Survey Deficiency Summary

33 Facilities Surveyed **Surveys Taken 10/4/17 to 11/28/17**

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

K Facility failed to notify the physician when there was a significant change in conditions for four patients. This failure to notify the physician of one paient's refusal of care, deteriorating surgical wounds and pressure ulcers, complaints of increasing pain, deteriorating condition and escalating behaviors resulted in actual harm and placed the patient in immediate jeopardy. The facility failure to notify the physican of elevated blood glucose levels and missed insulin doses placed another patient in immediate jeopardy. The facility failed to recognize, assess and report signs and symptoms of a deteriorating clinical condition to the physician resulted in actual harm and placed another patient in immediate jeopardy. This failure to notify the physician of increased severe levels of pain and the inability to secure a pain clinic appointment resulted in actual harm to a fourth patient and placed the patient in immediate jeopardy.

D Facility failed to notify the physician related to diagnostic testing for one patient.

D Facility failed to notify the physician and family of a fall for one patient.

D Facility failed to notify the physician of recommendations for one patient.

F160 Conveyance of funds upon death.

D Facility failed to refund account balances for one patient within 30 days of the patient's death.

F164 Right to privacy & confidentiality.

D Facility nurses failed to provide confidentiality of medical records during the medication pass. The computer screen was left open and unattended.

F176 Self-administration of drugs by resident.

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

F223 Right to be free of physical/verbal abuse.

J Facility failed to prevent and protect two patients from abuse (patient to patient). This failure resulted in harm to the patients.

F224 Mistreatment, neglect, misappropriation of resident property.

K Facility neglected to recognize and treat pressure ulcers, neglected to identify and treat deteriorating surgical wounds, neglected to recognize and address pain, neglected to recognize and respond promptly to significant changes in condition and neglected to recognize self destructive behaviors for four patients. These failures placed the patients in immediate jeopardy.

K Facility failedk to provide services to prevent neglect by failure to provide supervision and interventions to prevent falls for five patients. Facility failed to assess pain for two patients and failed to provide grooming and showers to two patients. Facility failed to provide supervision to prevent ongoing violent behaviors for two patients. These failures constituted an immediate jeopardy and substandard quality of care.

D Facility failed to prevent the misappropriation of medication for one patient.

D Facility failed to ensure one patient was free from misappropriation of patient property.

F225 Facility must not hire person with abuse history.

K Facility failed to investigate allegations of abuse for two patient and failed to report these allegations to the state agency. This failure resulted in harm for two patients and placed the patients in immediate jeopardy.

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

D Facility failed to promptly report an injury of unknown origin to the appropriate agencies.

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

L Facility failed to implement the abuse and neglect prohibititon policy and to provide training to facility and agency staff on abuse recognition, abuse prevention and abuse reporting. This failure resulted in harm to the patients.

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

E Facility failed to ensure dignity and respect for five patients observed during meals. The CNA touched a sandwich with her bare hands.

D Facility failed to provide care in a manner that ensure the patients' dignity, respect and quality of life when one CNA stood over a patient while assisting them to eat during dining observations.

D Facility failed to provide care in an environment that promoted dignity and respect when two LPNs stood at the patient's beside and assisted them with meals.

F246 Right to accommodations of individual needs & preferences.

D Facility failed to ensure patients' call lights were accessible in two rooms.

D Facility failed to honor the patient's preference for showers.

F250 Medically related social services.

K Facility failed to provide medically related social services that recognized and addressed suicide threats, self-destructive behaviors and pain management for three patients. These failures resulted in immediate jeopardy and actual harm to multiple patients.

F252 Safe, clean, comfortable & homelike environment.

E Facility failed to maintain cleanliness for one patient and failed to provide a water pitcher for one patient. Facility failed to maintain cleanliness for nine tables in the dining room.

E Facility failed to provide a home like environment for one meal. The sandwiches were not served on a plate.

F253 Housekeeping & maintenance services.

D Facility failed to provide a sanitary environment for four patients with a shared bathroom.

B Facility failed to maintain a sanitary, orderly and comfortable interior. The walls were not in good repair in four patient rooms.

F254 Clean bed & bath linens.

E Facility failed to make available a sufficient amount of linens (towels and washcloths) for the patients on two floors.

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

D Facility failed to accurately assess the use of oxygen for one patient and failed to identify a previous fall for one patient.

D Facility failed to ensure the MDS assessment was accurate for one patient.

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

D Facility failed to develop a comprehensive care plan for bathing and personal hygiene for one patient.

D Facility failed to develop a comprehensive care plan for one patient.

D Facility failed to identfy an implanted cardiac defibrillator with care and interventions for one patient. Facility failed to complete a comprehensive and timely care plan and failed to provide interventions to prevent falls for one patient. Facility failed to identify a focus of behaviors with interventions for two patients.

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

J Facility failed to revise the care plan to reflect falls for one patient. This failure to develop and implement an individualized plan of care that included interventions to address a vulnerable patient, who was blind and had bilateral lower extremity amputations, safety to travel independently/without an escort on a wheelchair van resulted in immediate jeopardy. The patient sustained a fall during transport resulting in a serious injury, a subarachnoid hemorrhage. The patient was hospitalized as a result of the fall, declined during hospitalization, and expired in the hospital. (The immediacy was removed prior to the exit of the surveyors.)

