Survey Deficiency Summary

22 Facilities Surveyed **Surveys Taken 4/19/17 to 5/17/17**

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

D Facility failed to provide the appropriate liability and appeal notice for two patients.

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

G Facility failed to notify the physician of poor nutritional intake, resulting in a 10.9% weight loss in a one month period (actual harm) for one patient.

D Facility failed to notify the physician of a medication recommendation by a consulting practitioner for one patient.

D Facility failed to notify the physician of the ordered urine analysis and culture was not obtained for one patient.

F166 Right to have grievances resolved.

D Facility failed to make prompt efforts to resolve a grievance for one patient.

F221 Right to be free from physical restraints.

K Facility failed to ensure restraint assessments were completed for 11 patients; failed to ensure correct restraint use for three patients; and failed to ensure physician's orders were obtained for the use of restraints for two patients. These failures placed all of these patients in immediate jeopardy.

J Facility failed to ensure patients were free from physical restraints. The failure of the facility to ensure one patient was assessed, care planned and had a physician order for side rails resulted in a serious and immediate threat to the health and safety of all patients and placed them immediate jeopardy. The patient was found between the side rail and the mattress without a pulse or respirations. There was not a thorough investigation of this incident by the facility. This was also substandard quality of care.

F223 Right to be free of physical/verbal abuse.

G Facility failed to protect one patient from verbal abuse and fear of retaliation. One patient suffered verbal abuse resulting in psychological harm as evidenced by her tearful, emotional response during interview.

F224 Mistreatment, neglect, misappropriation of resident property.

K Facility failed to ensure patients were free from abuse, neglect and mistreatment by facility staff. This failure resulted in serious and immediate threat to the health and safety of all patient and immediate jeopardy to four patients and psychological harm to one patient. This was also cited as a substandard quality of care.

F225 Facility must not hire person with abuse history.

K Facility failed to ensure all allegations involving death, abuse, neglect, mistreatment and injuries of unknown origin were thoroughly investigated. The facility failed to prevent futher potential abuse, neglect and mistreatment for five patients. The facility failed to thoroughly investigate the incident of a patient found dead between the bedside rail and the mattress and take immediate actions that would prevent potential entrapment deaths of other patients. The facility failed to report the death to the State Survey Agency. These failures resulted in serious and immediate threat to the health and safety of all patients and resulted in immediate jeopardy to four patients and psychological harm to one patient.

E Facility failed to conduct an investigation of an injury of unknow origin for one patient and failed to throughly investigate two behavior related incidents involving three patients.

E Facility failed to report an allegtion of abuse for one patient and failed to thoroughly investigate allegations of abuse for three patients.

D Facility failed to report and fully investigate an allegation of misappropriation for one patient.

D Facility failed to investigate injuries of unknown origin for one patient.

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

K Facility failed to identify abuse, investigate all allegations of abuse and mistreatement, report allegations of abuse, investigate injuries of unknown origin, investigate a patient death for possible entrapment, and provide a safe environment free of retaliation for five patients. The facillity failed to ensure all patients were free of abuse, neglect and mistreatment by the failure to implement policies and procedures and placed all patients in a serious and immediate threat to their health and safety resulting in immediate jeopardy to four patients and psychological harm to one patient. This was also cited as a substandard quality of care deficiency.

D Facility failed to report an allegation of abuse timely to the supervisor/administrator/abuse coordinator for one patient.

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

G Facility failed to maintain dignity by answering call lights in a timely manner to prevent incontinent episodes for three patients related to staffing. This failure resulted in psychological harm to three patients.

D Facility failed to ensure that patients were treated with dignity and respect as evidenced by one LPN entering a patient room without knocking and requesting permission to enter. Facility failed to refrain from the demeaning practice of referring to patient's briefs as diapers.

D Facility failed to ensure medication was administered to one patient in a private and dignified manner.

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

- E Facility failed to promote and facilitate patient self-determination through support of patient bathing choice for two patients.
- E Facility failed to offer three patient a frequency and choice in their method and timing of bathing.
- D Facility failed to honor the patient's choice for showers for one patient and failed to honor the days for showering for one patient.

