

Nursing Home Inspection Results by Tag Number, Scope and Severity 2009

Quarter 3

Type	Tag	S/S	Description
A	156	B	Failed to inform the resident and/or responsible party of the potential liability of payment and the right to request standard claim appeal be submitted to Medicare for 4 residents of 4 reviewed.
A	156	F	Failed to ensure information regarding resident advocacy groups was posted for resident review.
A	156	F	Failed to post information regarding state advocacy groups & prominently display information related to Medicare/Medicaid benefits.
A	157	D	Failed to notify the resident's physician in a timely manner relating to a change of condition and with-holding tube feeding formula for 2 residents of 22 sampled.
A	157	D	Failed to notify the physician of a significant blood pressure finding for 1 resident.
A	157	D	Failed to notify physician of a change in condition for 1 resident.
A	157	D	Failed to notify resident's physician of an increase in depression symptoms for 1 resident.
A	157	D	Failed to: notify 1 resident's physician of skin break down, possible side effects of medication and low blood pressure. To notify physician of fall with injury and an open area for 1 resident and to notify physician of low blood pressure for 1 resident.
A	157	D	Failed to notify the physician related to a change in one resident's condition.
A	157	D	Failed to notify the physician in a manner to initiate treatment for skin issues for 1 resident of 11 sampled.
C	157	D	Failed to notify the physician of abnormal symptoms and change of condition for 1 resident of 10 sampled.
A	157	E	Failed to notify the resident's legal rep. and/or physician of unplanned weight loss and pressure sores.
A	157	E	Failed to notify each resident's physician following a change in shin condition for 3 of 10 sampled.
A	164	D	Failed to ensure privacy during toileting and personal cares for 2 residents.
A	164	D	Failed to provide personal privacy to prevent unnecessary exposure of the resident's body who required assistance of staff.
A	164	E	Failed to ensure that curtains in 14 semi-private rooms offered full visual privacy for residents.
A	166	D	Failed to ensure that resident grievances for 2 residents were resolved.
A	166	D	Failed to ensure grievances voiced by residents were addressed and resolved.
A	166	E	Failed to ensure that grievances voiced by 8 residents were addressed and resolved.
A	176	D	Failed to assess one resident for self administration of medications and treatments.
A	176	D	Failed to fully complete an assessment for safe, self administration of medications for 1 resident.
A	176	D	Failed to monitor and/or document the self administration of medications and/or note in care plans who was responsible for storage & documentation.
A	221	D	Failed to identify wheelchair seat belt as physical restraints per regs. For 2 residents.
A	225	D	Failed to follow their policies and procedures for obtaining reference checks for 3 Nurse Aides prior to starting employment.

Type	Tag	S/S	Description
C	225	D	Failed to investigate and report an incident of alleged sexual abuse of a resident in accordance with regulations & policies.
A	225	D	Failed to report 2 allegations of abuse to state agencies in timely manner. Failed to follow HR policies by not obtaining former reference checks on 6 of 6 employee files reviewed.
C	225	D	Failed to ensure that significant accidents were reported to required state agency for 2 injury accidents for 2 or 6 sampled.
A	225	D	Failed to report to the required state agencies for 1 of 3 investigative files reviewed.
A	225	D	Failed to send the investigation report regarding misappropriation for 1 resident to the state agency.
A	225	D	Failed to report all incidents of potential abuse/neglect to the State Agency for 1 of 12 sampled and 4 non-sampled.
A	225	E	Failed to follow their Abuse policy for employee reference checks for 5 out 5 reviewed.
A	226	C	Failed to implement written policies/procedures to ensure protection of residents from potential abuse by failing to conduct past employment reference checks for 5 of 5 newly hired , 1 LPN, 1 Hsk, 3 NA's.
C	226	D	Failed to ensure that policies/procedures were implemented to protect residents from resident to resident abuse for 1 of 4 sampled.
A	226	D	Failed to send a report of the results of the investigation to state agency for 1 of 2 elopements.
A	226	D	Failed to follow abuse policy with regards to: 1) reporting alleged abuse; 2) thoroughly investigate issues related to abuse; and 3) develop a plan to prevent further incidents from occurring for 2 sampled out of 9.
A	226	D	Failed to ensure that policy regarding abuse allegations was followed for 1 resident.
