Survey Deficiency Summary

11 Facilities Surveyed **Surveys Taken 8/18/21-9/12/21**

E004

D Facility failed to review and update the emergency preparedness plan annually.

F554 Resident Self-Admin Meds-Clinically Appropriate

D Facility failed to assess one sampled resident for self-administration of medication. Resident was observed sitting on the bedside holding a nebulizer breathing treatment, unattended by nursing staff.

F561 Self Determination

D Facility failed to acknowledge a resident's self-determination of food choices when two CNAs failed to offer an alternative food item when a resident voiced dislike and smell of food.

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

D Facility failed to ensure resident's physician, responsible party and facility administration were promptly notified of bruising for one resident.

D Facility failed to notify the responsible party for one resident reviewed for resident rights.

F609 Reporting of Alleged Violations

D Facility failed to report an allegation of abuse to the State Survey Agency for one resident.

F610 Investigate/Prevent/Correct Alleged Violation

D Facility failed to ensure a thorough investigation was completed for an allegation of abuse.

F641 Accuracy of Assessments

D Facility failed to ensure an accurate MDS was completed for three residents.

F656 Develop/Implement Comprehensive Care Plan

D Facility failed to ensure a comprehensive care plan was developed for a side rail/enabler for two residents.

F657 Care Plan Timing and Revision

J Facility failed to revise a comprehensive care plan to include current code status for one resident. The failure to revise the care plan resulted in the resident receiving CPR against the resident's and resident representative's wishes.

D Facility failed to revise a care plan related to the use of a Broda chair for one resident.

F658 Services Provided Meet Professional Standards

D Facility failed to ensure a resident's medication was secured. The medications were in a cup on the bedside table with no supervision.

F678 Cardio-Pulmonary Resuscitation (CPR)

J Facility failed to ensure a process was in place to honor a resident's end of life wishes for one resident. Facility failed to make readily available a physician's order for a DNR code status and failed to make readily available a POST form indicating DNR.

F684 Quality of Care

E Facility failed to administer the prescribed medication for three residents.

F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers

D Facility failed to accurately assess a pressure injury for one resident.

F688 Increase/Prevent Decrease in ROM/Mobility

D Facility failed to implement a brace for one resident.

F692 Nutrition/Hydration Status Maintenance

E Facility failed to ensure Registered dietitian recommendations were implemented, failed to identify significant wight loss and failed to reweigh residents with a significant weight change.

F695 Respiratory/Tracheostomy care and Suctioning

D Facility failed to properly store respiratory equipment and failed to follow physician's orders for changing oxygen tubing and humidifier bottles for three residents. The nebulizer mask and nebulizer were sitting on the back of the oxygen concentrator with the mask lying against the wall uncovered.

D Facility failed to follow physician's orders for oxygen administration and failed to ensure oxygen supplies were labeled for two residents. One resident was ordered to have two liters of oxygen by nasal cannula and was observed without oxygen being administered. Oxygen tubing and humidifier bottle were not changed as evidenced by date on bottle and tubing.

F710 Resident's Care Supervised by a Physician

E Facility failed to ensure the physician or physician's representative was aware of weight loss for four residents.

F726 Competent Nursing Staff

E Facility failed to provide documentation a comprehensive orientation related to the destruction of controlled substances was completed for five licensed nurses.

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

D Facility failed to ensure a RN was on duty at least eight hours a day, seven days a week for three days.

D Facility failed to provide the services of a RN for the minimum requirement of eight hours for eight days of 17 days reviewed.

F755 Pharmacy Svcs/Procedures/Pharmacist/Records

D Facility failed to ensure a system of record-keeping for the destruction of controlled medications was accurate for one patient reviewed for narcotic medication reconciliation.

F760 Residents Are Free of Significant Med Errors

D Facility failed to ensure residents were free from significant medication errors when one nurse failed to provide a substantial snack or meal within 15 minutes of insulin administration.

F761 Label/Store Drugs & Biologists

D Facility failed to store a controlled substance in a safe manner during one medication cart observation.

D Facility failed to ensure medications were not stored past their expiration date and opened medications were properly labeled and dated in two medication storage areas.