Survey Deficiency Summary

35 Facilities Surveyed **Surveys Taken 4/03/19-6/10/19**

F732 Posted Nurse Staffing Information

D Facility failed to ensure posted staffing was correct for one observation day.

Survey Deficiency Summary

35 Facilities Surveyed **Surveys Taken 4/03/19-6/10/19**

E006 Plan Based on All Hazards Risk Assessment

D Facility failed to complete the risk assessment utilizing an all hazards approach.

E015 Subsistence for Staff and Patients

D Facility failed to include all policies and procedures for the subsistence needs of patients and staff in the emergency preparedness program.

E026

D Facility failed to include policies and procedures for the 1135 waiver in the emergency preparedness program.

E039 EP Testing Requirements

F Facility failed to participate in the full scale community exercise.

D Facility failed to conduct exercises to test the emergency plan at least annually. There was no documentation for a full-scale exercise or a table top exercise.

D Facility failed to conduct exercises to test the emergency plan at least annually per the requirements of the federal regulations. There was no documentation of participation in a full-scale exercise that was community based.

E041 Hospital CAH and LTC Emergency Power

D Facility failed to provide fuel agreements to maintain the generator power.

F550 Resident Rights/Exercse of Rights

E Facility failed to promote care that maintained patients' dignity, respect and quality of care while providing personal care for three patients and failed to provide a dignity bag for two patients with indwelling catheters.

D Facility failed to maintain the patient's dignity and respect when three RNs and a CNA failed to knock on the patient's door prior to entering the room and referred to the patient's as feeders during dining.

D Facility failed to promote care that maintained patient's dignity, respect, and quality of care when staff failed to provide a privacy bag for one patient with a catheter.

D Facility failed to maintain or enhance respect and dignity when one RN did not provide privacy during medication administration.

D Facility failed to promote care that maintained patients' dignity, respect, and quality of care when staff failed to provide a dignity bag for two patients with catheters.

F557 Respect, Dignity/Right to have Personal Property

D Facility failed to maintain a patient's dignity and respect during dressing changes for the patient. The patient's genitalia was exposed during a dressing change.

F558 Reasonable Accomidations of Needs/Preferences

D Facility failed to provide reasonable accommodations to promote comfortable sleep for one patient. The patient had complained about a bar under the mattress that made sleeping uncomfortable and hurting. The facility had not addressed this and the patient was sleeping in a recliner instead of his bed.

F561 Self Determination

D Facility failed to honor patients' preferences for bathing and beverages for two patients interviewed about choices. Both patients wanted a shower more often.

F565 Resident/Family Group and Response

D Facility failed to respond to the resident councils concerns for six months. The patients had the same complaints each month: the shower water ran around the toilet area and they could not go to the bathroom without getting their feet wet and ice was not being passed.

F569 Notice and Conveyance of Personal Funds

D Facility failed to ensure the patient trust was refunded within 30 days of a patient's death for two patient accounts.

D Facility failed to ensure patients receiving Medicaid funding did not have trust fund balances that exceed the SSI limit. Both accounts had more than four thousand dollars in it. The limit is 2200.00.

F578 Request/Refuse/Discontinue Treatment;Formulate Adv Directives

D Facility failed to ensure POST forms were completed for one patient. The physician had not signed the completed form.

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

D Facility failed to notify the physician that a CT scan was not completed as ordered for one patient.

D Facility failed to notify the physician concerning pressure ulcers and bowel function for two patients.

D Facility failed to notify the physician when a blood glucose result was out of range for one patient. The glucose was above 400 and the facility did not follow the physician order to call.

D Facility failed to notify the physician when a patient refused to have an indwelling urinary catheter removed for one patient.

F582 Medicaid/Medicare Coverage/Liability Notice

D Facility failed to provide an appropriate notice to the patient and/or legal representative in writing when skilled services were terminated for one patient.

F604 Right to be Free from Physical Restraints

D Facility failed to follow the policy for physical restraints for one patient reviewed for physical restraints.

D Facility failed to complete assessments before or during use of a position change alarm for two patients.

