Survey Deficiency Summary

40 Facilities Surveyed **Surveys Taken 11/10/2015 - 1/16/16**

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

J Facility failed to notify the patient's family member after falls, including a fall resulting in injury for one patient. This placed that patient in immediate jeopardy.

D Facility failed to notify the physician of a significant change in urinary incontinence status for one patient.

D Facility failed to notify the family of a patient's emergent transfer to the hospital.

D Facility failed to notify the physician and the patient's responsible party of a critically abnormal laboratory value for one patient.

D Facility failed to ensure a physician was notified of elevated blood glucose levels for one patient. The facility policy stated that physicians would be called anytime the blood glucose was above 300, and this was not done.

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

D Facility failed to provide quarterly account statements to one patient.

F160 Conveyance of funds upon death.

D Facility failed to convey the patient's funds to the patient's family or estate after the death of the patient.

F161 Assurance of financial security.

E Facility failed to ensure the security of all personal funds of patients deposited with the facility for three monthly bank statements. The surety bond was for $25,000, and the statement amounts exceeded that amount.

F164 Right to privacy & confidentiality.

E Facility failed to ensure privacy was maintained for four patients.

F166 Right to have grievances resolved.

D Facility failed to fully investigate and resolve grievances voiced by two patients.

F176 Self-administration of drugs by resident.

D Facility failed to ensure one patient was capable of self administration of medications.

F203 Notice before transfer or discharge.

D Facility failed to give a 30-day notice of discharge to one patient.

F223 Right to be free of physical/verbal abuse.

D Facility failed to ensure the safety of a patient immediately after an inappropriate incident.

F224 Mistreatment, neglect, misappropriation of resident property.

L Facility failed to provide wound care treatment and services for three patients with pressure ulcers resulting in neglect. This placed three patients in immediate jeopardy. This was also substandard quality of care.

D Facility failed to ensure one patient was free from misappropriation of personal property. The patient reported a missing DVD player.

F225 Facility must not hire person with abuse history.

K Facility failed to conduct investigations for injuries of unknown origin for three patients. This failure placed the patients in immediate jeopardy.

D Facility failed to immediately report an allegation of abuse for one patient. A CNA had gone into a patient room in the middle of the night and told the patient to "Shut up". This was reported to the charge nurse.

D Facility failed to report and investigate an allegation of misappropriation for one patient. The patient reported a missing DVD player.

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

D Facility failed to promote the dignity of one patient.

D Facility failed to ensure dignity was provided during dining when two CNAs stood while assisting patients with dining.

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

D Facility failed to ensure personal choices were honored for one patient.

F244 Facility follow-up on family group meetings.

E Facility failed to follow up on the resident council's concerns for three months of meeting minutes.

F246 Right to accommodations of individual needs & preferences.

D Facility failed to ensure the patients call lights were within reach for three patients.

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

D Facility failed to give advance notice of a room change for one patient.

F250 Medically related social services.

- D Facility failed to ensure the social worker immediately, thoroughly and completely investigated grievances related to care and complaints of misappropriation of personal property for two patients.
- D Facility failed to ensure medically related social services were provided to three patients.

F253 Housekeeping & maintenance services.

- E Facility failed to provide effective maintenance and housekeeping services to maintain a sanitary, orderly and comfortable environment as evidenced by dirty floors in patient rooms and bathrooms, holes in walls and doors of patient rooms and bathrooms, black marks on the walls and odors in multiple patient rooms.

F254 Clean bed & bath linens.

- D Facility failed to provide linen that was clean and in good condition to meet the needs of two patients.

F257 Comfortable & safe temperature levels.

- D Facility failed to provide a comfortable temperature for bathing in one shower room and failed to provide a comfortable temperature for one patient room.

F258 Comfortable sound levels.

- D Facility failed to maintain comfortable noise levels for two patients.

F272 Comprehensive assessment.

- D Facility failed to assess one patient for dental status and services.

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

- D Facility failed to accurately assess patients for pressure ulcers for one patient.
- D Facility failed to ensure the accuracy of the MDS for hospice.
- D Facility failed to accurately complete a MDS for one patient.

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

- E Facility failed to develop a care plan related to comfort measures, hospice and/or anticoagulant therapy for four patients.
- D Facility failed to ensure a care plan for visual needs was developed for one patient.
- D Facility failed to develop a care plan for psychotropic medication for one patient.

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

- K Facility failed to revise the care plan for four patients with falls and failed to revise the care plan for two patients with pressure ulcers. This failure placed these patients in immediate jeopardy.
- E Facility failed to revise the care plan related to pressure ulcers, nutrition and status of nothing by mouth (NPO). Facility failed to invite the patient or family member to the care plan meeting.
- D Facility failed to revise the care plan for range of motion (ROM) or pressure ulcers for two patients.
- D Facility failed to revise the care plan for two patients.
- D Facility failed to revise the care plan to include assessment of the patient's arteriovenous graft for thrill and bruit to ensure patency at least every shift for one patient.
- D Facility failed to follow the care plan for one patient.

F281 Services must meet professional standards of quality.

- G Facility failed to ensure physician orders for weekly weights had been followed, resulting in harm for one patient.
- D Facility failed to have professionally trained staff provide care for a patient with behavioral health needs.

F282 Services must be provided by qualified persons.

