Survey Deficiency Summary

14 Facilities Surveyed **Surveys Taken 11/17/21-12/16/21**

F550 Resident Rights/Exercse of Rights

D The facility failed to care for residents in a manner that maintained or enhanced dignity for two residents. Two residents with indwelling catheters were observed on different occasions in therapy, in the hallway and in the bed without a privacy bag on the urine collection bag.

D The facility failed to maintain or enhance resident's dignity and respect when two staff members stood over a resident while assisting with a meal.

F554 Resident Self-Admin Meds-Clinically Appropriate

D The facility failed to assess one resident for self-administration of medications. The resident was observed with a nebulizer treatment in progress without any staff members present. The resident had no self-administration assessment for nebulizer treatments.

F569 Notice and Conveyance of Personal Funds

E The facility failed to notify the family and/or resident when the amount in the resident's account exceeded the eligibility limit for seven residents.

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

D The facility failed to notify the physician timely for one resident reviewed for hospitalizations. The resident had been vomiting throughout the night and the physician was not notified until the following morning when the physician ordered the resident to be transferred to the ER.

F584 Safe/Clean/Comfortable/Homelike Environment

E The facility failed to ensure the environment was clean, comfortable and sanitary. Overbed tables were in disrepair in eight resident rooms.

F604 Right to be Free from Physical Restraints

D The facility failed to follow physician’s orders for siderails for one resident. The resident had a physician’s order and care plan for bilateral one-half side rails. The resident was observed by the surveyor in bed with four half side rails in the up position. The observation was made on four occasions.

F610 Investigate/Prevent/Correct Alleged Violation

D The facility failed to provide interventions to protect other vulnerable residents from further abuse during an investigation of an altercation for one resident. The resident was physically aggressive with multiple residents after the initial altercation, causing one resident to fall, before one-to-one monitoring was initiated. The resident was observed unattended in the hallway after one-to-one monitoring was initiated.

F636 Comprehensive Assessment & Timing

D The facility failed to complete a comprehensive assessment using the CMS RAI process within the regulatory time frames for two residents. The cognitive, mood, fall and pain sections of the assessment were not completed.

F638 Quarterly Assessment At Least every 3 Months

D The facility failed to complete quarterly assessments using the CMS RAI process within the regulatory time frames for five residents. One resident's quarterly assessment was completed greater than two months past the due date and four resident's quarterly assessments were past due and had not been completed.

F640 Encoding/Transmitting Resident Assessments

E The facility failed to complete discharge assessments, using the CMS RAI process within the regulatory time frames for 16 residents. The discharge assessments had not been completed for the 16 discharged residents and were beyond 14 days post discharge.

F641 Accuracy of Assessments

D The facility failed to accurately assess residents for the use of urinary catheters and antipsychotic medications for two residents. The indwelling catheter and use of antipsychotic medications were not coded on the resident's most recent MDS assessment.

F655 Baseline Care Plan

D The facility failed to develop a baseline care plan within 48 hours of admission that included the initial goals and needs for three residents.

F656 Develop/Implement Comprehensive Care Plan

D The facility failed to provide a comprehensive care plan for pressure ulcers for two residents. Two residents with stage three pressure ulcers did not have care plans for the skin impairment.

D The facility failed to develop a comprehensive care plan for wound management for one resident. The resident had a wound and a physician's order for wound care and had no care plan for wound management.

F657 Care Plan Timing and Revision

G The facility failed to revise the care plan with appropriate interventions to reflect the residents' current status for three residents. The failure to revise the care plan resulted in actual harm/ fracture to one resident when falls were not investigated consistently and appropriate interventions were not implemented for multiple falls prior to the fall and fracture.

D The facility failed to ensure the care plan was updated for two residents. One resident had developed a skin lesion and the care plan had not been updated to reflect the development and monitoring of the skin lesion. The second resident's care plan had not been updated to reflect the use of an indwelling urinary catheter.

D The facility failed to revise the care plan to reflect the residents' current status for two residents reviewed for splints and falls. The care plan for one resident was not revised to reflect the restorative splint/brace program that had been discontinued. The care plan for the second resident was not revised to reflect post fall interventions.