D Facility failed to assess for the use of a physical restraint and obtain a physician order for a physical restraint prior to use for one patient.

F607 Develop/Implement Abuse/Neglect, etc. Policies

C Facility failed to have abuse registry checks for eight employees.

F609 Reporting of Alleged Violations

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

D Facility failed to follow their abuse policy for reporting an allegation of abuse within federally required time frame for one patient.

D Facility failed to report an injury of unknown origin within two hours for one patient.

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

D Facility failed to report an allegation of abuse to the state survey agency timely for one patient.

D Facility failed to follow the abuse policy for reporting allegations of abuse for one patient and failed to report two allegations of abuse within two hours.

F610 Investigate/Prevent/Correct Alleged Violation

E Facility failed to follow the facility policy for abuse and failed to thoroughly investigate allegations of abuse for four patients.

D Facility failed to follow their abuse policy for investigation of two allegations of abuse for one patient and failed to investigate two allegations of abuse for one patient.

F623 Notice Requirements Before Transfer/Discharge

D Facility failed to send the Ombudsman a notice of transfer for one patient.

D Facility failed to notify the Ombudsman of a transfer for one patient.

D Facility failed to notify the Ombudsman of an emergency transfer for one patient for hospitalization.

F636 Comprehensive Assessment & Timing

D Facility failed to complete a comprehensive assessment using the CMS RAI process within the regulatory time frames for three patients.

D Facility failed to complete a quarterly MDS assessment timely for one patient.

F637 Comprehensive Assessment After Significant Change

D Facility failed to complete a significant change assessment using the CMS RAI process within the regulatory time frames for one patient.

F638 Quarterly Assessment At Least every 3 Months

D Facility failed to complete a quarterly assessment using the CMS RAI process within the regulatory time frames for four patients.

F640 Encoding/Transmitting Resident Assessments

C Facility failed to submit a discharge MDS timely for one patient.

F641 Accuracy of Assessments

E Facility failed to accurately assess patients for the use of unnecessary medications and pressure ulcers for seven patients.

D Facility failed to ensure assessments were completed to accurately reflect the patient's status for antipsychotic medication, dialysis and insulin administration for three patients.

D Facility failed to accurately complete a quarterly MDS assessment for the use of a physical restraint for one patient.

F655 Baseline Care Plan

D Facility failed to develop a baseline care plan to address the use of an indwelling urinary catheter for one patient and failed to address the tracheostomy care and supplies for one patient.

F656 Develop/Implement Comprehensive Care Plan

G Facility failed to implement a comprehensive care plan intervention for one patient resulting in actual harm. The patient rolled out of bed hitting his head on the night stand. The intervention was to move the night stand and it had not been done.

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

D Facility failed to develop a comprehensive care plan for dementia and diuretic use for three patients.

D Facility failed to develop and implement a comprehensive care plan for the use of a physical restraint for one patient.

D Facility failed to implement a fall intervention for one patient and failed to develop a care plan to include the use of a lap belt for one patient.

D Facility failed to develop a comprehensive care plan to include predetermined resuscitation status for one patient.

F657 Care Plan Timing and Revision

D Facility failed to revise a care plan related to significant weight loss for one patient.

D Facility failed to ensure each patient and/or legal representative was involved in developing the care plan and making decisions about his or her care for one patient.

D Facility failed to ensure patients and families were given the opportunity to participate in the development, review and revision of the care plan for two patients.

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

D Facility failed to revise the care plan in a timely manner for a nothing by mouth (NPO) regarding enteral feeding for one patient.

F677 ADL Care Provided for Dependent Residents

D Facility failed to provide scheduled showers for two dependent patients.

D Facility failed to ensure nail care was provided for one patient reviewed for activities of daily living.

F678 Cardio-Pulmonary Resuscitation (CPR)

D Facility failed to ensure a physician's order was obtained for full code status for one patient.

F679 Activities Meet Interest/Needs of Each Resident

D Facility failed to provide an ongoing program of activities designed to meet the interests, physical, mental and psychosocial well-being for one patient.

F684 Quality of Care

D Facility failed to follow physician's orders for IV care for one patient. The IV tubing had not been changed every 24 hours as ordered.

