Survey Deficiency Summary

18 Facilities Surveyed **Surveys Taken 4/21/22-5/24/22**

E004 Develop EP Plan, Review and Update Annually

D The facility failed to review the emergency preparedness plan annually. The plan contained outdated information that had not been reviewed.

E025 Arrangement with Other Facilities

D The facility failed to develop arrangements with other facilities or providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to the facility residents. The facility could not provide written agreements.

F550 Resident Rights/Exercse of Rights

E The facility failed to maintain or enhance residents' dignity and respect when five staff members failed to use courtesy titles when addressing residents, one staff member stood over a resident while assisting them with their meal and the staff failed to knock and request permission to enter the rooms of 14 residents. Staff were addressing the residents as "Sweetie" and "Honey".

D The facility failed to maintain or enhance residents' dignity and respect when staff failed to provide privacy for two residents during wound care. Staff members provided wound care and incontinence care for the residents without pulling the window blinds or the privacy curtain.

D The facility failed to ensure that all residents were treated in a dignified manner during the lunch meal. All meals were served on foam dishware due to short staffing. One CNA was standing while assisting a resident with their meal. One resident was observed in their room without a meal tray while the roommate was eating their meal. The curtain was not drawn between the two residents. In the dayroom, three of four residents were observed eating their meal for several minutes while the fourth resident had not been served.

D The facility failed to maintain or enhance residents' dignity and respect when two staff members failed to use courtesy titles for three residents. The staff members addressed the residents as either "momma" or "sweetheart". One resident was observed in a common area with a catheter bag not concealed in a privacy bag.

F553 Right to Participate in Planning Care

E The facility failed to ensure five residents, or their representatives were invited to participate in Care Plan conferences.

E The facility failed to conduct quarterly Interdisciplinary Team meetings/Care conferences for 13 residents. There were no care conferences since the most recent quarterly MDS was completed for the residents.

D The facility failed to ensure two residents, or their families were invited to participate in care plan meetings. The last care plan meeting for the two residents was held more than a year prior to the survey.

D The facility failed to include a resident or family member in the most recent Interdisciplinary Team Care Plan meetings for two residents.

F558 Reasonable Accomidations of Needs/Preferences

D The facility failed to provide reasonable accommodations to meet the residents' needs for use of a call light for three residents. Two residents call lights were out of the resident's reach. One resident's call light was not completely plugged into the receptacle and did not work when activated. A maintenance request had not been submitted for repair.

F578 Request/Refuse/Discontinue Treatment;Formulate Adv Directives

D The facility failed to provide information regarding a resident's right to develop an Advance Directive for four residents. There was no Advance Directive for the four residents and no documentation that the residents were informed of their right to formulate an Advance Directive upon admission.

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

D The facility failed to notify the resident's representative of a significant change in health condition for one resident. The resident had a significant weight loss. There were no progress notes or care plan meeting notes with documentation of notification of the resident's representative.

F583 Personal Privacy/Confidentiality of Records

D The facility failed to ensure resident information was kept confidential for two residents. The "Nurse Aide Information Sheet" for two residents were in the residents' rooms, visible to anyone entering the room. One computer screen was observed open and unattended on a medication cart. The computer screen was visible to visitors.

F584 Safe/Clean/Comfortable/Homelike Environment

E The facility failed to promote a homelike environment for seven residents observed during a breakfast meal in the secured unit dining room. The resident's trays were passed and set in front of them without removing the plate, drinks or dinnerware from the tray.

D The facility failed to ensure the environment was clean, comfortable and sanitary when wheelchairs were in disrepair and covered with dried food particles, smears and an unknown liquid for two residents. One wheelchair arm was broken and bent downward toward the resident's lap. Cushions in the wheelchairs had liquids underneath the cushion, food particles on top of the cushion and had a urine odor.

F600 Free from Abuse and Neglect

J The facility failed to provide adequate supervision to prevent neglect for one resident. The failure resulted in immediate jeopardy when the vulnerable resident exited the facility and was found 237 feet from the alarming exit door sitting in a chair. The staff were unaware the resident was missing from the facility. The resident was outside the facility, unsupervised, for approximately 20 minutes. During the survey, the surveyor triggered the alarm on an exit door and two nursing staff members on the hallway did not respond.

J The facility neglected to provide adequate supervision to prevent elopement for one resident and neglected to prevent resident-to-resident abuse for two residents. The facility's failure to prevent elopement and prevent resident-to-resident abuse resulted in immediate jeopardy. A cognitively impaired resident at risk for wandering, eloped from the facility and walked approximately one mile from the facility, crossed five lanes of high-volume traffic at a main intersection and got into a car with a passing motorist. The resident was found by a family member in a neighborhood known for "drug deals." The resident was unsupervised out of the facility for 14 hours. Multiple exit doors were unsecured when the surveyor checked the exits. The delayed release door did not alarm when released after 15 seconds. Immediate jeopardy was identified as a result of Resident #2 entering the room of Resident #4 and attempting to get into the resident's bed. Resident #4 pushed Resident #2 away resulting in the resident falling onto the floor. Resident #2 wandered into the resident's room a second time. The resident was upset. The facility admitted to failure to intervene after the first incident and failing to supervise the wandering resident.

D The facility failed to prevent abuse, a resident-to-resident altercation, for one resident. One resident had a history of refusing medications, paranoia and aggression toward others. The resident became agitated and shoved a table into another resident. The resident had exhibited the same behavior in a prior incident.

D The facility failed to protect resident #1 from sexual abuse when resident #2 was observed with their hand in the pants of resident #1, touching inappropriately. Resident #2 had not attempted to touch another resident inappropriately on any prior occasion. Resident #2 was transferred to the psychiatric hospital and did not return. Resident #1 was transferred to the hospital for evaluation, had no evidence of trauma and returned to the facility. Resident #1 was monitored for behavioral changes or evidence of psychosocial harm after the incident with no abnormal findings. NOTE: There are no findings in the deficiency indicating a deficient practice by the facility.

F604 Right to be Free from Physical Restraints

D The facility failed to document 30-minute checks and release every two hours for a restraint device used for one resident. The facility's policy required any restraint to be repositioned with the resident every two hours and checked every thirty minutes. There was a physician's order to check the Resident and the Merri Walker every 30 minutes and release every two hours. There was no documentation in the medical record indicating the resident had been checked every 30 minutes and released from the Merri Walker every two hours.