A	241	D	Failed to identify and address issues of 1 resident being treated in a undignified manner.
A	241	D	Failed to ensure 2 residents were treated with dignity by failing to provide coverage of the abdomen for 1 while setting in a wheelchair in the hall under the hair dryer and for 1 while reclined in their room.
A	241	E	Failed to promote care that enhanced each resident's dignity as 4 residents were in public areas in hospital gowns.
A	246	D	Failed to provide a wheelchair that ensured comfort and proper positioning for 1 current resident.
A	246	D	Failed to provide positioning devises for 2 residents of 15 sampled to allow them to assist with and maintain limited bed mobility.
A	246	E	Failed to provide appropriate positioning at the dinning tables for residents seated in wheelchairs to ensure comfortable positioning for ease of eating for 2 residents.
A	248	E	Failed to provide meaningful activities for 6 residents of 17 sampled plus 7 non-sampled.
A	250	D	Failed to provide interventions to meet the needs of 2 residents with a decline in psychosocial symptoms.
A	250	D	Failed to further assess and provide interventions to address an indentified decline in psychosocial status and symptoms of depression for 1 resident.
A	250	D	Failed to ensure that psychosocial needs of 1 resident when they expressed feeling unsafe and nervous about another resident on same hallway.
A	250	D	Failed to develop/implement interventions and monitoring related to a resident to resident personal interaction.
C	250	D	SS Staff failed to assess mood and behavioral response of placement on a non-secured unit for 1 resident.
C	252	D	Failed to ensure that resident's rooms were homelike for 1 sampled and 1 non-sampled resident.
A	253	C	Failed to maintain resident living areas in good repair; door kick plates were gouged & paint on jambs were chipped & worn to bare metal.

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A	253	D	Failed to ensure equipment was clean and in good repair for 2 of 9 sampled.
A	253	D	Failed to ensure that an electric fan was routinely cleaned to prevent buildup of black/gray material on the blades for 1 of 4 sampled.
A	253	D	Failed to maintain resident wheelchair eq. and shoes in clean condition for 3 residents of 22 sampled.
C	253	D	Failed to ensure environment was clean in a manner to minimize odors.
A	253	E	Failed to 1) routinely clean front door crash bar. 2) clean grounds outside entry doors of cigarette butts and leaves. 3) ensure 2 resident wheelchairs were clean. 4) ensure call light cord replaced when soiled for 1 resident.
A	253	E	Failed to ensure the cleanliness of 4 rooms to prevent odors and failed to ensure that the floors, walls, doorframes and windows ledges were in good repair in 6 rooms of 10 sampled.
A	253	E	Failed to 1) ensure counter top was free from sharp edges for 1 resident, 2) closet door was free from a hole for 1 resident, 3) floor was free from black marks and scratches for 2 residents, 4) 1 of 3 whirlpool chairs were free from rough chipped surface.
A	253	E	Failed to provide clean/sanitary housekeeping and maintain in good repair 24of24 dining chairs, 2of2 stools, 16 bedroom doors, 3 bathroom doors, the protective end covers for the 1/2 bedrails on 33 beds, basement exit door and door thresholds.
A	253	E	Failed to ensure table legs in the assisted dining room were clean and failed to ensure 2 chairs in large dining room were clean and in good repair.
A	253	E	Failed to maintain sanitary conditions related to furniture, floors, doors, vent systems, walls, wheelchairs, floor mats, nurses station desk and dining room menu board. This affected 9 resident rooms, 4 dining rooms, therapy restroom and 1 tub room.
A	253	E	Failed to 1) maintain living areas by cleaning heater vents in 4 resident rooms, main and family dining room 2) To clean sit to stand lift. 3) To repair cracks in wall near the nurses station and casing was pulled away from wall in main dining room.
C	253	E	Failed to ensure a clean and comfortable environment for 8 residents.
C	253	E	Failed to 1) Clean a sliding glass door accessible to residents and visitors. 2) identify and clean or repair resident flooring, ceilings or walls for 4 of 10 sampled.
A	254	E	Failed to provide soaker pads, wash cloths and bed linens for residents that were in good condition.
A	272	D	Failed to: 1) provide location and dates describing location of additional required RAP documentation; 2) provide RAP documentation exploring causal factors or unique risk factors for triggering RAP problem areas for 4 residents.