D Facility failed to administer treatment to restore normal bowel function for one patient. The patient had not had a bowel movement in 10 days and no interventions had been done.

D Facility failed to follow the bowel protocol for one patient reviewed for constipation.

D Facility failed to ensure the correct medications were sent home on discharge with one patient. The LPN sent another patient's medications home with the patient. None of that medication was administered to the patient and the nurse made arrangements to exchange the medicines. The patient was not charged.

F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers

E Facility failed to provide care and services to promote healing of pressure ulcers for two patients.

D Facility failed to provide care and services for the treatment of pressure ulcers for one patient.

D Facility failed to identify and assess one patient with pressure ulcers.

D Facility failed to ensure staff followed physician orders for one patient with pressure ulcers. The wound care orders had not been transferred to the treatment record.

F688 Increase/Prevent Decrease in ROM/Mobility

D Facility failed to ensure interventions were in place to prevent further decrease in range of motion for one patient.

F689 Free of Accident Hazards/Supervision/Devices

G Facility failed to provide supervision to prevent falls by ensuring fall interventions were in place for one patient. This failure resulted in actual harm to the patient.

D Facility failed to ensure fall interventions were in place for one patient.

D Facility failed to follow their policy for fall management by not completing a fall investigation for one patient.

D Facility failed to ensure the environment was free from accident hazards for one patient observed smoking. The patient had his own cigarettes and a lighter which was in violation of the facility smoking policies and had no assessment stating he was safe to smoke without supervision.

D Facility failed to follow interventions for the prevention of accidents for one patient. The patient had a bruise from hitting her head on the lift used to move her. The intervention was for the therapy department to review the transfer practice which had not been done.

D Facility failed to ensure the environment was free of accident hazards as evidenced by unsecured and unlabeled creams, unsecured razors, aerosol cans and unsecured wound cleanser in four patient shower rooms.

D Facility failed to ensure the environment was free from accident hazards when one patient transfer lift was not functioning properly.

D Facility failed to implement fall intervention to prevent accidents for one patient.

F690 Bowel/Bladder Incontinence Catheter, UTI

E Facility failed to provide care and services to maintain an indwelling urinary catheter when nursing failed to provide catheter care and failed to prevent the catheter tubing from touching the floor for two patients.

D Facility failed to provide appropriate care and services for two patients with an indwelling catheter.

D Facility failed to obtain a physician's order for catheter care and failed to document medical justification for the use of the catheter for three patients.

F692 Nutrition/Hydration Status Maintenance

D Facility failed to follow physician diet orders for one patient.

F693 Tube Feeding Management/Restore Eating Skills

D Facility failed to provide care and services to promote safe and effective nourishment for enteral tube feedings for one patient.

D Facility failed to properly label and follow physician's orders for an enteral tube feeding for one patient.

D Facility failed to ensure tube feedings were properly labeled for two patients.

D Facility failed to administer an enteral feeding at the correct rate as ordered by the physician for one patient.

D Facility failed to follow physician's orders for tube feeding for one patient.

F695 Respiratory/Tracheostomy care and Suctioning

D Facility failed to follow the physician's orders for oxygen use for one patient reviewed with respiratory issues. The oxygen rate was not what was ordered.

D Facility failed to have respiratory equipment at the bedside for one patient and failed to follow the physician's orders for oxygen for one patient.

D Facility failed to maintain respiratory equipment for suction equipment, nebulizer, and oxygen for two patients.

D Facility failed to administer oxygen therapy as ordered for one patient.

D Facility failed to provide appropriate oxygen therapy for one patient.

D Facility failed to obtain a physicians order for tracheostomy care and failed to administer oxygen therapy in accordance with the physician's order for one patient.

D Facility failed to administer oxygen as ordered by the physician for one patient.

F698 Dialysis

D Facility failed to provide appropriate care and services of a patient receiving dialysis.

F725 Sufficient Nursing Staff

E Facility failed to maintain adequate staffing levels to meet the care needs of two patients and failed to ensure medications were administered timely for one patient.