F684 Quality of Care

D The facility failed to ensure that one resident received medications timely. The facility policy required medications to be administered within one hour before and one hour after the designated administration time. One medication was administered more than two hours late and two other medications were administered more than three hours late according to review of administration details for the MAR. The resident's physician was not made aware.

D The facility failed to ensure one nurse administered medications according to the physician's order for one resident. The resident was observed with a nebulizer treatment in progress. There was no physician's order for the nebulizer treatment in the medical record.

D The facility failed to ensure medications were administered when a resident's respite stay was extended. The facility failed to extend the stop date on the resident's medications past the original discharge date resulting in omission of medications for the remainder of the resident's stay at the facility, a nine day period.

D The facility failed to ensure assistive devices were in place to aid with positioning for two residents. A resident was observed sitting up in a wheelchair with their feet dangling and not touching the floor. The foot pedals that attach to the resident's wheelchair was found in the resident's bathroom. Another resident had physician's orders for bilateral grab bars and a trapeze bar on the bed to assist with mobility and positioning. The resident was observed in the bed on two occasions with no grab bars and no trapeze bar. The staff reported the resident had changed rooms five days prior to the observation and the bed and assistive devices were not moved to the resident's new room.

D The facility failed to provide an immobilizer as ordered for one resident. A resident had an order for an immobilizer for stabilization of a fracture of the metatarsals of the foot. The immobilizer was not ordered and the order was not implemented.

D The facility failed to ensure positioning needs were in accordance with professional standards of practice for one resident. The resident required extensive assistance for bed mobility and was observed by the surveyor in the same position on four occasions over a period of five hours. The second resident had an order for a dressing on a surgical wound. The dressing was documented as changed on the two prior days, however, the resident reported it had not been changed in three days. The dressing was not covering the wound completely. The resident reported that dressings were not changed on the weekends due to the wound nurse working M-F only. The nurses confirmed the dressing had not been changed although it was documented on the treatment record.

F689 Free of Accident Hazards/Supervision/Devices

J The facility failed to ensure a safe environment to prevent an incident of elopement for one resident reviewed for elopement, wandering behaviors and safe smoking. A visually impaired resident with short term memory loss walked away from the nurse and others in the group at the designated smoking area unsupervised resulting in immediate jeopardy for the resident. The resident was found by a police officer near an intersection and returned to the facility approximately 10 minutes later. The resident was care planned to be at moderate to high risk for elopement while going out to smoke.

G The facility failed to implement appropriate interventions to prevent falls and injury for one resident resulting in actual harm when the resident sustained a fall with a fracture of the left femur. The resident sustained several falls, with one not investigated and others without appropriate interventions prior to the fall and fracture.

E The facility failed to ensure the environment was free of accident hazards. Unsecured sharps (disposable razors) were observed in four resident rooms.

D The facility failed to ensure accidents were reported and investigated for one resident reviewed for falls. Resident was identified with a hip fracture of unknown origin. Upon investigation, the facility identified that the resident had sustained a fall/was found by housekeeper and CNAs with knees on the floor beside the bed three days prior to identification of the fracture. There was no event note and the resident's nurse had no knowledge of the resident's fall which was not reported by the staff.

D The facility failed to follow their policy and the comprehensive care plan for resident transfers for one of three sampled residents reviewed for accident hazards. The residents care plan indicated the resident required use of a lift and two persons to assist with transfers. The resident's ADL Care Guide posted in the closet indicated the resident required assistance of one with use of a gait belt for transfers. The ADL Care Guide had not been updated with the transfer instruction for use of the lift and two staff members. In interview, the CNA reported transferring the resident with the lift with one staff member on multiple occasions.

D The facility failed to maintain a falls intervention for one resident reviewed for accidents. The resident was observed in bed without a fall mat at the bedside. The fall mat was implemented after a fall that had occurred two months prior to the observation.

D The facility failed to ensure medications were stored and administered safely for one resident. The nurse left the resident's medication unattended at the bedside.

D The facility failed to implement neuro checks and appropriate interventions after unwitnessed falls for two residents.

D The facility failed to follow their policy and the MDS for transfers for one resident. The facility policy required two staff members to transfer a resident with a mechanical lift. The annual MDS revealed the resident was totally dependent for ADLs and required two staff members for assistance with transfers. An incident report revealed a CNA was transferring a resident with a hoyer lift when the lift pad strap broke resulting in the resident falling onto their left side. In interview the CNA confirmed the resident was transferred with one staff member with the lift and stated "everyone is busy most of the time so I do it myself".