- D Facility failed to provide care and services in accordance with the patient's written plan of care for checking bruit and thrill every shift for one patient.
- D Facility failed to follow interventions for pressure ulcer treatments for one patient.
- D Facility failed to follow interventions for meal intake documentation, diet and/or pressure ulcer treatment for three patients.
- D Facility failed to ensure the care plan was followed for one patient.

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

- E Facility failed to follow physician's orders for four patients reviewed for medications.
- E Facility failed to ensure physician orders were followed for applying geri-sleeves, administering medications, notifying the physician of abnormal blood sugars or obtaining sliding scale insulin for four patients.
- D Facility failed to provide medication in a timely manner for one patient.
- D Facility failed to take a blood pressure and pulse, palpate for thrill and auscultate bruit and document findings upon return from dialysis for one patient.
- D Facility failed to follow physician's orders for three patients.

D Facility failed to follow the facility policy and physician order to obtain post dialysis weights for one patient.

D Facility failed to provide care and services related to dialysis for one patient.

D Facility failed to assess the peripheral access site and complete pre- and post- dialysis documentation per facility policy.

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

D Facility failed to ensure one patient who was unable to carry out activities of daily living (ADLs) received feeding assistance during meals.

D Facility failed to provide activities of daily living (ADL) care for one patient.

D Facility failed to provide oral hygiene and nail care for one patient.

F313 Proper treatment & devices to maintain vision and hearing abilities.

D Facility failed to ensure a patient received eye services and corrective glasses for one patient.

F314 Resident does not develop pressure sores.

L Facility failed to provide wound care for pressure ulcers as ordered for three patients with pressure ulcers. This was also substandard quality of care.

D Facility failed to provide treatments as ordered by the physician to promote healing for one patient.

D Facility failed to provide care and treatment as ordered to promote healing for two patients.

F315 Incontinent resident receives appropriate treatment and services.

G Facility failed to address restoration of normal urinary function and failed to prevent urinary tract infections for a patient with a catheter. This resulted in actual harm to the patient.

E Facility failed to provide treatment and services to restore as much normal bladder function as possible for one patient.

F322 Tube feeding/prevention.

G Facility failed to follow up on the registered dietitian's recommendations to prevent significant weight loss for one patient receiving enteral feeding. This cause actual harm when the patient sustained a significant weight loss.

D Facility failed to properly check the placement of the enteral feeding tube prior to administering medications for one patient.

D Facility failed to elevate the head of the bed for a patient with a feeding tube.

F323 Accident hazards.

L Facility failed to implement an effective fall prevention program for four patients with multiple falls. This placed these patients in immediate jeopardy. This also constitutes a substandard quality of care.

- E Facility failed to ensure staff supervised four patients who were observed smoking and failed to ensure toxic chemicals and razors were securely stored in three shower rooms.
- D Facility failed to ensure that a fall risk evaluations was completed after each fall for two patients.
- D Facility failed to conduct a thorough investigation of two falls sustained by a patient.

F325 Facility must ensure acceptable parameters of nutritional status.

- G Facility failed to ensure nutritional interventions were implemented timely for two patients reviewed for weight loss. This caused actual harm to one patient.
- D Facility failed to follow facility policy for monitoring weight loss for two patients.
- D Facility failed to ensure the correct diet was served to prevent a potential allergic reaction for one patient.
- D Facility failed to document meal intakes or failed to provide assistance with eating for two patients.
- D Facility failed to follow a therapeutic diet as ordered and initiate interventions to prevent weight loss for two patients.

F328 Proper treatment & care for specialized services.

- D Facility failed to correctly transcribe a physician's order for the use of oxygen, failed to follow the facility policy for transcribing and reviewing physician orders and documenting oxygen tubing changes, and failed to provide oxygen therapy to one patient.
- D Facility failed to ensure that the respiratory care equipment was maintained by trained personnel for one patient observed being transported with oxygen.

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

- D Facility failed to attempt a gradual dose reduction of a psychotropic medication or document the reason the medication should not be reduced for one patient.

F332 Facility medication error rates of 5% or more.

- E Facility failed to ensure a medication error rate of less than 5 percent. The error rate was 22.5 percent.
- D Facility failed to correctly administer two medications resulting in a 6 percent medication error rate.
- D Facility failed to ensure medication error rate was less than 5 percent. The error rate was 30 percent.

F333 Residents free of significant medication errors.

- D Facility failed to ensure one nurse administered medications free of significant medication errors. No snack was offered when insulin was administered, and a meal would not be served during the 15-20 minute window.
- D Facility failed to prevent significant medication errors for two patients.

- D Facility failed to administer medications as ordered by the physician resulting in a significant medication error for one patient.
- D Facility failed to prevent significant medication error for one patient. A medication administered for Parkinson's disease was two hours and 15 minutes late for administration.

F356 Nurse staffing data

- D Facility failed to post staffing in a public area. The staffing schedule was located in a nurse's station and not visible to the public.
- D Facility failed to post a completed staffing sheet for one of six days of survey.
- C Facility failed to post the current daily nurse staffing information.

F361 Dietary services staffing.

- F Facility failed to ensure a qualified dietitian provided oversight of the facility kitchen by planning, managing and implementing dietary service activities as evidenced by food outdated, opened food without an open date and wet nesting of pans. There were dusty ceiling lights, dirt build-up under the steam table, lack of appropriate hair restraints worn by staff, chemicals in the food preparation area and a failure to ensure a sufficient amount of emergency food supply was on hand.

