

Survey Deficiency Summary

16 Facilities Surveyed

Surveys Taken 5/11/2015 - 6/15/2015

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

- G Facility failed to notify the physician of the unavailability of pain medication to administer after a patient request for ordered pain medication. This resulted in actual harm to the patient.
- D Facility failed to notify the physician of a patient's change in condition and death. The facility failed to document that the physician had been notified when a patient with terminal cancer expired.
- D Facility failed to notify the responsible party and the physician after a significant clinical change for one patient.

F164 Right to privacy & confidentiality.

- D Facility failed to ensure privacy of the patient was maintained during medication administration for one patient. The nurse left the window blinds open while she was helping the patient change clothes.

F167 Right to examine survey results of the facility.

- C Facility failed to provide the most recent state survey results in a readily accessible location for all patients in the facility.

F176 Self-administration of drugs by resident.

- D Facility failed to monitor the self-administration of medication for one patient.

F204 Orientation for transfer or discharge by facility to resident.

- D Facility failed to provide sufficient orientation to ensure safe and orderly discharge from the facility for one patient.

F221 Right to be free from physical restraints.

- D Facility failed to assess one patient prior to the use of a physical restraint.

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

- E Facility failed to follow policy on investigation of misappropriation of patient's funds for four patients.
- D Facility failed to complete a thorough investigation for missing medications for one patient.

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

- D Facility failed to ensure one CNA treated patients with respect and dignity by standing to assist with meals and referring to the "feeder" dining room over the facility paging system.

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- D Facility failed to maintain and enhance patient dignity when two CNAs referred to patients as "feeders."

F252 Safe, clean, comfortable & homelike environment.

- E Facility failed to provide a homelike environment for dining in two of the dining rooms. There were seven patients seated in wheelchairs lined up along the wall of the dining room with an over-the-bed table placed in front of them.

F253 Housekeeping & maintenance services.

- E Facility failed to repair missing, broken and loose tile in the facility flooring.
- E Facility failed to provide effective housekeeping and maintain a sanitary, orderly and comfortable environment as evidenced by loose cove base, black build up in corners and around entry way door, and scuff marks on some patient room doors. There was also a dirt build up on two of two scales and two hooyer lifts.
- D Facility failed to ensure the patient's environment was clean and sanitary as evidenced by red and brown stains on the window curtains, a hem out of window curtain and a window curtain laying on the floor in two patient rooms.
- D Facility failed to ensure the environment was clean and sanitary as evidenced by stained, dirty floors, dirty walls, dirty privacy and closet curtains, urine odors, missing floor tiles, dirty commodes and burned out light bulbs.

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

- D Facility failed to complete a significant change MDS for a patient admitted to hospice.

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

- D Facility failed to accurately code the MDS for antipsychotic medication, oral/dental, and pressure ulcer status for three patients.
- D Facility failed to accurately assess the functional status of one patient.
- D Facility failed to ensure the MDS was correct for functional range of motion for one patient.

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

- D Facility failed to ensure a comprehensive care plan was developed to address urinary incontinence for one patient.
- D Facility failed to develop a comprehensive care plan for dental care for one patient.

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

- D Facility failed to ensure the care plan was updated for fall interventions, hospice services and nothing-by-mouth (NPO) status for six patients.

F281 Services must meet professional standards of quality.

- D Facility failed to obtain a physician's order to dispense a PRN medication for one patient. The nurse administered stock eye drops with no order.

F282 Services must be provided by qualified persons.

- D Facility failed to follow the care plan related to an abnormal involuntary movement score (AIMS) for one patient.
- D Facility failed to follow care plan interventions related to nutrition for one patient.

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

- G Facility failed to ensure pain medication was administered after a patient request for ordered pain medication for pain intensity of 10 resulting in a two-hour delay and actual harm to the patient.
- D Facility failed to obtain a physician's order to place an indwelling urinary catheter for one patient.
- D Facility failed to follow physician orders for one patient. The patient was to be on bedrest with the exception of mealtimes, and the physician had ordered her to be up. The staff had not followed the order and were feeding her while she was in the bed.