F607 Develop/Implement Abuse/Neglect, etc. Policies

D The facility failed to ensure two employees were screened for a history of abuse, neglect and exploitation prior to being hired. The facility failed to check the Abuse Registry for the two employees prior to hiring them.

F609 Reporting of Alleged Violations

D The facility failed to report an allegation of resident-to-resident abuse and failed to timely report a second allegation of resident-to-resident abuse for four residents. Two residents were involved in a physical and verbal altercation and two residents were involved in an altercation after a resident wandered into another resident's room and attempted to get into the bed. One incident was not reported, and the other incident was not reported timely, within two hours.

D The facility failed to report an incident of abuse, a resident-to-resident altercation, to the state agency.

F610 Investigate/Prevent/Correct Alleged Violation

K The facility failed to ensure thorough investigations of elopement and resident-to-resident abuse for five residents. The failure resulted in immediate jeopardy when one resident eloped from the facility and the other four residents were involved in resident-to-resident altercations. Review of the facility's investigation of the elopement incident revealed no written statements or interviews with staff from the shift prior to the elopement time. The Administrator was not certain regarding the number of interviews conducted and stated they were not timely notified of the elopement. The failure to investigate the resident-to-resident altercations resulted in immediate jeopardy. The facility could not produce documentation of psychiatric services follow up to recent behaviors despite being asked several times by the state surveyor. The Administrator did not know what immediate interventions were implemented.

J The facility failed to ensure a thorough investigation was completed for an incident of elopement for one resident. The failure to thoroughly investigate resulted in immediate jeopardy when the resident exited the facility and was found 237 feet from the alarming exit door sitting in a chair. The staff were unaware the resident was missing from the facility and the resident was outside the facility, unsupervised, for approximately 20 minutes. The facility obtained statements from the staff on duty and the prior shift, completed an incident report and did not investigate further. The facility failed to interview staff to determine the resident's behavior prior to the elopement and failed to identify triggers that influenced the resident to elope.

D The facility failed to timely and thoroughly investigate an incident of resident-to-resident abuse for two residents. The facility's investigation of the altercation did not include interviews or statements from staff members working the night of the incident other than the nurse and CNA.

D The facility failed to investigate an allegation of abuse for two residents. There was no investigation of a resident-to-resident altercation involving two residents on the secured unit.

F626 Permitting Residents to Return to Facility

D The facility failed to permit a resident to return to the facility after a hospitalization. A resident was transferred to a psychiatric facility after becoming aggressive toward staff who were attempting to clean the resident's room. The resident threw objects at the staff members and was not redirectable. The physician documented the reason for the transfer and the resident was inappropriate for the facility however, the physician failed to document the specific needs of the resident that could not be met by the facility or the services that another facility could provide. The facility could not produce documentation of the notice to the resident or resident representative or the long-term care ombudsman regarding the discharge.

F640 Encoding/Transmitting Resident Assessments

D The facility failed to complete discharge assessments for one resident. The resident was discharged four months prior to the survey and had no discharge MDS assessment completed.

F641 Accuracy of Assessments

D The facility failed to ensure assessments were completed to accurately reflect the residents' status for one resident with a tracheostomy. The resident was not coded on their MDS as having a tracheostomy.

D The facility failed to ensure assessments were completed to accurately reflect the residents' status for hospice services and ADLs for two residents. One resident was admitted to hospice and the significant change MDS did not include hospice. The facility failed to assess the resident's functional status on one MDS. The MDS was coded with "Not Assessed".

D The facility failed to accurately complete a MDS assessment following one resident's fall. The fall was not coded on the quarterly MDS.

F644 Coordination of PASARR and Assessments

D The facility failed to refer one resident, after the resident was identified with a possible serious mental disorder, to the state-designated authority for a Level II PASARR. Diagnoses of Paranoid Schizophrenia and Major Depressive Disorder were added after admission. An updated PASARR was not submitted after the additions.

F655 Baseline Care Plan

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

F656 Develop/Implement Comprehensive Care Plan

J The facility failed to develop a comprehensive care plan to prevent falls for two residents. The failure to develop care plans and implement interventions for fall prevention resulted in actual harm and immediate jeopardy for the two residents when both residents had head injuries as a result of a fall. The first resident had a fall in the facility with no interventions initiated and no revision to the care plan to reduce the risk of additional falls. The resident fell again, resulting in a laceration to their head requiring emergency room intervention. The second resident was determined to be at high risk for falls upon admission. There was no care plan initiated to reduce the risk for falls for the resident. The resident fell and had a head injury as a result. A facility staff member informed the surveyor that a falls care plan is not initiated until after a fall.

G The facility failed to implement the intervention of an anti-roll back device on a resident's wheelchair after a fall. The failure resulted in actual harm to the resident when the resident had a subsequent fall with a laceration to their head.

D The facility failed to ensure the care plan for ADLs was implemented and followed for one resident. The care plan included an intervention to keep the resident's nails clean. The resident was observed with long fingernails with a dried brown substance underneath the nails.

D The facility failed to implement a care plan intervention for one resident. The resident had a care plan intervention for plastic forks and spoons and no knives with each meal. The resident was observed during a meal with regular silverware and a knife. The intervention was not included on the resident's tray card.

F657 Care Plan Timing and Revision

D The facility failed to revise the care plan to reflect the current status of two residents. The two residents had no revision to their care plan after having a fall.

D The facility failed to revise the care plan for one resident. The resident had fallen on three occasions. The care plan was not revised after any of the three falls.

D The facility failed to revise the care plan to reflect the resident's current status for one resident. The resident's care plan was not revised to include hospice services when the resident was admitted to hospice.

D The facility failed to revise a care plan for three residents. One resident's care plan included IV antibiotics and care of a PICC line that had been discontinued two months prior. A second resident had an intervention for a STOP sign on his room entry door. There was no STOP sign on the resident's door. A third resident's care plan included an intervention for an electronic alarm on the resident's bed and wheelchair and the non-slip tape on the floor at the resident's bedside was to be removed. The resident did not have an alarm on either the bed or the wheelchair. The non-slip tape had not been removed from the floor at the resident's bedside.

D The facility failed to revise and update the care plan to include a restraint device for one resident. The care plan did not include the resident's Merri Walker and did not have interventions to check the resident every 30 minutes and release the resident from the restraint every 2 hours.

