Survey Deficiency Summary

30 Facilities Surveyed **Surveys Taken 8/28/17 to 10/31/17**

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

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

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

G Facility failed to notify the physician and patient representative of a fall sustained by the patient. This failure resulted in harm to the patient since timely notification to the physician would have led to earlier intervention and less discomfort for the patient.

G Facility failed to notify the physician of severe weight loss for two patients. This failure resulted in actual harm to one patient.

F176 Self-administration of drugs by resident.

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

F221 Right to be free from physical restraints.

D Facility failed to ensure one patient was free from the use of a restraint.

F223 Right to be free of physical/verbal abuse.

G Facility failed to prevent abuse for one patient. One patient had a verbal altercation with a smoke technician. The smoke technician raised her voice and raised her hand as if to strike the patient. The patient was alert and oriented and told the surveyor that she was afraid and felt threatened.

D Facility failed to prevent abuse in the form of involuntary seclusion for one patient.

D Facility failed to ensure freedom from abuse/exploitation for one patient. A CNA took a picture of a patient and herself with her cell phone. This was a violation of facility policy.

D Facility failed to provide dignity covers for catheter bags for two patients. This had the potential to demean patients.

F224 Mistreatment, neglect, misappropriation of resident property.

J Facility failed to ensure two patients were free from neglect. The staff neglected to provide services in a manner that did not cause physical harm to patients who were aggressive and resistive during care being provided. The facility failed to educate staff after a nurse physically intervened resulting in an injury to one patient. The facility failed to ensure a care plan was in place for the patient's aggressive behavior during personal care. These failures resulted in immediate jeopardy for two patients as well as substandard quality of care.

G Facility failed to prevent abuse/neglect for one patient sustaining a fall with subsequent fracture; two patients having to lie in excreta for an extended period of time. This failure resulted in actual harm to one patient with a hip fracture requiring surgery.

F225 Facility must not hire person with abuse history.

J Facility failed to conduct a thorough investigation for one abuse allegation. After receiving an allegation of abuse from one patient the facility failed to suspend the accused employee who then worked with the patient on the same night. The facility failed to provide education or training following the incident to staff, including the accused employee. These failures resulted in immediate jeopardy for two patients.

E Facility failed to have evidence all alleged violations were thoroughly investigated for eight patients for abuse allegations which included injury of unknown origin, sexual abuse, misppropriation of patient's properly and resident-to-resident altercations.

D Facility failed to conduct a thorough investigation into a patient to patient abuse for two patients.

D Facility failed to provide supervision to protect two patients from the physical agression of another patient.

D Facility failed to thoroughly investigate an allegation of verbal abuse for one patient and injury of unknown origin for one patient.

D Facility failed to ensure all allegations of abuse, neglect, exploitation or mistreatment were reported timely to the state agency for four patients.

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

J Facility failed to implement their abuse policy related to the proper identification, training and investigation of abuse/neglect. The facility failed to operationalize its abuse policy after an allegation of abuse against a patient by an LPN. This failure resulted in the potential for continued abuse against patients with whom the LPN cared for during her work assignment. This failure resulted in an immediate jeopardy to the health and safety of the patients who resided on the unit. The facility futher failed to properly identify neglect regarding a patient as related to not substantiating abuse after a CNA intervened during resistive care of a patient by using physical force. The facility failed to ensure patients were free from abuse/neglect as per their abuse policy for two patients. This failure resulted in immediate jeopardy for two patients.

D Facility failed to follow the abuse policy and procedure related to investigation and failed to follow up in response to incidents of resident-to-resident abuse; allegations of sexual abuse; and allegations of misappropriation of patient property.

D Facility failed to develop policies and procedures to address abuse prevention.

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

E Facility failed to ensure patient dignity, related to facial grooming, was maintained for four patients.

D Facility failed to maintain the dignity of two patients by failing to change a soiled brief when requested.

D Facility failed to provide dignity covers for catheter bags for two patients. This had the potential to demean patients.

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

D Facility failed to honor the shaving and bathing preferences for one patient.

F253 Housekeeping & maintenance services.

E Facility failed to ensure a comfortable and sanitary environment as evidenced by rusty bed frames, paint peeling on walls, drywall visible, baseboard peeling off the wall, chipped paint with wood showing, rust on metal under sinks and long black marks on the wall.

D Facility failed to maintain a sanitary, homelike environment for three rooms and failed to control odors on one floor.