F246 Right to accommodations of individual needs & preferences.

- D Facility failed to ensure the call light was in reach for one patient.
- D Facility failed to accommodate individual needs by providing daily care inconsistent with the patient's desire to be awakened early in the morning. The night shift was waking patients up starting at 3:45 a.m. to get them up for the day.

F253 Housekeeping & maintenance services.

- E Facility failed to provide effective housekeeping services to maintain a clean and sanitary interior for 52 patients.
- E Facility failed to maintain sanitary patient bathrooms for two halls.
- D Facility failed to provide an environment free of odors for one hallway.
- D Facility failed to maintain the bathroom in a sanitary condition for one patient bathroom.
- C Facility failed to provide and maintain a clean, safe, comfortable and homelike environment in patient rooms and patients' shared common areas. Some of the furniture was damaged.

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

- D Facility failed to conduct an accurate assessment for one patient.
- D Facility failed to accurately assess the antidepressant medication administration for one patient.
- D Facility failed to accurately reflect the patient's status for one patient.

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

- D Facility failed to ensure an individualized psychosocial care plan was developed for one patient.
- D Facility failed to develop a comprehensive care plan for one patient.
- D Facility failed to develop a comprehensive care plan for one patient.
- D Facility failed to develop a comprehensive care plan for behavior management for one patient.

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

J Facility failed to revise a care plan to include the need to do a restraint assessment quarterly, and failed to include monitoring the use of a soft waist belt for two patients. This failure placed two patients in immediate jeopardy.

D Facility failed to revise the care plan for the use of an anticoagulant medication to communicate the risks of the medication, the signs and symptoms of complications to report to nursing and the interventions to implement to minimize the risk of complications for one patient.

D Facility failed to update the care plan after a change in the method of transfer for one patient.

D Facility failed to update or revise the comprehensive care plan for two patients related to accidents, one patient related to behaviors and one patient related to medication review.

D Facility failed to complete a care plan within seven days after the completion of the comprehensive assessment and failed to revise a care plan for behaviors involving hallucinations for one patient.

F281 Services must meet professional standards of quality.

D Facility failed to follow the comprehensive care plan for one patient related to floor mat placement and failed to appropriately transcrbe physician's orders for two patients.

D Facility failed to provide services to meet professional standards for two patient reveiwed for antipsychotic medications.

D Facility failed to obtain a physician order for a skin treatment for one patient.

F282 Services must be provided by qualified persons.

J Facility failed to follow the care plan for application of the correct restraint for one patient; failed to complete the quarterly physical restraint reduction assessments for two patients and failed to follow the care plan for weight loss and poor nutritional intake for one patient. These failures placed the patients in immediate jeopardy.

E Facility failed to follow a care plan for neuro-checks, lifts, activities of daily living (ADLs) and geri-sleeves for four patients.

D Facility failed to monitor and document behaviors for psychotropic drug use for one patient.

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

D Facility failed to provide behavior monitoring to attain or maintain the highest practicable mental and psychosocial well-being for one patient.

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

E Facility failed to ensure ADLs were performed for two patients. These patients had no documentation that showers had been given three times a week as scheduled.

D Facility failed to provide assistance for toileting for one patient.

F314 Resident does not develop pressure sores.

D Facility failed to complete skin assessment weekly for one patient reviewed for pressure ulcers.

F317 No reduction in range of motion.

D Facility failed to prevent a reduction in range of motion for one patient.

F318 Range of motion.

D Facility failed to provide appropriate treatment and services to increase range of motion to prevent further decrease in ROM for one patient.

F322 Tube feeding/prevention.

D Facility failed to ensure a patient who is fed by a percutaneous endoscopic gastrostomy (PEG) tube receives nutrition without complications. The patient was not positioned correctly and the feeding tube feedings were not being administered as ordered.

F323 Accident hazards.