F661 Discharge Summary

E The facility failed to ensure the completion of a discharge summary with a recapitulation of the resident's stay, the disposition status at discharge, a post discharge plan of care and a physician's order for discharge for four residents.

D The facility failed to ensure the completion of a discharge summary with a recapitulation of the resident's stay and a transfer form at the time of discharge. The resident was discharged three months prior to the survey. The confirmed the documentation was not completed.

F677 ADL Care Provided for Dependent Residents

D The facility failed to ensure two residents were assisted with ADLs. One resident was observed with dry, flaky skin and had white flakes in his hair. The facility could not produce documentation that the resident had received a bath or shower at any time during the prior three weeks. The facility was missing documentation for a bath or shower on multiple days during the prior three months for a second resident.

D The facility failed to assist one resident with ADLs. The resident was observed in the hallway unshaven and wearing soiled clothing.

D The facility failed to provide ADL care for one resident. The resident was observed with a dried white on their mouth and was observed on two occasions with stains on their clothing. The resident was wearing only one sock with their tennis shoes which were soiled.

D The facility failed to ensure one resident had clean and groomed fingernails. The resident's fingernails on one hand had brown debris underneath the nails.

F684 Quality of Care

D The facility failed to ensure medications were administered for one resident and failed to implement treatment orders following an injury for one resident. Review of the first resident's MAR revealed multiple days over the prior three months with no documentation of administration of the resident's antidepressant medication. A second resident had sustained a laceration to the ankle. The progress note indicated the resident was treated with antibiotic ointment, gauze and a kerlix. There was not order for the wound treatment in the medical record.

D The facility failed to follow physician's orders for one resident. One resident had an order for nebulizer treatments. The order had not been transcribed and the resident had not received the nebulizer treatments.

F689 Free of Accident Hazards/Supervision/Devices

K The facility failed to provide a safe environment to prevent elopement, failed to provide adequate supervision while a resident was smoking and failed to ensure wandering assessments were completed for two residents. The facility's failure to prevent elopement and prevent resident-to-resident abuse resulted in immediate jeopardy. A cognitively impaired resident at risk for wandering, eloped from the facility and walked approximately one mile from the facility, crossed five lanes of high-volume traffic at a main intersection and got into a car with a passing motorist. The resident was found by a family member in a neighborhood known for "drug deals". The resident was unsupervised out of the facility for 14 hours. Multiple exit doors were unsecured when the surveyor checked the exits. The delayed release door did not alarm when released after 15 seconds. Immediate jeopardy was identified as a result of Resident #2 entering the room of Resident #4 and attempted to get into the resident's bed. Resident #4 pushed Resident #2 away resulting in the resident falling onto the floor. Resident #2 wandered into the resident's room a second time. The resident was upset. The facility admitted to failure to intervene after the first incident and failing to adequately supervise the wandering resident. The facility failed to provide adequate supervision while smoking without an apron for one resident.

K The facility failed to provide adequate supervision to prevent falls for five residents, failed to complete an admission falls risk assessment, failed to provide an environment free from accident hazards for one resident, and failed to complete a thorough falls investigation after a fall for five residents. The facility's failure to implement an effective falls prevention program resulted in actual harm and immediate jeopardy for five residents who sustained injuries as a result of a fall.

J The facility failed to ensure a safe environment and provide adequate supervision to prevent elopement for one resident and failed to ensure residents at risk for wandering/elopement were identified in the Code Silver books at each nurses' station for four residents. The failure resulted in immediate jeopardy for one vulnerable resident when the resident exited the facility and was found 237 feet from the alarming exit door sitting in a chair. The staff were unaware the resident was missing from the facility. The resident was outside the facility, unsupervised, for approximately 20 minutes. During the survey, the surveyor triggered the alarm on an exit door and two nursing staff members on the hallway did not respond. Some interior doors had chimes, and some did not. The chimes could not be heard halfway up the hallway from the door. There were discrepancies between the facility's investigation, staff interviews, statements by staff and the documentation in the medical record when compared to the DON's interview and report to the State Agency. Knowledge of the location of the Code Silver books was inconsistent among CNAs and housekeeping staff who were interviewed.

G The facility failed to prevent an accident which resulted in actual harm to one resident. The facility failed to implement the intervention of an anti-roll back device on a resident's wheelchair after a fall. The failure resulted in actual harm to the resident when the resident had a subsequent fall with a laceration to their head.

G The facility failed to implement appropriate interventions to prevent falls, failed to perform assessments for those at risk for falls and failed to perform post-fall assessments for six residents. The facility's failure to provide and implement appropriate interventions resulted in harm when one resident sustained two falls which resulted in a laceration, multiple skin tears and a hematoma. For the three prior falls for this resident, there were no revisions to the care plan and no post-fall risk assessments completed. The resident was observed by the surveyor without multiple fall interventions that were in included in the fall prevention care plan. To explain one of the missing interventions, the staff reported the resident had been moved from one room to another and the concave mattress was not moved with the resident. The other five residents were noted without interventions as listed on their fall care plan and had no post-fall risk assessments after their falls. The facility failed to ensure a safe environment when disposable razors were found in one resident's bathroom and when three residents were not using smoking aprons when smoking.

E The facility failed to ensure investigations, neuro checks and assessments were completed for three residents reviewed for falls. One resident did not have an event note, a fall risk assessment or an investigation post fall. Two residents did not have neuro checks for unwitnessed falls.

E The facility failed to ensure a safe and secure environment and failed to ensure fall risk assessments were completed for four residents. The surveyor observed a plastic container of disinfectant wipes in the resident's room. The container was labeled with a warning "Hazardous to Humans". The post fall risk assessment was not completed for two residents as required per facility policy. A quarterly fall risks assessments was not completed timely and one quarterly fall risk assessment was not completed.

D The facility failed to perform complete neuro checks for one resident who had an unwitnessed fall. The resident's incident report indicated the resident reported while reaching for an object on the floor, the resident had fallen headfirst, and hit their eyebrow on the bedside table. Neuro checks were initiated but were completed at random times.

D The facility failed to prevent an accident which resulted in an injury. The resident had a skin tear and bruise on their hand and forearm. One resident was hit by a food tray cart and was found on the floor. The investigation revealed the staff member was pushing the food cart from behind, could not see around it and hit the resident.