F257 Comfortable & safe temperature levels.

D Facility failed to maintain a comfortable temperature range of 71-81 degrees F. One patient room was 70 degrees F and they were complaining of being cold.

F272 Comprehensive assessment.

D Facility failed to ensure notification of care plan meetings for one patient.

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

D Facility failed to provide an accurate MDS assessment for one patient.

D Facility failed to ensure the accuracy of the MDS assessment for medications and wound care measurements.

D Facility failed to accurately complete a MDS for two patients.

D Facility failed to accurately assess the diagnoses related to urinary catheter use for one patient.

D Facility failed to accurately identify the patient's status on the MDS.

D Facility failed to accurately assess the toileting use for one patient.

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

J Facility failed to develop a comprehensive care plan for two patients. This failure resulted in immediate jeopardy for one patient.

G Facility failed to develop and implement a comprehensive nutritional care plan for one patient. This failure resulted in actual harm to the patient.

E Facility failed to ensure care plans had been updated after falls for two patients and after resident-to-resident altercations.

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

D Facility failed to revise the care plan interventions after two patients fell and failed to revise the care plan after a wound site was healed and when a new wound site developed.

F281 Services must meet professional standards of quality.

K Facility failed to administer 204 medications to three patients between July 1, 2017 and August 20,2017. The resulting failure constituted an immediate jeopardy for failure to administer medications per the physician's order and was directly correlated to insufficient staffing.

F282 Services must be provided by qualified persons.

G Facility failed to implement care plan interventions to prevent falls and injury for one patient. This failure resulted in actual harm to the patient when one patient fell and received an intracerebral hemorrhage that formed a subdural hematoma as well as a left clavicular fracture.

D Facility failed to follow the care plan interventions related to dialysis care for one patient.

D Facility failed to follow the care plan for two patients.

D Facility failed to ensure staff followed care plan interventions related to psychoactive medication side effect monitoring for three patients.

D Facility failed to follow the care plan to provide or arrange for mental health services for one patient.

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

K Facility failed to provide the highest practicable well-being for 73 patients due to insufficient nurse staffing. Facility failed to provide education and orientation to agency staff responsible for patient care and failed to ensure medication administration to 31 patients. This was an immediate jeopardy for failure to provide services per each patient's care plan. The facility also failed to provide the necessary care and services to maintain the highest level of functioning for three patients. This failure resulted in harm to one patient with a delay in needed surgical intervention.

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

D Facility failed to complete skin assessments for one patient.

D Facility failed to ensure medications were administered as ordered by the physician.

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

E Facility failed to provide staff assistance for hygiene and/or bathing for six patients.

D Facility failed to provide incontinence care and toileting assistance for one patient.

F314 Resident does not develop pressure sores.

D Facility failed to ensure accurate wound assessments were done for one patient with a pressure ulcer.

F319 Psychosocial adjustment difficulty.

D Facility failed to obtain psychiatric services as ordered for one patient.

F323 Accident hazards.

G Facility failed to provide supervision to prevent a fall with fractures for one patient and failed to prevent elopment for one patient reviewed for abuse. This failure caused harm to one patient.

G Facility failed to implement interventions to prevent falls and injury for one patient. This failure to provide two person assist with care resulted in acutal harm. The patient sustained a fall which resulted in an intracerebral hemorrhage that formed a subdural hematoma as well as a clavicular fracture.

D Facility failed to ensure the environment was free of accident hazards when unsecured sharps were found in one crash cart and hand rails were broken and rough on one hall.

D Facility failed to ensure falls had been thoroughly and completely investigated to ensure interventions were put in place and monitored to minimize repeat falls for two patients.

D Facility failed to ensure a door alarm was functioning for one patient reviewed for falls.

D Facility failed to ensure the environment was free from accident hazards when unsecured razors were found in one patient bathroom.

D Facility failed to ensure one handrail was free from broken jagged edges.

D Facility failed to complete the fall risk assessment after two patients fell and failed to completely investigate the fall for one patient.

F325 Facility must ensure acceptable parameters of nutritional status.

G Facility failed to prevent severe wight loss for three patients. This failure resulted in actual harm for three patients with severe weight loss.

D Facility failed to provide adequate nurtritional interventions to aid in wound healing for one patient.

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

E Facility failed to ensure patients were monitored for side effects of psychoactive medications.