A	272	E	Failed to complete RAP summaries for the RAI for 5 of 12 residents sampled.. Failed to ensure a section of the MDS entitled "background" information at admission for 2 residents had been signed or dated by person completing the section.
A	272	E	Failed to follow RAI Manual when completing the MDS and RAP's for 8 sampled residents.
A	273	D	Failed to complete admission assessment RAP's within the required time frames for 2 non-sampled and 1 sampled.
A	274	D	Failed to identify MDS assessed declines as a significant change for 1 resident.
A	278	D	Failed to accurately code comprehensive assessment MDS records pertaining to restorative programs, surgical wounds and other skin problems.
A	278	D	Failed to Failed to accurately code the weight status for 1 sampled resident.
A	278	D	Failed to accurately code the MDS for 2 of 9 residents sampled.
A	278	E	Failed to accurately code the MDS regarding nursing restorative services for 6 residents.
A	278	E	Failed to accurately code the comprehensive assessment MDS relating to Nursing Rehabilitation/Restoration Care for 3 residents.

Type	Tag	S/S	Description
A	278	F	Failed to accurately code MDS assessments for 6 of 6 sampled residents identified by the facility roster/matrix as being dehydrated.
A	279	D	Failed to develop 2 resident care plans to reflect current needs or problems.
A	279	D	Failed to develop CCP related to behavior monitoring/interventions for a history of suicidal ideation for 1 resident of 15 sampled.
A	279	D	Failed to develop care plans for 2 sampled receiving psychotropic medications and exhibiting active mood swings and behavior issues.
C	279	D	Failed to develop a CCP related to a skin tear that required a physician's care for 1 resident.
C	279	D	Failed to provide correct transfer technique per 1 resident's comprehensive care plan.
A	279	E	Failed to develop the care plan to reflect current needs or identified MDS problems for 5 of 12 sampled residents.
A	279	E	Failed to develop care plan problems and interventions for ongoing pain for 3 of 9 residents sampled.
A	279	E	Failed to develop 3 resident Comp Care Plans to address needs, including relationships between residents.
A	280	D	Failed to 1) Update care plan for diet for 1 sampled. 2) update care plan to include intervention for wound/skin condition for 1 sampled.
A	280	D	Failed to review/revise the CCP to accommodate needs for 1 resident and to revise CCP relating to the change in status, needs and service for 1 resident.
A	280	D	Failed to review/revise the CCP to ensure accuracies regarding transfers for 1 resident.
A	280	D	Failed to update the care plan to reflect the current needs for 1 current resident related to skin care, anxiety and heartburn.
A	280	D	Failed to revise/update CCP to reflect problems and provide appropriate and timely interventions for 2 of 13 sampled.
A	280	D	Failed to develop a care plan for transfer technique with use of oxygen for 2 residents. Failed to review/revise CCP for nutritional intervention to prevent additional weight loss.
A	280	D	Failed to revise care plan interventions for 2 resident of 9 sampled with declines in mood and behavior symptoms.
A	280	D	Failed to review/revise the CCP for one resident on a quarterly basis or with a change of condition or service.
A	280	D	Failed to revise and update CCP to reflect that a resident was noncompliant with the diet order.
A	280	D	Failed to revise Comp Care Plan to reflect ambulatory need for 1 resident.
A	280	E	Failed to update and follow the care plan to reflect the current needs for 5 of 23 sampled.
A	280	E	Failed to ensure RCP interventions & goals were reviewed & revised to include hydration needs for 4 residents at risk.
A	281	D	Failed to ensure that medications are properly administered via g-tubes according to accepted standards for 2 residents.
A	281	D	Failed to ensure that oxygen was administered as ordered by the physician for 1 resident of 20 sampled.
A	281	D	Failed to ensure physicians orders for routine medications & treatment were followed for 2 of 9 sampled.
A	281	D	Failed to follow physician orders in administering medication as ordered for 2 residents
C	281	D	Failed to follow physicians orders for administering a routine medication for 1 of 5 sampled.
A	281	D	Failed to follow standards of practice to ensure that residents swallowed administered medications.
A	281	D	Failed to follow physician's orders for 1 resident.

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A	281	D	Failed to follow physician's order for 1 resident and failed to assess/implement interventions according to nursing standards to treat 1 resident's low blood sugar levels.