F690 Bowel/Bladder Incontinence Catheter, UTI

D The facility failed to provide physician's order for two residents with indwelling urinary catheters. One resident had an order for the catheter, but no orders for the size of the catheter and the frequency of catheter changes. The second resident had no order for the catheter.

D The facility failed to provide a physician's order for an indwelling urinary catheter or for catheter care for one resident.

F692 Nutrition/Hydration Status Maintenance

G The facility failed to follow their policy for monitoring weights and failed to follow the RD's recommendations to provide nutritional intervention for two residents. For both residents, the RD had recommended nutritional supplements, reweight and weekly weight measurements. The nutritional supplements were not initiated for five days after ordered by the RD. Reweights and weekly weights were not completed. The failure to monitor the weights and follow the RD recommendations for nutritional intervention resulted in actual harm for one of the two residents who had a severe weight loss.

D The facility failed to document meal intake percentages for one resident. There were multiple days without documentation of meal intake.

D The facility failed to keep water within one resident's reach. The surveyor observed the resident's water pitcher and glass on the bedside table out of the resident's reach.

F693 Tube Feeding Management/Restore Eating Skills

D The facility failed to provide care and services for residents with enteral feedings. One staff member administered a bolus feeding of an incorrect formula. A second resident was receiving a continuous enteral feeding of the incorrect type and at an incorrect rate.

D The facility failed to provide care and services for a resident with enteral feedings when staff failed to ensure there was a physician's order for monitoring and cleaning a PEG tube for one resident. The DON confirmed the PEG tube site should be cleaned and monitored for signs and symptoms of infection at least once per shift and also confirmed there should be a physician's order for the site monitoring and cleaning.

F694 Parenteral/IV Fluids

D The facility failed to follow professional standards of practice for a midline catheter for one resident. The resident had no orders for or documentation of the care and monitoring of the midline catheter.

F695 Respiratory/Tracheostomy care and Suctioning

D The facility failed to obtain orders for oxygen therapy for two residents. Both residents were receiving oxygen at 2L/Nasal Cannula. One resident had no order or documentation for the oxygen. The second resident had an order for the oxygen without a specified flow rate.

D The facility failed to obtain orders for oxygen for one resident receiving continuous oxygen therapy. The resident was observed with oxygen at 4 Liters per nasal cannula. There was no order for the oxygen in the medical record.

D The facility failed to follow the physician's order for oxygen flow rate for one resident. The resident was observed on multiple occasions throughout the survey with oxygen set at various flow rates, other than what was ordered by the physician.

D The facility failed to obtain physician's order for oxygen therapy for one resident. The resident was observed with continuous oxygen therapy at 3 Liters per nasal cannula. There was no physician's order for the oxygen therapy in the medical record.

D The facility failed to properly store nebulizer equipment for three residents. The surveyor observed the residents' nebulizer masks uncovered, not in a bag.

F697 Pain Management

D The facility failed to administer pain medications and provide appropriate pain management for two residents. One resident was not administered a scheduled dose of pain medication for a period of ten days. Another resident had not received 4 scheduled doses of pain medication. Both residents reported having unrelieved pain.

F698 Dialysis

D The facility failed to communicate with the hemodialysis center regarding one resident. The facility was unable to provide documentation of communication with the dialysis center on multiple days the resident had received dialysis.

D The facility failed to maintain ongoing written communication between the facility and the dialysis center for one resident. There were no communication forms for multiple days during the three months prior to the survey.

D The facility failed to provide communication with the dialysis center for one resident receiving dialysis services. The facility was unable to provide a dialysis communication record for multiple dates.

D The facility failed to obtain a physician's order to include the individualized dialysis prescription for one resident. The order did not include the frequency of treatments per week, the days of the week or the name of the dialysis center.

F744 Treatment/Service for Dementia

D The facility failed to develop and implement a behavioral health care plan for one resident diagnosed with dementia. The resident had a history of calling out and resisting care but had no individualized interventions in the behavioral care plan to address the behaviors.

F755 Pharmacy Svcs/Procedures/Pharmacist/Records

D The facility failed to follow nursing procedures when administering controlled drugs and failed to keep accurate records of administration of controlled drugs for one resident. A nurse was observed administering medications to a resident. There was no narcotic log on the medication cart to document administration of the controlled substance medications. The nurse reported that the controlled medications would be placed on the log at the end of the shift. The LPN stated the log sheets should be completed when the meds are given. The surveyor noted the controlled medications were not signed out on the narcotic log for the entire shift. The QA nurse confirmed in interview that nurses should be logging the medications as soon as they are given, and the narcotic book should always be kept at the med cart. The facility's policy required staff to maintain accurate accountability of the inventory of all controlled drugs at all times. NOTE: The facility was cited for failing to adhere to their policy regarding controlled substances. There is no regulatory requirement to document on a controlled substance log as soon as a medication is given. Medication administration should be documented on the MAR when medications are given.

F757 Drug Regimen is Free From Unnecessary Drugs

D The facility failed to provide behavioral monitoring and failed to monitor for side effects of psychotropic medications for two residents. One resident had a history of calling out and resisting care but had no behavior monitoring in the record. A second resident received scheduled doses of antipsychotic and antidepressant medications. There was no documentation of monitoring for side effects of the medications in the medical record.

D The facility failed to ensure one resident was monitored for Tardive Dyskinesia. The resident was administered an antipsychotic medication daily. There was no AIMS assessment completed for the resident.

D The facility failed to ensure one resident receiving an antipsychotic drug had adequate monitoring for Tardive Dyskinesia. The assessments were inconsistently performed and were not conducted at least every six months.

F758 Free from Unnec Psychotropic Meds PRN Use

D The facility failed to ensure residents were monitored for the presence of side effects of antipsychotic medications for one resident. There was no documentation in the "behavior monitoring record" for the presence or absence of side effects of the antipsychotic medication over the prior two months. NOTE: The deficiency did not contain any reference to routine AIMS testing.

F759 Free from Medication Error Rates of 5% or More

E The facility failed to ensure one nurse administered medications with a medication error rate of less than 5%. A total of 34 medication errors were observed out of 42 opportunities resulting in an error rate of 80.95%. The 34 errors were due to administration of the medications more than one hour past the scheduled administration time.

D The facility failed to ensure a medication administration rate of less than 5% when medications were improperly administered to two residents. Multiple medications were crushed, mixed and administered together without a physician's order for two residents.

