Survey Deficiency Summary

32 Facilities Surveyed | **Surveys Taken 11/28/16-1/24/17**

F166 Right to have grievances resolved.

D Facility failed to resolve a grievance for one patient. The patient reported missing items which were not addressed by the facility.

F176 Self-administration of drugs by resident.

D Facility failed to determine if it was clinically appropriate for one patient to self-administer medications.

F204 Orientation for transfer or discharge by facility to resident.

D Facility failed to provide sufficient discharge preparation for home health services for one patient.

F223 Right to be free of physical/verbal abuse.

D Facility failed to ensure the patient gave permission to place him in a secure unit. The facility failed to provide a lease restrictive alternative for the patient prior to being secluded from his room and familiar patients.

F225 Facility must not hire person with abuse history.

E Facility failed to thoroughly investigate an injury of unknown origin for one patient and allegations of abuse for two patients.

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

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

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

D Facility failed to promote care that maintained patient dignity and quality of life when six CNAs referred to patients as "feeders" and "baby", stood over a patient during dining, left a dependent patient unassisted during dining, and failed to knock or obtain permission from a patient prior to entering the patient's room.

D Facility failed to maintain and enhance the dignity of two patients by speaking in a loud, derogatory manner during meal service.

D Facility failed to provide an environment that promoted and enhanced the dignity for one patient.

F253 Housekeeping & maintenance services.

E Facility failed to provide effective housekeeping and maintenance services to maintain a sanitary, orderly and comfortable environment as evidenced by holes in the walls, light bulgs out, peeling wall covering, odors and patient equipment dirty and/or in disrepair.

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

- D Facility failed to ensure the accuracy of the MDS assessment related to hospice for one patient.
- D Facility failed to maintain an accurate care area trigger for one patient.

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

- D Facility failed to develop an accurate care plan for one patient.

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

- E Facility failed to revise the care plan to reflect the patient's current status related to dental status, participation in plan of care, wandering, weight loss and anticoagulant use.
- D Facility failed to update a care plan for one patient.

F282 Services must be provided by qualified persons.

- G Facility failed to follow the care plan for placement of fall mats at the bedside for one patient. This failure caused actual harm when the patient was found face down in the floor at bedside and suffered a broken nose and maxilla.
- E Facility failed to follow the care plan for dialysis, nutrition, notification of change, weight maintenance for a patient receiving nutrition throug a PEG tube and behavior monitoring for four patients.
- D Facility failed to monitor potential adverse effects of psychotropic drug use for one patient.

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

- D Facility failed to obtain a current physician's order for dialysis treatments and for the care and treatment of an access device for dialysis, failed to monitor fluid restrictions and failed to ensure renal medications were administered for one patient.
- D Facility failed to ensure physician's orders and care plans were followed for one patient.
- D Facility failed to provide sufficient discharge preparation for home health services for one patient and an antibiotic was not administered as ordered for one patient.

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

- D Facility failed to ensure fingernails were clean and well-manicured by providing nail care for one patient.
- D Facility failed to provide incontinence care in a timely manner for one patient.

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

- D Facility failed to ensure proper treatment and assistive devices were obtained or maintained for visual impairment for one patient.

F314 Resident does not develop pressure sores.

D Facility failed to prevent the development of a pressure ulcer for one patient.

F315 Incontinent resident receives appropriate treatment and services.

D Facility failed to complete an assessment and develop an individualized toileting plan for the patient.

D Facility failed to ensure appropriate incontinence care for one patient with a catheter.

F322 Tube feeding/prevention.

E Facility failed to ensure one nurse properly administered medications through a PEG tube.

D Facility failed to ensure one LPN flushed a PEG tube before administering medication through the tube.

F323 Accident hazards.

G Facility failed to implement accident prevention interventions for one patient. This failure placed the patient in actual harm from a fall sustaining a broken nose and maxilla.

E Facility failed to ensure the environment was free from accident hazards for sharps, hair dryers, linen warmers and chemicals in six patient rooms and in one bath/shower room.

D Facility failed to implement and monitor interventions in order to reduce the risk of elopement for one patient.

D Facility failed to ensure a soft belt was applied correctly for one patient.