F363 Menus meet the nutritional needs.

- E Facility dietary department failed to serve the chicken casserole according to the specified portion for 20 trays. Four ounces was to be served and only two and a half ounces was served.

F371 Store, prepare, distribute, & serve food.

- F Facility failed to maintain a sanitary environment for one refrigerator and one freezer in the dietary department.
- F Facility failed to store food in a sanitary manner and failed to maintain a sanitary kitchen. There were opened and undated food in the walk-in freezer. One oven had a heavy build-up of brown and black debris on the sides, doors and glass windows of the ovens.
- F Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by open food items with no open date, staff not wearing hair restraints, pans and mixer with dried food particles and splatters, and wet nesting of trays, pans and dishware.
- F Facility failed to ensure food was stored, prepared and served under sanitary conditions. This was evidenced by opened food items with no open date, kitchen staff not wearing hair covers correctly, and two staff members failing to perform hand hygiene during dining.
- F Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by wet nested baking sheets and dinner plates, food requiring refrigeration were not in the refrigerator, and open food items with no open date.

F Facility failed to ensure food was prepared and served under sanitary conditions as evidenced by a mixer with white powder in crevices and sticky substance on the base of the mixer, a dirty deep fat fryer, the double ovens were dirty with dried food particle build-up, a male staff member with exposed facial hair.

F Facility failed to provide sanitary conditions in the kitchen for two employees. The hair coverings did not completely cover the hair.

F Facility failed to ensure food was served under sanitary conditions as evidenced by the dietary manager not wearing a beard cover for facial hair on two days of the survey.

F Facility failed to ensure food was stored and prepared under sanitary conditions when one LPN entered the kitchen with no hair covering and a dark brownish substance was on the ice machine.

F Facility failed to maintain a sanitary kitchen for proper cleaning of kitchen equipment, to secure opened, prepared foods and to monitor expired prepared foods.

E Facility failed to ensure food was prepared and served under sanitary conditions as evidenced by male staff members observed in the dishwashing area and kitchen with exposed facial hair.

E Facility failed to ensure food was served under sanitary conditions as evidenced by failure to preform hand hygiene during meal time, dirty meal trays placed on the clean meal cart, a tray of open packaged rolls placed on a medication cart without cleaning the medication cart surface, meal cards touching food and standing water in the bin on the ice cart.

D Facility failed to ensure that food supplements were not stored past their expiration dates in one nourishment room.

D Facility failed to serve food under sanitary conditions as evidenced by three staff members not performing hand hygiene and/or touched food barehanded during dining.

D Facility staff failed to serve food in a sanitary manner as evidenced by handling food with their bare hands and failing to perform hand hygiene after touching a patient.

F372 Disposes of garbage & refuse.

C Facility failed to maintain a clean area, free of debris, for four dumpsters.

F412 Medicaid patients must be provided with dental services.

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

D Facility failed to provide dental services to meet the needs of one patient.

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

D Facility to provide a medication for one patient.

D Facility failed to begin a medication timely as ordered by the physician, resulting in a delay in treatment for a patient with a urinary tract infection (UTI).

F431 Labeling of drugs & biologicals.

- E Facility failed to ensure expired intravenous supplies were not available for patient use for one medication room. Facility failed to ensure opened blood glucose controls were dated when opened and failed to ensure personal food items were not stored in the medication refrigerator.
- E Facility failed to ensure safe and secure storage of medications in five hall medication carts and one medication storage area.
- E Facility failed to ensure medications were properly stored as evidenced by unsecured refrigerator narcotic boxes, medications stored past their expiration dates, and/or medication cart left unattended and out of the sight of the nurse.
- E Facility failed to ensure medications were stored and labeled in seven medication storage areas.
- D Facility failed to properly dispose of one medication requiring disposal.
- D Facility failed to ensure medications were labeled and dated on one medication cart.
- D Facility failed to ensure medications were stored securely in one medication storage area.
- D Facility failed to permit only authorized personnel access to one of the medication rooms. The social worker was in the room using the fax machine with no licensed nurses present.
- D Facility failed to ensure needles, medications and petroleum jelly were not stored past the expiration date in three medications storage rooms.

F441 Investigates, controls/prevents infections.

- F Facility failed to use proper hand washing in between patients.
- E Facility failed to ensure four staff members prevented the potential spread of infection by not performing hand hygiene, handling food bare handed and picking up a napkin from the floor and handing it to a patient to reuse.
- E Facility failed to track and trend infections and failed to prevent the potential spread of infection and cross contamination as evidenced by toilet paper sitting on the bathroom floor, unlabeled urinals and wound care products and briefs stored on the floor in four patient rooms. There were black and brown substances on the walls and ceiling, leaky faucets, feces on the edges of the trash can, clear trash bag with dirty clothes on the floor, disinfectant cleaner sitting on the HVAC unit, dirty grout and dirt build-up on wheels of the shower chairs. The facility failed to process linens so as to prevent the spread of infection in one washer.
- D Facility failed to ensure hands were disinfected after glove removal during a dressing change for one patient.
- D Facility failed to ensure the isolation policy was followed for one patient in isolation, and one LPN failed to perform hand hygiene during medication administration.
- D Facility failed to follow the infection-control policy to don gloves before a subcutaneous injection for one patient.