F760 Residents Are Free of Significant Med Errors

D The facility failed to ensure residents were free from significant medication errors for one resident. The facility failed to adhere to the physician's ordered parameters for insulin administration and did not hold the insulin for a blood glucose of 110 or less. In the prior three months, the resident had received the insulin on 12 occasions when the insulin should have been held.

F761 Label/Store Drugs & Biologists

E The facility failed to ensure medications were properly stored and secured when medications were found unsecured and not attended by authorized staff, open, undated and expired in four medication storage areas. While the surveyor was observing medication pass, a nurse handed a lidocaine patch to the surveyor and left the medication cart to get scissors. The nurse left the medication unsecured and unattended by authorized staff when leaving it with the surveyor. Multi-dose vials of insulin and Tubersol were opened and undated. Acetic acid irrigation solution was opened and undated. One tuberculin skin testing solution was expired.

E The facility failed to ensure medications were properly stored and secured when medications were found unattended and unsecured in two resident rooms. Nystatin powder was observed on the overbed table in one room and medicated vapor ointment was observed on the overbed table in the second room. One staff member removed a box of Diclofenac from the treatment cart, placed it on top of a medication cart and left it unsecured and unattended. Two nurses left the medication carts unlocked and unattended while passing medications on a resident hall.

E F761E
The facility failed to ensure staff conducted temperature checks for two med room medication storage refrigerators and failed to ensure expired medications were discarded from one refrigerator. Review of the medication refrigerator temperature log revealed no temperatures were documented for 77 days. A second refrigerator was missing entries on the temperature monitoring log for seven days of the current month. Acetaminophen suppositories stored in the refrigerator were expired.

D The facility failed to ensure medications were properly stored and secured. A medication cart and a wound treatment cart were observed opened and unattended.

D The facility failed to ensure medications were properly stored. Medications were observed during the initial surveyor tour, at the bedside, unattended and unsecured in two resident's rooms.

D The facility failed to ensure medications and biologicals were stored and discarded properly in two medication carts. Medications were observed in two resident's rooms in a cup at the bedside unattended. Unopened insulin pens were stored on the medication cart. One insulin pen was not discarded 28 days after opening.

F790 Routine/Emergency Dental Services in SNFs

D The facility failed to provide dental services for one resident. The resident complained of having problems with her lower teeth in an interview with the surveyor. The resident had not been offered assistance with a dental consult.

F802 Sufficient Dietary Support Personnel

F The facility failed to maintain a sufficient number of dietary staff to safely and effectively carry out the function of the food and nutrition service on one occasion. The dietary staff did not report for duty on one day and the facility pulled staff from other departments to cook and serve breakfast until dietary staff were deployed from other associated facilities.

F803 Menus Meet Res Needs/Prep in Advance/Followed

D The facility failed to ensure five residents had alternative food and menu choices. Multiple residents reported not getting menus.

F804 Nutritive Value/Appa, Palatable/Prefer Temp

D The facility failed to ensure the food and drinks were at the proper temperature during the noon meal. The milk was 46 degrees F on the test tray. Three residents complained of their food being cold. Food was served on foam containers.

F809 Frequency of Meals/Snacks at Bedtime

E The facility failed to ensure there were no more than 14 hours between the supper and breakfast meals, unless a nourishing snack was served at bedtime and the resident council agreed to the extended time frame. The breakfast meal followed the prior evening's dinner meal by 15 hours. There was no documentation in the Resident Council minutes related to discussion or agreement to the time frame. The dietary manager reported having snacks available in the nourishment rooms, however, the residents reported that no snacks were offered at bedtime.

F810 Assistive Devices - Eating Equiptment/Utensils

D The facility failed to provide the appropriate equipment necessary to maintain the ability to drink independently for one resident. The resident was to have lids on all cups due to a tremor. The lids were not provided.

F812 Food Procurement Store/Prepare/Serve - Sanitary

F The facility failed to maintain a sanitary kitchen. Observations made by the surveyor included undated, expired, uncovered food in one refrigerator and two freezers, debris in a plastic storage bin, dietary staff not performing hand hygiene appropriately, food temperatures were measured with a previously used and unwashed thermometer and, inappropriate and expired items were stored under the steam table. A dietary aide was observed working the prep table while wearing gloves then touched various surfaces within the kitchen, checked food temperatures and returned to the prep table without changing gloves or performing hand hygiene.

F The facility failed to ensure food was stored, prepared and served under sanitary conditions. Observations by the surveyor included: carbon build-up on pots and pans, a large storage rack with white and brown crumbs, the water curtain in the ice machine had a large amount of a pink substance along the bottom, the floor had a large amount of dark stains that extended under the sink, the dish machine had a large amount of dried food particles and dark brown stains covering the top and, a prep table and six utility carts had a large amount of food substance and brown stains.

F The facility failed to maintain a sanitary environment in the kitchen. Observations included: there was no documentation on the weekly cleaning schedule indicating the deep fryer had been cleaned for the prior two months, the can opener had food debris behind the blade, there was food debris on the top of the oil reservoir and on the side of the deep fryer, a copious amount of food debris on the top of the stove/range, the burners and the removable crumb tray and food debris splashed down the side, on the front door and beneath the burners. The mobile steam tray/hot cart had food debris in the bottom of all three serving bins.

F The facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by opened and undated food items, staff wearing a mask below their nose, and staff handling plates with their bare hands. Plastic containers with cornmeal, flour and sugar were unlabeled and undated in the kitchen. Multiple staff members were observed with their mask below their nose in the kitchen. Items (dinner rolls and taco seasoning) were observed opened, undated and in the original packaging in the dry food storage room.

F The facility failed to ensure dietary staff maintained appropriate hand hygiene practices during meal preparation in the dietary department. Staff members were observed donning and doffing gloves without sanitizing their hands in between glove changes, after removal of gloves and before donning gloves.

E The facility failed to ensure food was served under sanitary conditions when three staff members failed to perform proper hand hygiene while assisting with meals for 13 residents. The staff members failed to perform hand hygiene after removing gloves and failed to perform hand hygiene after assisting a resident and before assisting another resident. Staff members were observed touching food with their bare hands and failed to perform hand hygiene after touching random surfaces in the resident's room and before assisting to set up their meal tray.

D The facility failed to properly store and discard expired food in one nourishment room. The surveyor observed an opened bag of cheese without labeling indicating the date opened or the resident's name. Also observed were two opened bottles of water and one opened Sprite without labeling indicating the date opened and the resident's name.