F756 Drug Regimen Review, Report Irregular, Act on

D Facility failed to follow pharmacy recommendations for one patient reviewed for unnecessary medications.

F759 Free from Medication Error Rates of 5% or More

D Facility failed to ensure two LPNs administered medications with an error rate of less that five percent. The error rate was 9.09 percent.

D Facility failed to ensure two nurses administered medications with a medication error rate of less than 5 percent. The error rate was 10.34 percent.

D Facility failed to ensure two medications were administered per the physician orders. This resulted in an error rate of 6.45 percent on the medication pass.

F760 Residents Are Free of Significant Med Errors

D Facility failed to ensure two LPNs administered medications free of significant medication errors. Both administered insulin outside of the proper time frames for food intake.

F761 Label/Store Drugs & Biologists

E Facility failed to ensure medications were stored securely and safely when opened and undated medications were found in three medications carts and when one LPN left medications out of sight and unattended.

D Facility failed to ensure medication were stored properly and safely in one medication storage area. There were opened bottles of influenze vaccine in the medication refrigerator that were not dated when opened.

D Facility failed to ensure medications were securely locked and inaccessible to patients, unauthorized staff and visitors.

D Facility failed to ensure one LPN properly stored a controlled medication when morphine sulfate was left unattended and unsecured on the medication cart during medication administrations.

D Facility failed to properly store open multi-dose vials to prevent microbiological contamination in one medication storage room.

D Facility failed to ensure medications were properly stored in two medication carts and expired medications were found in one cart. The medication cart was left unlocked and unattended during medication administration.

D Facility failed to ensure medications were stored securely and safely when two RNs left medications out of sight and unattended.

D Facility failed to properly label and store medications for one medication cart.

Facility failed to ensure medications were stored properly and safely in one medication storage area. Internal medications were in the same drawer with no divider with external medications.

F773 Lab Svs Physician Order/Notify of Results

D Facility failed to ensure appropriate follow-up with the physician for abnormal laboratory results for one patient.

F803 Menus Meet Res Needs/Prep in Advance/Followed

D Facility failed to follow the registered dietician recommendation for a house supplement at lunch for one patient and failed to assess food preferences in a timely manner for one patient.

F804 Nutritive Value/Appa, Palatable/Prefer Temp

D Facility failed to provide palatable and appetizing food for three patients. All three complained of food "not tasting right" and one complained about watery gravy and stated everything came out of a can now.

F806 Resident Allergies, Preferences and Substitutions

D Facility failed to honor patient's request related to food. The patient stated that the eggs were always cold at breakfast.

F812 Food Procurement Store/Prepare/Serve - Sanitary

F Facility failed to ensure food was stored, prepared, and served under sanitary conditions as evidenced by outdated and unsealed food, dust in the walk-in cooler, dented can, unlabeled and undated food and dust on the ice machine and water filter.

F Facility failed to ensure food was stored, prepared, and served under sanitary conditions as evidenced by opened and expired foods stored in the refrigerator and meat thawing improperly in the refrigerator.

F Facility failed to ensure food was stored, prepared, and served under sanitary conditions as evidenced by outdated food items, unlabeled and undated food items.

F Facility failed to ensure food was store, prepared and served under sanitary conditions as evidenced by unsealed, unlabeled, and undated food items, a dirty drip pan, carbon build-up, expired food, three staff members hair was not completely restrained, improper handwashing and glove use in the kitchen, a dented can, and CNAs not using proper hand hygiene while serving meals.

F Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by dusty vents over food and dishware, dirty floors, carbon build-up, a hole in the wall and CNAs who did not perform proper hand hygiene during meal service.

F Facility failed to store clean pans and kitchen equipment under dry sanitary conditions; failed to ensure an expired food item and expired emergency water supply was not available for patient use.

F Facility failed to ensure dishes and food service equipment were clean and sanitary.

E Facility failed to ensure food was stored, prepared, and served under sanitary conditions when two staff members placed a potentially contaminated meal tray back on the cart containing clean meal trays and touched food with their bare hands during dining observations.

