Survey Deficiency Summary

20 Facilities Surveyed **Surveys Taken 10/20/2016 - 12/7/2016**

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

J Facility failed to promptly notify the physician of the presence of a pressure ulcer for two patients. This failure placed the patients in immediate jeopardy.

E Facility failed to notify the physician of eleven missed doses of an intravenous antibiotic for one patient.

D Facility failed to promptly notify the physician of a change in condition for one patient.

F160 Conveyance of funds upon death.

D Facility failed to convey a patient's funds within 30 days after death.

F161 Assurance of financial security.

E Facility failed to ensure the surety bond covered the amount in the patient trust for 43 patients.

F167 Right to examine survey results of the facility.

C Facility failed to label and place the state survey results in a readily accessible location for patient use.

F176 Self-administration of drugs by resident.

D Facility failed to evaluate one patient for safe self-administration of medications.

F203 Notice before transfer or discharge.

D Facility failed to timely notify a family member or legal representative of a patient's discharge plans, including the reason for the discharge, effective date of the discharge and right of appeal for one patient.

F221 Right to be free from physical restraints.

G Facility failed to ensure one patient reviewed for physical restraints was assessed and reassessed for the least restrictive device, failed to monitor the patient in the restraint and failed to have an active plan in place to decrease the usage and/or eventual removal of the restraint. These failures resulted in actual harm to the patient.

F222 Right to be free from chemical restraints.

J Facility failed to ensure two patients were free from chemical restraints administered to manage a patient's behavior and not required to treat the patient's medical symptoms. This failure placed two patients in immediate jeopardy.

F223 Right to be free of physical/verbal abuse.

K Facility failed to prevent mental, physical and verbal abuse for nine patients. This systematic failure to immediately remove the accused, failure to report allegations to administration and failure to investigate allegations of abuse placed 6 patients in immediate jeopardy. This was also sub-standard quality of care.

J Facility failed to protect one patient from physical and mental abuse. There was a video recording of a staff member who forcefully and repeatedly struck out at the patient.

F224 Mistreatment, neglect, misappropriation of resident property.

J Facility failed to prohibit mistreatment, neglect and abuse for one patient. This failure placed one patient in immediate jeopardy.

J Facility failed to provide services to prevent neglect for three patients. The facility's failure to provide services to prevent neglect is likely to place all patients requiring assistance with incontinence care in immediate jeopardy. This was also substandard quality of care.

D Facility failed to follow their policy for controlled substances which allowed for misappropriation of narcotics for one patient.

D Facility failed to ensure patients were free from abuse for one patient.

F225 Facility must not hire person with abuse history.

K Facility failed to immediately report allegations of abuse and complete thourough investigations for allegations of abuse for seven patients. This placed all patients in immediate jeopardy. This was also substandard quality of care.

D Facility failed to identify, investigate and report an allegation of abuse for one patient.

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

D Facility failed to conduct a complete in-depth investigation into injuries of unknown origin for two patients.

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

J Facility failed to ensure all staff followed the facility policies that identified, intervened and immediately reported situations in which abuse, neglect and mistreatment occurred for one patient. This failure placed the patient in immediate jeopardy.

D Facility failed to ensure facility staff followed the facility policy for immediate reporting of any allegation of abuse for one patient.

D Facility failed to follow their abuse policy for immediate suspension of an employee accused of abusive behavior toward a patient.

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

J Facility failed to provide timely incontience care to maintain dignity for three dependent patients. This failure placed the patients in immediate jeopardy. This was also substandard quality of care.

D Facility failed to promote patient dignity in dining in dining room. The patients were drinking milk from the cartons. There was no evidence they had been asked if they preferred a cup.

D Facility failed to maintain the dignity for one patient. The patient was not given privacy during wound care treatment. The blinds were not closed.

D Facility failed to maintain dignity for one patient observed during dining. The patient was at the table eating with another patient. The patient had an actively bleeding skin tear on his arm that was dressed at the table by the LPN rather than taking the patient to a private place.

F250 Medically related social services.

J Facility social worker failed to ensure the patient was assessed in a timely manner, frequently visited, allowed to verbalize fears/concerns and provided psychological support following a known abuse for one patient.