F814 Dispose Garbage & Refuse Properly

D The facility failed to ensure that waste was properly contained and maintained in a sanitary condition. Two dumpsters were observed open with a large amount of garbage lying in front and around the bases.

F835 Administration

K The facility failed to provide administration and oversight of its resources effectively to attain and maintain the highest practicable well-being of residents with wandering/elopement behaviors, failed to provide oversight and training of staff to prevent neglect and provide appropriate care to meet residents' needs, failed to provide adequate supervision to prevent elopement and failed to provide safe smoking practices, failed to complete a thorough investigation of an elopement incident, three incidents of resident-to-resident abuse and one incident of unsafe smoking.

J The facility failed to provide administration and oversight of its resources to attain the highest practicable well-being of residents with wandering/elopement behaviors. Administration failed to provide oversight and training of staff to prevent neglect and provide appropriate care to meet resident's needs and failed to complete a thorough investigation of an elopement incident. The failure to ensure a safe environment and provide adequate supervision to prevent elopement resulted in immediate jeopardy for one vulnerable resident when the resident exited the facility and was found 237 feet from the alarming exit door sitting in a chair. The staff were unaware the resident was missing from the facility. The resident was outside the facility, unsupervised, for approximately 20 minutes. During the survey, the surveyor triggered the alarm on an exit door and two nursing staff members on the hallway did not respond. Some interior doors had chimes, and some did not. The chimes could not be heard halfway up the hallway from the door. There were discrepancies between the facility's investigation, staff interviews, statements by staff and the documentation in the medical record when compared to the DON's interview and report to the State Agency. Knowledge of the location of the Code Silver books was inconsistent among CNAs and housekeeping staff interviewed.

F838 Facility Assessment

D The facility failed to have a completed facility assessment reflecting all residents in the facility. The facility did not include the secured unit residents as part of the facility assessment.

F842 Resident Records - Identifiable Information

D The facility failed to maintain accurate medical records related to dietary intake and weights for two residents. Both residents had multiple days without documentation of meal intake percentage. The second resident had an order for daily weights. The weights were not documented daily, and the facility confirmed the inaccuracy of the weights that were recorded

D The facility failed to maintain accurate medical records related to dietary intake for two residents. There was no documentation of meal intake percentage for multiple days over the prior two months for two residents.

F849 Hospice Services

D The facility failed to ensure a physician's order was obtained to provide hospice services for one resident.

F867 QAPI/QAA Improvement Activities

K The QAPI Committee failed to ensure systems and processes were in place that involved tracking/trending, quantitative and qualitative data analysis, evaluation and reevaluation of interventions, data and trends to address quality concerns related to wandering and elopement, resident-to-resident abuse and safe smoking practices. The failure resulted in immediate jeopardy for five residents including one elopement incident, three incidents of resident-to-resident abuse and one incident of unsafe smoking.

K The facility's QAPI Program failed to have an effective ongoing QAPI program to ensure an effective falls program was implemented to prevent falls resulting in injury. The QAPI Committee's failure to monitor previously identified deficient practice and corrective actions to ensure residents were accurately identified as at high risk for falls, to ensure falls investigations were completed, to ensure care plans were revised with appropriate interventions after a fall, and to ensure care plans were developed for residents at risk for falls placed five residents in immediate jeopardy when the residents sustained falls resulting in injuries. The facility had implemented a plan of correction in response to a deficiency six months prior to the survey for the same issues. The facility had not followed the plan of correction.

J The QAPI Committee failed to ensure systems and processes were in place and consistently followed by staff to address quality concerns related to wandering and elopement behaviors. The QAPI Committee failed to ensure a thorough investigation of a resident elopement incident and failed to identify quality deficiencies and effective interventions for care of residents with wandering and elopement behaviors. The failure to ensure a safe environment and provide adequate supervision to prevent elopement resulted in immediate jeopardy for one vulnerable resident when the resident exited the facility and was found 237 feet from the alarming exit door sitting in a chair. The staff were unaware the resident was missing from the facility. The resident was outside the facility, unsupervised, for approximately 20 minutes. During the survey, the surveyor triggered the alarm on an exit door and two nursing staff members on the hallway did not respond. Some interior doors had chimes, and some did not. The chimes could not be heard halfway up the hallway from the door. There were discrepancies between the facility's investigation, staff interviews, statements by staff and the documentation in the medical record when compared to the DON's interview and report to the State Agency. Knowledge of the location of the Code Silver books was inconsistent among CNAs and housekeeping staff interviewed.

F880 Infection Prevention & Control

F The facility failed to follow CDC guidelines to prevent the spread of COVID-19 when multiple staff members failed to complete the entry screening process prior to working. Four staff members failed to perform appropriate hand hygiene and infection control practices during perineal care. Two staff members performed perineal care on a female resident from back to front and one staff member failed to rinse the perineal area after cleaning the perineal area with soap. Two staff members did not wash their hands for at least 20 seconds.

F The facility failed to follow CDC infection control guidelines to ensure practices to prevent the potential spread of COVID-19 when eight staff members failed to complete screenings for the detection of COVID-19 prior to reporting for duty.

E The facility failed to ensure practices to prevent the potential spread of infection were maintained when one staff member failed to properly don PPE before entering an isolation room, three staff members failed to perform hand hygiene after testing themselves for COVID-19 and failed to clean the nebulizer mask and a reusable syringe used with gastric tube feedings while administering medications. The nebulizer mask or the medication reservoir were not cleaned after a nebulizer treatment and a piston syringe was not cleaned after administering medications through a PEG tube. Three staff members were observed caring for residents with their surgical mask positioned below their nose.

E The facility failed to provide a safe, sanitary and comfortable environment to help prevent the spread of infection. Staff members placed dirty meal trays and tray lid covers on a clean meal tray cart containing clean trays. An ice scoop was observed uncovered on an ice cart. Resident care items and personal items were placed on clean linen carts. The items included peri-wash spray, gloves, garbage bags, disposable briefs and packets of barrier cream.

D The facility failed to ensure infection control practices were followed for three residents and failed to ensure appropriate precautions were taken to prevent COVID-19 transmission in the facility. Staff members were observed entering rooms requiring transmission-based precautions without the appropriate PPE: gown, face shield or goggles. One employee exited the room, removed their gown and discarded it down the hall at the nurses' station. One staff member exited an isolation room without removing PPE and proceeded down the hallway until corrected by another staff member. One staff member wore her personal glasses instead of a face shield or goggles and thought the practice was acceptable.