E Facility failed to revise the comprehensive care plan related to fall interventions for three patients and failed to revise the code status and Foley catheter status for two patients.

E Facility failed to develop and implement interventions following falls for three patients.

D Facility failed to review the care plan quarterly for behaviors, depression, congestive heart failure, diabetes and diuretic medication.

D Facility failed to revise the care plan for one patient.

F281 Services must meet professional standards of quality.

K Facility failed to ensure the implementation of professional standards of practice for four patient who were being transported to and from dialysis by a transporation wheelchair van service. The facility failed to ensure patients' safety by conducting patient safety risk assessments in order to determine the patients' abilities to independently travel in a transportation van service to and return from dialysis treatments. Facility failed to ensure a safety plan was developed and implemented to patients' safe transportation. This failure placed patients in immediate jeopardy. (The immediacy was cleared prior to the exit of the surveyors.)

F282 Services must be provided by qualified persons.

K Facility failed to follow the care plan interventions for a therapeutic diet for one patient. This failure resulted in an immediate jeopardy for the patient when a dependent patient was served a food that was specifically excluded from her therapeutic diet resulting in a life-threatening choking event. The patient sustained a fracture to her sternum as a direct result of the life-saving interventions required to prevent her death from choking. (The immediacy was removed by the acceptance of the AOC prior to the surveyors exiting the facility. It continued at an E-level scope and severity)

K Facility failed to ensure that care was provided according to the comprehensive care plan for five patients. This failure to follow the care plan placed one patient in immediate jeopardy when the patient displayed behaviors and the facility failed to get a psychiatric evaluation, failed to monitor the wound site for signs and symptoms of infection and failed to administer pain medication as care planned resulting in actual harm. These failures placed the patients in immediate jeopardy.

K Facility failed to follow the care plan interventions for a therapeutic diet for one patient. This failure resulted in an immediate jeopardy for the patient when a dependent patient was served a food that was specifically excluded from her therapeutic diet resulting in a life-threatening choking event. The patient sustained a fracture to her sternum as a direct result of the life-saving interventions required to prevent her death from choking. (The immediacy was removed by the acceptance of the AOC prior to the surveyors exiting the facility. It continued at an E-level scope and severity)

D Facility failed to ensure the care plan was followed for activities of daily living (ADL), baths showers and incontinent care. Facility failed to perform checks every two hours for patients.

D Facility failed to ensure a follow-up appointment was obtained for one patient.

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

K Facility failed to ensure a comprehensive approach to all care services provided to facility patients and ensure communication between the dialysis center and the facility. The facility failed to ensure patients' safety by conducting patient safety risk assessments in order to determine the patients' abilities to independently travel in a transportation van service to and return from dialysis treatments. Facility failed to ensure a safety plan was developed and implemented to patients' safe transportation. This failure placed patients in immediate jeopardy. (The immediacy was cleared prior to the exit of the surveyors.)

K Facility failed to provide care and services necessary to maintain the highest practicable physical, mental and psychosocial well-being of patients when staff failed to follow physician orders for therapeutic diets for one patient. The patient was placed in immediate jeopardy when a specifically excluded food item was fed to her. The patient choked and required emergency medical interventions that included the use of abdominal thrusts, irway suctioning, and physical removal of the food item. Due to the interventions the patient sustained a fracture to the sternum. This was also a substandard quality of care. (The immediacy was removed prior to the surveyors exiting the facility.)

K Facility failed to ensure that care and services were provided to ensure the highest practicable physical, mental and psychosocial well being for three patients. The facility failed to ensure comprehensive wound assessments and treatments were provided and resulted in actual harm to one patient and placed the patient in immediate jeopardy. The facility failed to ensure pain management was provided which resulted in actual harm and placed two patients in immediate jeopardy. The facility failed to ensure that diabetic monitoring and insulin were provided as ordered and placed one patient in immediate jeopardy.

K Facility failed to provide care and services for the patient's highest practicable well-being by failure to assess the need for pain medication after a fall resulting in a hip fracture and prior to the removal of embedded sutures to one patient. Facility failed to monitor blood pressure and heart rate prior to administration of cardiac medications for one patient and failed to assess and monitor behaviors for two patients. These failures resulted in immediate jeopardy to the patients. This was also substandard quality of care.

K Facility failed to provide care and services necessary to maintain the highest practicable physical, mental and psychosocial well-being of patients when staff failed to follow physician orders for therapeutic diets for one patient. The patient was placed in immediate jeopardy when a specifically excluded food item was fed to her. The patient choked and required emergency medical interventions that included the use of abdominal thrusts, irway suctioning, and physical removal of the food item. Due to the interventions the patient sustained a fracture to the sternum. This was also a substandard quality of care. (The immediacy was removed prior to the surveyors exiting the facility.)

D Facility failed to provide physician's orders for one patient reviewed receiving hospice and one patient reviewed receiving dialysis services.

D Facility failed to follow the physician's orders for intravenous therapy for one patient.

