Survey Deficiency Summary

20 Facilities Surveyed | **Surveys Taken 12/5/17 to 1/22/18**

A145 Patient Rights: Free from Abuse/Harassment

D609 Reporting of Alleged Violations

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

D677 ADL Care Provided for Dependent Residents

D Facility failed to provide nail care and grooming for one patient.

E001 Establishment of the Emergency Program

D Facility failed to establish and maintain an emergency preparedness program.

F550 Resident Rights/Exercse of Rights

D Facility failed to preserve the dignity of one patient when staff failed to provide privacy for a tracheostomy treatment.

F557 Respect, Dignity/Right to have Personal Property

E Facility failed to ensure patients were treated in a dignified manner for timely meal service and feeding assistance for four patients.

F558 Reasonable Accomidations of Needs/Preferences

D Facility failed to maintain the dignity and well-being for two patients.

F584 Safe/Clean/Comfortable/Homelike Environment

D Facility failed to provide a sanitary environment for three rooms. Equipment in three patient rooms was dirty.

D Facility failed to provide a clean, sanitary environment for two patients.

F600 Free from Abuse and Neglect

K Facility failed to prevent abuse by three patients who were perpetrators. Facility failed to provide a safe environment for nine patients who were victims. Facility failed to ensure the safety of an unknown number of other potential victims whom the facility could not identify.

F602 Free from Misappropriation/Explotation

E Facility failed to prevent misappropriation of medication for five patients.

- D Facility failed to ensure patients were free from misappropriation of medications for three patients.

F609 Reporting of Alleged Violations

- E Facility failed to report all allegations of abuse to the state survey agency. In addition, the facility failed to ensure that the results of all investigations were reported to the agency within five working days of the incident.
- D Facility failed to thoroughly investigate and report timely an allegation of abuse for one patient.

F610 Investigate/Prevent/Correct Alleged Violation

- E Facility failed to ensure appropriate interventions were put into place to ensure patients were protected from abuse by three patients who were perpetrators and three patients who were victims.

F623 Notice Requirements Before Transfer/Discharge

- D Facility failed to provide written discharge notice as soon as practicable for three patients.

F637 Comprehensive Assessment After Significant Change

- D Facility failed to ensure a significant change in status assessment was completed related to hsopice services on one patient.

F640 Encoding/Transmitting Resident Assessments

- E Facility failed to complete and transmit MDS assessments timely for five patients.

F641 Accuracy of Assessments

- D Facility failed to ensure assessments were completed to accurately reflect the status for falls and tracheostomy care for two patients.

F655 Baseline Care Plan

- D Facility failed to develop a baseline care plan to address the care and treatment of an indwelling urinary catheter and feeding tube for one patient.

F656 Develop/Implement Comprehensive Care Plan

- D Facility failed to follow the care plan resulting in a fall for one patient.

F657 Care Plan Timing and Revision

- D Facility failed to update the care plan of one patient.
- D Facility failed to revise a care plan for one patient.
- D Facility failed to revise the care plan to include isolation precautions related to the flu for one patient.

F658 Services Provided Meet Professional Standards

- E Facility failed to ensure medications were administered according to professional standards as well as the facility policy for two patients.
- D Facility failed to follow the physician's order for one patient.

F659 Qualified Persons

- D Facility failed to ensure care plan interventions were followed for provisions of activities of daily living and fall prevention for two patients.

F660 Discharge Planning Process

- D Facility failed to have evidence of thorough discharge planning for two patients.

F661 Discharge Summary

- D Facility failed to complete a discharge summary, which included a recapitulation of the patient's stay, a final summary of the patient's stay, a final summary of the patient's status at the time of discharge and a post-discharge plan of care for one patient.

F671 Label/Store Drugs and Biologicals

- D Facility nurses failed to ensure medications and biologicals were stored safely when medications were left unattended in a patient's room during medication administration.

F676 Activities of Daily Living (ADLs/Maintain Abilities)

- D Facility failed to provide patients the necessary care and services to ensure activities of daily living for baths and showers were done for 20 patients.

F677 ADL Care Provided for Dependent Residents

- D Facility failed to ensure incontinence care was provided for one patient.