D Facility failed to ensure practices to prevent the potential spread of infection were maintained when two nurses administering medications dried their clean hands with a paper towel which they had used to turn off the faucet.

D Facility failed to ensure infection control principles were maintained during medication administration for one patient.

D Facility failed to ensure practices to prevent the potential spread of infection were maintained by failing to follow the physician's orders for patients with a potential infectious disease, failing to maintain sanitary conditions during dining and lack of hand hygiene during dining by staff members.

D Facility failed to ensure practices to prevent the potential spread of infection were maintained in one laundry room.

D Facility failed to utilize proper hand washing during lunch service between patient rooms for four patients.

D Facility failed to ensure one LPN performed hand hygiene to prevent the potential spread of infection during medications administration. She did not wash her hands between gloves.

D Facility failed to ensure one nurse performed practices to prevent the potential spread of infection.

D Facility failed to maintain clean linen storage to prevent the spread of infection for one linen cart. There were items other than linen on the cart.

D Facility failed to handle food in a safe manner during dining observations. A CNA touched the patient's food with bare hands.

D Facility failed to perform hand hygiene to ensure food trays were delivered to patients in a sanitary manner in one hallway.

F456 Sufficient space & equipment maintenance.

E Facility failed to maintain two essential pieces of equipment (washing machines) in the laundry as evidenced by a washer leaking water and a washer out of order. One washer had been out of order for two months.

F463 Resident call system.

E Facility failed to ensure the patient call system was functional and in working order on three halls.

F464 Designated rooms for dining & activities.

E Facility failed to provide adequate space for patient dining during two dining observations.

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

E Facility failed to ensure the environment was safe and sanitary as evidenced by tiles broken or missing, black and brown substance on the walls and ceiling in shower rooms, leaky faucets and feces on the edges of the trash can. There was a clear plastic bag of dirty clothes laying on the floor and disinfectant cleaner sitting on the HVAC unit. There was dirty grout, diet build-up on wheels of a shower chair and foul, offensive odors in two shower rooms.

D Facility failed to ensure the environment was clean, sanitary and free of offensive odors on one hall.

F469 Effective pest control.

D Facility failed to ensure the facility was free of from pests as evidenced by ants in one patient room.

F490 Administration.

L Facility failed to be administered in a manner to ensure notification of family of changes in condition, to prevent neglect by not providing treatment and services for prevention of pressure ulcers, to investigate injuries of unknown origin, to provide wound care and treatments as ordered by the physician, to restore bladder function and prevent UTIs, to ensure revision of care plans were done with appropriate falls interventions, and to prevent or treat pressure ulcer. There was a failure to ensure appropriate and individualized interventions was implemented to prevent patient from having multiple falls and injuries with the falls.

F493 Governing body.

L Facility medical director failed of ensure notification to family of changes in condition, to prevent neglect by not providing treatment and services for prevention of pressure ulcers, to investigate injuries of unknown origin, to provide wound care and treatments as ordered by the physician, to restore bladder function and prevent UTIs, to ensure revision of care plans were done with appropriate falls interventions and to prevent or treat pressure ulcer. There was a failure to ensure appropriate and individualized interventions was implemented to prevent patient from having multiple falls and injuries with the falls.

F497 Regular in-service education.

F Facility failed to ensure 17 CNAs employed the entire year received at least 12 hours of in-service education.

D Facility failed to ensure one CNA employed the entire year received at least 12 hours of in-service training.

F498 Proficiency of nurse aides.

E Facility failed to ensure six facility CNAs had documentation of competency in skills and techniques necessary to provide care for patients.

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.

L Facility failed to be administered in a manner to ensure notification to family of changes in condition, to prevent neglect by not providing treatment and services for prevention of pressure ulcers, to investigate injuries of unknown origin, to provide wound care and treatments as ordered by the physician, to restore bladder function and prevent UTIs, to ensure revision of care plans were done with appropriate falls interventions and to prevent or treat pressure ulcer. There was a failure to ensure appropriate and individualized interventions was implemented to prevent patient from having multiple falls and injuries with the falls.

F502 Provide or obtain clinical laboratory services.

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

D Facility failed to obtain lab work timely for one patient.

F505 Promptly notify physician of findings of lab results.

D Facility failed to report lab work results to the physician in a timely manner for one patient.

D Facility failed to notify the physician of laboratory results causing a delay in receiving treatment for one patient.

F514 Criteria for clinical records.

E Facility failed to have patient records readily accessible and systematically organized which caused a delay in obtaining necessary information and failed to have accurate and complete documentation for seven patients.

D Facility failed to maintain a complete and accurate clinical record for one patient.

D Facility failed to ensure accurate documentation for ADL care was completed for one patient.

D Facility failed to maintain an accurate and complete medication record for one patient.

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

D Facility failed to ensure a discharged patient medical record was complete. There was no order on the chart to pronounce the patient's death or to release the body to the mortuary.

F517 Emergency/disaster plans.

F Facility failed to ensure emergency food supplies were on hand at all times, as evidenced by insufficient amount of food in the emergency food supply.

- F Facility failed to ensure emergency food supplies were on hand at all times as evidenced by an insufficient amount of food in the emergency supply closet.

F520 Quality assessment & assurance.