J Facility failed to follow facility policies, manufacturer's guidelines and patient care plans for fall interventions, side rail use, and mechanical lift use for two patients. This failure resulted in a serious and immediate threat to the health and safety of all patients and placed them in immediate jeopardy when one patient was found between the siderail and the mattress without a pulse or respirations. This is also a substandard quality of care citation.

J Facility failed to ensure a safe and appropriate device for one patient and failedl to ensure a restraint was applied correctly for two patients. These failures placed three patients in immediate jeopardy. This was also substandard quality of care.

E Facility failed to prevent falls for one patient.

D Facility failed to use safe transfer techniques for one patient.

D Facility failed to prevent an altercation for two patients.

F325 Facility must ensure acceptable parameters of nutritional status.

G Facility failed to maintain acceptable nutritional status resulting in a 10.9 percent weight loss in one month (actual harm) for one patient.

F328 Proper treatment & care for specialized services.

D Facility failed to suction respiratory secretions to ensure airway patency for one patient.

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

E Facility failed to monitor behavior and assess pain correctly and completely for four patients.

D Facility failed to ensure one patient had adequate indications for the use of psychotropic medications evidenced by the staff's failure to document the patient's targeted mood and behavioral symptoms.

D Facility failed to ensure one patient received a medication in a decreased dosage as ordered by the physician.

D Facility failed to ensure the consutant pharmacist recommendation summary was received, reviewed and responded to by a physician in a timely manner.

F332 Facility medication error rates of 5% or more.

E Facility failed to correctly administer medications resulting in a 20.68 percent error rate.

D Facility failed to administer an opthalmic medication correctly for one patient and failed to administer insulin timely for one patient.

F333 Residents free of significant medication errors.

D Facility failed to ensure one patient was free from a significant medication error. Lantus insulin was mixed with Novolog. This is a precaution listed with Lantus to not mix it with any other insulins or solutions because the insulin may be altered unpredictably.

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

G Facility failed to provide sufficient staff to meet the needs of three patients who needed assistance with toileting. This causes psychological harm to the patients.

E Facility failed to provide sufficient staff for bathing according to the facility shower schedule for more than a month.

F356 Nurse staffing data

C Facility failed to post staffing requirements for 79 days.

C Facility failed to post the nurse staffing information for three days.

C Facility failed to post the current patient census and nurse staffing data for one day of the survey.

F364 Food preparation.

F Facility dietary department failed to serve mechanically altered food at or greater than 135 degrees Fahrenheit (F) and failed to reheat the food to 165 degrees F prior to serving for one meal service.

F367 Therapeutic diets.

D Facility failed to obtain or clarify physician orders for therapeutic diets for one patient.

F371 Store, prepare, distribute, & serve food.

F Facility dietary department failed to maintain food storage equipment and food preparation equipment in a sanitary manner.

F Facility failed to store canned good and frozen foods in a sanitary manner, hold and serve cooked foods at acceptable temperatures, maintain kitchen sanitation, and ensure the functional order of food production equipment in accordance with professional standards or food service safety.

F Facility failed to maintain sanitary conditions in the dietary department and failed to maintain proper food temperatures.

F Facility dietary department failed to prevent possible contamination of clean dishes during one observed dish room operations and for possible contamination of exposed food on the steam table during three meal services.

E Facility failed to ensure the proper concentration of sanitizer in the containers used for disinfecting the counter tops in the food preparation area.

D Facility failed to ensure food was stored under sanitary conditions as evidenced by expired food items stored in one patient refrigerator and failed to check temperatures in one nourishment refrigerator.

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

D Facility failed to properly dispose of one medication. The pill was disposed of in the regular trash.

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

E Facility consultant pharmacist failed to conduct an in-depth medication regimen review which would have revealed evidence of inadequate monitoring of behaviors and assessment of pain for four patients.

F431 Labeling of drugs & biologicals.

F Facility failed to maintain two medication storage rooms and two medication carts in a clean and orderly manner.

E Facility failed to ensure expired medications in two medication storage rooms were discarded.

D Facility failed to store medication at the proper temperature in one cart.