E Facility failed to ensure practices to prevent the potential spread of infection were maintained when one staff member failed to perform hand hygiene and touched food with bare hands and one dietary aide did not perform hand hygiene with glove use while preparing meal trays.

E Facility failed to ensure meal trays were served under sanitary conditions when three CNAs failed to perform proper hand hygiene during dining.

E Facility failed to clean exhaust filters and a food processor in the kitchen.

D Facility failed to follow infection control procedures to prevent the potential spread of infection when one CNA failed to perform hand hygiene and placed a dirty plate lid cover on a clean meal cart.

D Facility failed to ensure proper hand hygiene when two CNAs failed to perform hand hygiene during dining.

D Facility failed to ensure practices to prevent the potential spread of infection were maintained when five CNAs failed to perform hand hygiene during dining.

F842 Resident Records - Identifiable Information

D Facility failed to accurately document treatment and services related to pressure ulcers for one patient reviewed for pressure ulcers.

F865 QAPI Program/Plan, Disclosure/Good Faith Attempt

F Facility quality assurance committee failed to ensure an effective QAPI program that recognized and addressed ongoing concerns with patient dignity, resident council grievances, resident trust funds, MDS timeliness, care plans, provision of pressure ulcer treatments, proper care and treatment for indwelling Foley catheters, proper enteral tube feeding care, kitchen sanitation, maintain an effective infection control program, providing an antibiotic stewardship program and maintaining administrative and nursing staff.

F880 Infection Prevention & Control

E Facility failed to ensure practices to prevent the potential spread of infection were maintained when a catheter tip syringe was stored improperly for one PEG tube patient.

E Facility failed to ensure practices to prevent the potential spread of infection were maintained by failing to track or trend the facility's infections for three months.

E Facility failed to ensure facility staff practiced infection control techniques to prevent the spread of infection when one LPN failed to use a clean oral medication syringe during medications administration and when one LPN failed to maintain sterile technique during tracheostomy care.

E Facility failed to ensure practices to prevent the potential spread of infection were maintained when two RNs did not maintain a sterile technique during a sterile dressing change and two LPNs did not perform hand hygiene, contaminated medications, and did not rinse a nebulizer cup after a nebulizer treatment during medication administration.

E Facility failed to maintain infection control practices during dining observations in two of three dining rooms and one hall, failed to follow contact isolation precautions for one patient and failed to maintain infection control practices during one medication administration observation.

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

D Facility failed to ensure practices to prevent the potential spread of infection were maintained when one staff member failed to perform hand hygiene during incontinent care and properly dispose of gloves.

D Facility failed to ensure practices to prevent the potential spread of infection were followed when one staff failed to follow facility policy related to linen transport and two LPNs failed to perform hand hygiene during medication administration.

D Facility failed to store an ice scoop under sanitary conditions for one hall and failed to ensure practices were followed to maintain infection control for one patient during perineal care.

D Facility failed to ensure practices to prevent the potential spread of infection were followed when one CNA failed to cover a bedside commode while transporting it through the hall. Facility failed to ensure LPNs changed gloves and performed hand hygiene before administering eye drops, cleaned nebulizers properly and obtain a new piston syringe to administer gastrostomy medications to a patient.

D Facility failed to prevent the potential spread of infection when the facility failed to provide proper placement of supplies for one patient with a tracheostomy and failed to keep the indwelling catheter bag off the floor for one patient with a catheter.

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 and one RN failed to clean a medication container during wound care.

D Facility failed to ensure practices to prevent the spread of infection were followed when one nurse failed to perform hand hygiene after removal of soiled gloves during the medication pass.

D Facility failed to ensure practices to prevent the potential spread of infection were maintained when one CNA failed to perform hand hygiene during indwelling catheter care.

D Facility failed to maintain infection control practices for one patient. The nurse failed to wash her hands after taking off her gloves during a wound treatment.

D Facility failed to ensure practices to prevent the spread of infection were maintained for one patient reviewed with C. Diff.

F881 Antibiotic Stewardship Program

F Facility failed to establish an antibiotic stewardship program to educate the staff and the community, failed to document the antibiotics used, and failed to track with diagnostics to ensure the correct antibiotic use, doses and duration for all the patients.