F690 Bowel/Bladder Incontinence Catheter, UTI

E The facility failed to provide care and services to maintain an indwelling urinary catheter for two residents. While being observed by the surveyor, two CNAs failed to follow the correct procedure for indwelling catheter care for two residents, one male and one female. For the female resident, the CNA used a back and forth motion with a washcloth that was visibly soiled with a brown stain.

D The facility failed to provide care and services to maintain an indwelling urinary catheter for two residents. One resident did not have a physician's order for an indwelling urinary catheter. The staff members performing catheter care did not use correct technique for two residents. Hand hygiene was not performed after removal of gloves for both residents. Cleansing and drying of the peri area was performed in a back and forth motion with a brown stained cloth and the catheter tubing was cleaned in the direction from the port to the urinary meatus for the second resident observed.

F693 Tube Feeding Management/Restore Eating Skills

D The facility failed to properly label an enteral feeding for one resident. The tube feeding bag was not labeled with the type of formula for the same resident on three days of the survey.

F694 Parenteral/IV Fluids

D The facility failed to provide an appropriate set-up for IV fluid administration for one resident. The resident was observed four days after initiation of IV fluids with an IV fluid bag hanging from the light fixture above the resident's bed and regulated with a dial-a-flow device. In interview, the nurse stated that an IV pole could not be located.

F695 Respiratory/Tracheostomy care and Suctioning

E The facility failed to ensure oxygen supplies were changed and dated for eight residents. The facility policy required weekly changes of oxygen tubing and devices. The tubing and devices observed by the surveyor were either not dated or had dates that were prior to the previous seven days.

D The facility failed to ensure oxygen supplies were changed and dated for two residents. One resident was receiving oxygen with tubing that was not dated and the humidifier bottle was dated 12 days prior to the observation. The second resident's oxygen tubing and storage bag was dated 18 days prior to the observation. The facility's policy for the frequency of changing the oxygen tubing and humidifier bottle is weekly.

D The facility failed to provide tracheostomy care according to the facility's policy for one resident. The nurse failed to use a sterile trach tray and did not don sterile gloves and a face shield for the procedure and did not clean around the tracheostomy site. The resident was allowed to hold the neck plate in place with his bare hands.

D The facility failed to change the humidifier bottle weekly for two residents, failed to change oxygen tubing weekly for three residents and failed to store a nebulizer mask in a sanitary manner for one resident. The facility policy required weekly changes of the oxygen tubing and humidifier bottle or a change of the humidifier bottle when the water reaches the minimal fill line. The nebulizer mask was undated and uncovered and on top of the bedside dresser.

F698 Dialysis

D The facility failed to have a current physician's order for dialysis and failed to provide adequate dialysis services for one resident. There was no order to assess the thrill and bruit upon return from dialysis until nine days after admission and there was no order for post dialysis vital signs and dry weights until ten days after admission. There were no pre/post dialysis communication forms for two dialysis days. One pre/post dialysis communication form was incomplete. The form did not have staff signatures pre and post dialysis and no post dialysis documentation of vital signs or assessment of thrill or bruit.

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

D The facility failed to schedule a RN for at least 8 consecutive hours a day for 11 of 42 days reviewed. The facility had an average census of 42 during this time period.

D The facility failed to ensure 8 consecutive hours of RN coverage for 3 of 14 days reviewed. The facility had an average census of 77 during that time.

D The facility failed to have eight consecutive hours of RN coverage for four days out of eighteen months reviewed.

F757 Drug Regimen is Free From Unnecessary Drugs

D The facility failed to perform an Abnormal Involuntary Movement Assessment (AIMS) for the use of Reglan for one resident reviewed for unnecessary medications.

F758 Free from Unnec Psychotropic Meds PRN Use

D The facility failed to provide a duration for the use of PRN psychotropic medications for three residents reviewed for unnecessary medications.

F759 Free from Medication Error Rates of 5% or More

D The facility failed to ensure two nurses administered medications with an error rate of less than 5%. A total of four medication errors were made out of 28 opportunities resulting in a medication error rate of 14.29%. The nurses administered drugs by PEG tube and left small portions of the drug in the medication cups.