F253 Housekeeping & maintenance services.

D Facility failed to keep one air intake vent clean and free of dust, lint and debris.

F258 Comfortable sound levels.

E Facility failed to maintain comfortable noise levels
in the facility. There was a patient who had increased agitation and was screaming out throughout the day.

F272 Comprehensive assessment.

D Facility failed to ensure a comprehensive assessment was completed for one patient.

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

J Facility failed to revise the care plan to ensure appropriate interventions to meet the patients needs with restrains, behaviors and falls for two patients. This failure placed one patient in immediate jeopardy.

J Facility failed to revise the care plan to include interventions for an immobilizer for two patients and failed to revise the care plan for pressure ulcers for three patients. This failure placed the patients in immediate jeopardy.

F285 Preadmission screening for mentally ill individuals.

D Facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed for one patient.

F287 Automated data processing requirement of resident's assessments.

D Facility failed to submit MDS information for one patient.

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

J Facility failed to provide wound assessment and treatment for three patients for non-pressure wounds; failed to obtain weights as ordered for one patient with congestive heart failure; and failed to follow facility policy for taking pre-and post vital signs and monitoring of a dialysis catheter. This failure placed the patients in immediate jeopardy and substandard quality of care.

G Facility failed to provide continuing neurological assessments after a patient on anticoagulant medication fell, resulting in harm to the patient.

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

J Facility failed to provide incontinence care for three patients. This failure caused the patients to be in immediate jeopardy. This was also substandard quality of care.

F314 Resident does not develop pressure sores.

J Facility failed to provide the necessary care to prevent avoidable pressure sores from developing or worsening for three patients. This failure placed the patients in immediate jeopardy. This is also substandard quality of care.

F315 Incontinent resident receives appropriate treatment and services.

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

F319 Psychosocial adjustment difficulty.

J Facility failed to identify the root cause of the behaviors, track, trend and analyze negative behaviors to the purpose of appropriate interventions, update individualized care plans with goals and interventions for appropriate restraints, yelling and screaming and self injurious behavior were effective for three patients. This failure place two patients in immediate jeopardy.

F322 Tube feeding/prevention.

D Facility failed to verify placement of a PEG tube for one patient prior to administration of water through the tube.

F323 Accident hazards.

K Facility failed to investigate all falls, failed to put interventions in place to prevent further falls, failed to supervise patients appropriately to prevent falls, failed to perform fall risk assessments, neurological assessments and accurately document for 72 hours after falls for three patients. The facility failed to ensure the environment was free from accident hazards for chemicals, medications, aerosol sprays, an unhinged closet door and sharps in six patient rooms. The facility failed to ensure sharp containers were safe and secure as evidenced by sharps being full past the fill line, missing closure flaps, improperly attached closure flaps and an improper disposal of a razor in a sharps container (it was above the flap and not in the container) in 11 patient rooms.

G Facility failed to identify an accident hazard and implement interventions to reduce the risk of injury for one patient. This failure resulted in actual harm from a fractured tibia/fibula.

D Facility failed to maintain a patient room free of hazards on one hallway of five hallways observed. There were two over-the-counter medications on the bedside table in on patient room.

F332 Facility medication error rates of 5% or more.

D Facility failed to administer medication without error rate of 5 percent or less. The error rate was 6.45 percent.

D Facility failed to properly administer medications resulting in a 6.45 percent error rate.

F333 Residents free of significant medication errors.

E Facility failed to ensure one patient was free of a significant medication error. Multiple doses of an intravenous antibiotic were ordered and not administered.

F353 Adequate nursing staff to provide nursing & related services..

K Facility failed to ensure adquate staffing to provide necessary personal care assistance and incontinence care in a timely manner for 11 patients. This failure caused the patients to be immediate jeopardy.

F356 Nurse staffing data

C Facility failed to accurately post the daily nurse staffing data for two days.

F371 Store, prepare, distribute, & serve food.

F Facility failed to maintain sanitary conditions and failed to safely store canned foods in the dietary department.

F Facility failed to maintain a proper temperature for one reach-in cooler, to label and date repackaged foods and to separate staff and patient food.

