# Survey Deficiency Summary

**13Facilities Surveyed** **Surveys Taken 12/14/20-2/17/21**

**F557 Respect, Dignity/Right to have Personal Property**

D Facility failed to maintain or enhance patient dignity and respect when one staff member failed to knock and announce their presence before entering a patient room during dining observations and two staff members referred to a patient as a "feeder".

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

J Facility failed to immediately notify the physician of a significant decline in condition after the patient had a change in vital signs and was noncompliant with ordered oxygen therapy. This failure placed the patient in immediate jeopardy.

D Facility failed to inform the patient's responsible party of a missed doctor's appointment.

**F584 Safe/Clean/Coortable/Homelike Environment**

E Facility failed to ensure appropriate temperatures were maintained on one hallway. The patient complained they were freezing. There were multiple heating units that went out at the same time on that hallway. There was also a scarcity of blankets according to the

**F600 Free from Abuse and Neglect**

J Facility failed to ensure a patient was free from neglect when and RN and LPN neglected to respond immediately to a patient's change in condition. This resulted in immediate jeopardy for the patient.

The staff reported the patient did not look good and had labored breathing and the nurses did not respond until 38 minutes after they were called. The patient was transferred to the hospital and was diagnosed with a myocardial infarction and respiratory failure.

**F610 Investigate/Prevent/Correct Alleged Violation**

J Facility failed to thoroughly investigate an incident of elopement for one patient reviewed for wandering and elopement. This resulted in immediate jeopardy when the patient exited the facility through an emergency exit door and was located in a residential area approximately 1600 feet from the facility and unsupervised.

**F657 Care Plan Timing and Revision**

D Facility failed to revise the care plan with new falls interventions for one patient.

**F658 Services Provided Meet Professional Standards**

J Facility failed to provide nursing care that met professional standards of clinical practice for one patient reviewed. The facility failure to ensure care was provided appropriately placed the patient in immediate jeopardy. The patient expired.

**F684 Quality of Care**

J Facility failed to provide reassessment, monitoring, and nursing interventions after identification of a change in condition and identification of the patient's inability to maintain oxygen therapy. This failure placed the patient in immediate jeopardy. The patient expired.

The patient was diagnosed with Covid-19 with an order to notify the physician if the O2 level fell below 92 percent. The O2 level went to 86 percent during the night and the physician was not called.

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D Facility failed to provide weekly assessments for one patient reviewed with surgical wounds.

D Facility failed to provide daily showers per a physician order for one patient.

**F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers**

E Facility failed to provide weekly assessments for two patients reviewed with pressure ulcers.

E Facility failed to provide skin assessments and treatments for one patient with pressure ulcers and failed to provide skin assessments for five patients determined to be at high risk of developing pressure ulcers.

**F689 Free of Accident Hazards/Supervision/Devices**

J Facility failed to ensure a safe environment that provided adequate supervision to a cognitively impaired patient with exit seeking behaviors. This failure resulted in immediate jeopardy.

J Facility failed to ensure a safe environment that provided adequate supervision to a cognitively impaired patient with exit seeking behavior. The patient exited the facility by crawling through a window, traveled across the lawn and up a four foot embankment onto a two land highway and was located in a rock lined ditch about 20 minutes later. The recorded temperature was 49 degrees Fahrenheit (F). Nine days later the same resident exited through another window on the secure hall and was gone for approximately 10 minutes. The recorded temperature was 53 degrees F.

D Facility failed to ensure fall interventions were in place, failed to ensure through falls investigations were conducted and failed to ensure interventions were implemented to prevent further falls for one patient.

**F692 Nutrition/Hydration Status Maintenance**

E Facility failed to monitor weights for three patients.

**F761 Label/Store Drugs & Biologists**

D Facility failed to ensure medications were properly secured when one medication storage area was unlocked and unsecured with medications and IV catheters inside.