D Facility failed to ensure medications were properly stored as evidenced by one LPN observed during medication administration that left medications unattended and out of sight.

F441 Investigates, controls/prevents infections.

F Facility failed to store personal protective equipment (PPE) appropriately for four patients. Facility failed to ensure staff donned PPE when entering contact isolation rooms. Facility failed to follow proper infection control standards for the storage of personal items for one patient. Facility failed to perform hand hygiene and disinfect medical equipment for one patient.

D Facility failed to ensure practices to prevent the potential spread of infection were maintained by two LPNs during PEG site care and urinary catheter care. The nurses failed to ensure the patient's urinary catheter bag did not touch the floor and infection control practices were followed for catheter care provided for two patients.

D Facility failed to maintain an environment free from possible contamination for one patient.

D Facility failed to maintain the universal precautions by not using gloves during an injection.

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

F Facility failed to maintain the function and the sanitary conditions in two shower rooms.

F490 Administration.

K Facility failed to be administered in a manner that enabled its use of resources effectively and efficiently to attain and maintain the highest practicable, physical, mental, and psychosocial well being of each patient. Administration failed to ensure thorough and timely investigations of allegations of abuse, mistreatment, injuries of unknow origin and accidental and unusual deaths. The administration failed to ensure all staff were trained and competent on the use of equipment per manufacturer's guidelines, and were knowledgeable of and implemented facility policies and procedures for the provision of patient care. These failures of administration to assume responsibility for the care delivered by the staff resulted in a serious and immediate threat to the health, safety and well-being of all patients and resulted in an immediate jeopardy to four patients and psychosocial harm to one patient.

K Facility failed to be administered in such a manner that ensured the facility's policy for restraints was implemented by all staff, failed to follow a systematic process of assessing for appropriate use of the restraint and failed to ensure safety with the use of soft waist belts as a restraint for eleven patient. These failures caused immediate jeopardy for all of the facility patients with restraints.

F493 Governing body.

K Facility governing body failed to provide oversight of the facility's operations and ensure patients received care in a safe environment. The governing body failed to ensure policies were implemented to ensure patients were free from abuse and mistreatment and that staff followed established policies in a manner that enabled the use of its resources effectively and efficiently to prevent abuse, neglect and mistreatment of patients. The governing body failed to ensure incidences were investigated and all unusual or accidental patient deaths were thoroughly investigated and reported to proper authorities. These failures caused immediate jeopardy for four patients and psychosocial harm to one patient.

F498 Proficiency of nurse aides.

K Facility failed to ensure 33 CNAs had a CNA compentency skills check list, including types of restraints and return demonstration of restraint application completed. This failure placed residents with restraints in immediate jeopardy.

F501 A physician must be designated as medical director.

K Facility medical director failed to provide oversight of the facility's operations and ensure patients received care in a safe environment. The medical director failed to ensure policies were implemented to ensure patients were free from abuse and mistreatment and that staff followed established policies in a manner that enabled the use of its resources effectively and efficiently to prevent abuse, neglect and mistreatment of patients. The medical director failed to ensure incidences were investigated and all unusual or accidental patient deaths were thoroughly investigated and reported to proper authorities. These failures caused immediate jeopardy for four patients and psychosocial harm to one patient.

K Facility medical director failed to coordinate medical care in the facility by ensuring that patients were appropriately assessed for the use of restraints and failed to ensure patients were safe with the use of restraints. This failure placed all patients with restraints in immediate jeopardy.

F514 Criteria for clinical records.

D Facility failed to maintain complete and accurate medical records for two patients.

D Facility failed to maintain an accurate medical record for two patients.

F516 Clinical record information loss, destruction or unauthorized use.

D Facility failed to maintain confidentiality of a patient's private healthcare information for one patient. The information was on the computer screen which was unattended.

F520 Quality assessment & assurance.

