The facility failed to consistently follow a systemic process to ensure medications administered were ordered by the physician or NP. Facility failed to ensure medication orders were transcribed accurately on the MAR and failed to ensure medications were given as ordered. These failures resulted in immediate jeopardy.

F356 Nurse staffing data

D Facility failed to accurately post nursing staff directly responsible for patient care for two days.

C Facility failed to provide a current posting of daily nurse staffing.

F364 Food preparation.

D Facility failed to maintain palatable food temperatures for a test tray on one hall.

F371 Store, prepare, distribute, & serve food.

F Facility failed to ensure food was stored under sanitary conditions as evidenced by milk stored past the expiration date. Dietary staff members failed to change gloves, and dietary staff failed to maintain a daily log documenting temperature and sanitizer concentration for the dish machine and three compartment sink.

F Facility failed to ensure that food was protected from sources of contamination in the kitchen as evidenced by failing to ensure kitchen and storage rooms were clean. Facility failed to ensure refrigerated food was labeled, dated and not expired. Facility failed to ensure dishes were cleaned and sanitized, failed to prevent cross contamination between dirty and clean dishes, and failed to ensure the food preparation areas and equipment were clean. The facility failed to ensure all employees entering the kitchen had appropriate hair covering on and failed to ensure frozen food items were thawed appropriately.

F Facility failed to ensure hand hygiene was performed during meal service; failed to ensure expired milk was not available; and failed to eliminate the presence of pests for one of the kitchens reviewed. Facility failed to maintain a thermometer in the nourishment refrigerator for one nursing unit.

E Facility failed to ensure that four CNAs served food under sanitary conditions by delivering food uncovered and/or handled food with bare hands.

C Facility failed to ensure food was protected from physical contaminates and other sources of contamination as evidenced by the presence of dark brown, gritty dust build-up under the edge of one freezer. Facility failed to distribute food under sanitary conditions as evidenced by two staff members entering the kitchen without a hair net.

F386 Physician review resident's total program of care.

K Facility failed to ensure the physician reviewed the patients total program of care, including medications and treatments and all orders were signed and dated for 11 patients. This failure resulted in immediate jeopardy.

F387 Frequency of physician visits.

F Facility failed to ensure the physicians followed the facility's policy for completing a medical assessment within 72 hours of admission and/or a readmission to the facility for 25 patients.

F406 Facility must provide or obtain specialized rehabilitative services.

G Facility rehabilitation department failed to provide a restorative nursing program for ROM exercises and failed to provide education to direct care staff for bathing for two patients. This resulted in actual harm.

F411 Medicare patients must be provided with dental services.

D Facility failed to schedule a dental appointment for tooth extraction in a timely manner to meet the needs of one patient.

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

L Facility pharmacist failed to ensure 12 patients were free of significant medication errors. The pharmacist failed to follow a systemic process to ensure medications administered were ordered by the physician or NP and failed to ensure medication orders were transcribed accurately on the MAR. The pharmacist failed to ensure medications were given as ordered and/or admission orders were verified with the physician for accuracy which resulted in immediate jeopardy.

F431 Labeling of drugs & biologicals.

E Facility failed to ensure medications were stored securely, medication containers and storage areas were clean, opened medications were labeled and dated and medications were not stored past the expiration date in 11 emergency carts.

F441 Investigates, controls/prevents infections.

F Facility failed to ensure practices to prevent the potential spread of infection were implemented by one nurse who failed to ensure the glucometer was cleaned before and after use. Nurses and respiratory therapists were not washing their hands prior to tracheostomy care and failed to ensure the environment was clean, sanitary and free of odors.

D Facility failed to ensure practices to prevent the spread of infection were maintained when two nurses administered medications without using proper hand hygiene and failed to sanitize reusable equipment between patients. One CNA touched food and dining utensils without proper hand hygiene during meal service.

D Facility failed to implement hand hygiene during a dressing change for one patient.

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 25 rooms.

E Facility failed to ensure the environment was safe, functional and sanitary as evidenced by a dirty microwave, a dirty cabinet, dirty floors, a non-functioning sink hanging off the wall, a dirty sink, loose tiles and a dirty wall on three floors.

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 ensure an effective process that monitored and addressed the potential for adverse consequences related to anticoagulant therapy administration. Administration failed to ensure medications were not administered without a physician/NP order, failed to ensure medication orders were signed and dated, and failed to ensure ordered lab tests were obtained as ordered. Administration failed to ensure staff obtained clarification of orders for the correct dose of anticoagulant medications to be given and administration failed to ensure staff notified the physician or NP of critical and sutherapeutic lab results. Administration failed to ensure weekly skin assessments were done for patients at risk of impaired skin integrity, failed to ensure ADLs were performed for all patients, and failed to ensure psych services were obtained for patients with behaviors. Administration failed to ensure catheter care was provided and obtain orders for hospice care for 23 patients. These failures resulted in immediate jeopardy.

