Survey Deficiency Summary

6 Facilities Surveyed **Surveys Taken 2/23/21-3/10/21**

F557 Respect, Dignity/Right to have Personal Property

E Facility failed to treat the patient's personal clothing with respect by not returning clothing items after they were sent to the laundry for three patients.

F600 Free from Abuse and Neglect

J Facility failed to provide adequate supervision to prevent neglect for one patient reviewed with wandering behaviors. Staff members left a patient that had eloped unattended and alone outside for eight minutes after staff members found the patient which resulted in immediate jeopardy to the patient.

The patient left the facility through a window in an unoccupied patient room. The facility was unaware the patient was missing for nine minutes. Then two staff members found him then left the premises, leaving him unattended for another eight minutes. The patient had walked down a steep hill, across the driveway and was sitting under a pavilion, next to a broken fence with an unsecured gate and near a creek with swift moving water.

F609 Reporting of Alleged Violations

D Facility failed to report allegations of abuse within two house for two patients reviewed for alleged abuse. An allegation of sexual abuse was reported to the social worker by a representative from the dialysis clinic. The patient had told the dialysis worker she had been raped the previous night. (The allegation was not substantiated.)

F610 Investigate/Prevent/Correct Alleged Violation

J Facility failed to ensure a thorough investigation was completed for two patients reviewed with wandering behaviors and accidents which resulted in immediate jeopardy for both patients. Both patients left the facility via a window.

D Facility failed to thoroughly investigate allegations of abuse for two patients.

F655 Baseline Care Plan

E Facility failed to develop a baseline care plan within 48 hours of admission that included the initial goals and needs for eight patients.

F656 Develop/Implement Comprehensive Care Plan

K Facility failed to develop and implement comprehensive care plans and interventions that are person-centered and address the needs of thirteen patients with wandering behaviors and falls. This placed all of those patients in immediate jeopardy.

F660 Discharge Planning Process

D Facility failed to provide discharge planning services for one patient.

F684 Quality of Care

D Facility failed to transcribe the physician's order and administer the prescribed medication for one patient.

F689 Free of Accident Hazards/Supervision/Devices

K Facility failed to ensure a safe environment, provide adequate supervision to prevent elopement, and failed to investigate elopement incidents for two patients. This placed the patients in immediate jeopardy.

F726 Competent Nursing Staff

K Facility failed to ensure licensed nurses had the knowledge and skills necessary to provide care and assure safety for fourteen patients reviewed at risk of falls and/or wandering/elopement. The facility failure to assess patients, complete fall risk assessments, complete neurological checks, implement appropriate interventions, develop comprehensive care plans and provide care for patients with behaviors resulted in immediate jeopardy for multiple patients.

F760 Residents Are Free of Significant Med Errors

D Facility failed to ensure one patient reviewed for medication administration were free from significant medication errors. The patient was given the roommate medication by mistake.

F761 Label/Store Drugs & Biologists

D Facility failed to ensure medications were stored securely by authorized staff in areas accessible to patients for one mediation cart. The care was unlocked and not in direct observation of the unlocked cart at all times.

F835 Administration

K Facility administration failed to administer the facility in a manner that enabled the facility to use its resources effectively and efficiently to attain the highest practicable well-being of the patients. Administration failed to provide oversight, ensure a safe environment, complete a thorough investigation of patient elopements and conduct quality assurance and performance improvement (QAPI) committee meetings when a patient exited the facility without facility knowledge. Facility administration failed to ensure patients at risk for falls was assessed, adequately supervised, and had a comprehensive care plan with appropriate interventions that were put into place and implemented to prevent falls and wandering/exit seeking behaviors. Administration failed to ensure the licensed nurses had the specific knowledge and skill sets necessary assess patients, complete fall risk assessments, complete neurological checks, implement appropriate interventions, provide care for patients with behaviors, and failed to investigate incidents. These failures placed the patients in immediate jeopardy and actual harm.

F867 QAPI/QAA Improvement Activities

K Facility QAPI committee failed to ensure systems and processes were in place and consistently followed by staff to address quality concerns related to falls and elopement/wandering behaviors. The QAPI committee failed to ensure a safe environment, a thorough investigation of patient elopement was completed and failed to conduct a QAPI meeting when patients eloped from the facility without staff knowledge.

F880 Infection Prevention & Control

E Facility failed to properly prevent the potential for Covid19 when five staff members failed to wear the appropriate PPE and failed to perform hand hygiene. Facility failed to provide proper signage on the isolation room doors and the facility failed to have PPE available outside of the isolation rooms. Residents were not moved off of the new/readmission isolation hall after their 14-day quarantine. There were no Covid-19 cases in the facility but the potential of a possible outbreak could have affected the 33 patients residing in the isolation hall.

D Facility failed to properly prevent covid-19 when three staff members did not apply proper PPE before entering a quarantine room. There were no Covid-19 patient cases in the facility.

N728 Basic Services; Pharmaceutical Services

Facility failed to ensure medications were stored securely by authorized staff in areas accessible to patients for one medication cart.