A	281	D	Failed to ensure physician orders were followed for 1 current resident in the administration of oxygen at ordered letter level.
A	281	D	Failed to perform complete cleansing of the tracheostomy stoma for 1 resident.
A	281	D	Failed to ensure that physician orders were met for one resident's individualized needs.
A	281	D	Failed to ensure that 2 residents dressing changes were completed utilizing aseptic technique according to SOP.
A	281	D	Failed to get a physician order for replacing g-tube for 1 resident.
C	281	D	Failed to ensure nurses completed neurological checks as indicated per nursing standards of practice and facility policy for 2 of 4 sampled.
A	281	D	Dietary staff failed to assess 1 resident of 10 sampled.
A	281	D	Failed to follow physician's orders for 1 resident that resulted in a 2% medication error rate and failed to follow universal precautions for blood glucose testing for 3 residents.
C	281	D	Failed to ensure that physician orders were followed for 2 non sampled resident.
C	281	D	Failed to ensure that physician orders were followed for 1 sampled resident.
A	281	E	Failed to ensure disposable gloves were used for injections for 2 of 4 sampled.
A	281	E	Failed to 1) ensure physician orders were followed for 2 sampled, 2) ensure that the medication nurses checked the prescription label with the physician's orders at least 3 times per nursing standards to reduce risk of medication errors for 3 non sampled.
A	281	E	Failed to provide medications as ordered by physician for 1 of 10 sampled and to provide a system and policy to assess each residents individual needs related to swallowing of medications for 3 of 10 sampled.
A	281	E	Failed to ensure medications were documented immediately after administration for 4 residents; Failed to observe the actual swallowing of medications for 2. med cart was locked and failed to ensure safely as an insulin syringe was carried in hallway.
A	281	E	Failed to follow physician's orders regarding medications, lab testing and treatments for 10 of 14 sampled.
A	282	D	Failed to ensure that care plan interventions were implemented regarding the use of a hearing aid for 1 resident of 20 sampled.
A	282	D	Failed to implement the care plan approaches to reduce the risk of dehydration for 2 current sampled residents dependent on the staff for eating and drinking.
A	282	D	Failed to implement care planned interventions regarding nutrition for 1 resident with significant weight loss.
A	284	D	Failed to develop a post discharge plan of care for 1 resident regarding anticipated discharge to different level of care.
A	309	D	Failed to provide care & treatment for 1) 1 resident with skin wounds. 2) 1 resident with symptoms of hypoglycemia.
A	309	D	Failed to track 1 resident wandering behaviors. Failed to develop/implement interventions to prevent resident from wandering into other residents' rooms.
C	309	D	Failed to follow policies and procedures by having a nurse aide report a fall to a charge nurse for 1 resident so they could receive follow up care after resident was found on the floor.
A	309	D	Failed to assess & promote 1 resident's bowel elimination pattern & to assess 1 residents blood glucose status.
A	309	D	Failed to track and failed to develop and implement interventions for 1 residents physically abusive, threatening verbalizations and exit seeking behaviors.

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C	309	D	Failed to assure staff completed assessments after a fall for 1 resident of 3 residents reviewed who had falls and sustained injury.
A	309	D	Failed to implement their bowel protocol to prevent potential bowel complications for 1 resident or 23 sampled.
C	309	D	Failed to have a physical assessment of the residents (1's) condition after resident (2) was lying in the bed at 4:00 AM.
A	309	D	Failed to promote skin integrity & prevent injury.
A	309	D	Failed to assess, monitor and obtain treatment orders to promote healing for areas of skin breakdown for 1 of 20 sampled.
A	309	D	Failed to assess and provide treatment plan for pain issues for 1 discharged resident and failed to assess and document skin wounds for 2 sampled residents.
C	309	D	Failed to thoroughly assess and provide care for a resident after a fall with injuries for 1 of 4 sampled.
A	309	D	Failed to provide interventions to promote healing of skin issues for 1 resident of 11 sampled.
C	309	D	Failed to evaluate casual factors related to wandering behaviors and to evaluate placement from secured to general population for 1 resident.
A	309	D	Failed to ensure that bowel management interventions were followed to prevent bowel problems for 1 of 12 sampled.