D Facility failed to follow physician's orders for two patients. The patients were on sliding scale insulin and the insulin units administered did not follow the parameters.

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

D Facility failed to follow a physician's medication order for one patient.

D Facility failed to ensure physician orders were followed related to insulin administration for one patient.

D Facility failed to follow a physician's order for colostomy care and failed to process a physician's order for an antibiotic for one patient.

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

D Facility failed to ensure ADL baths or showers and incontinent checks every two hours were performed.

D Facility failed to carry out and maintain grooming, bathing and personal hygiene for two patients.

F314 Resident does not develop pressure sores.

J Facility failed to ensure the identification and the necessary treatment and services were provided to prevent the development and worsening of pressure ulcers for two patients. This resulted in actual harm to one patient and placed the patient in immediate jeopardy.

D Facility failed to ensure weekly skin assessments were completed for two patients reviewed with pressure ulcers.

D Facility failed to implement interventions for the treatment of pressure ulcers for one patient.

F315 Incontinent resident receives appropriate treatment and services.

D Facility failed to assess one patient for a toileting program for urinary incontinence.

F318 Range of motion.

D Facility failed to provide range of motion services to meet the needs of two patients.

F319 Psychosocial adjustment difficulty.

J Facility failed to comprehensively assess and provide appropriate psychosocial treatment and services to two patients who displayed self-destructive behaviors, psychosocial adjustment difficulty and had a history of trauma. This failure placed the patient in immediate jeopardy.

F323 Accident hazards.

K Facility failed to ensure patients at risk for falls were completely and accurately assessed for fall risk. Facility failed to ensure falls were thoroughly investigated with the implementation of new interventions to prevent further falls for one patient and failed to ensure safety assessments were completed for four patient for outpatient dialysis prior to transportation without an escort outside the facility for medical services. This was an immediate jeopardy. (The immediacy was removed prior to the surveyors exit.)

K Facility failed to provide supervision and interventions to prevent accidents resulting in falls for five patients. One patient sustained a hip fracture. These failures constituted an immediate jeopardy and substandard quality of care.

E Facility failed to maintain an environment free from accident hazards for one handrail in the corridor.

E Facility failed to complete a thorough investigation and implment interventions to prevent further falls for three patients and failed to provide adequate supervision to prevent falls for one patient reviewed for accidents.

D Facility failed to ensure the environment was free from accident hazards of unsecured razors in one shower room.

D Facility failed to ensure chemicals were properly stored and secured in one storage closet.

D Facility failed to ensure the environment was free from accident hazards of unsecured razors in one common shower room.

D Facility failed to ensure one patient was free from accident hazards. The patient had a lighter.

D Facility failed to ensure the safety of one patient.

F325 Facility must ensure acceptable parameters of nutritional status.

K Facility failed to ensure therapeutic diets were served and nutritional care and services were provided to three patients.

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

D Facility administered unnecessary medication to one patient. The patient received a double dose of oxycodone.

D Facility failed to attempt to taper an antidepressant medication for one patient reviewed for unnecessary medications.

F333 Residents free of significant medication errors.

G Facility failed to prevent significant medication errors for three patients. One error caused harm to one patient from being overly sedated and requiring Narcan.

E Facility failed to ensure significant medications were administered in a timely manner for four patients.

D Facility failed to ensure a patient was free from a significant medication error when one nurse failed to administer insulin within the proper time frame related to meals.

D Facility failed to ensure patients were free of significant medication errors. The patient received one tablet for seizures and should have received two.

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

L Facility failed to ensure nursing staff were competent to provide nursing care to maintain the highest practical, physical and psychosocial well being for 10 patients. The facility failed to ensure nursing staff competently assessed patients' physical and mental health concerns, administered medications and treatments correctly or documented care provided. These failures placed the patients in the facility in immediate jeopardy.

K Facility failed to provide sufficient nurse staffing for supervision and care in the prevention of falls for five patients. This failure resulted in immediate jeopardy.

D Facility failed to provide sufficient staffing to meet the needs of two patients.

F356 Nurse staffing data

D Facility failed to ensure posted staffing was updated daily.

F361 Dietary services staffing.

K Facility registered dietitian failed to provide oversight to ensure dietary staff prepared and served therapeutic diets as ordered by the physician and failed to provide education to dietary managers. This resulted in immediate jeopardy to one patient when the diet received was not the therapeutic diet as ordered and the patient choked. This was cited as an immediate jeopardy and the immediacy was removed prior to the exit of the surveyors.

K Facility registered dietitian failed to provide oversight to ensure dietary staff prepared and served therapeutic diets as ordered by the physician and failed to provide education to dietary managers. This resulted in immediate jeopardy to one patient when the diet received was not the therapeutic diet as ordered and the patient choked. This was cited as an immediate jeopardy and the immediacy was removed prior to the exit of the surveyors.

F362 Dietary services employ sufficient staff.

K Facility failed to ensure dietary staff members were sufficiently trained to provide the correct mechanically altered threapeutic diet for one patient. This failure placed one patient in immediate jeopardy.

K Facility failed to ensure dietary staff members were sufficiently trained to provide the correct mechanically altered threapeutic diet for one patient. This failure placed one patient in immediate jeopardy.