K Facility quality assurance committee failed to provide oversight of the facility's operations and ensure patients received care in a safe environment. The QA committee failed to ensure policies were implemented to ensure patients were free from abuse and mistreatment and that staff followed established policies in a manner that enabled the use of its resources effectively and efficiently to prevent abuse, neglect and mistreatment of patients. The QA committee failed to ensure incidences were investigated and all unusual or accidental patient deaths were thoroughly investigated and reported to proper authorities. These failures caused immediate jeopardy for four patients and psychosocial harm to one patient.

K Facility quality assurance committee failed to implement a program for the management of restraints; failed to identify and address probelems with correct application of restraints; failed to identify issues with use of correct restraints; failed to monitor restraint use; failed to identify problems with obtaining physician's orders for restrains; and failed to identify problems with completing required restraint assessments for 11 patients. These failures placed the patients in immediate jeopardy.

E Facility quality assurance committee failed to identify an allegation of abuse for one patient.

K200 Means of Egress Requirements

D Facility failed to comply with the means of egress requirements.

D

K211 Alcohol Based Hand Rub Dispensers

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

F Facility failed to ensure corridors in the means of egress were maintained clear of all obstructions per the requirements of 2012 NFPA 101.

D Facility failed to maintain the means of egress. There was a picnic table and chair on the egress pathway in the courtyard.

D Facility failed to maintain the means of egress.

D Facility failed to maintain the means of egress.

K222 NFPA 101 Egress Doors

E Facility failed to maintain the egress doors.

D Facility failed to maintain the egress doors.

D Facility failed to maintain the egress doors. The staff member did not know the exit code to the emergency egress door.

K223 Doors with Self-Closing Devices

D Facility failed to maintain the cross corridor doors. The medication cart was obstructing the closure of the doors.

D Facility failed to maintain the cross corridor doors.

D Facility failed to maintain the cross corridor doors with self-closing devices.

K227 Ramps and Other Exits

D Facility failed to maintain the ramp handrails.

K271 Discharge from Exits

D Facility failed to maintain discharge from exits.

K281 Illumination of Means of Egress

E Facility failed to ensure illumination of means of egress shall be continuously in operation per the requirements of NFPA 101.

E Facility failed to maintain the means of egress.

K291 Emergency Lighting

D Facility failed to maintain the emergency lighting. The monthly test had not been done in over a year.

K311 Vertical Openings - Enclosure

D Facility failed to maintain vertical openeings in accordance with NFPA 101. There was a three inch pipe penetration in the elevator shaft.

K321 Hazardous Areas; Enclosure

E Facility failed to maintain the hazardous area.

D Facility failed to maintain the hazardous areas.

D Facility failed to maintain hazardous areas. There was unapproved fire stop material used on the fire walls.

D Facility failed to maintain the hazardous areas.

K324 Cooking Facilities

D Facility failed to protect the cooking equipment.

D Facility failed to maintain the cooking facilities. The deep fat fryer was not restrained.

D Facility failed to protect the cooking equipment.

D Facility failed to maintain the cooking facilities. The kitchen staff did not know what to do in case of fire.

D Facility failed to maintain the cooking facilities.

D Facility failed to ensure the new upblast fan for the kitchen hood exhaust system was installed properly. It did not have a hinge and was not provided with a grease collection container.

D Facility failed to protect the cooking equipment.

K331 Interior Wall and Ceiling Finish

F Facility failed to ensure interior wall surface finishes had a flame spread rating of B or less per the requirements.

K342 Fire Alarm System - Initiation

F Facility failed to ensure all required devices initiate the fire alarm.

K345 Fire Alarm System; Testing and Maintenance

E Facility failed to maintain the fire alarm system. Smoke detectors and heat detectors had not been tested.

D Facility failed to maintain clearance around manual fire pull stations.

D Facility failed to maintain the fire alarm system.

D Facility failed to maintain the fire alarm system. There were inconsistencies with the pattern of the fire alarm.

D Facility failed to maintain the fire alarm system.

D Facility failed to maintain the fire alarm system.

K351 Sprinkler System; Installation

D Facility failed to maintain the installation of the sprinkler system.

D Facility failed to have sprinklers where required. One of the closets did not have a sprinkler.