- L Facility quality assurance committee failed to ensure notification of family of changes in condition, to prevent neglect by not providing treatment and services for prevention of pressure ulcers, to investigate injuries of unknown origin, to provide wound care and treatments as ordered by the physician, to restore bladder function and prevent UTIs, to ensure revision of care plans were done with appropriate falls interventions and to prevent or treat pressure ulcer. There was a failure to ensure appropriate and individualized interventions was implemented to prevent patient from having multiple falls and injuries with the falls.
- E Facility quality assurance (QA) committee was found ineffective as evidenced by repeat deficiencies for failure to ensure the environment was clean and sanitary; pressure ulcer interventions were followed; physicians orders were followed; medical records were organized and accessible; and infection control policies were followed. The QA committee failed to identify issues and develop and implement appropriate plan of action to correct quality issues.

K011 Common Wall

- F Facility failed to maintain their fire doors. There were unsealed penetrations in some of the doors.
- E Facility failed to ensure corridor doors would close to a positive latch.
- D Facility failed to maintain the fire resistance of fire barriers and communicating openings. There were unsealed penetrations in the fire wall.

K018 Construction of Doors

- F Facility failed to maintain doors protecting corridor openings. There was a wedge holding doors open in multiple areas of the facility.
- E Facility failed to maintain doors to resist the passage of smoke. There were penetrations around the door knob cover plate on the door to the dining room.
- E Facility failed to ensure corridor doors closed to a positive latch.
- E Facility failed to maintain doors protecting corridor openings. The releases were not working properly.
- D Facility failed to provide doors with only one releasing motion.
- D Facility failed to maintain the doors protecting the corridors.
- D Facility failed to maintain the corridor doors. The door did not latch within the frame.

K020 Sleeping Room Egress

- D Facility failed to maintain vertical openings. There were penetrations in the fire wall.

- D Facility failed to ensure stairwell fire doors were maintained.

K021 Automatic Closing Doors

- D Facility failed to have a fire door close and latch.
- D Facility failed to maintain the corridor doors.
- D Facility failed to maintain corridor doors.
- D Facility failed to maintain the cross corridor fire doors. They did not latch positively to the frame.
- D Facility failed to have fire doors close and latch.

K022 Enclosure Doors Serving Exits

- E Facility failed to properly identify doors as not an exit.

K025 Smoke Partition Construction

- E Facility failed to maintain fire/smoke barriers.
- E Facility failed to ensure smoke barrier walls are being maintained. There were unsealed penetrations in the fire wall.
- D Facility failed to ensure smoke barrier's one hour fire rated construction is maintained.
- D Facility failed to maintain the fire/smoke detectors.
- D Facility failed to maintain the fire/smoke barriers.
- D Facility failed to maintain the fire/smoke barriers.
- D Facility failed to ensure fire barrier's with one hour fire rated construction are maintained.
- D Facility failed to maintain smoke/fire barriers. There were unsealed penetrations in the fire wall.

K027 Doors In Smoke Barriers

- D Facility failed to maintain smoke doors.

K029 Hazardous Areas Separated By Construction

- F Facility failed to provide hazardous areas with one hour fire rated protection.
- D Facility failed to have self-closing hazardous room doors.
- D Facility failed to ensure hazardous areas are protected by one hour fire rated construction.
- D Facility failed to provide hazardous rooms with smoke resistant smoke partitions and doors that are self-closing.
- D Facility failed to have self-closing doors to hazardous areas.

- D Facility failed to maintain one hour fire walls in hazardous areas. There were unsealed penetrations in the wall.
- D Facility failed to maintain the one-hour fire walls.
- D Facility failed to ensure hazardous areas are protected by one hour fire rated construction.

K038 Exit Accessible At All Times

- F Facility failed to have an irreversible process on delayed egress doors.
- F Facility failed to provide the required delayed egress signage.
- E Facility failed to maintain the exits. When the fire alarm was silenced the delayed egress locks reactivated.
- E Facility failed to arrange exits so that they are readily accessible at all times. The signage is faded and not clearly visible.
- D Facility failed to maintain the exits.
- D Facility failed to only have one releasing motion on doors and approved locking hardware.
- D Facility failed to ensure an exit access from the building was of a hard surface so as not to impede exit access during inclement weather.
- D Facility failed to maintain exit doors.
- D Facility failed to provide exit access that are readily accessible at all times. The gate at one exit was difficult to open.

K047 Exit Signs

- D Facility failed to maintain all exit signs. One of the exit sign lights was not working.

K051 Fire Alarm System

- F Facility failed to have smoke detector sensitivity checked every two years.
- F Facility failed to have magnetically locked doors and corridor hold open devices release and de-energize during fire alarm activation.
- E Facility failed to ensure smoke detectors were mounted at least three feet from airflow.

K052 Testing of Fire Alarm

- F Facility failed to ensure smoke detector sensitivity testing is tested in accordance with NFPA 72.
- F Facility failed to maintain the fire-sprinkler system.
- F Facility failed to maintain the fire alarm system.
- F Facility failed to install smoke detectors more than three feet from air-flow registers.
- F Facility failed to ensure smoke detector sensitivity was conducted every two years.

- D Facility failed to maintain the fire alarm. The smoke detector in one elevator shaft had not been tested annually.
- D Facility failed to maintain the fire alarm. There was a smoke detector within three feet of a heating and air diffuser.
- D Facility failed to ensure smoke detectors were not installed within three feet of air flow registers.
- D Facility failed to maintain the fire alarm system. The strobes at the nurses station were not synchronized.
- D Facility failed to maintain the fire alarm system. Two duct detectors on the roof were not supervised by the fire alarm system.