K000

C

K131 Multiple Occupancies

D Facility failed to maintain the two hour fire separation wall. There was unapproved fire stop being used to patch some holes in the fire wall.

K222 NFPA 101 Egress Doors

F Facility failed to have egress doors with magnetic locking on them release with fire alarm activation.

D Facility failed to have egress doors with magnetic locking on them release with fire alarm activation.

D Facility failed to provide all magnetically locked doors release with fire alarm activation.

K232 Aisle, Corridor or Ramp Width

F Facility failed to ensure corridors in the means of egress were maintained clear of all obstructions.

K321 Hazardous Areas; Enclosure

E Facility failed to ensure hazardous area fire rating were maintained. There were penetrations in the fire wall.

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

D Facility failed to maintain the hazardous areas. There were penetrations in the one hour fire ceiling.

D Facility failed to maintain the hazardous areas. The kitchen door was wedged open.

K324 Cooking Facilities

D Facility failed to maintain fire protection in the kitchen. The deep fryer was not centered under the fire suppression nozzle.

D Facility failed to protect the cooking equipment. The deep fat fryer was not centered under the suppression system.

D Facility failed to maintain the cooking equipment. There was no documentation of two hood inspections in 2018.

K331 Interior Wall and Ceiling Finish

D Facility failed to maintain the interior wall finish. There was wood paneling in one room with no documentation of the flame spread rating.

K345 Fire Alarm System; Testing and Maintenance

D Facility failed to maintain the fire alarm system. There was not fire alarm sensitivity test within the last two years

K351 Sprinkler System; Installation

D Facility failed to install sprinklers in all locations. The sprinkler head had been removed in a treatment supply room.

D Facility failed to maintain the automatic sprinkler system. There were mixed sprinkler heads in one patient room. There was a sprinkler head blocked by a light fixture in the central supply room.

K353 Sprinkler System; Testing and Maintenance

D Facility failed to maintain the fire sprinkler system. There was a painted sprinkler head in the bathroom.

D Facility failed to maintain the sprinkler system. The sprinkler inside the deep freezer was covered with a foreign material (ice).

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

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 was no record of the 10 year sample testing for the dry sprinklers that are over 10 years old on systems one and two.

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

D Facility failed to maintain the sprinkler system. There was no documentation for a fourth quarter sprinkler inspection. There was no documentation for a three year full flow test for the dry sprinkler system. There was no documentation for an annual sprinkler system backflow inspection.

D Facility failed to maintain the sprinkler system. One of the sprinkler heads was corroded in one bathroom.

D Facility failed to maintain the sprinkler system. There was no documentation of a three year air leakage test on the dry sprinkler system.

D Facility failed to ensure the sprinkler system is maintained.

D Facility failed to maintain the fire sprinkler system.

D Facility failed to ensure the sprinkler system is maintained. There was no documentation that the 5-year harsh environment testing of the sprinkler system.

D Facility failed to maintain the sprinkler system. The sprinkler head in one closet had been removed.

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

K355 Portable Fire Extinguishers

D Facility failed to maintain the fire extinguishers. The fire extinguisher in the elevator had not been inspected monthly in 2019.

K372 Subdivision of Building Spaces; Smoke Barriers

E Facility failed to maintain the smoke barrier wall.

D Facility failed to maintain the smoke barriers. There was improper fire stop filling in some of the fire rated walls.

K511 Utilities - Gas and Electric

D Facility failed to maintain the electrical equipment. There were open junction boxes on the ceiling in the kitchen.

K521 HVAC

D Facility failed to maintain the fire/smoke dampers. There was no damper inspection within the last four years.

K711 Evacuation and Relocation Plan

D Facility failed to ensure staff was trained so they are familiar with procedures in a kitchen fire.

K712 Fire Drills

D Facility failed to conduct fire drills for the 3rd shift in the 2nd quarter.

D Facility failed to conduct quarterly fire drills on each shift.

K741 Smoking Regulations

D Facility failed to prohibit smoking in non-designated areas. There were more than 15 cigarette butts in the grass outside in the Alzheimer's unit garden.