D Facility failed to monitor for behaviors for one patient reviewed for unnecessary medication use.

D Facility failed to monitor for behaviors and side effects for one patient reviewed for unnecessary medication use.

D Facility failed to provide justification for antibiotic use for a urinary tract infection for one patient.

F332 Facility medication error rates of 5% or more.

D Facility failed to prevent medication errors of less than 5 percent. The error rate was 11.1 percent.

D Facility failed to ensure a medication error rate of less than 5 percent by administering medications by the wrong route for one patient. This was a 25 percent error rate.

D Facility failed to administer medications as ordered by the physician for two medications of 30 medications observed. This resulted in a 6.6 percent error rate.

F333 Residents free of significant medication errors.

K Facility failed to administer 239 significant medications, failed to check blood sugars 55 times, and failed to check blood pressures 15 times. These failures resulted in an immediate jeopardy for failure to administer medications per the physician's orders.

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

K Facility failed to provide sufficient nursing staff to provide nursing and related services to provide the highest practicable well-being for 73 patients. Facility failed to provide education and orentation to agency staff responsible for patient care in the facility and failed to administer medications to 31 patients. This was an immediate jeopardy.

E Facility failed to provide adequate staffing to ensure services such as bathing and shaving to six patients.

F362 Dietary services employ sufficient staff.

D Facility failed to employ sufficient support personnel competent to carry out the functions of the dietary service.

F371 Store, prepare, distribute, & serve food.

F Facility failed to store and maintain dry food in a sanitary manner; failed to dispose of potentially hazardous food in one walk-in refrigerator by the use date and failed to maintain dietary equipment in a sanitary manner.

F Facility failed to store food in a sanitary manner, failed to follow manufacturer's recommendations for low temperature and chemical sanitation of dishes and failed to maintain clean food preparation equipment.

F Facility failed to provide a safe, sanitary water temperature for washing dishes affecting 91 patients. The facility failed to serve ground meat at a safe temperature for three patients.

F Facility failed to dispose of food by the use by date in one walk-in freezer and failed to label foods removed from the orginal container.

F Facility failed to maintain clean and sanitary conditions in the food preparation and service department of the kitchen.

E Facility failed to ensure dietary equipment was clean and stored in a sanitary manner.

D Facility failed to serve cold food at or less than 41 degrees F.

F372 Disposes of garbage & refuse.

F Facility failed to maintain a clean and sanitary area around three dumpsters to ensure garbage and refuse were disposed of properly.

F441 Investigates, controls/prevents infections.

E Facility failed to provide care and services to prevent the potential spread of infection for two patients with pressure ulcers.

E Facility failed to ensure practices to prevent the potential spread of infection were maintained by failure to ensure appropriate cleansing and disinfecting of blood spills in two patient bathrooms.

E Facility failed to maintain two patient snack refrigerators in a sanitary manner. There was unlabled food from unknown sources and refrigerator surfaces with spilled dried liquids and debris on them.

D Facility failed to store respiratory equipment in a sanitary manner for one patient.

D Facility failed to follow infection control practices during medication administration for two patients.

F463 Resident call system.

D Facility failed to ensure there was an operational call system in place for two shared bathroom and patient bathrooms.

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

E Facility failed to ensure floors were kept in good repair in two patient halls.

D Facility failed to ensure the environment was in good repair, clean and sanitary as evidenced by organe/yellow spots, brown and black matter and dirt on the baseboards and door frames, and rust and dirt on the door frames and exit doors in two hallways.

F468 Corridors equipped with hand rails.

D Facility failed to ensure two handrails were securely affixed to the wall on one hall.

F490 Administration.

K Facility administrator failed to administer the facility in a manner to maintain the highest practicable well-being of each patient to include adequate staffing; prevent elopement; and protect from accidents, abuse and neglect. This resulted in immediate jeopardy for the patients in the facility.

J Facility administrator failed to administer the facility in an effective manner, utilizing all its resources including the proper investigation process per the abuse/neglect policy and procedure and training and education on how to handle aggressive patient interactions during care provided, resulting in immediate jeopardy for two patients.

E Facility administrator failed to ensure adequate staffing to ensure patients were shaved and bathed as scheduled and/or per preference for six patients. Administrator failed to adminster the facility to ensure falls/accidents were thorougly investigated and care plans were updated for two patients. Administration failed to administer the facility to ensure all alleged violations were thoroughly investigated and care plans were updated.