F325 Facility must ensure acceptable parameters of nutritional status.

G Facility failed to ensure all patients maintained acceptable parameters of nutritional status, failed to accurately assess, care plan and implement interventions to prevent severe and significant weight loss and failed to follow physician's orders for diet and nutritional supplements for four patients. These failures resulted in actual harm to patients.

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

D Facility failed to ensure patients had appropriate diagnoses for antipsychotic medications for one patient.

F332 Facility medication error rates of 5% or more.

E Facility failed to ensure two LPNs administered medications with a medication error rate of less than 5 percent. The error rate was 17.24 percent.

D Facility failed to ensure that it is free of medication error rates of five percent or greater. The error rate was 7.4 percent.

F333 Residents free of significant medication errors.

- E Facility failed to ensure one LPN administered medications free of significant med errors. Insulin was not administered at the proper time.
- D Facility failed to prevent significant medication errors for two patients. The nurses were administering the wrong dosage of insulin.

F356 Nurse staffing data

- D Facility failed to post accurate nurse staffing information.
- D Facility failed to post the daily nurse staffing at the beginning of each shift.
- C Facility failed to post accurate staffing data and record the census.
- C Facility failed to post staffing in a prominent place readily accessible to patients and visitors.
- C Facility failed to provide a current posting of daily nurse staffing.

F371 Store, prepare, distribute, & serve food.

- F Facility failed to maintain the kitchen area in a clean, sanitary manner evidenced by food preparation equipment stored with dried debris; failed to store food in a safe, sanitary manner evidenced by opened and unlabeled food products stored in the freezer.
- F Facility failed to maintain food preparation equipment and serving equipment in a clean and sanitary manner affecting all patients.
- F Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by carbon build-up on the stove and pans, convection oven rack stored on the floor and food stored in a cooler not covered securely. There was also undated milk product and the unsanitary use of a food thermometer. Hair was not completely covered with hair restraints. The pureed food and cold food temperatures were unsafe on the tray line. Staff members failed to perform proper hand hygiene during dining observations.
- F Facility failed to ensure food was prepared and served under sanitary conditions as evidenced by wet nesting of plates, failure of staff to perform proper hand hygiene and placement of soiled items on a cart used for serving food.
- F Facility failed to ensure food and non-food contact surfaces and hood exhaust vents were clean and free from debris.
- F Facility failed to label and date food items in one walk-in refrigerator and one walk-in freezer. Facility failed to maintain a clean freezer and did not maintain a sanitary staff handwashing sink.

F372 Disposes of garbage & refuse.

- D Facility failed to ensure garbage was disposed of properly when garbage was noted on the ground around the outside storage receptacle on one day.

F412 Medicaid patients must be provided with dental services.

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

F431 Labeling of drugs & biologicals.

- F Facility failed to appropriately dispose of expired medications and biologicals for two medication storage rooms.
- D Facility failed to ensure medications were not stored past their expiration date in one medication storage unit.
- D Facility failed to ensure medications were properly stored by one nurse during medication administration.
- D Facility failed to promptly dispose of discontinued medications for two patients.
- D Facility failed to secure a controlled substance to prevent diversion for one patient.
- D Facility failed to ensure the treatment cart was locked in one hallway.

F441 Investigates, controls/prevents infections.

- E Facility failed to ensure practices were followed to prevent the potential spread of infection as evidenced by six staff members not performing proper hand hygiene and one staff member failing to clean a glucometer correctly.
- D Facility failed to maintain safe and sanitary shower rooms. Some of the equipment in the shower room was dirty.
- D Facility failed to follow infection control guidelines for one patient with a catheter.

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

- D Facility failed to ensure the environment was clean and safe, as evidenced by an unsanitary common area in one activity room and an unsanitary shower room.

F502 Provide or obtain clinical laboratory services.

- D Facility failed to obtain a laboratory test for one patient.

F514 Criteria for clinical records.

- D Facility failed to ensure medical recores were completely and accurately documented related to dialysis, medication, supplements and services provided; the results of any preadmission screening conducted by the state and progress notes.
- D Facility failed to maintain an accurate medical record for one patient.