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

- D Facility failed to provide proper oral hygiene for one patient.
- D Facility failed to provide assistance to maintain continence care for one patient.
- D Facility failed to ensure one patient who was unable to perform activities of daily living without assistance received assistance with oral hygiene.

F314 Resident does not develop pressure sores.

- D Facility failed to ensure nurses completed weekly skin assessments and identified pressure ulcers timely for two patients with pressure ulcers. This failure resulted in actual harm to the patient.

F315 Incontinent resident receives appropriate treatment and services.

- E Facility failed to develop a bladder retraining program for three patients with urinary incontinence.
- D Facility failed to follow up on lab results related to a urinary tract infection for one patient reviewed.
- D Facility failed to provide a physician's order for the use, indication and care of an indwelling urinary catheter for one patient.

F318 Range of motion.

- E Facility failed to provide ROM services, failed to prevent a decline in ROM and failed to follow facility policy regarding the restorative program for two patients.

F322 Tube feeding/prevention.

- D Facility failed to ensure there were current physician's orders for the patient's nothing-by-mouth status for one patient with a PEG tube.

F323 Accident hazards.

- G Facility failed to ensure patients at risk for falls were adequately supervised and had appropriate interventions implemented after each fall for four patients. This failure resulted in actual harm to one patient.

F325 Facility must ensure acceptable parameters of nutritional status.

- D Facility failed to provide a nutritional supplement as ordered for one patient.

F332 Facility medication error rates of 5% or more.

- D Facility failed to ensure one LPN administered medications with an error rate of less than five percent. The error rate was 9.67 percent.
- D Facility failed to ensure one nurse administered medications with a medication error rate of less than five percent. The error rate was 7.69 percent.

F333 Residents free of significant medication errors.

- D Facility failed to ensure that patients were free of significant medication errors when one LPN failed to administer insulin within the proper time frame before meals.

F371 Store, prepare, distribute, & serve food.

- F Facility failed to maintain a sanitary kitchen by not properly cleaning the deep fryer and the stationary can opener, by failure to use opened three bean salad and tapioca pudding by the use by dates, by failing to maintain safe milk temperatures, and by failure to remove a build-up of dust particles on a dual cooling fan for one walk-in freezer.
- F Facility failed to maintain a sanitary kitchen by not properly maintaining one walk-in freezer and by failure to sanitize the hands during food service.
- D Facility failed to store, prepare and serve food under sanitary conditions as evidenced by lack of hair restraint for four dietary employees in the kitchen.
- D Facility failed to ensure food was stored under sanitary conditions as evidenced by opened food that was unlabeled and undated on one day of the survey.

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

- G Facility failed to ensure pain medication was administered after a patient request for ordered pain medication for pain intensity of 10 resulting in a two-hour delay and actual harm to the patient.

F431 Labeling of drugs & biologicals.

- E Facility failed to properly store and dispose of medications in three medication carts.
- D Facility failed to store drugs and medical supplies in accordance with facility policy in one supply room. There were some expired medications in the medication room.
- D Facility failed to ensure medications were stored safely in one medication storage area.
- D Facility failed to ensure medications were stored properly as evidenced by a medicine cup with applesauce on top of a medication cart, and the top drawer pulled open and the medication cart unlocked and unattended.

F441 Investigates, controls/prevents infections.

- E Facility failed to ensure two nurses followed the facility policy for disinfecting a glucometer between patients and failed to clean and store a nebulizer mask following a treatment.
- E Facility failed to follow infection control practices to minimize the potential for cross contamination between patients at meal times. Facility failed to follow infection control guidelines for handwashing during medication administration and failed to ensure patient care lifts were cleaned between patients.
- D Facility failed to maintain an infection control program to ensure meals were distributed in a sanitary manner for one dining area.
- D Facility failed to ensure pain medication was administered after a patient request for ordered pain medication for pain intensity of 10 resulting in a two-hour delay and actual harm to the patient.
- D Facility failed to develop a policy for the care and cleaning of contaminated, reusable CPAP equipment to maintain infection control for two patients.
- D Facility failed to ensure infection control practices were maintained to prevent the potential spread of infections as evidenced by an untagged, unlabeled urinal in a shared bathroom.

F460 Full visual privacy in room design.

