Survey Deficiency Summary

12 Facilities Surveyed **Surveys Taken 1/24/18 to 2/14/18**

D642 Coordination/Certification of Assessment

D Facility failed to sign the comprehensive assessment certifying the completion for two patients.

E006 Plan Based on All Hazards Risk Assessment

C Facility failed to ensure the emergency preparedness plan was based on and included a facility based and community-based risk assessment using an all-hazards approach.

F550 Resident Rights/Exercse of Rights

D Facility failed to ensure clothing promoted dignity for one patient and failed to achieve a dignified appearance for one patient.

F580 Notify of Changes (Injury/Decline/Room, Etc.)

G Facility failed to notify the physician in a timely manner of changes in patient's condition for two patients. This failure resulted in harm to both patients.

F600 Free from Abuse and Neglect

H Facility failed to prevent patient-to-patient abuse for eight patients and failed to fulfill a care-taking obligation to provide good and services necessary to avoid pain resulting in neglect and harm for three patients.

D Facility failed to prevent abuse for one patient. One patient struck her after she wandered into his room.

F602 Free from Misappropriation/Explotation

D Facility failed to prevent misappropriation for one patient. A staff member admitted taking the patient's cigarettes.

F609 Reporting of Alleged Violations

D Facility failed to report allegation of abuse within the two-hour time frame as required by federal and state law.

D Facility failed to report an allegation of abuse to the state agency within two hours in accordance with federal law.

F636 Comprehensive Assessment & Timing

D Facility failed to complete the comprehensive assessment within the regulatory time frame for two patients.

F642 Coordination/Certification of Assessment

D Facility failed to provide interpreter services for two patients whose primary language was not English.

F655 Baseline Care Plan

D Facility failed to implement a baseline care plan related to hemodialysis and nutrition for one patient.

D Facility failed to provide an interim plan of care for one patient.

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

F656 Develop/Implement Comprehensive Care Plan

D Facility failed to develop and implement a comprehensive care plan for one patient related to hemodialysis and nutrition.

D Facility failed to update a care plan after two patient-to-patient incidents occurred for one patient.

F657 Care Plan Timing and Revision

D Facility failed to update a baseline care plan for one patient.

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

F658 Services Provided Meet Professional Standards

D Facility failed to ensure medications were administered according to professional standards as well as the facility policy for one patient with respiratory treatments.

D Facility failed to follow professional standards to provide wound care treatments per the comprehensive care plan for one patient.

F677 ADL Care Provided for Dependent Residents

D Facility failed to provide activities of daily living (ADL) care for one patient.

D Facility failed to provide incontinence care for one patient.

F684 Quality of Care

D Facility failed to provide services by a specialty physician for one patient. He was referred to a spine neurologist for back pain and the appointment had not been scheduled by the facility.

F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers

D Facility failed to provide pressure ulcer treatment and wound care treatment as ordered for one patient.

F689 Free of Accident Hazards/Supervision/Devices

D Facility failed to implement interventions to prevent falls for one patient.

D Facility failed to implement new interventions to prevent future falls for one patient.

F692 Nutrition/Hydration Status Maintenance

D Facility failed to notify the registered dietician (RD) and the physician of significant weight loss for one patient.

F693 Tube Feeding Management/Restore Eating Skills

D Facility failed to check the gastric tube placement for one patient prior to administration of medication through the tube.

D Facility failed to administer enteral feedings as ordered and failed to maintain patency of the gastrostomy tube for one patient.

F697 Pain Management

G Facility failed to manage or prevent pain to help patients attain or maintain the highest practicable level of well-being for three patients. This failure resulted in actual harm to the patients.

F698 Dialysis

D Facility failed to assess and monitor the hemodialysis access for one patient reviewed for dialysis.

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

F Facility failed to provide registered nurse staffing at least eight hours a day, seven days a week for five days of 92 days reviewed.

F744 Treatment/Service for Dementia

D Facility failed to develop an individualized care plan with interventions care to address the care and treatment of dementia.

F758 Free from Unnec Psychotropic Meds PRN Use

D Facility failed to provide evaluation and rationale for continued use of a PRN anti-anxiety drug beyond 14 days for one patient.

F761 Label/Store Drugs & Biologists

D Facility failed to safety store home medications for one patient and failed to ensure medication was properly stored on one medication cart.

D Facility failed to ensure medications were secure and inaccessible for one patient.

D Facility failed to ensure expired medications were not available for patient use in one medication cart.

F777 Radiolofy/Diag. Svcs Ordered/Notify Results

D Facility failed to obtain chest x-rays timely as ordered by the physician for one patient.

F805 Food in Form to Meet Individual Needs

D Facility dietary department failed to prepare and serve pureed foods at an appropriate texture on the tray line. All of the foods started running together on the plate.