K Facility administration failed to prevent abuse for one patient and failed to prevent neglect for two patients reviewed. The facility failed to ensure facility policies and procedures for reporting significant escalation of aggressive, violent behaviors to the physician were followed. Facility failed to ensure staff knew and followed policies for increased supervision when a patient exhibited aggressive and violent behaviors. Facility administration failed to follow policies to report abuse and neglect. This placed all patients in immediate jeopardy.

F493 Governing body.

L Facility governing body 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 ensure an effective process that monitored and addressed the potential for adverse consequences related to anticoagulant therapy administration. The governing body failed to ensure medications were not administered without a physician/NP order, governing body failed to ensure medication orders were signed and dated, and failed to ensure ordered lab tests were obtained as ordered. The governing body failed to ensure staff obtained clarification of orders for the correct dose of anticoagulant medications to be given and failed to ensure staff notified the physician or NP of critical and sutherapeutic lab results. The governing body failed to ensure weekly skin assessments were done for patients at risk of impaired skin integrity, failed to ensure ADLs were performed for all patients, and failed to ensure psych services were obtained for patients with behaviors. The governing body failed to ensure catheter care was provided and obtain orders for hospice care for 23 patients. These failures resulted in immediate jeopardy.

F496 Registry verification.

D Facility failed to ensure one CNA certification status was current.

F501 A physician must be designated as medical director.

L Facility failed to ensure the medical director assisted the facility with identifying, evaluating and addressing clinical concerns, coordinated the medical care and provided clinical guidance and oversight regarding the implementation of patient care policies and procedures that reflect the current standards of practice for patients in the facility. This failure placed the patients in immediate jeopardy.

F502 Provide or obtain clinical laboratory services.

K Facility failed to follow a systematic organized and documented approach to obtain lab tests as ordered by the physician for eight patients. This failure placed the patients in immediate jeopardy.

F505 Promptly notify physician of findings of lab results.

K Facility failed to promptly notify the physician or NP of lab results so that prompt actions could be taken for six patients. This failure placed the patients in immediate jeopardy.

F508 Provide/obtain radiology & other diagnostic services.

D Facility failed to complete a chest x-ray for one patient.

F514 Criteria for clinical records.

K Facility failed to ensure medical record documentation was complete, accurate, organized and in the appropriate chart for seven patients. This failure placed the patients in immediate jeopardy.

E Facility failed to ensure medical records contained complete and accurate documentation of patient conditions related to post fall assessments and documentation, behavior monitoring, weekly nursing summaries, fall risk assessments, documentation of fall interventions, transcription of physician's orders and/or narcotic medications signed out and documented as given for 10 patients.

E Facility failed to maintain complete and accurate medical records of medication administration for seven patients.

D Facility failed to ensure urinary continence evaluations were complete and documented for one patient.

F520 Quality assessment & assurance.

L Facility quality assurance (QA) failed to maintain the highest practicable physical and psychosocial well-being by failing to ensure an effective process that monitored and addressed the potential for adverse consequences related to anticoagulant therapy administration. The quality assurance committee failed to ensure medications were not administered without a physician/NP order. QA failed to ensure medication orders were signed and dated and failed to ensure ordered lab tests were obtained as ordered. QA failed to ensure staff obtained clarification of orders for the correct dose of anticoagulant medications to be given, and administration failed to ensure staff notified the physician or NP of critical and sutherapeutic lab results. QA failed to ensure weekly skin assessments were done for patients at risk of impaired skin integrity, failed to ensure ADLs were performed for all patients, and failed to ensure psych services were obtained for patients with behaviors. QA failed to ensure catheter care was provided and obtain orders for hospice care for 23 patients. These failures resulted in immediate jeopardy.

K Facility quality assurance performance improvement program failed to identify and put in place corrective action plans to ensure patients with aggressive behaviors were supervised to prevent abuse to another patient. Facility failed to ensure staff were knowledgeable and implemented facility policy and procedures for abuse and behavioral management. This placed all the patients in immediate jeopardy.

K029 Hazardous Areas Separated By Construction

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

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

K038 Exit Accessible At All Times

F Facility failed to have the means of egress readily accessible at all times.

E Facility failed to have delayed egress door arranged accordingly. Some of the delayed egress doors did not open in the required 15 seconds.

E Facility failed to ensure means of egress were maintained as accessible at all times.

K045 Exit Lighting

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

K046 Emergency Lighting

D Facility failed to ensure all emergency lighting was operational.

K047 Exit Signs

D Facility failed to ensure all means of egress were provided with directional signs.

K061 Automatic Sprinkler - Main Control Valve

D Facility failed to ensure all control valves for the sprinkler system were electronically supervised.

K062 Automatic Sprinkler - Maintenance

E Facility failed to maintain the automatic sprinkler system and its components. There had been no 10-year test conducted on the dry sprinklers. The sprinkler gauges had not received the five-year calibration test or been replaced.