D Facility failed to prohibit smoking in non-designated areas.

K761 Maintenance, Inspection & Testing - Doors

D Facility failed to inspect and maintain fire door assemblies. The annual inspection and testing of the fire door assemblies had not been done.

D Facility failed to inspect the fire door assemblies. There was no documentation of an annual inspection and testing of the fire door assemblies.

D Facility failed to maintain the fire/smoke doors. There were no door labels on the cross corridor doors in one area.

K914 Electrical System; Maintenance and Testing

D Facility failed to maintain the electrical systems. The facility could not provide the annual retention testing on all patient room electrical receptacles.

K918 Electrical Systems - Essential Electric System Maintenance and Testing

F Facility failed to ensure the generator was being maintained. There was no annual fuel quality test being conducted on the diesel generator.

D Facility failed to maintain the emergency generator. The facility failed to conduct the monthly load testing of the emergency generator.

D Facility failed to maintain the generator. The facility did not exercise the emergency generator under load for 30 minutes each month from June 2018 until March 2019.

K919 Electrical Equipment - Other

F Facility failed to perform an annual fuel test on the diesel generator.

E Facility failed to have a distinctive color for the electrical receptacles or cover plates for the electrical receptacles supplied from the life safety branch.

K920 Electrical Equipment; Power Cords and Extension Cords

D Facility failed to maintain the electrical equipment. There were two power steps plugged into each other in the DON office.

D Facility failed to maintain electrical equipment. There were unapproved power strips in three patient rooms.

D Facility failed to use the proper power taps in the patient care area. Personal patient equipment was plugged into unapproved power strips.

D Facility failed to maintain electrical equipment. There were unapproved power strips in two patient rooms and extension cords in the business office.

D Facility failed to maintain the electrical equipment. There were piggy-backed surge protectors in use in the kitchen.

K921 Electrical Equipment; Testing and Maintenance

F Facility failed to conduct and have testing intervals established through policies and procedures for portable patient-care related electrical equipment for the physical integrity, resistance, leakage current and touch current.

F Facility failed to establish policy and protocols for the physical integrity, resistance, leakage current, and touch current test for fixed and portable PCREE that indicates the tests, repairs, and modifications that are in accordance with service manuals, instructions, and procedures provided by the manufacturer.

Facility failed to conduct and have testing intervals established through policies and procedures for portable patient-care related electrical equipment (PREE) for the physical integrity, resistance, leakage current and touch current.

K923 Gas Equipment - Cylinder and Container Storage
Container Storag

D Facility failed to maintain gas equipment. The empty and full oxygen cylinders were mixed in the same storage rack in the oxygen room.

D Facility failed to maintain gas equipment. The full and empty oxygen cylinders were mixed in the same rack.

D Facility failed to properly store portable oxygen bottles.

N1102 Records and Reports; Recording of Unusual Incidents

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

Facility failed to report an injury of unknown origin within two hours for one patient. This was a type C pending penalty.

Facility failed to report an allegation of abuse for one patient. This was a type C pending penalty.

N1411 Disaster Preparedness; Fire Safety Drills

Facility failed to perform disaster drills. There was no bomb threat drill performed in 2018.

N415 Administration; Resident Funds

C Facility failed to have abuse registry checks for eight employee personnel files.

N505 Admissions, Discharges and Transfers; PAE

Facility failed to provide proof of liability insurance prior to admission.

N645 Nursing Services

Facility failed to ensure the environment was free of accident hazards as evidenced by unsecured and unlabeled creams, unsecured razors, aerosol cans and unsecured wound cleanser in four patient shower rooms. This was a type C pending penalty.

N669 Nursing Services; Physician Notification

Facility failed to notify the physician that a CT scan was not completed as ordered for one patient. This was a type C pending penalty.

Facility failed to notify the physician of the condition of a patient with pressure ulcers and problematic bowel function.

N727 Pharmaceutical Services

Facility failed to ensure medications were stored securely and safely when opened and undated medications were found in three medications carts and when one LPN left medications out of sight and unattended. This was a type C pending penalty.