D Facility failed to install sprinklers under a canopy with combustible storage.

K353 Corridor - Doors

E Facility failed to maintain the sprinkler system. There was no quarterly sprinkler inspection during the third quarter.

K353 Sprinkler System; Testing and Maintenance

F Facility failed to maintain the automatic sprinkler system.

F

F Facility failed to maintain the automatic sprinkler system. The drum drips for the dry system was not provided with proper signage.

E Facility failed to maintain the sprinkler system. The ten-year test report for the dry sprinkler system.

E Facility failed to ensure spinkler heads were maintained. Some of the sprinkler heads in the attic were covered with insultaion.

E Facility failed to maintain the automatic sprinkler system. There was storage within 18 inches of the sprinklers in several locations.

D Facility failed to maintain the sprinkler system.

D Facility failed to maintain the sprinkler system. Some of the sprinkler heads were covered with debris.

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

D Facility failed to maintain the sprinkler system.

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

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

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

K355 Portable Fire Extinguishers

D Facility failed to maintain the clearance around fire extinguishers.

D Facility failed to ensure fire extinguishers complied with the requirements of 2010 NFPA. One of the fire extinguisher had not been inspected monthly and there was no ABC fire extinguisher located in the laundry.

K363 Corridor - Doors

D Facility failed to maintain the corridor doors.

D Facility failed to maintain the doors protecting corridor openings.

D Facility failed to maintain the corridor doors. The doors did not latch in a positive frame.

D Facility failed to maintain the corridor doors. They did not latch within the frame.

D Facility failed to maintain corridor doors. The doors did not close to a positive latch.

K364 Corridor - Openings

D Facility failed to maintain the corridor openings.

K372 Subdivision of Building Spaces; Smoke Barriers

E Facility failed to maintain the fire resistance of smoke barriers per the requirements of 2012 NFPA 101. There were penetrations in the smoke wall.

D Facility failed to maintain the smoke barriers in areas required by NFPA 101.

D Facility failed to maintain the smoke barriers.

K511 Utilities - Gas and Electric

F Facility failed to ensure gas related piping and equipment was protected. The gas regulator was not protected to prevent damage.

D Facility failed to maintain the electrical system.

D facility failed to maintain the utilities. One of the ground plug grounding prongs was missing on the hair dryer.

D Facility failed to maintain the utilities.

K521 HVAC

F Facility failed to ensure fire dampers were provided in the ductwork passing through the rated ceiling of one common area.

F Facility failed to maintain the fire dampers.

D Facility failed to maintain the HVAC system. There was no four-year fire damper inspection.

K711 Evacuation and Relocation Plan

F Facility failed to ensure the fire safety plan included all requirements of NFPA 101. There was no emergency phone call to the fire department or 911.

F Facility failed to ensure all dietary staff were familiar with the kitchen hood suppression system and components.

D Facility failed to maintain the emergency evacuation and relocation plan.

K712 Fire Drills

F Facility failed to properly train staff on fire drills.

E Facility failed to conduct fire drills timely.

D Facility failed to comply with fire drill requirements.

K741 Smoking Regulations

D Facility failed to maintain the smoking area.

D Facility failed to maintain the smoking areas.

D Facility failed to comply with the smoking regulations.

D Facility failed to comply with smoking regulations.

K753 Combustible Decorations

F Facility failed to ensure combustible decorations on patient doors were treated with a fire retardant product as required.

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

E Facility failed to identify that combustible decorations have been treated with a flame spread product.

K754 Soiled Linen and Trash Containers

D Facility failed to ensure soiled linen or trash receptacles exceeding 32 gallons in capacity were located in a room protected as hazardous when not attended.

K902 Gas and Vacuum Piped Systems

D Facility failed to ensure medical gas cylinder storage locations were secured with lockable doors or gates per the requirements of NFPA 99.

K908 Gas and Vaccum Piped Systems

D Facility failed to maintain the gas and vacuum systems.

K909 Gas and Vaccum Piped Systems

D Facility failed to maintain the piped in oxygen lines.