A	309	D	Failed to develop, implement and re-evaluate interventions to address the aggressive, resistive & sexual inappropriate behavior.
A	309	G	Failed to provide pain management to reduce pain during routine care for 1 resident.
A	309	G	Failed to ensure that interventions to minimize pain during cares were implemented for 1 resident and failed to develop/implement non-pharmacological interventions for 2 residents.
A	311	D	Failed to provide services to prevent a potential for decline in ambulation for one resident.
A	312	E	Failed to provide complete pericare for 3 residents of 10 sampled.
A	312	E	Failed to ensure that skin was cleansed in a manner to be free of urine/BM following incontinent episodes for 4 residents.
A	314	D	Failed to 1) ensure treatment for pressure ulcer was completed to prevent potential infection and contamination for 1 resident. 2) ensure pressure ulcers were assessed to determine depth of wound and progress towards healing.
A	314	D	Failed to ensure the elbow protectors were in place to promote healing of pressure ulcer on 1 resident.
A	314	D	Failed to ensure a resident who enters facility without pressure sores does not develop sores unless condition is unavoidable.
A	314	D	Failed to provide new interventions to promote the healing of a pressure ulcer for 1 resident of 17 sampled.
A	314	D	Failed to ensure a resident who enters facility without pressure sores does not develop sores unless condition is unavoidable.
A	314	D	Failed to assess causative factors and nutritional needs for wound healing for 1 resident and to assess and monitor skin condition for 1 resident.
A	314	D	Failed to ensure a resident who enters facility without pressure sores does not develop sores unless condition is unavoidable and a resident having sores is treated, to promote healing, prevent infection and prevent new sores.
A	314	H	Failed to plan nutritional interventions with input of resident; to monitor/revise nutrition to promote healing of pressure sores and failed to assess and perform dressing changes to promote healing and prevent new sores from developing.
A	315	D	Failed to ensure that 1 resident was evaluated/assessed to ensure that catheter placement was most appropriate intervention prior to placement of the indwelling catheter.
A	315	D	Failed to 1) insure catheter tubing kept off floor/lift for 3 residents. 2) urine catheter drainage bags were below the level of bladder for 2 residents. 3) ensure proper perineal care. 4) proper irrigation of suprapubic catheter.

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A	315	D	Failed to provide catheter care interventions to reduce risk for urinary tract infection for 1 resident of 9 sampled.
A	315	D	Failed to provide pericare in a manner to prevent potential urinary tract infections for 2 residents of 10 sampled.
A	315	D	Failed to provide supporting diagnosis for the use of an indwelling catheter for 1 current resident.
A	315	D	Failed to ensure that 1 resident's skin was free of urine following an incontinent episode.
A	315	D	Failed to evaluate the need for continued use of an indwelling catheter for 1 resident.
A	315	D	Failed to provide perineal care in a manner to prevent urinary tract infection for 2 residents.
A	315	D	Failed to assess medically related indications for the use of an indwelling catheter for 1 resident of 20 sampled.
A	315	D	Failed to provide personal cares in a manner to prevent a potential urinary infection for 2 residents.
A	315	D	Failed to ensure a resident entering facility without indwelling catheter is not catheterized unless clinically necessary and a resident who is incontinent of bladder receives appropriate care.
A	315	D	Failed to follow policies and procedures for urinary catheter flushes for 1 resident.
A	315	E	Failed to ensure that toileting plans were developed and implemented for 1 incontinent resident based on individual needs.
A	315	E	Failed to ensure pericare was performed in a thorough manner to prevent potential urinary tract infection for 2 residents.
A	318	D	Failed to provide restorative services in a manner to prevent potential decline in ROM for 3 residents of 18 sampled.
A	322	D	Failed to elevate the head of bed for 1 resident with a gastrostomy feeding tube to prevent potential complication for 1 resident.
A	322	D	Failed to ensure that 1 resident received G/J tube medications were administered per policy/procedure.
A	322	D	Failed to follow procedural technique for the administration of medications per gastrostomy tube for 3 residents.
A	322	D	Failed to ensure medications administered through a G-tube were administered according to standards of practice for one resident.
A	322	D	Failed to provide appropriate treatment and services to 1 resident with a g-tube.
A	322	E	Failed to provide appropriate treatment & services to 2 residents with g-tubes.