F888 COVID-19 Vaccination of Facility Staff

F The facility failed to ensure six unvaccinated staff members donned appropriate PPE to ensure precautions were taken to properly prevent COVID-19 transmission in the facility. The facility policy required unvaccinated staff with exemptions to wear a face shield or goggles and an N95 mask at all times. Five of the six staff members were observed with a surgical mask instead of an N95 mask and no eye protection and one of the six did not wear eye protection.

F The facility failed to document and track staff vaccinations for COVID-19 according to the current guidelines to prevent the potential spread of COVID-19 for five staff members and one contracted environmental service employee. The facility was unable to provide documentation of the second dose in the series of COVID-19 vaccinations for three staff members and reported not having a system to follow up. Three other staff members had no vaccination records on file. One staff member had an incomplete exemption form on file.

F919 Resident Call System

D The facility failed to provide a call light for one resident.

F921 Safe/Functional/Sanitary/Comfortable Environment

D The facility failed to provide a sanitary environment in four resident rooms. Observations included a brown smear on the resident's blanket, a bedspread on the floor, toothbrushes in a shared bathroom without labels, a trash can overflowing with soiled briefs, resident care items stored underneath the bathroom sink, and an IV pole and pump with smears of white dried debris.

K222 NFPA 101 Egress Doors

D The facility failed to maintain a means of egress. One delayed egress door failed to release within 15 seconds when manually tested. One delayed egress door failed to release with fire alarm activation.

K712 Fire Drills

E The facility failed to conduct staff in-service for fire drills. The facility could not produce documentation for staff fire drill training for the first shift during the last three quarters of 2020 and on the second shift for all four quarters of 2020.

K754 Soiled Linen and Trash Containers

D The facility failed to keep mobile soiled linen and trash containers in a room rated as a hazardous area. The surveyor observed a wheeled 55-gallon trash can full of soiled linen unattended in the bathroom of a resident room. A 55-gallon trash can full of trash was unattended in a corridor.

K929 Gas Equipment Precautions for Handling Oxygen

D The facility failed to ensure medical gas cylinders were secured. Two unsecured oxygen cylinders were identified at the nurses' station.

N1102 Records and Reports; Recording of Unusual Incidents

The facility failed to report an incident of abuse, a resident-to-resident altercation, to the state agency.

N1201 Resident Rights; Privacy in Treatment

The facility failed to ensure that all residents were treated in a dignified manner during the lunch meal. All meals were served on foam dishware due to short staffing. One CNA was standing while assisting a resident with their meal. One resident was observed in their room without a meal tray while the roommate was eating their meal. The curtain was not drawn between the two residents. In the dayroom, three of four residents were observed eating their meal for several minutes while the fourth resident had not been served.

N1207 Resident Rights

The facility failed to prevent abuse, a resident-to-resident altercation, for one resident. One resident had a history of refusing medications, paranoia and aggression toward others. The resident became agitated and shoved a table into another resident. The resident had exhibited the same behavior in a prior incident.

N1216 Resident Rights

The facility failed to ensure resident information was kept confidential for two residents. The "Nurse Aide Information Sheet" for two residents were in the residents' rooms, visible to anyone entering the room. One computer screen was observed open and unattended on a medication cart. The computer screen was visible to visitors.

N1227 Resident Rights; Resident Dignity

The facility failed to conduct quarterly Interdisciplinary Team meetings/Care conferences for 13 residents. There were no care conferences since the most recent quarterly MDS was completed for the residents.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

The facility failed to exercise and evaluate the disaster plans. The facility could not provide documentation and evaluation of drills for earthquake and flood for 2021 and 2022.

N416 Administration; Background Check

The facility failed to have a completed criminal background check for one staff member's personnel record.

N645 Nursing Services

The facility failed to ensure a safe and secure environment for one resident. The surveyor observed a plastic container of disinfectant wipes in the resident's room. The container was labeled with a warning "Hazardous to Humans". This is a Pending Type C Penalty #18.

This is a Type C Pending Civil Monetary Penalty #19. The facility failed to ensure the environment was clean, comfortable and sanitary when wheelchairs were in disrepair and covered with dried food particles, smears and an unknown liquid for two residents. One wheelchair arm was broken and bent downward toward the resident's lap. Cushions in the wheelchairs had liquids underneath the cushion, food particles on top of the cushion and had a urine odor.

The facility failed to provide a sanitary environment in four resident rooms. Observations included a brown smear on the resident's blanket, a bedspread on the floor, toothbrushes in a shared bathroom without labels, a trash can overflowing with soiled briefs, resident care items stored underneath the bathroom sink, and an IV pole and pump with smears of white dried debris.

N649 Basic Services; Infection Control

The facility failed to provide a safe, sanitary and comfortable environment to help prevent the spread of infection. Staff members placed dirty meal trays and tray lid covers on a clean meal tray cart containing clean trays. An ice scoop was observed uncovered on an ice cart. Resident care items and personal items were placed on clean linen carts. The items included peri-wash spray, gloves, garbage bags, disposable briefs and packets of barrier cream.

N688 Basic Services; Nursing Services

The facility failed to provide ADL care for one resident. The resident was observed with a dried white on their mouth and was observed on two occasions with stains on their clothing. The resident was wearing only one sock with their tennis shoes which were soiled.

The facility failed to ensure one resident had clean and groomed fingernails. The resident's fingernails on one hand had brown debris underneath the nails.

N689 Basic Services; Nursing Services

The facility failed to administer pain medications and provide appropriate pain management for two residents. One resident was not administered a scheduled dose of pain medication for a period of ten days. Another resident had not received 4 scheduled doses of pain medication. Both residents reported having unrelieved pain.

N727 Pharmaceutical Services

The facility failed to ensure medications and biologicals were stored and discarded properly in two medication carts. Medications were observed in two resident's rooms in a cup at the bedside unattended. Unopened insulin pens were stored on the medication cart. One insulin pen was not discarded 28 days after opening.