- D Facility failed to ensure full visual privacy could be maintained in one patient room.

F464 Designated rooms for dining & activities.

- E Facility failed to provide dining tables for dining in two dining rooms.

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

- E Facility failed to ensure the environment was clean, sanitary and free of odors in one shower room.
- D Facility failed to provide a clean and sanitary environment for patients shower rooms.
- D Facility failed to provide a safe, sanitary and comfortable environment as evidenced by a torn whirlpool seat cushion in one tub.

F502 Provide or obtain clinical laboratory services.

- D Facility failed to perform laboratory test according to physician's orders for one patient.

F514 Criteria for clinical records.

- G Facility failed to ensure medical records contained complete and accurate information of patient conditions and medication related to an AIMS, medication administration, pressure ulcers and physician recertification orders. This resulted in actual harm.
- D Facility failed to maintain a complete and accurate medical record for one patient. The notification of the physician after death for a terminal cancer patient was not documented.
- D Facility failed to maintain a complete documentation of a nutritional supplement for one patient.
- D Facility failed to ensure an accurate medical record related to narcotic medications signed out and documented as given, missing x-ray report, ADL, and targeted behavior identification and documentation for five patients.

K018 Construction of Doors

- E Facility failed to maintain the doors protecting the corridors. One corridor fire door had the bottom latching device removed.
- D Facility failed to maintain the corridor doors.
- D Facility failed to maintain all doors in the facility. Some of the required door closures had been removed.
- D Facility failed to maintain the doors protecting the corridor.

K021 Automatic Closing Doors

- D Facility failed to ensure one fire door was held open by approved devices.

K029 Hazardous Areas Separated By Construction

- D Facility failed to maintain all hazardous areas. There were unsealed penetrations in the fire walls.

K032 Two Acceptable Exits Provided On Each Floor

- D Facility failed to provide exit signs at the doors leading from two court yards.

K039 Width Of Aisles Or Corridors

E Facility failed to maintain the corridors width clear and unobstructed.

K045 Exit Lighting

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

K047 Exit Signs

D Facility failed to provide illuminated exit signs at one exit.

K050 Fire Drills

C Facility failed to conduct the required fire drills.

K051 Fire Alarm System

D Facility failed to provide strobes and horns in both court yards.

K052 Testing of Fire Alarm

E Facility failed to maintain the fire alarm system.

D Facility failed to provide an annunciator at a location to be heard and provide smoke detectors at required locations.

K062 Automatic Sprinkler - Maintenance

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

E Facility failed to maintain all sprinkler heads. Several had a build-up of lint.

E Facility failed to maintain the sprinkler system.

D Facility failed to maintain the sprinkler system. The hydraulic name plate was missing in the sprinkler riser room.

D Facility failed to ensure sprinkler heads were free of paint and excessive lint build-up.

D Facility failed to maintain the sprinkler system. Several sprinkler heads were dirty.

D Facility failed to have all portions of the automatic sprinkler system maintained.

K064 Portable Fire Extinguishers

D Facility failed to ensure fire extinguishers had complied with their hydrostatic test requirement.

D Facility failed to inspect a fire extinguisher monthly.

D Facility failed to maintain the portable fire extinguishers. Two ABC type fire extinguishers were overdue for the six-year maintenance procedure.

K066 Smoking Regulations

- D Facility failed to provide metal containers with self-closing cover devices at all smoking areas.

K067 Ventilating Equipment

- F Facility failed to maintain all fused link fire dampers.
- E Facility failed to provide inspection and maintenance to fire dampers every four years.
- E Facility failed to maintain the ventilation system. Several bathroom exhaust fans were not working.
- D Facility failed to ensure fire dampers were properly installed in accordance with manufacturer's instructions.

K069 Commercial Cooking Equip. Meets Requirements

- E Facility failed to protect the cooking facilities. There was a grease build-up on the sprinklers in the kitchen hood suppression system.
- D Facility failed to ensure commercial cooking equipment producing steam or grease-laden vapors were located under a commercial hood. A new deep fryer had been installed and was not under the hood.
- D Facility failed to ensure a hinged up blast fan supplied with flexible weatherproof electrical cable and service hold-open retainer to permit proper inspection and cleaning that is listed for commercial cooking equipment was installed.