A	323	D	Failed to ensure that an exit door in the dining room was maintained in a secure manner to prevent the potential elopement of 3 residents who had been identified as exit seeking.
A	323	D	Failed to ensure that the plan of care was followed for 1 resident of 10 sampled.
A	323	D	Failed to implement identified interventions to prevent falls for 2 of 13 sampled.
A	323	D	Failed to assess for casual factors and make changes in the care to prevent falls and failed to provide supervision to a resident to prevent a fall with injury.
A	323	D	Failed to investigate potential causal factors; re-evaluate effectiveness of existing interventions and implement new interventions as a measure to prevent injuries from falls for 2 residents of 15 sampled.
A	323	E	Failed to identify/implement interventions to prevent an elopement for 1 resident; failed to practice safe transfer techniques for 1 resident; to implement interventions to prevent falls for 2 residents.
A	323	E	Failed to replace hand cranks, located at the foot of the bed, underneath the foot-board frame.

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C	323	E	Failed to ensure that 1) interventions were in place to prevent elopement 2) ensure lab equip. was secure from residents 3) ensure safe & comfortable transfers for 4 residents.
C	323	E	Failed to ensure that the facility monitoring system was in place for 6 of 16 exit doors and/or monitored areas to prevent elopement for the 11 residents indentified as at risk and wearing bracelet tracking devices.
C	323	G	Failed to protect 2 residents from thermal injuries.
A	323	G	Failed to protect residents from injuries and ensure environment was safe to prevent accidents with injuries from occurring for 2 residents.
A	325	D	Failed to monitor nutrition interventions for 1 resident with unplanned weight loss of 20 sampled.
A	325	D	Failed to evaluate the cause of a weight loss, assess, monitor and evaluate nutritional interventions for 1 resident.
A	325	D	Failed to assess/implement interventions to prevent weight loss for 2 residents. Failed to obtain physicians orders to prevent further weight loss for 1 resident.
A	325	D	Failed to assess the nutritional value of food items for potassium content and failed to evaluate a resident for interventions to treat a critically high lab result of potassium.
A	325	D	Failed to assess residents' food likes and dislikes in planning effective nutritional interventions, failed to implement/revise planned interventions for resident with weight loss. Failed to follow diet order for 1 resident at risk for aspiration.
A	325	D	Failed to plan & monitor oral nutritional interventions for a resident with a daily tube feeding, depressed albumin & history of gradual weight loss.
A	325	G	Failed to ensure a resident 1) maintains acceptable nutritional status and 2) receives a therapeutic diet when there is a problem.
A	325	H	Failed to assess residents' food likes and dislikes in order to plan effective nutritional interventions, failed to implement, monitor, and revise nutritional interventions for residents with weight loss, low albumin and impaired skin integrity.
A	327	D	Failed to ensure that a dependent resident that received thickened liquids received sufficient fluids to prevent dehydration.
A	327	D	Failed to monitor a resident with a fluid restriction to ensure that the resident's hydration needs were met for 1 resident.
A	327	D	Failed to implement interventions to prevent potential for dehydration for 1 resident.
A	327	D	Failed to ensure that one resident received sufficient oral fluid intake to maintain adequate hydration.
A	327	D	Failed to monitor the actual fluid intake for a resident with orders of fluid restriction to ensure that the residents hydration needs were met.
A	327	D	Failed to ensure that 2 residents received adequate fluid intake based on their individual assessed needs.
A	327	D	Failed to provide adequate hydration to a resident at high risk for dehydration with signs and symptoms of dehydration.
A	327	E	Failed to ensure that 7 residents were re-evaluated for fluid needs and to ensure sufficient fluid intake was received to meet those needs.
A	329	D	Failed to: 1) Implement non-pharmacological interventions prior to use of psychoactive medications; 2) evaluate causal factors regarding need for psychoactive meds and 3) evaluate effectiveness of the meds for 3 residents.
A	329	D	Failed to ensure that residents not using antipsychotic drugs are not given unless specific condition diagnosed and recorded.
A	329	D	Failed to ensure residents not using antipsychotic drugs unless therapy is necessary as diagnosed & documented on record.
A	329	D	Failed to ensure residents not using antipsychotic drugs are not given unless therapy is necessary to treat as diagnosed and documented.