K918 Electrical Systems - Essential Electric System
Maintenance and Testing

F Facility failed to maintain the electrical systems. There was no generator testing documented.

F Facility failed to ensure the emergency generator was run for 30 minutes under load each month per the requirements.

K920 Electrical Equipment; Power Cords and Extension Cords

E Facility failed to ensure a safe and appropriate device for one patient and failed to ensure a restraint was applied correctly for two patients.

D Facility failed to provide power strips in patient care areas for patient-care-related electrical equipment (PRCEE) and non-PRCEE that meet UL 1363A or UL 60601-01.

D Facility failed to prohibit unapproved uses of power-strips and extension cords.

K921 Electrical Equipment; Testing and Maintenance

D Facility failed to maintain the electrical system.

D Facility failed to maintain the electrical system. There was no documentation for an annual retention outlet test for 2017.

K923 Gas Equipment - Cylinder and Container Storage
Container Storag

D Facility failed to properly store gas cylinders in accordance with NFPA 99. There was an oxygen cylinder stored within five feet of combustible materials.

D Facility failed to provide the correct signage on rooms that are storing oxygen cylinders.

K924 Gas Equipment Testing and Maintenance Requil

D Facility failed to maintain the oxygen storage areas.

K929 Gas Equipment Precautions for Handling Oxygen

D Facility failed to maintain the oxygen cylinders.

N1102 Records and Reports; Recording of Unusual Incidents

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

N1410 Disaster Preparedness; Fire Safety Procedures Plan

Facility failed to conduct the required external disaster preparedness training.

N1535 Nurse Aide Training; Performance Reviews

Facility failed to ensure 33 CNAs had a CNA compentency skills check list, including types of restraints and return demonstration of restraint application completed. This failure placed residents with restraints in immediate jeopardy.

N410 Administration; Personal Property

Facility failed to complete a record of patients personal belongings on admission for nine medical records reviewed.

N415 Administration; Resident Funds

Facility failed to verify references for three newly hired employees.

N416 Administration; Background Check

Facility failed to document reference checks for four employees.

N424 Administration; Filed Documentation of Abuse Registries

Facility failed to ensure a safe and appropriate device for one patient and failed to ensure a restraint was applied correctly for two patients.

N601 Performance Improvement Program

Facility failed to implement a program for the management of restraints.

N615 Medical Director Responsibilities

Facility medical director failed to coordinate medical care in the facility by ensuring that patients were appropriately assessed for the use of restraints and failed to ensure patients were safe with the use of restraints. This failure placed all patients with restraints in immediate jeopardy.

N682 Pharmaceutical Services; Storage of Medications

Facility failed to revise a care plan to include the need to do a restraint assessment quarterly and failed to include monitoring the use of a soft waist belt for two patients.

N698 Nursing Services; Restraints

Facility failed to maintain acceptable nutritional status resulting in a 10.9 percent weight loss for one patient.

N700 Nursing Services; Restraints

Facility failed to ensure physician's orders were obtained for the use of restraints for five patients.

N707 Medical Records; Record Maintenance

Facility failed to maintain an accurate medical record for two patients.

N831

Facility failed to maintain the physical plant.

N831 Building Standards

Facility failed to maintain the physical plant and overall environement.

Facility failed to maintain the physical plant. There were penetrations in the fire wall.

Facility failed to maintain the overall physical plant. There were penetrations in the fire wall.

Facility failed to maintain the physical environment. There was wall damage in several locations.

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

Facility failed to maintain the physical plant and overall environment. There was water damage on the ceiling in several locations.

Facility failed to maintain the physical plant and overall environment.

Facility failed to maintain the overall physical environment.

N848 Building Standards; Exhaust & Air Pressure

Facility failed to maintain air pressure where required.

Facility failed to maintain the correct air flow in the required areas.

Facility failed to maintain the correct air flow in the required areas. There was chemical storage in the kitchen janitors closet with no negative air flow.

Facility failed to maintain the correct air flow where required.

Facility failed to maintain the correct air flow where required. The negative air fans were not working in several locations.