K076 Nonflammable Medical Gas Systems

- E Facility failed to maintain the oxygen storage area.
- E Facility failed to maintain the oxygen cylinders. There was unsecured oxygen on one hallway.
- D Facility failed to ensure medical oxygen cylinders were stored away from combustibles.

K130 Other LSC Deficiency Not On 2786

- F Facility failed to have exits readily accessible and working correctly.
- F Facility failed to maintain four fire doors. The clearance under the boom of the one and one-half hour rated fire doors exceeded 3/4 inches.
- D Facility failed to properly train all staff members on how to use safety equipment.
- D Facility failed to maintain all fire wall assemblies. There were unsealed penetrations in the fire wall.

K144 Generators

- F Facility failed to ensure documentation indicated the emergency generator was run for 30 minutes under load each month.

- F Facility failed to inspect the emergency power supply batteries.
- F Facility failed to exercise the generator under load for at least 30 minutes a month.

K147 Electrical Wiring and Equipment

- F Facility failed to ensure the facility complied with the electrical requirements. There were some receptacles that should have been GFCI protected and were not.
- D Facility failed to maintain the electrical system. There was a junction box late missing in one hallway and some exposed wires in the attic.
- D Facility failed to maintain lighting fixtures. Several light fixtures did not have bulb protection.
- D Facility failed to maintain electrical outlet boxes. There were some blank covers which were missing.
- D Facility failed to maintain the electrical system. The facility did not conduct the required annual retention force test of the grounding blade of each electrical receptacle located in the patient area.

N505 Admissions, Discharges, and Transfers; Liability Insurance

Facility failed to disclose in writing to each patient prior to admission to the facility whether the facility had liability insurance.

N506 Admissions, Discharges and Transfers; Quarterly Review

Facility failed to provide each patient with the Adult Protective Services (APS) toll free telephone number upon admission.

N629 Infection Control; Disinfect Contaminated Items

Facility failed to ensure two nurses followed the facility policy for disinfecting a glucometer between patients and failed to clean and store a nebulizer mask following a treatment. This was a type C pending penalty.

Facility failed to ensure pain medication was administered after a patient request for ordered pain medication for pain intensity of 10 resulting in a 2-hour delay and actual harm to the patient. This was a type C pending penalty.

N645 Nursing Services

Facility failed to ensure the patients environment was clean and sanitary as evidenced by red and brown stains on the window curtains, a hem out of window curtain and a window curtain laying on the floor in two patient rooms. This was a type C pending penalty.

Facility failed to provide effective housekeeping and maintain a sanitary, orderly and comfortable environment as evidenced by loose cove base, black build up in corners and around entry way door, and scuff marks on some patient room doors. There was also a dirt build up on two of two scales and two hooyer lifts. This was a type C pending penalty.

Facility failed to ensure the environment was clean, sanitary and free of odors in one shower room. This was a type C pending penalty.

N728 Basic Services; Pharmaceutical Services

Facility failed to ensure medications were stored properly as evidenced by a medicine cup with applesauce on top of a medication cart, and the top drawer pulled open and the medication cart unlocked and unattended.

N765 Food and Dietetic Services; Freezer Temperature

Facility failed to store, prepare and serve food under sanitary conditions as evidenced by lack of hair restraint for four dietary employees in the kitchen. This was a type C pending penalty.

Facility failed to ensure food was stored under sanitary conditions as evidenced by opened food that was unlabeled and undated on one day of the survey. This was a type C pending penalty.

N831 Building Standards; Construction

Facility failed to ensure alterations to the facility were made with prior approval of the Department of Health. There was no approval for the installation of a deep fryer.

Facility failed to maintain the condition of all parts of the building. There were some ceiling penetrations, some vent covers were missing, and the basement file room had water covering part of the floor.

Facility failed to maintain an overall environment. There were unsealed penetrations in the fire wall.

N835 Building Standards; Approval of New Construction

Facility failed to submit plans for the new fire alarm replacement prior to installation.

N848 Building Standards; Exhaust & Air Pressure

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

N901 New Code Compliance

Facility failed to comply with the applicable building and fire safety regulations. There was trash in the attic.