F684 Quality of Care

- D Facility failed to schedule a follow up physician's appointment for one patient.
- D Facility failed to schedule a follow up physician's appointment for one patient.

F689 Free of Accident Hazards/Supervision/Devices

- J Facility failed to ensure each patient received the necessary supervision to prevent elopements from the facility for two patients who eloped and seven patients who were an elopement risk.
- E Facility failed to ensure fall prevention measures were followed for two patients.
- D Facility failed to ensure fall intervention measures were in place for one patient.
- D Facility failed to ensure one patient was free from accidents.

D Facility failed to ensure one patient was free from accidient hazards by failing to refer one patient to therapy after a fall based on facility policies.

F692 Nutrition/Hydration Status Maintenance

D Facility failed to ensure accurate nutritional assessments were completed for two patients.

F693 Tube Feeding Management/Restore Eating Skills

D Facility failed to ensure a continuous tube feeding was administered for one patient.

F727 RN 8 Hrs/7 days/Wk, Full Time DON

Facility failed to ensure that drugs were safely and securely stored by one LPN. The nurse left opened medications unattended and out of sight. This was a type C pending penalty.

F758 Free from Unnec Psychotropic Meds PRN Use

D Facility failed to ensure psychotropic medication behavior monitoring was completed for one patient.

D Facility failed to determine a stop date for PRN psychotropic medications for one patient.

F760 Residents Are Free of Significant Med Errors

D Facility failed to ensure patients were free of significant medication errors for one patient.

F761 Label/Store Drugs & Biologists

D Facility failed to ensure that drugs were safety and securely stored by one LPN.

D Facility failed to ensure medication was disposed of in an appropriate manner. There was an insulin vial containing insulin found lying on the ground next to the dumpster.

F770 Laboratory Services

D Facility failed to provide timely laboratory services to meet the needs of one patient.

F802 Sufficient Dietary Support Personnel

D Facility failed to ensure a newly admitted patient received a meal when one patient did not receive a lunch tray.

F803 Menus Meet Res Needs/Prep in Advance/Followed

E Facility failed to follow the menus for three patients with no concentrated sweet diets, for one patient on a fortified diet and for two patients on mechanical soft fortified nutrition diets.

F804 Nutritive Value/Appa, Palatable/Prefer Temp

D Facility failed to maintain appropriate food temperatures for two halls during dining.

F812 Food Procurement Store/Prepare/Serve - Sanitary

D Facility failed to maintain two patient refrigerators and two ice machines in a sanitary manner.

F835 Administration

K Facility administrator failed to administer the facility in a manner to provide adequate supervision to prevent unsafe wandering and elopement from the facility. Facility failed to provide adequate supervision to two patient with multiple incidents of physical abuse toward other patients. These failures caused immediate jeopardy.

F837 Governing Body

K Facility governing body failed to ensure adequate supervision was provided to prevent unsafe wandering and elopement from the facility for one patient. The governing body failed to ensure adequate supervision was provided for one patient with multiple incidents of inappropriate sexual contact toward other patients and failed to ensure adequate supervision was provided to two patients with multiple incidients of physical abuse toward other patients. These issues caused immediate jeopardy to the patients in the facility.

F842 Resident Records - Identifiable Information

F Facility failed to maintain a complete and accurate medical record for seven patients.

D Facility failed to maintain a complete clinical record which was readily accessible for one patient.

D Facility failed to ensure outputs for patients with indwelling catheters were completely documented and systemically organized.

F867 QAPI/QAA Improvement Activities

K Facility quality assurance committee failed to assess and monitor behavior in and elopement from the facility; failed to identify the root cause of incidents; and failed to develop a plan with interventions to prevent abuse and elopement and protect victims of abuse. These failures placed the patients in immediate jeopardy.

F880 Infection Prevention & Control

E Facility failed to clean patient care equipment in a sanitary manner for one patient.

D Facility failed to ensure practices to prevent the potential spread of infection were maintained when isolation precautions were not initiated and maintained for two patients with extended spectrum beta-lactamase (ESBL) urinary tract infections and when one nurse failed to clean a nebulizer after a breathing treatment was administered.