D Facility administrator failed to administer the facility in a manner to ensure the facility completely investigated abuse, accidents, falls and injuries of unknown origin. The administrator failed to recognize verbal abuse and failed to ensure care plans were revised timely with interventions after an accident.

F501 A physician must be designated as medical director.

K Facility medical direct faileld to be involved in his role/function related to coordination of medical care and/or implementation of patient care policies. This failure resulted in immediate jeopardy.

F502 Provide or obtain clinical laboratory services.

D Facility failed to ensure a laboratory test had been completed for one patient.

F514 Criteria for clinical records.

E Facility failed to maintain complete and accurate medical records, failed to provide surveyors computer access to review data and failed to provide date in a timely manner for seven patients.

D Facility failed to document the accurate location of topical medication placement for one patient.

D Facility failed to ensure medical records were accurate and complete related to PEG tube feedings and wound care assessments.

D Facility failed to ensure a complete medical record for one patient. The patient had a stat order for Humalog insulin due to a blood glucose level of 494. There was no documentation that the insulin had been administered nor the rechecking of the glucose levels.

D Facility failedk to maintain accurate and/or complete medical records for a skin assessment for one patient and failed to monitor behaviors for one patient using antipsychotic medications. Facility failed to identiry the behavior exhibited for one patient using anti-anxiety medication.

F520 Quality assessment & assurance.

K Facility quality assurance committee failed to recognize inadequate staffing; failed to ensure medications were administered per physician orders; failed to prevent neglect of patients; and failed to implment an appropriate plan of action to correct the deficient practice. These failures resulted in immediate jeopardy to the patients in the facility.

G Facility quality assurance committee failed to have an effective ongoing quality program that identified, developed, implemented and monitored appropriate plans of action to correct issues. The failure to provide two person assist with care resulted in acutal harm. The patient sustained a fall which resulted in an intracerebral hemorrhage that formed a subdural hematoma as well as a clavicular fracture.

D Facility quality assurance committee failed to identify and investigate verbal abuse, failed to have complete fall investigations, failed to complete wound assessments and failed to identify behavior to monitor for psychotropic medication.

K131 Multiple Occupancies

D Facility failed to maintain the occupancy separation two hour fire wall assembly.

K211 Alcohol Based Hand Rub Dispensers

D Facility failed to maintain the means of egress free of obstructions.

D Facility failed to maintain the exits. The latch on the south courtyard gate was not operable from the egress side.

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

K222 NFPA 101 Egress Doors

E Facility failed to have correct signage on delayed egress doors.

K232 Aisle, Corridor or Ramp Width

D Facility failed to maintain the capacity of the means of egress.

D Facility failed to maintain the corridor width. Linen carts were being stored in the corridor.

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. Continuous lighting was in available in multiple patient rooms.

D Facility failed to provide all requirements for egress lighting that is on a motion sensor.

K311 Vertical Openings - Enclosure

D Facility failed to maintain the elevator shaft. There were unsealed penetrations in the shaft.

D Facility failed to maintain vertical openings. There was a penetration in the elevator shaft.

K321 Hazardous Areas; Enclosure

D Facility failed to maintain hazardous areas. The door to the biohazard room did not close within the frame.

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

D Facility failed to maintain the hazardous areas. One patient room was being used for storage and did not have a self-closing door.

D Facility failed to protect the hazardous areas.

K324 Cooking Facilities

D Facility failed to maintain hood suppression system. The flat cooktop was not centered under the nozzles of the hood suppression system.

D Facility failed to maintain the cooking facilities. The kitchen vent hood was not being cleaned by properly trained, qualified or certified personnel.

D Facility failed to maintain the hood system. There were missing components on one of the hood suppression nozzles (blowoff caps).

D Facility failed to maintain the commercial hood system. There was no drip tray installed on the commercial hood system.

D Facility failed to protect the cooking facilities.

D Facility failed to protect the cooking equipment. There was no documentation of a first sem-annual hood system inspection for 2017.

K341 Fire Alarm System; Installation

D Facility failed to maintain the fire alarm system.

K342 Fire Alarm System - Initiation

E Facility failed to provide fire alarm initiation devices as required.

K345 Fire Alarm System; Testing and Maintenance

D Facility failed to maintain the fire alarm system. There were smoke detectors too close to the airflow ducts.