F760 Residents Are Free of Significant Med Errors

D The facility failed to ensure residents were free from a significant medication error. One nurse failed to provide a substantial snack or meal within 15 minutes of insulin administration.

D The facility failed to ensure residents were free from significant medication errors when a nurse failed to administer the ordered dose of sliding scale insulin for one resident. The nurse administered 10 units instead of 12 units as ordered per the sliding scale.

F761 Label/Store Drugs & Biologists

E The facility failed to ensure medications were properly stored in five medication storage areas (medication room, three med carts and one treatment cart). Multidose vials were opened and not dated, an insulin pen was opened and not dated, two injectable medications were expired and one bottle of medicated wound packing was expired.

E The facility failed to ensure medications were stored properly in five of eleven medication carts and one nurse failed to ensure medications were not left unattended and out of sight during the medication pass. Medications that expire prior to the manufacturers date after opening were still in use: various inhalers and insulin pens. One nurse left the resident's medications unattended on the overbed table while washing hands in the bathroom.

D The facility failed to ensure medications were labeled and stored appropriately. Unsecured medications (two boxes of medicated cream and an inhaler) were identified in one resident's room.

D The facility failed to assure drugs and biologicals were properly labeled, were stored in sanitary conditions, were not expired and were stored in a locked compartment for one medication cart. The medication cart was observed unlocked and unattended. The surveyor identified an expired bottle of COVID-19 Ag reagent, an expired bottle of B-12 tablets and an expired tube of medicated ointment.

D The facility failed to ensure medications were properly stored in two medication storage areas (treatment cart and medication room). The treatment cart was left unlocked and unattended and contained antiseptic solution, alcohol wipes, ointments, wound cleanser, skin protectants, medicated dressings and tubes of enzymatic debrider. An unidentifiable substance in syringes and opened/undated medications (multi-dose vials and rectal suppositories) were observed in the medication storage room. An insulin pen was left unattended on top of a medication cart.

F809 Frequency of Meals/Snacks at Bedtime

F The facility failed to deliver meal trays to residents in a timely manner which resulted in delayed mealtimes on five halls. The dinner meal trays were served late by over one hour on each of the five halls on one day of the survey.

F The facility failed to provide a nourishing snack at bedtime between the evening and breakfast meal which was 15 hours. The facility policy indicated the resident council may approve up to a 16 hour time frame between the evening and breakfast meals, however they had not done so. The facility's scheduled meal times were 5PM for dinner and 8AM for breakfast.

F812 Food Procurement Store/Prepare/Serve - Sanitary

F The facility failed to separate resident and staff food items, failed to discard expired food and failed to maintain a sanitary environment in three of three resident pantry rooms. Food items were found inside the refrigerators or inside cabinets opened and unlabeled or labeled with only a first name. Expired foods were identified. The following items were stored under a working dual sink: sandwich bags, toilet plunger, water filtration filter, a lemon water drink and a spoon in a plastic bag. Inappropriate items were identified under two other sinks. The following items were identified in a sink: water glasses, spoons, a maraschino cherry and a used wet washcloth with orange stains.

F The facility failed to maintain dietary equipment in a sanitary manner. The following observations were made: debris on the can opener blade, the base slot, on shelves under the steam table, convection oven, prep tables, side surfaces and back splash plate on the stove, dried food particles in the bottom of fry baskets, and debris on the plate dome rack. The deep fryer had food crumbs floating in the used oil and sticky debris on the side surfaces.

E The facility failed to ensure food was served under sanitary conditions when three staff members served meal trays with food uncovered for seven residents. Salads and desserts were not covered during transport of the meal tray from the cart to the resident.

E The facility failed to provide hand hygiene for residents before dining for five residents reviewed during dining observations. The staff did not encourage the residents to perform hand hygiene and did not offer to perform hand hygiene for the residents prior to their meal. One resident was noted with a black substance underneath the fingernails and one resident reported eating with fingers.

E The facility failed to ensure food was served under sanitary conditions. A CNA placed dirty trays from two residents on the meal tray cart with clean trays.