D Facility failed to ensure practices to prevent the potential spread of infection were followed when two LPNs failed to perform hand hygiene during medication administration.

D Facility failed to follow acceptable and appropriate infection control practices for dressing change for one patient and nebulizer care for two patients.

H1202 Patient Rights

K211 Alcohol Based Hand Rub Dispensers

E Facility failed to comply with the general egress requirements. The walkways were covered with ice and snow.

K281 Illumination of Means of Egress

E Facility failed to provide lighting at exit discharges.

K311 Vertical Openings - Enclosure

E Facility failed to maintain the vertical openings. There were penetrations in the ceiling.

K321 Hazardous Areas; Enclosure

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

K324 Cooking Facilities

D Facility failed to protect the cooking equipment.

D Facility failed to protect the cooking equipment. The shelf install on the stove was obstructing the hood suppression system.

K345 Fire Alarm System; Testing and Maintenance

D Facility failed to maintain components of the fire alarm system. There was a smoke detector loose from the ceiling in the corridor.

K351 Sprinkler System; Installation

F Facility sprinkler system was not installed correctly. There were some sprinkler heads mounted incorrectly.

K353 Sprinkler System; Testing and Maintenance

F Facility failed to maintain components of the sprinkler system. Multiple sprinkler heads had paint, corrosion or physical damage.

F Facility failed to ensure the sprinkler system dry system was maintained dry at all times per the requirements of NFPA 25, which resulted in frozen sprinkler piping and an impaired sprinkler system.

F Facility failed to ensure wet sprinkler system containing water filled piping was being maintained at a minimum temperature of 40 degrees F and not exposed to freezing conditions per the requirements of NFPA 101.

F Facility failed to ensure dry pipe sprinkler systems are kept dry at all times. The pipes had frozen and burst.

F Facility failed to maintain the automatic sprinkler system.

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

D Facility failed to maintain the sprinkler system in accordance with NFPA25. There was no documentation of a first quarter sprinkler inspection.

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

D Facility failed to maintain the sprinkler system.

D Facility failed to maintain the sprinkler system. The sprinkler heads were dirty in several patient rooms.

K372 Subdivision of Building Spaces; Smoke Barriers

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

K500 Building Services - Other

D Facility failed to maintain the emergency lights.

K511 Utilities - Gas and Electric

D Facility failed to maintain the utilities. An electrical junction box was missing the cover in the compressor room.

K711 Evacuation and Relocation Plan

D Facility failed to maintain required documents and training per the requirements of NFPA 101. The facility fire plan did not include an emergency call to the fire department.

K712 Fire Drills

D Facility failed to hold a fire drill at least quarterly on each shift.

D Facility failed to ensure all staff were familiar with the fire drill procedures.

K904 Gas and Vacuum Piped Systems - Warning System

F Facility failed to maintain the medical gas system.

K918 Electrical Systems - Essential Electric System Maintenance and Testing

D Facility failed to maintain the emergency power generator. The 30-minute generator load tests were not done for a full 30 minutes.

K920 Electrical Equipment; Power Cords and Extension Cords

D Facility failed to comply with regulations for extension cords and power strips.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

Facility failed to exercise the required disaster drills prior to March. There was no record of the tornado, flood and earthquake drills completed before March of 2017.

N629 Infection Control; Disinfect Contaminated Items

Facility failed to ensure practices to prevent the potential spread of infection were maintained when one LPN faileld to clean a nebulizer after a breathing treatment. This was a type C pending penalty.

N643 Infection Control; Individual Responsible for Laundry Service

F Facility failed to document the influenza vaccination for four employees.

N727 Pharmaceutical Services

Facility nurses failed to ensure medications and biologicals were stored safely when medications were left unattended in a patient's room during medication administration. This was a type C pending penalty.

N831 Building Standards

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

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

Facility failed to maintain the physical plant. There was damaged drywall found in several locations in the facility.

N848 Building Standards; Exhaust & Air Pressure

Facility failed to maintain negative air pressure in the soiled areas.

Facility failed to maintain the correct air pressure. There was not correct air flow in some of the storage closets.