D Facility failed to maintain the fire alarm system. There was no documentation of the annual fire alarm inspection taking place in 2016 or 2017.

K351 Sprinkler System; Installation

D Facility failed to maintain the sprinkler system.

D Facility failed to correctly install components of the sprinkler system.

D Facility failed to properly install components of the sprinkler system. There was storage within 18 inches of the sprinkler in the beauty shop.

K353 Sprinkler System; Testing and Maintenance

F Facility failed to maintain the sprinkler system. There were several sprinkler heads with paint on them.

F Facility failed to maintain the automatic sprinkler system.

F Facility failed to maintain the automatic sprinkler system. Both fire department connections did not have the required signage. The gauges on the front riser were over five years on the replacement calibration. No leakage testing had been conducted on the dry system. The medical records room had sprinkler heads within 4 inches of the wall.

F Facility failed to maintain the automatic sprinkler.

D Facility failed to maintain the sprinkler system. There was a corroded sprinkler head in the laundry.

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

D Facility failed to replace corroded sprinkler heads in several areas of the building.

D Facility failed to maintain the sprinkler system. There was paint and rust on several sprinkler heads in the facility.

D Facility failed to maintain the sprinkler system.

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

D Facility failed to maintain the sprinkler system. There were leaking sprinklers in two closets.

D Facility failedk to maintain the sprinkler system. There was corrosion on several sprinkler heads.

K355 Portable Fire Extinguishers

E Facility failed to maintain the fire extinguishers. There were several fire extinguishers mounted over five feet.

K363 Corridor - Doors

D Facility failed to maintain the corridor doors. Several doors would not close to a positive frame.

D Facility failed to maintain the corridor doors. There were louvered doors that would not resist the passage of smoke in the event of a fire.

D Facility failed to maintain corridor doors. Some doors failed to close to a positive latch.

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

K372

D Facility failed to maintain the smoke barrier walls.

K372 Subdivision of Building Spaces; Smoke Barriers

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

K500 Building Services - Other

D Facility failed to maintain the building services. The transfer switch room did not have emergency lights.

K511 Utilities - Gas and Electric

D Facility failed to maintain the utilities. There was a flexible cord spliced to the power supply of a soap dispensing machine in the soiled linen room.

D Facility failed to maintain the utilities. The deep fat fryer was on rolling casters and was not restrained.

K521 HVAC

D Facility failed to maintain the HVAC system. The fire/smoke damper inspection was not completed in the last four years.

D Facility failed to maintain the fire dampers. There was not a four-year damper inspection.

K711 Evacuation and Relocation Plan

D Facility failed to maintain the required documents. There was no call to the fire department in the fire plan.

D Facility failed to maintain the required documents. There was no call to the fire department in the fire plan.

K741 Smoking Regulations

D Facility failed to follow their non-smoking policy. The facility had been smoke free since January 2017 but there were multiple cigarette butts observed on the ground and in the trash can outside in the old smoking area.

K753 Combustible Decorations

D Facility failed to prohibit combustible decorations.

D Facility failed to limit combustible decorations. One room contained a large amount of combustible decorations covering the walls from floor to ceiling.

K912 Electrical Systems

D Facility failed to maintain the electrical equipment. There were multiple damaged electrical outlets in the facility.

K918 Electrical Systems - Essential Electric System Maintenance and Testing

D Facility failed to maintain the emergency generator. There was not a generator load bank for 2016 or 2017.

K920 Electrical Equipment; Power Cords and Extension Cords

- E Facility failed to provide power strips in patient care areas for patient care related electrical equipment that meet UL 1363A.
- D Facility failed to maintain the power cords. There was an unapproved surge protector in the therapy gym.
- D Facility failed to properly use power cords and extension cords. There were two power strips plugged back to back in one room.
- D Facility failed to maintain electrical equipment. There were unapproved power strips in use in multiple patient rooms.
- D Facility failed to comply with power cord and extension cord regulations.
- D Facility failed to comply with power cord and extension cord regulations. There were unapproved power strips being used througout the facility.
- D Facility failed to comply with power cord and extension cord regulations. Unapproved power strips were being used throughout the facility.
- D Facility failed to maintain the electrical equipment. Unapproved surge protectors were used in patient care areas throughout the facility.