F812 Food Procurement Store/Prepare/Serve - Sanitary

F Facility failed to maintain a sanitary environment in the dietary department and failed to maintain the dietary equipment in a clean and sanitary manner.

F Facility failed to maintain the dish machine to ensure dishes were sanitized; failed to properly sanitize dishes in the three compartment sink; failed to maintain kitchen equipment and floors in a clean and sanitary manner; and failed to properly store and label dry foods and refrigerated food items.

F Facility dietary department failed to follow the manufacturer's sanitation level recommendation in the three-compartment sink for one of three observations. Facility failed to serve cold food at or below 41 degrees F and failed to follow the manufacturer's wash cycle temperature recommendation in five of 15 cycles observed. Facility dietary staff failed to maintain dietary equipment in a sanitary manner.

D Facility failed to ensure expired nurtritional supplements were not available for patient use in one medication cart.

F842 Resident Records - Identifiable Information

D Facility failed to accurately document administered medication on the medication administration record (MAR) for one patient.

F880 Infection Prevention & Control

D Facility failed to follow the facility policy for hand hygiene during medication administration for one patient. Facility failed to follow infection control practices during a wound dressing change.

D Facility failed to store nebulizer masks in a sanitary manner for two patients receiving nebulizer treatments.

F908 Essential Equiptment, Safe Operating Condition

D Facility dietary department failed to maintain a hood filter in operating condition for one filter.

K211 Alcohol Based Hand Rub Dispensers

F Facility failed to maintain the fire-rated doors.

F Facility failed to maintain fire-rated doors. There was no documentation that the annual fire door inspections had occurred.

D Facility failed to maintain the exit doors. One of the doors exiting from the physical therapy department would not open.

K222 NFPA 101 Egress Doors

E Facility failed maintain delayed egress doors. It took excessive force to initiate the delayed egress unlocking process on one door. Two of the doors did not have proper signage. And the door from the therapy department did not open.

K271 Discharge from Exits

D Facility failed to maintain the exit discharge. There was an elevation in the concrete of the exit walkway.

K291 Emergency Lighting

D Facility failed to maintain the emergency lighting. There was no monthly and annual emergency light testing during 2017.

K321 Hazardous Areas; Enclosure

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

D Facility failed to properly separate hazardous areas from other spaces. One of the storage room doors did not close in a positive frame.

K324 Cooking Facilities

D Facility failed to protect the cooking facilities. There was shelf blocking the hood suppression system in the kitchen. The deep fat fryer was not under a suppression nozzle and the stove and deep fat fryer were mounted on castors with a restraint device.

D Facility failed to maintain the cooking facilities. The following moveable gas powered equipment was not restrained: stove; deep fryer; and oven.

K331 Interior Wall and Ceiling Finish

F Facility failed to maintain flame spread documentation.

K343 Fire Alarm System - Notification

D Facility failed to ensure the notification of the smoke detectors. A disposable glove was wrapped around the smoke detector in the electrical room on the third floor.

K351 Sprinkler System; Installation

D Facility failed to install sprinklers where required. The janitorial closet in the laundry room was not sprinklered.

K353 Sprinkler System; Testing and Maintenance

E Facility failed to maintain the automatic sprinkler system.

E Facility failed to maintain the automatic sprinkler system. Some of the sprinkler heads were corroded. No air leakage test had been conducted on the dry sprinkler system. The low point drain at the back of the facility was broken.

D Facility failed to maintain their sprinkler system in accordance with NFPA 25. There were damaged and/or corroded sprinkler heads in the facility.

K363 Corridor - Doors

F Facility failed to maintain the corridor doors.

K521 HVAC

D Facility failed to maintain the HVAC systems. The 4-year fire damper inspection had not been done.

K712 Fire Drills

D Facility failed to have all staff familiar with fire procedures. The dietary staff were not familiar with the hood suppression system.

K741 Smoking Regulations

D Facility failed to maintain smoking areas. The metal container with a self-closing lid was filled with paper and empty cigarette packages.

D Facility failed to comply with the smoking regulations. The metal self-closing containers for emptying ashtrays were filled with combustible materials.

K920 Electrical Equipment; Power Cords and Extension Cords

E Facility failed to maintain the electrical system. Unapproved multi-plug adapters were being used in patient rooms.

K923 Gas Equipment - Cylinder and Container Storage
Container Storag

E Facility failed to maintain oxygen storage rooms/areas. The oxygen storage room did not have the required signage.

D Facility failed to maintain the oxygen storage room. The room did not have the required signage.

N831 Building Standards

Facility failed to maintain the physical plant and overall environment. There was a window-mounted air-conditioning unit installed in the kitchen without proper filters and protective coverings.

Facility failed to construct, arrange and maintain the building to ensure patient safety. There were penetrations in the walls.

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

N835 Building Standards; Approval of New Construction

Facility failed to obtain approval from the department of health prior to modifying the structure.