F Facility failed to properly store dry stock and frozen food items in a sanitary manner; failed to serve food in a sanitary manner; failed to ensure kitchen equipment, walk-in cooler and non-food contact surfaces were clean; and failed to properly air dry steam table pans in five stacked steam table pans.

F Facility failed to maintain sanitary conditions in the kitchen. Hair nets and/or beard restraints were not being used by all dietary employees.

F372 Disposes of garbage & refuse.

D Facility failed to safely dispose of regulated waste for one dumpster. There was a syringe, a blood glucose lancet, two medicine cups and one glove lying on the ground outside of the dumpster.

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

D Facility pharmacist failed to recognize and report the staff were not assessing the heart rate prior to the administration of Digoxin for one patient.

D Facility pharmacy failed to notify the attending physician and director of nursing regarding low trough (blood levels) of the monitored IV antibiotic Vancomycin for one patient.

F431 Labeling of drugs & biologicals.

F Facility failed to appropriately store medications and biologicals for two medication storage rooms.

D Facility failed to maintain the control of the controlled substance inventory for one patient. A nurse diverted Ativan for her own use.

D Facility failed to properly store liquid Ativan in the medication refrigerator according to manufacturer's recommendations and as labeled by the pharmacy.

D Facility failed to ensure controlled substances were securely stored on one medication cart and failed to verify waste of a narcotic and antianxiety medication for four patients.

D Facility failed to ensure flood glucose control strips were not expired and available for use for one medication cart.

F441 Investigates, controls/prevents infections.

F Facility failed to ensure infection control precautions for two medication storage rooms.

E Facility failed to ensure staff wore appropriate personal protective equipment (PPE) before entering an isolation room for a patient with C. Diff.

D Facility failed to establish and maintain standard precautions during a pressure ulcer dressing change for one patient.

D Facility failed to serve food in the dining room in a sanitary manner for three patients and failed to ensure a sanitary environment related to the sanitizing or washing of the hands during the medication pass.

D Facility failed to perform proper hand hygiene between the delivery and set-up of lunch trays for four patients.

D Facility staff failed to sanitize the hands after patient contact on one wing.

F464 Designated rooms for dining & activities.

F Facility failed to provide adequate ventilation during and after patient and staff smoking breaks for two hallways and one dining room. There was a strong lingering odor of cigarette smoke.

F469 Effective pest control.

F Facility failed to eliminate the presence of insects; failed to eliminate sources of food and failed to routinely clean to eliminate harborage conditions in the dietary department.

F490 Administration.

K Facility administration failed to use resources effectively and efficiently to attain and maintain the highest practicable functioning of all patients by failing to ensure an effective quality assurance program that recognized and developed an appropriate plan to ensure patients were free from physical and chemical restraints. The administration failed to ensure protection of patients from abuse and neglect and failed to properly investigate an allegation of abuse. The administration failed to have an effective abuse and neglect policy. The administration failed to ensure the patients' environment was free from the accident hazards of chemicals, medications, aerosol sprays and sharps. Administration failed to ensure effective care plan interventions related to falls, restraints, and behaviors. Administration failed to ensure the consultant pharmacist recognized and reported the staff were not assessing the patient's heart rate prior to the administration of Digoxin. Administration failed to ensure that a patient was monitored for agitation prior to administration of PRN Ativan. The administration failed to ensure a CNA was working with a current certification. Administration failed to ensure medical records were accurate and complete. The administration failed to ensure the QA program was effective in identifying issues and concerns within the facility and was establishing and maintaining plans of correction. These failures placed the patients in immediate jeopardy and substandard quality of care.

K Facility failed to be administered in a manner to ensure wound care protocols were available and followed to assess and treat all wounds; to ensure patients with medical devices did not develop pressure ulcers related to use of the device; to ensure the physician was notified for changes in condition and to obtain treatment orders; to ensure all patients were protected from neglect and abuse and all allegations of neglect and abuse were reported and investigated; to ensure patients were safe from accidents; and to ensure adquate staffing to provide care and services to patients according to their needs and care plans. These failures placed the patients in immediate jeopardy.

F493 Governing body.