D Facility failed to maintain the sprinkler system. A canopy greater than 4-foot in length made of combustible material was not sprinklered.

D Facility failed to maintain all sprinkler heads. There were several sprinkler heads with a build-up of foreign material on them.

D Facility failed to maintain the automatic sprinkler system. The sprinkler pit had an accumulation of approximately one foot of standing water.

D Facility failed to ensure sprinkler systems containing water-filled piping was being maintained at a minimum temperature of 40 degrees F and not exposed to freezing conditions.

K066 Smoking Regulations

D Facility failed to provide smoking areas with metal containers with self-closing lids into which ashtrays can be emptied.

D Facility failed to comply with the currently adopted smoking policy.

K067 Ventilating Equipment

D Facility failed to test all fire dampers.

K072 Furnishings and Decorations

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

K147 Electrical Wiring and Equipment

E Facility failed to ensure electrical components complied with the national electrical code, NFPA 70. There were boxes of combustibles stored in front of the electrical panels.

N003 Special Circumstances

Facility failed to maintain a single wait list that included the name of the applicant, name of the contact person or designated representative, address of the applicant and the contact person, etc.

N1102 Records and Reports; Recording of Unusual Incidents

Facility failed to perform a complete and thorough investigation of an allegation of misappropriation of patient property and failed to report the incident to the state survey and certification agency within five working days of the reported incident.

N1405 Disaster Preparedness; Physical Facility and Community Emergency Plans

Facility failed to have a bomb threat plan as well as an earthquake plan.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

Facility failed to exercise the earthquake drill annually.

N1411 Disaster Preparedness; Fire Safety Drills

Facility failed to exercise a bomb threat drill annually.

N507 Admissions, Discharges, and Transfers; Resident Evaluation

Facility interdisciplinary team failed to assess one patient prior to admission to the secure unit.

N629 Infection Control; Disinfect Contaminated Items

Facility failed to ensure practices to prevent the potential spread of infection were implemented by one nurse who failed to ensure the glucometer was cleaned before and after use. Nurses and respiratory therapists were not washing their hands prior to tracheostomy care.

N645 Nursing Services

Facility failed to ensure the environment was clean, sanitary and free of odors and furniture was not in disrepair in 22 patient rooms. The facility failed to ensure environment was safe, functional and sanitary as evidenced by a dirty microwave, a dirty cabinet, dirty floors, a non-functioning sink hanging off the wall, a dirty sink, loose tiles and a dirty wall on three floors.

Facility failed to provide housekeeping services to maintain a sanitary, orderly and comfortable environment as evidenced by an odor in one patient bathroom.

N728 Basic Services; Pharmaceutical Services

Facility failed to ensure medications were stored securely, medication containers and storage areas were clean, opened medications were labeled and dated and medications were not stored past the expiration date in 11 emergency carts.

N734 Pharmaceutical Services

Facility failed to ensure the physician reviewed the patients total program of care, including medications and treatments and all orders were signed and dated.

N765 Food and Dietetic Services; Freezer Temperature

Facility failed to ensure food was stored under sanitary conditions as evidenced by milk stored past the expiration date. Dietary staff members failed to change gloves and dietary staff failed to maintain a daily log documenting temperature and sanitizer concentration for the dish machine and three compartment sink.

Facility failed to clean a build-up of dark brown gritty dust under the edge of one freezer.

Facility failed to ensure that food was protected from sources of contamination in the kitchen as evidenced by failing to ensure kitchen and storage rooms were clean. Facility failed to ensure refrigerated food was labeled, dated and not expired. Facility failed to ensure dishes were cleaned and sanitized, failed to prevent cross contamination between dirty and clean dishes, and failed to ensure the food preparation areas and equipment were clean. The facility failed to ensure all employees entering the kitchen had appropriate hair covering on and failed to ensure frozen food items were thawed appropriately.

Facility failed to ensure that four CNAs served food under sanitary conditions by delivering food uncovered and/or handled food with bare hands.

N831 Building Standards; Construction

Facility failed to ensure overhead lights had the cover on them.

Facility failed to maintain the overall environment. There was a water heater leaking in one maintenance area.

Facility failed to maintain areas of the building to ensure the overall environment for the patient's safety. The facility did not maintain the fire doors.

N834 Building Standards; Approval of New Construction

Facility failed to follow new construction regulations. A canopy greater than 4-foot made of combustible material was added without approval.

N835 Building Standards; Approval of New Construction

Facility failed to obtain written approval from the Tennessee Department of Health to upgrade one kitchen fire suppression systems.

N848 Building Standards; Exhaust & Air Pressure

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

Facility failed to maintain negative air pressure in all toilet rooms.

N901 New Code Compliance

Facility did not comply with applicable fire safety regulations. There were penetrations in the fire wall.