K923 Gas Equipment - Cylinder and Container Storage
Container Storag

- D Facility failed to maintain storage of medical gas cylinders.
- D Facility failed to maintain storage of medical gas cylinders. Some oxygen cyliners in the storage rooms were not designated with signage as full or empty.
- D Facility failed to provide required precautionary signage at oxygen storage rooms.
- D Facility failed to maintain storage of medical gas cylinders. There was no signage to identify empty cylinders.
- D Facility failed to maintain oxygen storage rooms. There were nine unsecured cylinders on top of the storage rack.
- D Facility failed to maintain oxygen storage room. There was not a way to tell which oxygen cylinders were empty or full.
- D Facility failedk to maintain oxygen storage. There was oxygen stored within 5 feet of combustibles in the storage closet.
- D Facility failed to have outside oxygen storage arranged correctly.

N629 Infection Control; Disinfect Contaminated Items

- E Facility failed to ensure practices to prevent the potential spread of infection were maintained by failure to ensure appropriate cleansing and disinfecting of blood spills in two patient bathrooms and one patient room. This was a type C pending penalty.

N645 Nursing Services

Facility failed to ensure floors were kept in good repair in two halls. This was a type C pending penalty.

Facility failed to ensure a comfortable and sanitary environment as evidenced by rust on bed frames, paint peeling on walls, drywall visible, baseboard peeling off the wall, chipped paint with wood showing, rust on metal under sinks and long black marks on the wall. This was a type C pending penalty.

N831 Building Standards

D Facility failed to maintain the overall nursing home environment. There was unapproved fire caulk in the several locations in the facility.

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

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

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

Facility failed to maintain the physical plant. There was wet gypsum board that is crumbling.

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

Facility failed to maintain the overall nursing home environment. There were penetrations in the fire wall.

Facility failed to maintain the physical plant and overall environment. There was a non-rated access door in the ceiling outside one patient room.

Facility failed to maintain the overall nursing home environment. There were penetrations in the fire wall.

Facility failed to maintain the overall nursing home environment. There were penetrations in the fire wall.

Facility failed to maintain the building to ensure patient safety. The fire door lower latching mechanism did not extend down into the floor.

N843 Building Standards; New Construction and Renovation

D Facility failed to ensure there was an operational call system in place for two shared bathrooms.

N848 Building Standards; Exhaust & Air Pressure

Facility failed to maintain proper air pressure. There was no positive air in the clean linen room.

Facility failed to maintain negative air pressure in all required areas.

Facility failed to maintain proper air flow. There was no positive air flow in the linen closets.

Facility failed to maintain negative air pressure in required areas. The exhaust fans were not working in several patient bathrooms.

Survey Deficiency Summary

30 Facilities Surveyed **Surveys Taken 8/28/17 to 10/31/17**

Evacuation and Relocation Plan

D Facility failed to ensure staff was trained so they are familiar with procedures in a kitchen fire per the requirements of NFPA.

F157 Notify of Changes (injury/decline/room, etc)

D Facility failed to notify the physician of the family's request to hold a medication order for one patient.

F157 Notify of changes (Injury/decline/ room/ etc)

D Facility failed to notify the responsible party of a non-abuse allegation timely for one patient.

F164 Personal Privacy/confidentiality of records

D Facility failed to ensure privacy during medication administration by one LPN.

F224 Prohibit mistreatment/neglect/misappropriation

D Facility failed to prevent neglect of one patient. A CNA failed to make rounds every two hours during the night.

F224 Prohibit mistreatment/neglect/misappropriation

K Facility failed to prevent neglect by failing to provide the services necessary to avoid physical harm for patients utilizing electrical power strips for one patient. Facility failed to prevent neglect by failing to ensure the facility utilized approved electrical power strips for 14 patients and failed to prevent neglect by failing to prevent exploitation of five patients for abuse. These failures placed all the patients in immediate jeopardy.

E Facility failed to prevent misappropriation of patient narcotic medication for seven patients. The narcotic counts were not done appropriately and narcotics were not accounted for and were missing from the patient supply.

F225 Investigate/report allegations/ individuals

D Facility failed to properly complete an investigation for one patient. The hand written statements were all done in the same handwriting from 8 potential witnesses.

F225 Investigate/report allegations/individuals

E Facility failed to thoroughly investigate an allegation of abuse for one patient and failed to timely report allegations of abuse for three patients and for one patient with an injury of unknown origin.

D Facility failed to report a non-abuse allegation to the state agency within 24 hours of the event.