F371 Store, prepare, distribute, & serve food.

F Facility failed to ensure food was stored in a sanitary manner when expired foods were observed in the walk-in refrigerator, and failed to prevent the potential spread of infection when equipment was improperly stored affecting all patients in the facility.

F Facility failed to ensure food was prepared and served under sanitary conditions. The facility failed to ensure four CNAs performed hand hygiene during meals. Facility failed to prevent wet nesting of plate domes, soup bowls, cups and plate bases. There was also carbon build up on equipment.

F Facility failed to hold and serve cooked foods at the acceptable temperature.

F Facility failed to store food items in a sanitary manner in three refrigerators.

F Facility failed to properly air dry pans and maintain safe operating temperatures in one reach in refrigerator in the dietary department.

F Facility failed to serve sanwiches on plates to patients; failed to serve lemon squares on plates; failed to wash or sanitize hands prior to donning gloves and serving food; failed to remove contaminated gloves prior to handling bulk food; failed to thoroughly dry plate lids prior to use; failed to maintain a clean and sanitary ice machine and nourishment refrigerator; failed to dispose of expired buttermilk; and failed to date applesauce and sandwiches.

D Facility failed to ensure food was served under santiary conditions when one CNA failed to wear personal protective equipment (PPE) for a patient in isolation.

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

J Facility failed to ensure the pharmacist identified and reported irregularities related to pain medication documentation for signing out narcotic pain medication and administration of those medications for two patients. This placed the patients in immediate jeopardy.

D Facility failed to act on a pharmacy recommendation for an antidepressant gradual dose reduction for one patient.

F431 Labeling of drugs & biologicals.

E Facility failed to ensure medications were properly stored as evidenced by five medication storage areas with expired medications, open and undated medications.

E

D Facility failed to ensure medications were properly stored when medications were left unattended.

D Facility failed to ensure medications were stored properly as evidenced by medications stored in one patient room, medication carts left unloced and unattended and an undated insulin pen in one medication storage unit.

D Facility failed to ensure medications were properly stored in one patient room. There was a pill in a medication cup sitting on the patient's over-bed table. There was no nurse in attendance.

Facility failed to discard expired medications in one medication refrigerator and to secure controlled medications under a double lock system for two medication refrigerators.

F441 Investigates, controls/prevents infections.

E Facility failed to ensure practices to prevent the potential spread of infection were maintained by failing to ensure isolation signage on the doors of three patients in isolation.

E Facility failed to ensure measures to prevent the potential spread of infection were followed when two CNAs failed to perform hand hygiene before performing perineal care and a bed bath.

E Facility failed to ensure staff maintained infection control for the glucose meter and to disinfect the glucose meters with appropriate disinfectant.

E Facility failed to handle and store linen to prevent the spread of infection, failed to provide sanitized water pitchers for 10 patients and failed to perform appropriate handwashing.

D Facility nurses did not follow appropriate infection control practices to prevent the potential spread of infection during the medication pass observations.

D Facility failed to ensure measures to prevent the otential spread of infection were followed when one LPN failed perform handwashing correctly.

D Facility failed to ensure infection control measures were followed when one LPN failed to perform hand hygiene during medication administration and failed to wear gloves while performing capillary finger sticks during the medication pass.

D Facility failed to ensure measures to prevent the spread of infections were followed by two LPNs during medication administration.

D Facility failed to follow contact isolation infection control guidelines for one patient.

D Facility failed to ensure infection control hand hygiene measures were followed when one LPN failed to perform hand hygiene correctly during a wound treatment.

D Facility failed to dispose of soiled linen to contain contamination for one hallway and failed to provide wound care in a sanitary manner for one patient. The facility failed to perform hand hygiene during medication administration for one nurse.

D Facility failed to ensure measures to prevent the spread of infections were followed by two LPNs during medication administration.

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

F Facility failed to maintain a clean, comfortable and homelike environment on two units.

E Facility failed to ensure the environment was in good repair, clean and sanitary as evidenced by a soiled laundry room with dirty wet floors, foul odor and a dirty metal double sink.

E Facility failed to provide a safe, functioning and sanitary environment for six rooms.

F468 Corridors equipped with hand rails.

E Facility failed to ensure the facility corridors were equipped with firmly secured handrails.

F490 Administration.

L Facility administrator failed to administer the facility in a manner that enabled the facility to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychological well-being of the patients when they failed to ensure the physician was notified of changes in condition. Administrator failed to prevent neglect by not identifying, assessing and implementing wound treatments and failed to ensure pain management. Administrator failed to ensure a patient's self-destructive behavior was addressed and failed to ensure care was provided as written on the care plan. Administrator failed to ensure that medically related social services were available and that wound treatments were done as ordered. Administrator failed to ensure medications were given and documented as ordered and failed to ensure competent staff. Administrator failed to ensure an accurate and complete medical record and failed to ensure the quality assurance program was effective. These failures placed the facility in immediate jeopardy.

L Facility administrator failed to maintain safe, trained and oriented staff which contributed to neglect, falls and/or abuse for 10 patients. This failure resulted in immediate jeopardy.