K Facility failed to ensure there was an effective governing body responsible for the overall operation and management of the facility and to use resources effectively and efficiently to attain and maintain the highest practicable functioning of all patients. The governing body failed to ensure the facility managed an effective QA program that recognized and developed an appropriate plan to ensure patients were free from abuse and neglect, physical and chemical restraints, environment was free from the accident hazards of chemicals, medications, aerosol sprays, and sharps. The facility failed to ensure neurological checks were completed after each fall. The facility failed to ensure the governing body provided oversight to ensure the social worker assessed a patient in a timely manner, frequently visited, allowed to verbalize fears/concerns, and provided psychological support following known abuse. The governing body failed to ensure care plan interventions were effective related to falls, restraints, and behaviors. The governing body failed to ensure patients with behaviors were being monitored. The governing body failed to ensure the consultant pharmacist recognized and reported the staff were not assessing the heart rate prior to the administration of Digoxin and monitor for agitation prior to the administration of PRN Ativan. The governing body failed to ensure a CNA was working with a current certification. The governing body failed to ensure medical records were accurate and complete. The governing body failed to ensure the QA program was effective in identifying issues and concerns within the facility and maintaining plans of corrections. These failures placed the patients in immediate jeopardy and substandard quality of care.

K Facility governing body failed to ensure wound care protocols were available and followed to assess and treat all wounds; to ensure patients with medical devices did not develop pressure ulcers related to use of the device; to ensure the physician was notified for changes in condition and to obtain treatment orders; to ensure all patients were protected from neglect and abuse and all allegations of neglect and abuse were reported and investigated; to ensure patients were safe from accidents; and to ensure adequate staffing to provide care and services to patients according to their needs and care plans. These failures placed the patients in immediate jeopardy.

F499 Staff qualifications.

D Facility failed to ensure that one CNA was certified.

F501 A physician must be designated as medical director.

K Facility medical director failed to ensure wound care protocols were available and followed to assess and treat all wounds; to ensure patients with medical devices did not develop pressure ulcers related to use of the device; to ensure the physician was notified for changes in condition and to obtain treatment orders; to ensure all patients were protected from neglect and abuse and all allegations of neglect and abuse were reported and investigated; to ensure patients were safe from accidents; and to ensure adquate staffing to provide care and services to patients according to their needs and care plans. These failures placed the patients in immediate jeopardy.

F514 Criteria for clinical records.

E Facility failed to ensure medical records were complete and accurate by failing to accurately document post fall assessments and neurological assessment checks for three patients.

F520 Quality assessment & assurance.

K Facility quality assurance committee failed to ensure wound care protocols were available and followed to assess and treat all wounds; to ensure patients with medical devices did not develop pressure ulcers related to use of the device; to ensure the physician was notified for changes in condition and to obtain treatment orders; to ensure all patients were protected from neglect and abuse and all allegations of neglect and abuse were reported and investigated; to ensure patients were safe from accidents; and to ensure adquate staffing to provide care and services to patients according to their needs and care plans. These failures placed the patients in immediate jeopardy.

J Facility QA failed to use resources effectively and efficiently to attain and maintain the highest practicable functioning of all patients by failing to ensure an effective quality assurance program that recognized and developed an appropriate plan to ensure patients were free from physical and chemical restraints. The QA committee failed to ensure protection of patients from abuse and neglect and failed to properly investigate an allegation of abuse. The QA committee failed to have an effective abuse and neglect policy. The QA committee failed to ensure the patients' environment was free from the accident hazards of chemicals, medications, aerosol sprays and sharps. The QA committee failed to ensure effective care plan interventions related to falls, restraints and behaviors. The QA committee failed to ensure the consultant pharmacist recognized and reported the staff were not assessing the patient's heart rate prior to the administration of Digoxin. The QA committee failed to ensure that a patient was monitored for agitation prior to administration of PRN Ativan. The QA committee failed to ensure a CNA was working with a current certification. The QA committee failed to ensure medical records were accurate and complete. The QA committed failed to ensure the QA program was effective in identifying issues and concerns within the facility and was establishing and maintaining plans of correction. These failures placed the patients in immediate jeopardy and substandard quality of care.

K014 Interior Finish - Corridors

F Facility failed to maintain the interior finish requirements for means of egress. The deficient practice affected all corridors. There was not documentation of the flame spread rating for newly installed carpet.