K061 Automatic Sprinkler - Main Control Valve

- F Facility failed to maintain the sprinkler system supervisory attachments.
- E Facility failed to ensure sprinkler system control valves were provided with electronic supervisory tamper switches.
- D Facility failed to ensure sprinkler system control valves were provided with electronic supervisory tamper switches.

K062 Automatic Sprinkler - Maintenance

- F Facility failed to maintain the automatic sprinkler system. No 10-year dry sprinkler test had been conducted.
- F Facility failed to maintain the automatic sprinkler system. There are a variety of different sprinkler heads being utilized in the facility.
- E Facility failed to maintain the fire-sprinkler system. There were some corroded sprinkler heads in the facility.
- E Facility failed to maintain the sprinkler system.
- E Facility failed to maintain the sprinkler system.
- E Facility failed to maintain all sprinkler heads. There was paint on several of the sprinkler heads.
- E Facility failed to maintain the sprinkler system.
- E Facility failed to maintain the sprinkler system. There were corroded sprinkler heads in the facility.
- D Facility failed to maintain an 18 inch clearance around the sprinkler heads.
- D Facility failed to ensure the sprinkler system is being maintained. There was paint on several of the sprinkler heads.
- D Facility failed to maintain the sprinkler system. One of the sprinkler heads was loose.
- D Facility failed to maintain the sprinkler system.

- D Facility failed to maintain sprinkler heads assemblies with the same characteristics. There were different types of sprinkler heads in the facility.
- D Facility failed to maintain the sprinkler system.
- D Facility failed to maintain the sprinkler system.
- D Facility failed to maintain the sprinkler system and its components.
- D Facility failed to maintain the automatic sprinkler system in reliable operating condition.

K064 Portable Fire Extinguishers

- E Facility failed to maintain four of 13 fire extinguishers.
- D Facility failed to provide signage for the K class fire extinguisher in the kitchen.
- D Facility failed to maintain the fire extinguishers.
- D Facility failed to do monthly inspections on all fire extinguishers.

K066 Smoking Regulations

- D Facility failed to provide metal containers with self-closing lids at designated smoking areas into which ashtrays can be emptied into.
- D Facility failed to ensure designated smoking areas were provided with a metal container with a self-closing lid.

K067 Ventilating Equipment

- F Facility failed to ensure the four-year damper maintenance had been conducted.
- E Facility failed to install and protect HVAC duct penetrations by fire dampers.

K069 Commercial Cooking Equip. Meets Requirements

- D Facility failed to limit the movement of gas equipment with casters to prevent strain on the connection.
- D Facility failed to ensure kitchen cooking equipment complied with NFPA 54.
- D Facility failed to maintain all kitchen equipment. The deep fryer was within 16 inches of the gas range burners.
- D Facility failed to conduct monthly inspection on all fire extinguishing equipment.
- D Facility failed to ensure commercial cooking equipment producing grease-laden vapors complies with NFPA 54.

K070 Space Heaters

- E Facility was using unapproved portable space heaters.
- D Facility failed to prohibit portable space heaters. Several of the offices had portable space heaters that were in operation.

- D Facility failed to ensure unapproved heaters were not being used in the facility.

K072 Furnishings and Decorations

- F Facility failed to ensure corridors in the means of egress were maintained clear of all obstructions.
- D Facility failed to maintain exit corridors of all obstructions. A table and chairs was blocking one of the exit doors.
- D Facility failed to have the means of egress continuously maintained free of all obstructions.

K073 Flammable Furnishings

- F Facility failed to ensure combustible decorations were not highly flammable.
- E Facility failed to ensure combustible decorations were not highly flammable.
- E Facility failed to ensure combustible decorations were not highly flammable.

K076 Nonflammable Medical Gas Systems

- D Facility failed to ensure electrical components in medical gas storage locations were located greater than five feet above the floor.
- D Facility failed to maintain the oxygen storage area.
- D Facility failed to ensure electrical components in medical gas storage locations were located greater than five feet above the floor.
- D Facility failed to ensure medical gasses were stored properly.

K077 Piped-In Oxygen System

- D Facility failed to maintain medical gas piping.

K104 Penetration of Smoke Barriers

- E Facility failed to maintain all fire compartments. There were penetrations in the fire walls.
- D Facility failed to provide testing on all fire dampers. The fusible link fire dampers had not been inspected.
- D Facility failed to maintain the fire dampers. The four-year damper inspection had not been done.
- D Facility failed to provide four year inspection and testing of fire dampers.
- D Facility failed to maintain the fire dampers. The four year fire damper inspection had not been done.

K130 Other LSC Deficiency Not On 2786

- F Facility failed to install correct hardware on fire doors.
- E Facility failed to maintain the fire doors.

E Facility failed to maintain the sprinkler system.

E Facility failed to provide ventilation and outside exhaust to all patient toilets and support areas.

E Facility failed to maintain fire doors to ensure labeling is visible. The labels had been painted over on some of the doors.

E Facility failed to maintain the fire resistive rating of fire barriers to maintain the fire resistive rating of fire barriers and communicating openings.

E Facility failed to maintain the fire resistive rating of fire barriers.