F842 Resident Records - Identifiable Information

D The facility failed to ensure documentation of medications. Two nurses failed to document medications administered on the MAR for two residents observed during medication administration.

F880 Infection Prevention & Control

F The facility failed to properly prevent and/or contain COVID-19 when 53 of 82 agency staff members (26 LPNs and 27 CNAs) did not complete the screening log for COVID-19 prior to working on 7 of 7 days reviewed. This could have affected the 96 residents residing in the facility.

F The facility failed to properly prevent and/or contain COVID-19. Review of staff screening logs revealed 47 staff members failed to complete screenings prior to working on 7 of 7 days reviewed. This could have affected all residents of the facility.

F The facility failed to properly prevent and/or contain COVID-19. Review of staff screening logs revealed 53 staff members failed to complete screenings prior to working on 13 days reviewed. This could have potentially affected all residents in the facility.

F The facility failed to ensure practices to prevent the spread of infection were maintained. Three nurses failed to perform hand hygiene appropriately during medication administration and one nurse discarded a needle in the trash. The staff turned off the faucet after washing their hands with the same paper towel they used for drying their hands. One nurse placed supplies directly on a resident's overbed table that the surveyor described as dirty. The facility failed to follow CDC guidelines when 28 staff members failed to complete the screening log prior to working on 7 of 14 days reviewed.

F The facility failed to properly prevent and/or contain COVID-19 when eight staff members failed to complete the screening log for COVID-19 prior to working on five of seven days reviewed.

F The facility failed to properly prevent and/or contain COVID-19 when 21 staff members failed to complete screenings for COVID-19 prior to working on 14 of 14 days reviewed.

E The facility failed to ensure practices to prevent the spread of infection were maintained. Two nurses failed to clean reusable medical equipment (stethoscopes) during medication administration after verifying PEG tube placement. Another nurse failed to change gloves and sanitize hands after removing a soiled dressing and before applying a clean dressing. A nurse failed to remove soiled gloves and sanitize hands after repositioning a resident and touching supplies and equipment and before applying a clean dressing on a wound.

E The facility failed to handle soiled transmission based precautions linen in a manner to prevent the spread of infection and failed to ensure oxygen tubing was kept off the floor. A laundry staff member was observed removing soiled linen from the laundry bin on the isolation/observation hall while wearing a face shield, mask and gloves but without a gown. Undated oxygen tubing was on the floor of one resident's room and was stepped on by the nurse. The tubing was not replaced.

F921 Safe/Functional/Sanitary/Comfortable Environment

D The facility failed to maintain a safe, functional and comfortable environment for one resident. The surveyor observed a large hole in the wallboard behind the resident's bed with crumbled plaster and white dust particles on the floor,

D The facility failed to provide and maintain a sanitary and comfortable environment. Overbed tables were in disrepair in one of three dining rooms on the memory care unit.

D The facility failed to provide a safe, functional, sanitary and comfortable environment for two residents. A pole for a tube feeding pump was noted with debris on the pole and on the base of the pole in two resident's rooms. A dried white substance was noted on the bedside table of one resident.

F924 Corridors Have Firmly Secured Handrails

D The facility failed to maintain a safe environment. The handrails in the hallway were loose and not secured to the wall in one of five hallways.

K232 Aisle, Corridor or Ramp Width

E The facility failed to maintain clear and unobstructed corridors. The following observations were made: wheeled carts (nutrition carts and linen cart) were noted in the hallways and in the same locations over a period of 36 minutes and other carts (nutrition cart, linen cart and computer cart) in the same locations for 30 minutes.

K293 Exit Signage

D The facility failed to ensure exit signs were displayed with continuous illumination. Exit signs in two locations were not illuminated.

K324 Cooking Facilities

D The facility failed to protect their cooking facilities. The kitchen's deep fryer was not centered under the suppression system nozzles. Interview with a kitchen staff member revealed the staff member was not knowledgeable of the proper fire procedures for fires under the kitchen hood including use of the hood suppression fire extinguishing system as a primary means of extinguishment and the location of the manual activation for the hood fire extinguishing system.

D The facility failed to protect the cooking facilities. The kitchen's cook stove was not centered under the suppression system nozzles. Upon interview, a kitchen staff member was not knowledgeable of the facility's proper fire procedures for fires under the kitchen hood including use of the hood suppression fire extinguishing system as a primary means of extinguishment.