K017 Corridors Separated With Fire Walls

D Facility failed to maintain the corridor walls. There were several holes in the corridor walls.

K018 Construction of Doors

E Facility failed to maintain the corridor doors. There were penetrations in the restroom door on one hall.

K020 Sleeping Room Egress

D Facility failed to maintain the elevator shaft. There were two penetrations not sealed in the back of the elevator shaft masonry wall outside the kitchen entrance on the first floor.

D Facility failed to maintain the elevator shaft. There was a three inch hydraulic steel pipe not sealed penetrating the shaft masonry.

K021 Automatic Closing Doors

D Facility failed to maintain the cross corridor fire doors. One of the doors was not latching on the bottom.

D Facility failed to maintain the cross corridor smoke doors. One did not latch in the frame.

K025 Smoke Partition Construction

F Facility failed to maintain six smoke barriers. There were penetrations in the fire walls.

K029 Hazardous Areas Separated By Construction

E Facility failed to maintain the hazardous areas. There were multiple penetrations in the fire wall.

D Facility failed to have doors to hazardous locations self-closing.

K038 Exit Accessible At All Times

D Facility failed to maintain the exits. One exit door was locked by two locking arrangements (thumb latch and magnetic lock).

K045 Exit Lighting

D Facility failed to ensure the illumination of means of egress. The exit discharge lighting at the back street hall exit and the front hall exit is only a single bulb.

K051 Fire Alarm System

D Facility failed to ensure fire alarm manual pull stations were at exit. The exit from the dining room did not have a manual pull station within 5 feet.

K052 Testing of Fire Alarm

D Facility failed to maintain the fire alarm. An emergency flashing strobe was not flashing outside the dietary manager's office.

K054 Smoke Detector Maintenance

D Facility failed to maintain the smoke detectors. There were smoke detectors within three feet of an air flow in several locations.

K062 Automatic Sprinkler - Maintenance

F Facility failed to maintain the automatic sprinkler systems.

D Facility failed to maintain the sprinkler system. There was a damaged sprinkler deflector inside the kitchen.

D Facility failed to maintain the sprinkler system. There were corroded sprinkler heads in the facility.

D Facility failed to maintain the automatic sprinkler system. Some of the sprinkler heads were corroded.

K064 Portable Fire Extinguishers

D Facility failed to maintain the portable fire extinguishers. There was a portable fire extinguisher in the therapy department sitting in a cabinet and not secured.

K069 Commercial Cooking Equip. Meets Requirements

D Facility failed to maintain the kitchen hood suppression system. There was a metal shelf above the commercial kitchen stove obstructing the spray pattern of the kitchen hood fire suppression system.

D Facility failed to ensure dietary staff were trained on hood suppression system. Two dietary staff members were unfamiliar with the hood suppression system.

D Facility failed to protect the kitchen equipment. The staff member was not familiar with procedures in event of manual activation of the kitchen hood suppression system in the event of a fire.

K073 Flammable Furnishings

F Facility failed to ensure combustible decorations and floral arrangements were not highly flammable per the requirements of NFPA 101 18.7.5.4. There were combustible decorations on patient doors.

E Facility failed to prohibit combustible decorations. There were door decorations throughout the facility that were not treated with flame retardant.

K144 Generators

F Facility failed to load bank test two of two diesel generators.

K147 Electrical Wiring and Equipment

D Facility failed to maintain the electrical system. The facility failed to conduct an annual 1 1/2 hour generator load bank test during 2015.

K232 Aisle, Corridor or Ramp Width

F Facility failed to ensure wheeled non-medical equipment is stored in the corridors per the requirements of NFPA 101, 2012 edition.

K321 Hazardous Areas; Enclosure

E Facility failed to maintain doors to hazardous areas per the requirements of NFPA. There were no self-closing doors on the supply closet or medical records storage.

D Facility failed to maintain the hazardous area's rated assemblies. There were penetrations in the fire wall.

K324 Cooking Facilities

F Facility failed to ensure dietary staff was familiar with the hood suppression system operation. Two dietary staff were unfamiliar with the hood suppression system operation.

D Facility failed to maintain the cooking facilities. The facility failed to provide the documentation for the semi-annual hood suppression inspection.