**F812 Food Procurement Store/Prepare/Serve - Sanitary**

F Facility Failed to ensure food was prepared and served under sanitary conditions when five staff members were observed in the kitchen not properly wearing masks.

**F814 Dispose Garbage & Refuse Properly**

E Facility failed to ensure that waste was properly contained and maintained in a sanitary condition to prevent the harborage and feeding of pests when two dumpsters were overflowing with bags of garbage and the lids were open.

**F835 Administration**

J Facility administrator failed to ensure a safe environment that provided adequate supervision to prevent in incident of elopement, failed to provide oversight to monitor and ensure the training of staff, failed to ensure a safe environment and failed to complete a thorough investigation of elopement when one patient eloped from the facility. This resulted in immediate jeopardy to that patient.

J Facility administration failed to provide oversight and training of staff, ensure staff supervision and ensure a safe environment for one patient reviewed for effective administration. These failures resulted in immediate jeopardy for elopement twice by one patient.

**F842 Resident Records - Identifiable Information**

D Facility failed to accurately document assessments for three patients reviewed for pressure ulcers and one patient for surgical wounds.

**F867 QAPI/QAA Improvement Activities**

J Facility QAPI committee failed to ensure an effective QAPI program that identified opportunities for improvement related to elopement, failed to thoroughly investigate an incident of elopement, failed to perform a root cause analysis of the elopement, failed to develop and implement activities for elopement in order to provide a safe environment for patients and failed to ensure systems and processes were in place and consistently followed by staff and administration. This resulted in immediate jeopardy to one patient.

J Facility QAPI committee failed to ensure an effective QAPI program that identified opportunities for improvement related to elopement, failed to develop and implement corrective actions and performance improvement activities for elopement to provide a safe environment for patients and failed to ensure systems and processes were in place and consistently followed by staff and administration. These failure caused one patient to be in immediate jeopardy.

**F880 Infection Prevention & Control**

K Facility failed to follow CDC infection control guidelines when the facility labeled and stored worn, potentially contaminated surgical masks in open, zippered, plastic bags labeled with staff member's name outside of five patient rooms. These failure resulted in immediate jeopardy.

F Facility failed to properly follow Covid-19 policies and procedures to prevent and contain Covid-19 when one patient on the quarantine hall wandered off the hall and onto other halls in the facility. The facility failed to ensure staff Covid-19 screening logs were complete and accurate for 12 staff members on multiple days.

E Facility failed to properly follow Covid-19 policies and procedures to prevent and contain Covid-19 when staff members' screening logs were not complete and accurate.

E Facility failed to follow guidance for staff working while infection with Covid-19 for three staff members.

E Facility failed to ensure employees adhered to proper infection control practices for the use of personal protective equipment (PPE) and hand hygiene, and failed to post signs on patient doors indicating isolation precautions to prevent the spread of Covid-19.

E Facility failed to ensure staff adhered to proper infection control practices while cleaning and disinfecting patient rooms to prevent the spread of infection with the potential to affect patients in three hallways. The facility failed to ensure the staff wore appropriate PPE and disinfected hands before and after entering Covid-19 isolation precaution rooms.

E Facility failed to properly prevent and contain Covid-19 when three staff members failed to complete Covid-19 screening logs for 12 of 16 days.

E Facility failed to monitor patients daily for temperature and oxygen saturation for the patient who were not Covid-19 positive and failed to monitor three times per day the vital signs and oxygen saturation for patients who were Covid-19 positive. The facility failed to maintain infection control practices on one hall for use of PPE.

E Facility failed to properly prevent and/or contain Covid-19 when patients' mask were improperly stored for two patient and soiled laundry was observed in the bathroom floor in one room. CNAs were also noted for failure to apply PPE before entering an isolation room.

**F885**

E Facility failed to inform the patient, their representatives, and families of all confirmed Covid-19 cases in the facility.

E Facility failed to notify patients and patient families of new positive cases of Covid-19 for 21 patient cases and 21 patient cases.