K Facility administrator failed to administer the facility in a manner that enabled it to use it's resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychological well-being of the patient when they failed to recognize safety concerns during transportation to ouside facilities. Facility administrator failed to ensure assessments for patients for safety during transportation and failed to ensure a system was implemented for the monitoring of patients during the transportation process. These failures resulted in immediate jeopardy for the patients. (The immediacy was removed prior to the exit of the surveyors.)

K Facility administrator failed to administer the facility in a manner that enabled it to use it's resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychological well-being of the patients. Administrator failed to ensure staff implemented care plan interventions for a therapeutic diet; failed to ensure staff followed physician's orders for therapeutic diets; failed to ensure the regional registered dietitian provided oversight to ensure dietary staff membes were sufficiently trained to compently perform their job duties and failed to investigate to determin the root cause of a choking incident. These failure placed one patient in immediate jeopardy from a choking incident. (The immediacy was removed prior to the exit of the surveyors.)

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F493 Governing body.

L Facility governing body failed to administer the facility in a manner that enabled the facility to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychological well-being of the patients when they failed to ensure the physician was notified of changes in condition. The governing body failed to prevent neglect by not identifying, assessing and implementing wound treatments and failed to ensure pain management. The governing body failed to ensure a patient's self-destructive behavior was addressed and failed to ensure care was provided as written on the care plan. The governing body failed to ensure that medically related social services were available and that wound treatments were done as ordered. The governing body failed to ensure medications were given and documented as ordered and failed to ensure competent staff. The governing body failed to ensure an accurate and complete medical record and failed to ensure the quality assurance program was effective. These failures placed the facility in immediate jeopardy.

K Facility governing body failed to ensure the facility administrator administered the facility in a manner that enabled it to use it's resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychological well-being of the patient when they failed to recognize safety concerns during transportation to ouside facilities. Facility governing body failed to ensure assessments for patients for safety during transportation and failed to ensure a system was implemented for the monitoring of patients during the transportation process. These failures resulted in immediate jeopardy for the patients. (The immediacy was removed prior to the exit of the surveyors.)

K Facility governing body failed to have an effective governing body that established and implemented policies and procedures that recognized concerns with hazards to health and safety, identified the root cause of the problems, and ensure systems and processes were developed and consistently followed by staff to address quality concerns. The governing body failed to have corrective actions consistently monitored to ensure the staff followed physician orders for therapeutic diets and interventions on the care plans. These failures resulted in immediate jeopardy for one patient due to a choking hazard. (The immediacy was removed prior to the exit of the surveyors.)

K Facility governing body failed to have an effective governing body that established and implemented policies and procedures that recognized concerns with hazards to health and safety, identified the root cause of the problems, and ensure systems and processes were developed and consistently followed by staff to address quality concerns. The governing body failed to have corrective actions consistently monitored to ensure the staff followed physician orders for therapeutic diets and interventions on the care plans. These failures resulted in immediate jeopardy for one patient due to a choking hazard. (The immediacy was removed prior to the exit of the surveyors.)

F501 A physician must be designated as medical director.

L Facility failed to ensure the medical director assisted the facility with identifying, evaluating and addressing clinical conerns, coordinating the medical care and providing clinical guidance and oversight regarding the implementation of patient care policies and procedures for patients residing in the facility. The medical director failed to address concerns related to patient neglect, wounds, pain management, therapeuting diets, psychosocial needs, patient behaviors, diabetic monitoring, medication administration accurate and complete medical records and staff competencies. These failure resulted in immediate jeopardy.

L Facility medical director failed in his role related to a fall prevention program, protocol or interventions, abuse investigations and a behavioral monitoring program. This failure resulted in immediate jeopardy.

K Facility failed to ensure the medical director assisted the facility with identifying, evaluating and addressing clinical conerns, coordinating the medical care and providing clinical guidance and oversight regarding the implementation of patient care policies and procedures that reflect the current standards of practice for the patients residing in the facility. The facility failed to ensure the medical director assisted with addressing clinical concerns and provided guidance regarding patient care by failing to ensure here was an effective process that monitored and addressed the potential for adverse consequences related to accidents/falls during transportation for medical care outside the facility. The medical director failed to ensure the facility investigated and implemented appropriate interventions after falls during transport, resulting in immediate jeopardy. (The immediacy was removed prior to the exit of the surveyors.)

F502 Provide or obtain clinical laboratory services.

D Facility failed to obtain accurate laboratory results for one patient.

F511 Promptly notify physician of radiology/diagnostic findings.

J Facility failed to notify the physician or nurse practitioner of a hip fracture for one patient. This failure resulted in immediate jeopardy.

F514 Criteria for clinical records.

K Facility failed to ensure medical records were organized, accurately documented and complete for four patients. This failure placed the patients in immediate jeopardy.

F515 Retention of clinical records.

F Facility failed to maintain patient clinical records for the appropriate time frame.

F520 Quality assessment & assurance.

L Facility quality assurance committee failed to identify and address concerns to ensure patients were not neglected for pain management, behavior management, receiving correct therapeutic diets, recognizing and reporting a change in condition, wound treatment and documentation, and competent staffing. The QA committee failedl to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently and that the medical director assisted the facility with identifying, evaluating, and addressing clinical conerns, coordinated the medical care and provided clinical guidance and oversight regarding the implementation of patient care. These failures placed the patients in immediate jeopardy.