K712 Fire Drills

D The facility failed to conduct the required in-service training on the current fire plan/fire and life safety procedures for all employees.

K781 Portable Space Heaters

D The facility failed to prohibit portable space heaters. Portable space heaters with a temperature higher than 212 degrees fahrenheit were observed in a managers office and the therapy gym.

D The facility failed to prohibit portable space heaters. Portable space heaters exceeding 212 degrees F were identified in three office locations.

K920 Electrical Equipment; Power Cords and Extension Cords

E The facility failed to ensure the electrical system was not overloaded. The surveyor observed “daisy chained” power strips in three locations.

K923 Gas Equipment - Cylinder and Container Storage
Container Storag

D The facility failed to ensure oxygen cylinders were stored properly. Empty and full oxygen cylinders were stored in the same cart in the medication room.

N421 Administration; Verification of Personnel Licensure

The facility failed to ensure that one newly hired RN was certified in CPR. There was no CPR card in the personnel file. The facility policy required all licensed nurses to have an active CPR certification upon hire and throughout their employment.

N645 Nursing Services

The facility failed to ensure the environment was free of accident hazards. Unsecured sharps (disposable razors) were observed in four resident rooms.

The facility failed to ensure the environment was clean, comfortable and sanitary. Overbed tables were in disrepair in eight resident rooms and in one resident dining room.

N649 Infection Control

The facility failed to handle soiled transmission based precautions linen in a manner to prevent the spread of infection and failed to ensure oxygen tubing was kept off the floor. A laundry staff member was observed removing soiled linen from the laundry bin on the isolation/observation hall while wearing a face shield, mask and gloves but without a gown. Undated oxygen tubing was on the floor of one resident's room and was stepped on by the nurse. The tubing was not replaced.

N657 Nursing Services; Physician Notification

The facility failed to have eight consecutive hours of RN coverage for four days out of eighteen months reviewed. The facility's policy stated the facility must use the services of a RN for at least eight consecutive hours a day, seven days a week.

N669 Nursing Services; Physician Notification

The facility failed to notify the physician timely for one resident reviewed for hospitalizations. The resident had been vomiting throughout the night and the physician was not notified until the following morning when the physician ordered the resident to be transferred to the ER.

N688 Nursing Services

The facility failed to ensure positioning needs were in accordance with professional standards of practice for one resident. The resident required extensive assistance for bed mobility and was observed by the surveyor in the same position on four occasions over a period of five hours. The second resident had an order for a dressing on a surgical wound. The dressing was documented as changed on the two prior days, however, the resident reported it had not been changed in three days. The dressing was not covering the wound completely. The resident reported that dressings were not changed on the weekends due to the wound nurse working M-F only. The nurses confirmed the dressing had not been changed although it was documented on the treatment record.

N727 Pharmaceutical Services

The facility failed to assure drugs and biologicals were properly labeled, were stored in sanitary conditions, were not expired and were stored in a locked compartment for one medication cart. The medication cart was observed unlocked and unattended. The surveyor identified an expired bottle of COVID-19 Ag reagent, an expired bottle of B-12 tablets and an expired tube of medicated ointment.

N728 Basic Services; Pharmaceutical Services

The facility failed to ensure medications were labeled and stored appropriately. Unsecured medications (two boxes of medicated cream and an inhaler) were identified in one resident's room.

The facility failed to ensure medications were properly stored in two medication storage areas (treatment cart and medication room). The treatment cart was left unlocked and unattended and contained antiseptic solution, alcohol wipes, ointments, wound cleanser, skin protectants, medicated dressings and tubes of enzymatic debrider. An unidentifiable substance in syringes and opened/undated medications (multi-dose vials and rectal suppositories) were observed in the medication storage room. An insulin pen was left unattended on top of a medication cart. This is a pending Type C Penalty #7.

N730 Basic Services - Pharmaceutical Services

The facility failed to provide a safe, functional, sanitary and comfortable environment for two residents. A pole for a tube feeding pump was noted with debris on the pole and on the base of the pole in two resident's rooms. A dried white substance was noted on the bedside table of one resident.

