Survey Deficiency Summary

7 Facilities Surveyed **Surveys Taken 3/10/21-4/15/21**

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

J Facility failed to ensure an LPN notified the patients' attending physician and responsible party when there was a significant change in the patient's condition for one patient. This placed the patient in immediate jeopardy.

F600 Free from Abuse and Neglect

K Facility failed to provide adequate supervision to prevent neglect for two patients reviewed for wandering and elopement behaviors when two patients eloped from the facility which resulted in immediate jeopardy for the patients.

J Facility failed to ensure a patient was free from neglect when an LPN neglected to provide adequate treatment for a patient with a significant decline in his condition which resulted in immediate jeopardy for the patient. The licensed staff failed to monitor the patient and did not notify the physician for five and a half hours after the patient suffered respiratory distress. This placed the patient in immediate jeopardy.

J Facility failed to ensure one patient was free from neglect when the patient eloped from the facility and was walking on a busy two-lane road with his walker. The patient was escorted back to the safety of the facility by an off duty employee. The staff failed to respond appropriately to an exit door alarm on an open door and failed to immediately search the grounds or perform a head count placing the patient in immediate jeopardy and substandard quality of care.

F609 Reporting of Alleged Violations

K Facility failed to report incidents of elopement and neglect to the state survey agency resulting in immediate jeopardy when two patients eloped from the facility.

J Facility failed to report an allegation of elopement and neglect to the state survey agency withing 24 hours of the incident for one patient. The facility also failed to notify the administrator of the elopement until 48 hours after the incident. This resulted in immediate jeopardy and substandard quality of care.

F610 Investigate/Prevent/Correct Alleged Violation

K Facility failed to thoroughly investigate incidents of elopement, and injury of unknown origin, patient to patient altercations and misappropriation of patient funds for six patients. This failure resulted in immediate jeopardy for the patients.

F641 Accuracy of Assessments

D Facility failed to ensure assessments were completed to accurately reflect the patient's status for falls, cognition, signs and symptoms of delirium, mood, and participation in the assessment and goal setting for six patients.

F657 Care Plan Timing and Revision

K Facility failed to revise the implement person-centered care plans and interventions that address the needs for five patients reviewed for behaviors, wanting, injuries of unknown origin, patient to patient altercations, and misappropriation of funds which placed these patients in immediate jeopardy.

J Facility failed to implement care plan interventions and revise the care plan in a timely manner for a patient with a known history of elopement attempts, which resulted in the patient leaving the facility unsupervised. This placed the patient in immediate jeopardy.

F684 Quality of Care

J Facility failed to provide the needed care and services timely when two LPNs failed to monitor a patient with a noticeable change of responsiveness and a decreased oxygen saturation level. This failure resulted in immediate jeopardy for the patient and substandard quality of care.

F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers

E Facility failed to provide treatment and services to prevent and/or heal pressure ulcers for five patients.

F689 Free of Accident Hazards/Supervision/Devices

K Facility failed to supervise vulnerable and confused patients that were at risk for wandering and elopement and failed to investigate elopements for two patients. This failure resulted in immediate jeopardy for the patients.

J Facility failed to provide adequate supervision for a patient who was a high elopement risk and cognitively impaired. This placed the patient in immediate jeopardy when the patient left the facility with his walker and was unsupervised. The patient was found walking along a busy two-lane road.

F726 Competent Nursing Staff

K Facility failed to ensure staff recognized and responded to door alarms when they sounded, failed to perform a complete assessment of patients before and after elopements and failed to ensure education was provided as necessary to ensure safety of the patients reviewed at risk for elopement. This failure resulted in immediate jeopardy for the patients.

F760 Residents Are Free of Significant Med Errors

D Facility failed to ensure patients were free of significant medication errors. The nursing staff failed to administer antihypertensive medications as ordered for two patients.

F835 Administration

K Facility administration failed to provide supervision and oversight to prevent serious injury and harm when one patient exited the facility scooting on his back without staff knowledge. Another patient had exited on at least two different occasions without staff knowledge. A staff member also charged $2800.00 on a patient debit card and two patients were involved in an altercation that was not investigated or reported. These failures placed the patients in immediate jeopardy.

F841 Responsibilities of Medical Director

K Facility medical director failed to provide supervision and oversight to prevent serious injury and harm when one patient exited the facility scooting on his back without staff knowledge. Another patient had exited on at least two different occasions without staff knowledge. A staff member also charged $2800.00 on a patient debit card and two patients were involved in an altercation that was not investigated or reported. These failures placed the patients in immediate jeopardy.

F867 QAPI/QAA Improvement Activities

K Facility quality assurance and performance improvement committee (QAPI) failed to ensure systems and processes were in place and consistently followed by staff to address quality concerns related to elopement, injuries of unknown origin, patient to patient altercations, misappropriation of patient funds and failed to conduct QAPI meetings as scheduled. These failures placed the patients in immediate jeopardy.

J Facility QAPI committee failed to ensure an effective QAPI program that recognized concerns related to neglect of patients and failed to develop plans of action and interventions for patient neglect. The QAPI committee failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently. This failure resulted in immediate jeopardy for one patient.

F880 Infection Prevention & Control

E Facility failed to properly prevent the potential for Covid-1 when five staff members failed to wear the appropriate personal protective equipment (PPE), failed to perform hand hygiene, and failed to have isolation signage on the isolation room door. The facility failed to have PPE available outside of the isolation rooms and patients were not moved off of the New/Readmission isolation hall after their 14 day quarantine period. The facility did not have Covid in the facility by the potential of a possible outbreak could have affected the patients residing in the isolation hall.

E Facility failed to follow contact isolation precautions when three staff members failed to use PPE before entering an isolation room, and failed to perform appropriate hand hygiene. The facility failed to properly prevent and contain Covid-19 when seven staff members failed to complete the Covid screening logs on two of nine days.

F883 Influenza and Pneumococcal Immunizations

D Facility failed to ensure three of the patients were vaccinated for pneumonia.