A	329	D	Failed to ensure non pharmacological interventions were implemented before an anti anxiety medication was administered for 2 residents and failed to assess the medications effectiveness after initiation.

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A	329	D	Failed to ensure that residents not on antipsychotic drugs are not given unless diagnosed and documented that it is necessary.
A	329	D	Failed to initiate non pharmacological interventions prior to medicating 1 resident with psychoactive medication.
A	329	D	Failed to ensure that non pharmacological interventions were tried prior to the administration of prn psychotropic medications for 2 residents.
A	329	D	Failed to ensure residents who have not used antipsychotic drugs are not given those drugs unless condition is diagnosed/documentated that it is necessary.
A	329	D	Failed to ensure that residents not on antipsychotic drugs are not given unless diagnosed and documented that it is necessary.
A	329	E	Failed to ensure that non-pharmacological interventions were provided prior to the use of anti-psychotic medications for 4 residents and that sleep assessments were completed/utilized provide atmosphere conducive to sleep without meds for 2 residents.
A	329	E	Failed to ensure that non-pharmacological interventions were implemented prior to the use of PRN psychoactive meds for 3 residents. Failed to review effectiveness of sedative-hypnotic meds for 1 resident.
A	332	D	Failed to administer medications to 1 resident at a error rate of less than 5%.
A	332	D	Failed to ensure facility is free from medication error rates of 5% or greater.
A	332	E	Failed to follow signed physician's orders and pharmacy recommendations for medications administered creating an error rate of 14% involving 6 medications out of 41 observed affecting 3 residents.
A	332	E	Failed to ensure medications were prepared/administered at less than a 5% error rate for 1 resident. & failed to administer within the correct time frame for 2 residents.
A	333	D	Failed to administer medications as ordered by the physician and failed to ensure 1 resident was free from medication error related to insulin.
A	333	E	Failed to prevent significant medication errors for 3 residents of 14 sampled.
C	333	G	Failed to ensure 1 resident of 9 sampled was free from significant medication error.
A	356	C	Failed to 1) post the daily staffing in a clearly identifiable and readable format and 2) accurately post staffing hours and resident census.
A	362	F	Failed to ensure that the dietary department was managed to ensure quality of food services.
A	363	D	Failed to follow recipes while preparing pureed food items to ensure daily nutritional requirements were met.
A	363	E	Failed to ensure that the milk portion of the regular menu and the milk and bread portion of the Pureed menus was followed.
A	363	E	Failed to follow the menu by: 1) Omitting food items listed on the menu for residents utilizing the Assisted Dining Room and 2) preparing pureed foods per written menu instructions for 2 residents.
A	363	E	Failed to follow recipes while preparing pureed food items to ensure resident daily nutritional requirements were met.
A	363	E	Failed to ensue that: a) the protein portion of regular and consistent carb menu was followed; b) all residents were offered all selections on the menu; c) the residents on the Consistent Carb diets for diabetes control received the items on the menu.
A	363	E	Failed to follow recipes while preparing pureed food items to ensure resident daily nutritional requirements are met.
A	363	F	Failed to ensure that nutritional needs of 5 of 5 residents with puree diets orders were met.
A	364	E	Failed to provide residents with food that was at a palatable temperature and texture.
A	364	E	Failed to serve sandwiches that were attractive and palatable.
A	364	E	Failed to prepare pureed foods using methods to conserve the nutritive value of the food.

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A	364	E	Failed to prepare food in an attractive & palatable regarding excessive vegetable juices causing other food on plates to become wet and soggy.
A	365	D	Failed to ensure that pureed foods were prepared to appropriate consistency.
A	365	D	Failed to ensure that pureed foods were prepared to an appropriate consistency.
A	365	D	Failed to prepare pureed food in a manner to meet the resident needs for 1 of 15 sampled.
A	365	E	Failed to ensure that pureed foods were of smooth in consistency to prevent potential chewing or swallowing problems.This affected the 5 residents on a pureed diet.
A	366	E	Failed to ensure that a meal substitution for the main entrée was of similar nutritive value for 4 of 10 sampled.
A	367	E	Failed to ensure that all the pureed foods were of smooth consistency for 8 residents of 13 sampled.
A	367	E	Failed to ensure that foods were the appropriate consistency.
A	368	F	Failed to ensure that 3 substantial meals were offered to residents daily and at times recognized as normal meal times.