N757 Food and Dietetic Services; Food Temperature

The facility failed to maintain dietary equipment in a sanitary manner. The following observations were made: debris on the can opener blade, the base slot, on shelves under the steam table, convection oven, prep tables, side surfaces and back splash plate on the stove, dried food particles in the bottom of fry baskets, and debris on the plate dome rack. The deep fryer had food crumbs floating in the used oil and sticky debris on the side surfaces.

N766 Food and Dietetic Services; Freezer Temperature

The facility failed to ensure food was served under sanitary conditions when three staff members served meal trays with food uncovered for seven residents. Salads and desserts were not covered during transport of the meal tray from the cart to the resident.

The facility failed to ensure food was served under sanitary conditions. A CNA placed dirty trays from two residents on the meal tray cart with clean trays. This is a pending Type C Penalty #22.

N831 Building Standards

The facility failed to maintain the physical plant and overall environment. The following observations were made by the surveyor: multiple penetrations by insulated copper pipe, copper pipe and steel pipe not sealed and not fully sealed with fire stopping materials in a 1-hour fire rated ceiling, the kitchen staff member was not knowledgeable of proper fire procedures for fires under the kitchen hood including use of the hood suppression system as a primary means of extinguishment and the manual activation of the hood suppression system.

The facility failed to maintain the physical plant. Observations made by the surveyor included: mixed sprinkler occupancy in two locations, significant water damage to the drywall ceiling in one location and penetrations through the one-hour fire rated ceiling were not fire stopped with approved firestop systems in two locations.

The facility failed to maintain the physical environment. The following observations were made by the surveyor: a one-hour smoke barrier had conduit, pipes and low-voltage wires not properly fire stopped in six locations, a one-hour smoke barrier wall was not properly fire stopped at the ceiling roof assembly and the cooking steamer and deep fryer were not installed six inches inside the kitchen's hood system.

The facility failed to maintain the physical plant. The surveyor observed four sprinklers in the kitchen that were painted.

The facility failed to maintain the physical plant. The following observations were made: penetrations through a one hour fire rated ceiling were not firestopped with approved firestop systems in two locations, and one painted sprinkler and two corroded sprinklers were identified in the kitchen area.

The facility failed to maintain the condition of the physical plant and the overall nursing home environment. The surveyor observed unsealed penetrations in multiple locations.

The facility failed to maintain the physical plant. A corroded sprinkler was identified in an office. Penetrations were identified through the one-hour smoke wall that were not firestopped with an approved firestop system in two areas.

The facility failed to maintain the physical plant. Corroded sprinklers were identified in two locations in the kitchen.

The facility failed to maintain the physical plant. Review of records revealed the five-year internal obstruction investigation on the sprinkler system was past due. The last five-year internal investigation was conducted in 2015. Observations made by the surveyor included: UL rating labels on storage area fire doors were painted, penetrations in a two hour fire wall were not properly fire stopped, nine corroded sprinklers were identified in the kitchen and the door of a resident's room would not close and latch.

The facility failed to maintain the physical plant. Penetrations were identified through the one-hour fire rated ceiling that were not firestopped with approved firestopping systems in two locations. Sprinkler escutcheons were not seated properly in two locations. Four powerstrips were connected together in the therapy room. Corroded sprinklers were identified in two locations. One sprinkler was identified with heavy lint. One damaged sprinkler was identified in a hallway.

N835 Building Standards; Approval of New Construction

The facility failed to obtain prior written approval from the TN Dept. of Health before making alterations to the facility. An activity office had been converted into an emergency covid stock room without prior approval.

The facility failed to to obtain prior written approval from the TN Dept. of Health before making alterations to the facility. A bathroom was being used as storage. Approval had not been obtained from the TN Dept. of Health before the alteration was made.

The facility failed to obtain prior written approval from the TN Dept. of Health before making alterations to the nursing home. A resident room was being used as storage. The facility did not obtain prior approval from the TN Dept. of Health prior to converting the room.

The facility failed to obtain prior written approval from the TN Dept. of Health before making alterations to the facility. A storage room had been constructed in the back half of the salon without approval by the TN Dept. of Health.

N848 Building Standards; Exhaust & Air Pressure

The facility failed to maintain the negative air pressure in soiled areas. The exhaust fan in a soiled linen room was not functional.