N728 Basic Services; Pharmaceutical Services

The facility failed to ensure medications were properly stored and secured when medications were found unsecured and not attended by authorized staff, open, undated and expired in four medication storage areas. While the surveyor was observing medication pass, a nurse handed a lidocaine patch to the surveyor and left the medication cart to get scissors. The nurse left the medication unsecured and unattended by authorized staff when leaving it with the surveyor. Multi-dose vials of insulin and Tubersol were opened and undated. Acetic acid irrigation solution was opened and undated. One tuberculin skin testing solution was expired. This is a Pending Type C Penalty #7.

The facility failed to ensure medications were properly stored. Medications were observed during the initial surveyor tour, at the bedside, unattended and unsecured in two resident's rooms.

The facility failed to ensure medications were properly stored and secured when medications were found unattended and unsecured in two resident rooms. Nystatin powder was observed on the overbed table in one room and medicated vapor ointment was observed on the overbed table in the second room. One staff member removed a box of Diclofenac from the treatment cart, placed it on top of a medication cart and left it unsecured and unattended. Two nurses left their medication carts unlocked and unattended while passing medications on resident halls.

N733 Pharmaceutical Services

The facility failed to have a physician sign a telephone order within 10 days. The telephone order was received 50 days prior to the observation.

N758 Basic Services; Food and Dietetic Services

The facility failed to ensure there were no more than 14 hours between the supper and breakfast meals, unless a nourishing snack was served at bedtime and the resident council agreed to the extended time frame. The breakfast meal followed the prior evening's dinner meal by 15 hours. There was no documentation in the Resident Council minutes related to discussion or agreement to the time frame. The dietary manager reported having snacks available in the nourishment rooms, however, the residents reported that no snacks were offered at bedtime.

N766 Food and Dietetic Services; Freezer Temperature

The facility failed to ensure food was served under sanitary conditions when three staff members failed to perform proper hand hygiene while assisting with meals for 13 residents. The staff members failed to perform hand hygiene after removing gloves and failed to perform hand hygiene after assisting a resident and before assisting another resident. Staff members were observed touching food with their bare hands and failed to perform hand hygiene after touching random surfaces in the resident's room and before assisting to set up their meal tray. This is a Pending Type C Penalty #22.

The facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by opened and undated food items, staff wearing a mask below their nose, and staff handling plates with their bare hands. Plastic containers with cornmeal, flour and sugar were unlabeled and undated in the kitchen. Multiple staff members were observed with their mask below their nose in the kitchen. Items (dinner rolls and taco seasoning) were observed opened, undated and in the original packaging in the dry food storage room. This is a Type C Pending Penalty #22.

N768 Basic Services; Food and Dietetic Services

The facility failed to ensure the food and drinks were at the proper temperature during the noon meal. The milk was 46 degrees F on the test tray. Three residents complained of their food being cold. Food was served on foam containers.

N831 Building Standards

The facility failed to maintain the physical plant. Observation by the surveyor included: penetrations through the one-hour fire-rated ceiling and the one-hour fire rated wall not fire-stopped with approved fire-stop systems. Fire doors in four locations were not latching. A sprinkler was missing the escutcheon in one area. The emergency light in the main electrical room did not function. The facility could not provide documentation for the annual retention test or the quarterly sprinkler inspection.

The facility failed to maintain the physical plant. Surveyor observations included: extension cords in use in three areas, penetrations through the one-hour fire-rated ceiling or the one-hour block fire wall not fire-stopped with approved fire-stop systems in five locations, corroded sprinklers in three locations and space heaters in use in two locations.

The facility failed to maintain the condition of the overall nursing home environment. The facility could not produce documentation for a three-year air leakage test of the sprinkler system. The surveyor observed storage within 18 inches of the sprinkler in a storage closet.

The facility failed to maintain the physical plant and the overall nursing home environment. The facility was unable to produce documentation of the annual emergency lighting or exit lighting test for 2021 or monthly emergency lighting tests for all of 2021. The surveyor made the following observations: a rolling cart was blocking a fire alarm pull station and a fire extinguisher, sprinklers were loaded with foreign material in two areas and two missing duct detectors in the mechanical room. The fire alarm system did not function properly when tested. The new smoke detectors did not activate the panel and notification appliances did not function when the existing panel was in active alarm mode in eight of nine wings.

The facility failed to maintain the physical plant. The surveyor observed penetrations through the one-hour fire-rated ceiling not fire-stopped with approved fire stop systems in two locations. One sprinkler escutcheon was missing, and one sprinkler was damaged.

The facility failed to maintain the sprinkler system. The facility could not provide documentation for the 10-year replacement or sample testing of the dry sprinkler pendants.

The facility failed to maintain the physical plant. Surveyor observations included penetrations through the one-hour fire-rated ceiling, not fire-stopped with approved firestop systems in four locations. There was water damage to the ceiling in three locations. One sprinkler was noted to have paint on it and corroded sprinklers were identified in four areas.

The facility failed to maintain the physical plant. The following observations were made by the surveyor: penetrations not properly fire stopped per an approved fire stop system and a missing sprinkler escutcheon in the electrical room by the maintenance office.

The facility failed to maintain the condition of the physical plant and overall nursing home environment. Surveyor observations included: in-wall night lighting was not functioning throughout one hall, one hall had multiple temporary barriers that were obstructing sprinklers and smoke detectors, an extension cord powering a personal computer in one room and an extension cord powering the vending machines, a two foot by four foot hole in a shower wall and a six foot by two foot hole with exposed piping in another shower wall, a missing cover on a junction box, a light fixture hanging from the ceiling, exposed wiring from conduit at the ceiling, broken and missing receptacle covers in resident rooms, a broken receptacle cover with exposed contacts on an emergency outlet, two daisy-chained power strips in the copy room, 32 four-gallon containers of floor adhesive stored in one room, and, a one-inch hole in the rated ceiling of a bathroom.

N835 Building Standards; Approval of New Construction

The facility failed to have approved plans before making alterations to life safety systems. The facility was in the process of upgrading their fire alarm system including replacing the fire alarm control panel, control wiring throughout the building, initiation and notification devices as well as adding new notification devices. The facility had not submitted a project to TDOH for review and approval related to fire alarm system replacement.

The facility failed to obtain prior written approval from the TDOH before making alterations to the nursing home. The restroom in the beauty shop was being used for storage. Approval by the TDOH had not been obtained.

N848 Building Standards; Exhaust & Air Pressure

The facility failed to maintain the exhaust system. There was no negative air pressure in the biohazard closet.