N728 Basic Services; Pharmaceutical Services

Facility failed to ensure medications were securely locked and inaccessible to patients, unauthorized staff and visitors. This was a type C pending penalty.

Facility failed to ensure medications were properly stored in two medication carts and expired medications were found in one cart. The medication cart was left unlocked and unattended during medication administration. This was a type C pending penalty.

Facility failed to ensure medications were stored securely and safely when two RNs left medications out of sight and unattended. This was a type C pending penalty.

N729 Pharmaceutical Services

Facility failed to ensure medications were stored properly and safely in one medication storage area. Internal medications were in the same drawer with no divider with external medications. This was a type C pending penalty.

N730 Basic Services - Pharmaceutical Services

Facility failed to ensure facility staff practiced infection control techniques to prevent the spread of infection when one LPN failed to use a clean oral medication syringe during medications administration (she dropped the syringe, picked it up off the floor and proceeded to administer the medication) and when one LPN failed to maintain sterile technique during tracheostomy care. This was a type C pending penalty.

N766 Food and Dietetic Services; Freezer Temperature

Facility failed to ensure food was stored, prepared, and served under sanitary conditions as evidenced by outdated and unsealed food, dust in the walk-in cooler, dented can, unlabeled and undated food and dust on the ice machine and water filter. This was a type C pending penalty.

Facility failed to ensure food was stored, prepared, and served under sanitary conditions as evidenced by opened and expired foods stored in the refrigerator and meat thawing improperly in the refrigerator. This was a type C pending penalty.

Facility failed to ensure food was stored, prepared, and served under sanitary conditions as evidenced by outdated food items, unlabeled and undated food items. This was a type C pending penalty.

Facility failed to ensure food was stored, prepared, and served under sanitary conditions when two CNAs placed a potentially contaminated tray back on the cart containing clean meal trays and touched food with their bare hands during dining observations. There were opened and outdated food items stored and a brown, sticky substance in three of the nourishment room refrigerators.

Facility failed to ensure food was store, prepared and served under sanitary conditions as evidenced by unsealed, unlabeled, and undated food items, a dirty drip pan, carbon build-up, expired food, three staff members hair was not completely restrained, improper handwashing and glove use in the kitchen, a dented can, and CNAs not using proper hand hygiene while serving meals. This was a type C pending penalty.

Facility failed to ensure practices to prevent the potential spread of infection were maintained when one staff member failed to perform hand hygiene and touched food with bare hands and one dietary aide did not perform hand hygiene with glove use while preparing meal trays. This was a type C pending penalty.

Two CNAs failed to ensure proper hand hygiene during dining observations.

Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by dusty vents over food and dishware, dirty floors, carbon build-up, a hole in the wall and CNAs who did not perform proper hand hygiene during meal service. This was a type C pending penalty.

Facility failed to store an ice scoop under sanitary conditions for one hall and failed to ensure practices were followed to maintain infection control for one patient during perineal care. This was a type C pending penalty.

Facility failed to ensure practices to prevent the potential spread of infection were maintained when five CNAs failed to perform hand hygiene during dining. This was a type C pending penalty.

N831 Building Standards

Facility failed to maintain the physical environment. There was a structural support truss embedded in the one hour fire/smoke wall in the attic.

Facility failed to maintain the physical environment. The kitchen hood fan mounted on the roof was missing a grease collecting tray.

Facility failed to maintain the overall physical environment. There were unfilled penetrations in the facility walls and ceilings.

Facility failed to maintain the overall environment. There penetrations in the fire wall that were not properly sealed.

Facility failed to verify there is no recall on any PTAC units or parts with the manufacturer.

Facility failed to maintain the overall environment. There was unapproved fire stop in some of the fire wall penetrations.

N847 Building Standards; Hot Water Temperature

Facility failed to ensure hot water temperature range within 105 and 115 degrees F.

N848 Building Standards; Exhaust & Air Pressure

Facility failed to have positive air pressure in all clean areas including, but not limited to, clean linen rooms and clean utility rooms.

Facility failed to provide all dirty rooms with negative air pressure.