L Facility quality assurance committee failed to recognize inadequate staffing; failed to prevent neglect of patients; failed to prevent abuse of patients; failed to prevent accidents; failed to identify escalating behaviors; and failed to implement an appropriate plan of action to correct the deficient practice. Theses failures resulted in immediate jeopardy.

K Facility failed to ensure an effective quality assurance program to recognize concerns with hazards to health and safety, identified the root cause of the problems and ensure systems and processes were develooped and consistently followed by staff to address quality concerns. The QA committee failed to address concerns to ensure patients at risk for falls and/or accidents were properly assessed for safety and that the facility was administered in such a manner to enable it to use its resources effecively and efficiently. Failed to ensure the medical director assisted the facility to identify, evaluate and address clinical concerns, coordinate guidance and oversight regarding the implementation of patient care policies and procedures for safety hazards. These failures resulted in immediate jeopardy. (The immediacy was removed prior to the exit of the surveyors.)

K Facility quality assurance committee failed to recognize and develop an effective program that recognized and developed an appropriate plan to ensure the staff followed care plan interventions and physician orders for patient's receiving mechanically altered therapeutic diets. This failure place one patient in immediate jeopardy. (The immediacy was removed prior to the exit of the surveyors.)

K Facility quality assurance committee failed to recognize and develop an effective program that recognized and developed an appropriate plan to ensure the staff followed care plan interventions and physician orders for patient's receiving mechanically altered therapeutic diets. This failure place one patient in immediate jeopardy. (The immediacy was removed prior to the exit of the surveyors.)

G Facility quality assurance committee failed to identify and implement corrective measures to address medication administration errors for nine patients. They failed to ensure systems were in place for patients to receive medications as ordered by the physician and to be free of significant medication errors. This failure resulted in harm, sedation and respiratory depression requiring the administration of Narcan.

E Facility failed to ensure an effective quality assurance committee had a program to recognize and monitor falls and to ensure the program was effective in preventing repeat deficiencies.

K200 Means of Egress Requirements

D Facility failed to properly identify an exit with the correct signage.

K211 Alcohol Based Hand Rub Dispensers

D Facility failed to maintain the emergency exits. There were boxes in the hallway leading to the emergency exit.

D Facility failed to maintain exit doors. One exit door required more than 15 pounds of pressure to push the doors open.

K222 NFPA 101 Egress Doors

D Facility failed to maintain the egress doors. Some of the delayed egress doors would not activate during manual testing of the fire alarm.

K291 Emergency Lighting

D Facility failed to maintain the emergency lighting.

D Facility failed to test and maintain the exit lighting. There was no documentation of a monthly emergency light testing for 2017.

D Facility failed to maintain the emergency lighting. The emergency/exit lights would not illuminate when manually tested by the supervisor.

K321 Hazardous Areas; Enclosure

E Facility failed to provide hazardous rooms with doors that are self or automatic closing.

D Facility failed to maintain the hazardous areas. Some doors did not close to a positive latch.

D Facility failed to maintain hazardous room doors.

D Facility failed to ensure hazardsous area's fire rating was mintained per the requirements of NFPA 101.

K324 Cooking Facilities

D Facility failed to maintain the commercial cooking equipment.

D Facility failed to maintain the kitchen hood system. There was no hood suppression system inspection for the first half of 2017.

D Facility failed to protect the cooking facilities. The hood suppression system was not interconnected with the fire alarm.

K331 Interior Wall and Ceiling Finish

F Facility failed to ensure corridor wall covering had a flame spread rating of A or B.

K342 Fire Alarm System - Initiation

D Facility failed to maintain the accessibility of the manual fire alarm system installation.

D Facility failed to provide the required fire alarm initiating device.

K345 Fire Alarm System; Testing and Maintenance

D Facility failed to provide all testing for the fire alarm. There was no smoke sensitivity testing within the past two years.

D Facility failed to maintain the fire alarm. The smoke detectors had not had sensitvity testing every other year.

K351 Sprinkler System; Installation

D Facility failed to maintain the automatic sprinkler system.

D Facility failed to correctly install components of the sprinkler system. There was storage within 18 inches of the sprinkler heads in several locations.

D Facility failed to install the required sprinklers. There was not sprinkler in the medication cart alcove.

K353 Sprinkler System; Testing and Maintenance

F Facility failed to ensure the dry sprinkler system was maintained per the requirements of NFPA 13. The dry system 3-year air leak test had never been performed and a trip test preformed earlier in the year indicated the water flow to take "an excessive amount of time."

F Facility failed to conduct all sprinkler testing and maintenance procedures on the automatic sprinkler system.

D Facility failed to maintain the sprinkler system. There was a sprinkler pipe connection that appeared to be leaking in one closet.

D Facility failed to maintain the sprinkler system in accordance with NFPA25.

D Facility failed to ensure compliance with NFPA25. There was storage within 18 inches of the sprinkler head in three closets.

D Facility failed to maintain the automatic spinkler system. There were painted sprinkler heads in the facility.