E Facility failed to maintain the fire resistive rating of fire barriers. There were penetrations in the fire wall.

D Facility failed to maintain the fire walls.

D Facility failed to maintain their fire rated door assemblies.

D Facility failed to properly identify oxygen in use.

D Facility failed to secure an oxygen cylinder bottle to prevent possible damage.

D Facility failed to maintain special locking arrangements.

D Facility failed to maintain all exhaust fans.

D Facility failed to seal all penetrations in the fire walls.

D Facility failed to seal all penetrations in the fire rated assemblies.

D Facility failed to comply with the Life Safety Code when an oxygen tank was stored within five feet of combustible material in the oxygen storage room.

D Facility failed to provide an annunciator for the emergency generator.

K142 Electrical System

D Facility failed to maintain the electrical system.

K144 Generators

F Facility failed to maintain the generator. There was no documentation to show that the generator is having a two or four hour load bank test.

F Facility failed to ensure generator was being maintained and exercised as required.

F Facility failed to maintain the generator and its components.

F Facility failed to perform the annual load bank test on the generator.

D Facility failed to maintain battery-powered emergency lighting at the generator site.

D Facility failed to provide load bank testing for the generator.

D Facility failed to provide documentation for one monthly load test on the generator.

D Facility failed to maintain generators in accordance with NFPA 110. The generator transfer switch room in the dietary department was not provided with backup emergency battery power.

K147 Electrical Wiring and Equipment

F Facility failed to maintain the electrical system.

E Facility failed to maintain clearance in front of electrical equipment.

E Facility failed to maintain the electrical system.

E Facility failed to maintain the electrical system. There was equipment in patient rooms connected to power strips.

E Facility failed to maintain the electrical system. There was medical equipment plugged into power strips in multiple locations.

E Facility failed to prohibit the use of extension cords and improper use of power strips.

E Facility failed to provide electrical junction boxes as required. The electrical wiring to the fan was exposed and required a junction box.

E Facility failed to ensure electrical equipment was in accordance with NFPA 99. There were power strips being used with medical equipment.

E Facility failed to maintain all electrical outlets.

D Facility failed to maintain the electrical system. There was a power strip being used in a patient room for medical equipment.

D Facility failed to maintain the electrical system.

D Facility failed to maintain the electrical system. There was exposed wiring under the heating and air units in one of the areas.

D Facility failed to provide adequate amount of electrical outlets to prohibit the use of extension cords and multi-plug adapters.

D Facility failed to install ground faulty circuit interrupter (GFCI) receptacles within six feet of a water source.

D Facility failed to maintain the electrical system. There were some loose electrical outlets.

D Facility failed to maintain the electrical system. There was an extension cord powering the fountain in courtyard.

D Facility failed to maintain clearance in front of electrical panels.

D Facility failed to maintain the electrical system. There were power strips in use.

D Facility failed to ensure electrical equipment was in accordance with approved codes. There were extension cords in use.

K211 Alcohol Based Hand Rub Dispensers

D Facility failed to provide alcohol based hand rubs from being installed over an ignition source.

N1409 Disaster Preparedness; Physical Facility and Community Emergency Plans

Facility failed to conduct fire drills.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

Facility failed to exercise an earthquake drill annually.

Facility failed to conduct disaster drills.

N1411 Disaster Preparedness; Fire Safety Drills

Facility failed to exercise a bomb threat drill annually.

Facility failed to exercise bomb threat drills annually.

N1535 Nurse Aide Training; Performance Reviews

Facility failed to ensure 17 CNAs employed the entire year received at least 12 hours of in-service education.

N401 Administration

Facility failed to be administered in a manner to ensure notification to family of changes in condition, to prevent neglect by not providing treatment and services for prevention of pressure ulcers, to investigate injuries of unknown origin, to provide wound care and treatments as ordered by the physician, to restore bladder function and prevent UTIs, to ensure revision of care plans were done with appropriate falls interventions and to prevent or treat pressure ulcer. There was a failure to ensure appropriate and individualized interventions was implemented to prevent patient from having multiple falls and injuries with the falls.

N410 Administration; Personal Property

Facility failed to maintain a personal property record for one patient.

N421 Administration; Verification of Personnel Licensure

Facility failed to frame and permanently affix the Title VI/Section 504 policy in the main public entrance as required for one of three public notices.

N424 Administration; Filed Documentation of Abuse Registries

Facility failed to implement an effective fall prevention program for four patients with multiple falls. This placed these patients in immediate jeopardy. This also constitutes a substandard quality of care.

N425 Administration; Adequate Medical Screenings of Employees

Facility failed to display the liability insurance notice in the main public entrance as required for one of three public notices.

N430 Administration; Facility Information Postings

Facility failed to display the domestic violence statement and hotline number in the main public entrance as required for one of three public notices.

N505 Admissions, Discharges and Transfers; PAE

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

N601 Performance Improvement Program

Facility quality assurance committee failed to ensure notification of family of changes in condition, to prevent neglect by not providing treatment and services for prevention of pressure ulcers, to investigate injuries of unknown origin, to provide wound care and treatments as ordered by the physician, to restore bladder function and prevent UTIs, to ensure revision of care plans were done with appropriate falls interventions and to prevent or treat pressure ulcer. There was a failure to ensure appropriate and individualized interventions was implemented to prevent patient from having multiple falls and injuries with the falls.