K341 Fire Alarm System; Installation

D Facility failed to maintain the fire alarm system. The smoke detector in the 400 hall was less than three feet from the air diffuser.

K345 Fire Alarm System; Testing and Maintenance

E Facility failed to maintain the fire alarm system.

D Facility failed to maintain the fire alarm system. The facility failed to provide the annual fire alarm testing documentation for 2016.

K351 Sprinkler System; Installation

E Facility failed to ensure the sprinkler system is maintained per the requirements of NFPA 101. Sprinkler heads are located within four inches of the wall in several patient bathrooms.

K353 Sprinkler System; Testing and Maintenance

F Facility failed to maintain the automatic sprinkler system. Ductwork was resting on sprinkler pipe above the ceiling and the ceiling grid was tied to the sprinkler pipe.

D Facility failed to ensure the automatic fire sprinkler system heads were unobstructed.

D Facility failed to maintain the sprinkler system. There was storage within 18 inches of a sprinkler in several locations.

K372 Subdivision of Building Spaces; Smoke Barriers

F Facility failed to maintain fire/smoke assemblies. The ceilings throughout the facility had unsealed or improperly sealed penetrations where the sprinkler pipe passes through.

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

K711 Evacuation and Relocation Plan

D Facility failed to train dietary staff to be familiar with fire procedures with cooking equipment located under the kitchen hood per the requiremens of NFPA 101. A staff member was not familiar with the correct order of use for the K type fire extinguisher and the ANSUL hood extinguishing system for an appliance fire in the kitchen.

K741 Smoking Regulations

D Facility failed to maintain the smoking areas. The self-closing device installed on the metal container used for emptying ashtrays was not working properly.

K753 Combustible Decorations

F Facility failed to ensure combustible decorations and floral arrangements were not highly flammable per the requirements of NFPA 101.

E Facility failed to ensure combustible decorations are treated with an approved fire retardant coating.

K914 Electrical System; Maintenance and Testing

D Facility failed to conduct the required annual retention force test of the grounding blade of each electrical receptacle located in the patient care areas.

K920 Electrical Equipment; Power Cords and Extension Cords

D Facility failed to comply with regulated use of power strips. The medical equipment was plugged into multi-plug adapters that did not meet the approved UL listings.

K921 Electrical Equipment; Testing and Maintenance

F Facility failed to establish policy and protocols for the physical integrity, resistance, leakage current and touch current test for fixed and portable patient care related to equipment that indicates the tests, repairs and modifications that are in accordance with service manuals, instructions and procedures provided by the manufacturer.

N1208 Resident Rights; Restraints

Facility failed to ensure one patient reviewed for physical restraints was assessed and reassessed for the least restrictive device, failed to monitor the patient in the restraint and failed to have an active plan in place to decrease the usage and/or eventual removal of the restraint. These failures resulted in actual harm to the patient. Facility failed to ensure two patients were free from chemical restraints administered to manage a patient's behavior and not required to treat the patient's medical symptoms. This failure placed two patients in immediate jeopardy.

N413 Administration; Safeguarding of Personal Property

Facility failed to convey a patient's funds after death for one patient.

N432 Administration; Pain Assessment

Facility failed to provide adequate outside ventilation during and after smoking times for two patient wings and two hallways.

N604 Basic Services; Performance Improvement

Facility failed to ensure staff wore appropriate personal protective equipment (PPE) before entering an isolation room.

N645 Nursing Services

Facility failed to ensure cleaning supplies, toxic substances and equipment were secured at all times to prevent access by patients in six patient rooms and one common bath/shower room. The facility failed to ensure sharp containers were safe and secure as evidenced by sharps being full past the fill line, missing closure flaps, improperly attached closure laps and an improper disposal of a razor in a sharps container in eleven rooms.

N831 Building Standards

Facility failed to maintain the patient restroom doors. The bathroom door knob in one patient room was not operating properly.

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

Facility failed to maintain the physical plant and overall environment. There were penetrations in the cross corridor fire barrier wall.

N848 Building Standards; Exhaust & Air Pressure

Facility failed to maintain the clean linen room as required. The clean linen storage did not have a clean air supply.