D Facility failed to maintain the sprinkler system. There were two sprinklers with corrosion.

D Facility failed to ensure the dry sprinkler system was maintained and tested per the requirements of NFPA 13.

D Facility failed to maintain the sprinkler system. There were painted sprinkler heads in several areas.

K355 Portable Fire Extinguishers

D Facility failed to install protable fire extinguishers.

K363 Corridor - Doors

D Facility failed to maintain the corridor doors. Some doors had a gap larger than 1/2 inch at the top of the door.

K372 Subdivision of Building Spaces; Smoke Barriers

D Facility failed to maintain the smoke barrier.

K541 Rubbish Chutes, Incinerator, and Laundry Chutes

E Facility failed to ensure linen chute doors functioned properly per the requirements of NFPA 101.

K700 Operating Features - Other

D Facility failed to maintain vertical openings. Some doors did not close to a positive latch.

K711 Evacuation and Relocation Plan

F Facility failed to ensure the fire safety plan included all the requirements per NFPA 101.

F Facility failed to maintain the fire safety plan of the facility per the requirements of NFPA 101. The staff member was not trained to properly activate the suppression system if there is a fire under the kitchen hood.

D Facility failed to train dietary staff to be familiar with fire procedures with cooking equipment located under the kitchen hood per the requirements of NFPA 101.

K741 Smoking Regulations

E Facility failed to maintain smoking areas. There were not ashtrays or operational metal containers with self-closing lids in the smoking areas.

K918 Electrical Systems - Essential Electric System Maintenance and Testing

D Facility failed to maintain the generator. There was no monthly generator load test for 2017.

D Facility failed to maintain the generator.

K919 Electrical Equipment - Other

D Facility failed to maintain all electrical equipment. There was a spliced power cord on a mini-fridge in one patient room.

K920 Electrical Equipment; Power Cords and Extension Cords

D Facililty failed to use the proper UL standard for power strips.

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

D Facility failed to use the proper electrical equipment. There were extension cords being used in the patient areas.

D Facility failed to comply with requirements of electrical equipment. There were unapproved multi-plug adapters in use in the patient rooms.

K923 Gas Equipment - Cylinder and Container Storage
Container Storag

D Facility failed to maintain the oxytem storage room. No precautionary signage was posted.

D Facility failed to maintain oxygen cylinders and storage.

N1216 Resident Rights

Facility nurses failed to provide confidentiality of medical records during the medication pass. The computer screen was left open and unattended. This was a type C pending penalty.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

Facility failed to exercise the required disaster drills.

Facility failed to exercise an earthquake drill annually.

N1411 Disaster Preparedness; Fire Safety Drills

Facility failed to exercise the required bomb threat drill.

N401 Administration

Facility administrator failed to administer the facility in a manner that enabled the facility to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychological well-being of the patients when they failed to ensure the physician was notified of changes in condition. Administrator failed to prevent neglect by not identifying, assessing and implementing wound treatments and failed to ensure pain management. Administrator failed to ensure a patient's self-destructive behavior was addressed and failed to ensure care was provided as written on the care plan. Administrator failed to ensure that medically related social services were available and that wound treatments were done as ordered. Administrator failed to ensure medications were given and documented as ordered and failed to ensure competent staff. Administrator failed to ensure an accurate and complete medical record and failed to ensure the quality assurance program was effective. These failures placed the facility in immediate jeopardy. This was a type A penalty suspension of admissions.

N601 Performance Improvement Program

Facility quality assurance committee failed to identify and implement corrective measures to address medication administration errors for nine patients. The committee failed to ensure systems were in place for patients to receive medications as ordered by the physician and to be free of significant medication errors. This failure resulted in harm, sedation and respiratory depression requiring the administration of Narcan.

Facility quality assurance committee failed to identify and address concerns to ensure patients were not neglected for pain management, behavior management, receiving correct therapeutic diets, recognizing and reporting a change in condition, wound treatment and documentation, and competent staffing. The QA committee failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently and that the medical director assisted the facility with identifying, evaluating, and addressing clinical concerns, coordinated the medical care and provided clinical guidance and oversight regarding the implementation of patient care. These failures placed the patients in immediate jeopardy. This was a type A penalty and suspension of admissions.

N615 Medical Director Responsibilities

Facility failed to ensure the medical director assisted the facility with identifying, evaluating and addressing clinical conerns, coordinating the medical care and providing clinical guidance and oversight regarding the implementation of patient care policies and procedures that reflect the current standards of practice for the patients residing in the facility. The facility failed to ensure the medical director assisted with addressing clinical concerns and provided guidance regarding patient care by failing to ensure here was an effective process that monitored and addressed the potential for adverse consequences related to accidents/falls during transportation for medical care outside the facility. The medical director failed to ensure the facility investigated and implemented appropriate interventions after falls during transport, resulting in immediate jeopardy. (The immediacy was removed prior to the exit of the surveyors.) This was a type C pending penalty.

Facility medical director failed in his role related to a fall prevention program, protocol or interventions, abuse investigations and a behavioral monitoring program. This failure resulted in immediate jeopardy.