N611 Physician Services; Dental Services

Facility failed to provide dental services to meet the needs of one patient.

N615 Medical Director Responsibilities

Facility failed to be administered in a manner to ensure notification of family of changes in condition, to prevent neglect by not providing treatment and services for prevention of pressure ulcers, to investigate injuries of unknown origin, to provide wound care and treatments as ordered by the physician, to restore bladder function and prevent UTIs, to ensure revision of care plans were done with appropriate falls interventions and to prevent or treat pressure ulcer. There was a failure to ensure appropriate and individualized interventions was implemented to prevent patient from having multiple falls and injuries with the falls.

N645 Nursing Services

Facility failed to provide effective maintenance and housekeeping services to maintain a sanitary, orderly and comfortable environment as evidenced by dirty floors in patient rooms and bathrooms, holes in walls and doors of patient rooms and bathrooms, black marks on the walls and odors in multiple patient rooms. This was a type C pending penalty.

Facility failed to ensure safe storage of toxic chemicals in two wings of the facility. This was a type C pending penalty.

N682 Pharmaceutical Services; Storage of Medications

Facility failed to revise the care plan for four patients with falls and failed to revise the care plan for two patients with pressure ulcers. This failure placed these patients in immediate jeopardy.

N688 Nursing Services; Restraints

Facility failed to provide wound care for pressure ulcers as ordered for three patients with pressure ulcers. This was also substandard quality of care.

N727 Pharmaceutical Services

Facility failed to ensure safe and secure storage of medications in five hall medication carts and one medication storage area. This was a type C pending penalty.

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

N729 Pharmaceutical Services

Facility failed to ensure medications were stored and labeled in seven medication storage areas. This was a type C pending penalty.

N765 Food and Dietetic Services; Freezer Temperature

Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by open food items with no open date, staff not wearing hair restraints, pans and mixer with dried food particles and splatters, and wet nesting of trays, pans and dishware. This was a type C pending penalty.

Facility failed to ensure food was prepared and served under sanitary conditions as evidenced by male staff members observed in the dishwashing area and kitchen with exposed facial hair. This was a type C pending penalty.

Facility failed to ensure food was stored, prepared and served under sanitary conditions. This was evidenced by opened food items with no open date, kitchen staff not wearing hair covers correctly, and two staff members failing to perform hand hygiene during dining. This was a type C pending penalty.

Facility failed to ensure food was served under sanitary conditions as evidenced by failure to preform hand hygiene during meal time, dirty meal trays placed on the clean meal cart, a tray of open packaged rolls placed on a medication cart without cleaning the medication cart surface, meal cards touching food and standing water in the bin on the ice cart. This was a type C pending penalty.

Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by wet nested baking sheets and dinner plates, food requiring refrigeration were not in the refrigerator, and open food items with no open date. This was a type C pending penalty.

Facility failed to ensure food was prepared and served under sanitary conditions as evidenced by a mixer with white powder in crevices and sticky substance on the base of the mixer, a dirty deep fat fryer, the double ovens were dirty with dried food particle build-up, a male staff member with exposed facial hair. This was a type C pending penalty.

Facility failed to ensure a qualified dietitian provided oversight of the facility kitchen by planning, managing and implementing dietary service activities as evidenced by food outdated, opened food without an open date and wet nesting of pans. There were dusty ceiling lights, dirt build-up under the steam table, lack of appropriate hair restraints worn by staff, chemicals in the food preparation area and a failure to ensure a sufficient amount of emergency food supply was on hand. This was a type C pending penalty.

Facility failed to ensure food was served under sanitary conditions as evidenced by the dietary manager not wearing a beard cover for facial hair on two days of the survey. This was a type C pending penalty.

Facility staff failed to serve food in a sanitary manner as evidenced by handling food with their bare hands and failing to perform hand hygiene after touching a patient. This was a type C pending penalty.

Facility failed to ensure food was stored and prepared under sanitary conditions when one LPN entered the kitchen with no hair coving and a dark, brownish substance was on the ice machine. This was a type C pending penalty.

N779 Social Work Services; Availability of Social Services

Facility failed to ensure a social history was obtained for four patients.

N831 Building Standards; Construction

Facility failed to maintain the condition of the physical plant and overall nursing home environment for the safety of the patients.

Facility failed to maintain the fire doors. Some of the fire rating labels on the doors had been painted over.

Facility failed to maintain the overall environment of the nursing home. There were water stains on some of the ceiling tiles.

Facility failed to maintain the overall environment. There was a water damaged wall in one room.

N835 Building Standards; Approval of New Construction

Facility failed to ensure negative air pressure was maintained in dirty areas.

Facility failed to obtain prior written approval from the plans review office at the Department of Health to add a pantry inside the food storage area.

Facility failed to ensure new fire alarm system upgrade was made with prior approval from the Department of Health.

Facility failed to ensure alterations to the fire alarm system were made without prior approval from the Department of Health.

Facility failed to obtain written approval for alterations to the facility.

N843 Building Standards; New Construction and Renovation

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

N848 Building Standards; Exhaust & Air Pressure

Facility failed to maintain exhaust systems. Negative air pressure was not maintained in the staff bathroom.

N853 Building Standards

Facility failed to have an operable exhaust in dirty rooms.

N901 New Code Compliance

Facility failed to comply with the required applicable building and fire safety regulations. The emergency generator was not secured to the concrete pad.

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