N616 Physician Services; Medical Director

Facility failed to ensure the medical director assisted the facility with identifying, evaluating and addressing clinical conerns, coordinating the medical care and providing clinical guidance and oversight regarding the implementation of patient care policies and procedures for patients residing in the facility. The medical director failed to address concerns related to patient neglect, wounds, pain management, therapeuting diets, psychosocial needs, patient behaviors, diabetic monitoring, medication administration accurate and complete medical records and staff competencies. These failure resulted in immediate jeopardy. This was a type A penalty and suspension of admissions.

N645 Nursing Services

Facility failed to ensure the environment was in good repair, clean and sanitary as evidenced by a soiled laundry room with dirty wet floors, foul odor and a dirty metal double sink. This was a type C pending penalty.

Facility failed to ensure the environment was free from accident hazards of unsecured razors in one shower room. This was a type C pending penalty.

Facility failed to ensure medications were properly stored when medications were left unattended. This was a type C pending penalty.

Facility failed to ensure medications were stored properly as evidenced by medications stored in one patient room, medication carts left unloced and unattended and an undated insulin pen in one medication storage unit.

N669 Nursing Services; Physician Notification

Facility failed to notify the physician related to diagnositic testing for one patient. This was a type C pending penalty.

Facility failed to ensure nursing staff were competent to provide nursing care to maintain the highest practical, physical and psychosocial well being for 10 patients. The facility failed to ensure nursing staff competently assessed patients' physical and mental health concerns, administered medications and treatments correctly or documented care provided. These failures placed the patients in the facility in immediate jeopardy. This was a type A penalty suspension of admissions.

N682 Pharmaceutical Services; Storage of Medications

Facility failed to ensure that care was provided according to the comprehensive care plan for five patients. This failure to follow the care plan placed one patient in immediate jeopardy when the patient displayed behaviors and the facility failed to get a psychiatric evaluation, faileld to monitor the wound site for signs and symptoms of infection and failed to administer pain medication as care planned resulting in actual harm. These failures placed the patients in immediate jeopardy. This was a type A penalty suspension of admissions.

N683 Nursing Services

Facility failed to ensure nursing staff were competent to provide nursing care to maintain the highest practical, physical and psychosocial well-being for 10 patients. This failure was a type A penalty suspension of admissions.

N689 Nursing Services; Physical Restraints

Facility failed to prevent significant medication errors for three patients. One error caused harm to one patient from being overly sedated and requiring Narcan.

Facility failed to ensure that care and services were provided to ensure the highest practicable physical, mental and psychosocial well-being for three patients. The facility failed to ensure comprehensive wound assessments and treatments were provided and resulted in actual harm to patients. This was a type A penalty suspension of admissions.

N691 Nursing Services; Body Positioning

Facility failed to ensure the identification and the necessary treatment and services were provided to prevent the development and worsening of pressure ulcers for two patients. This resulted in actual harm to one patient and placed the patient in immediate jeopardy. This was a type A penalty suspension of admissions.

N707 Medical Records; Record Maintenance

Facility failed to ensure medical records were organized, accurately documented and complete for four patients. This failure placed the patients in immediate jeopardy. This was a type A penalty suspension of admissions.

N728 Basic Services; Pharmaceutical Services

Facility failed to ensure medications were properly stored in one patient room. There was a pill in a medication cup sitting on the patient's over-bed table. There was no nurse in attendance. This was a type C pending penalty.

N741 Food and Dietetic Services; Menus Must Meet the Needs of the Residents

Facility failed to prevent significant medication errors for three patients. One patient received the wrong medication and one patient received a double dose of oxycodone. The patient receiving oxycodone became overly sedated and required multiple doses of Narcan.

N751 Food and Dietetic Services; Menu Consultation

Facility failed to ensure therapeutic diets were served and nutritional care and services were provided to three patients.

N765 Food and Dietetic Services; Freezer Temperature

Facility failed to ensure food was stored in a sanitary manner when expired foods were observed in the walk-in refrigerator and failed to prvent the potential spread of infection when equipment was improperly stored. This was a type C pending penalty.

Facility failed to ensure food was prepared and served under sanitary conditions. The facility failed to ensure four CNAs performed hand hygiene during meals. Facility failed to prevent wet nesting of plate domes, soup bowls, cups and plate bases. There was also carbon build up on equipment. This was a type C pending penalty.

N778 Social Work Services

Facility failed to provide medically related social services that recognized and addressed suicide threats, self-destructive behaviors and pain management for three patients. These failures resulted in immediate jeopardy and actual harm to multiple patients. This was a type A penalty suspension of admissions.

N831 Building Standards

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

Facility failed to maintain the physical plant. There were water damaged ceiling tiles.

Facility failed to maintain the condition of the physical plant. There was a water leak in the elevator equipment room with standing water.

Facility failed to maintain the overall physical integrity of the facility. There were rood trusses that had had about 2 feet cut out of them.

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

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

N835 Building Standards; Approval of New Construction

Facility made major alterations to the building without prior approval from the Tennessee Department of Health.

N848 Building Standards; Exhaust & Air Pressure

Facility failed to maintain negative air pressure. Some of the exhaust fans did not work.

Facility failed to maintain proper air pressure. There was no negative air in the housekeeping storage area.