A	369	D	Failed to provide a specialized adaptive plate for 1 resident to maintain or improve independent eating ability.
A	371	E	Failed to cover food that was transported to resident's in their rooms.
A	371	E	Dietary Staff repeatedly failed to use gloves when preparing food.
A	371	E	Failed to provide a hand wash sink in the AU memory care large dining room and to ensure no bare hands contact with ready to eat food.
A	371	E	Failed to maintain the cleanliness of the kitchen for 2 of 6 residential houses.
C	371	E	Failed to clean and sanitize containers and carts used to transport and deliver ice for resident consumption.
A	371	F	Failed to ensure that ice machine & cappuccino machine were free from buildup & debris and that kitchen cabinet was free from rodent excrement.
A	371	F	Failed to cool potentially hazardous foods safely, hold foods at safe temperatures and clean ice cream machine at required frequency.
A	371	F	Failed to store & prepare foods using sanitary conditions by using contaminated gloves and unclean equipment.
A	371	F	Dietary Dept. failed to 1) wash hands after handling raw eggs 2) that dietary equip was clean to sight and touch and 3) that food in the Special Care Unit were labeled and dated.
A	371	F	Failed to ensure that food at the buffet table was protected and that serving scoops were cleaned.
A	371	F	Failed to 1) follow policies/food code for proper hand washing and 2) revise the facility policy to reflect current sanitation practices for the 3 compartment sink used to sanitize utensils and food prep equip to ensure adequate sanitation is obtained.
A	371	F	Failed to cool potentially hazardous food in an appropriate manner.
A	371	F	Failed to ensure proper sanitation of food preparation surfaces and to ensure bare hand contact did not occur with ready to eat food for 3 residents.
A	371	F	Dietary Dept. failed to follow policies/food code requirements for hand washing.
A	371	F	Dietary department failed to wash hands when soiled; failed to cleanse probe thermometers prior to insertion and failed to ensure milk temperatures were at appropriate levels to prevent potential bacterial growth.
A	371	F	Failed to immerse kitchen equip. in sanitizing rinse for time required by mfg.
A	371	F	Failed to ensure that potentially hazardous foods were reheated and held at required temperatures.

Type	Tag	S/S	Description
A	371	F	Failed to ensure dishwasher was sanitizing dishes according to mfg recommendations.
A	371	F	Failed to ensure that culinary sinks were indirectly drained and failed to follow manual dishwashing pro procedures.
A	371	F	Failed to 1) label and date foods 2) to prevent cross contamination when setting tables 3) to pass ice water to the residents in a clean manner.
A	371	F	Failed to ensure that the drain system for the ice machine was installed according to approved standards.
A	371	F	Failed to cover trash receptacles in the kitchen and failed to cover food items and beverages to protect from potential contamination until served.
A	371	F	Failed to ensure: a) staff not wear nail polish when handling clean equip/food; b)handle foods to avoid contact with ready to eat foods; c) to handle equip to prevent contamination of contact surface of tableware d)maintain clean ref/storeroom vent fans.
A	371	F	Failed 1) to ensure cooking ingredients did not contain contaminants 2) to label bulk foods & 3) that preset cups of water were protected from contamination.
A	371	F	Dietary Dept: 1) failed to label and date opened foods; 2) failed to pass ice water to residents in a manner to prevent the spread of infections.
A	372	C	Failed to dispose of garbage and refuse in covered dumpsters.
A	425	D	Failed to ensure that multidose insulin vials were dated when opened for 1 non sampled resident.
A	425	D	Failed to ensure that a multidose insulin vial was sated when opened for 1 non-sampled resident.
A	425	E	Failed to ensure that medications were available for administration to 6 of 11 sampled.
A	428	D	Failed to ensure that the consultant Pharmacist continued to review and take action as a response to indentified medication irregularities for 1 resident.
A	428	D	Failed to request medication review of duplicate diuretic therapy following an abnormal lab result for 1 of 9 sampled.
A	428	D	Failed to ensure that the Consultant Pharmacist indentified irregularities regarding the use of medications above the recommended dose for 1 resident and for longer than the mfg recommended guidelines for 1 resident.
A	431	E	Failed to date 2 stock medications when opening the bottles.
A	431	E	Failed to secure the medication cart to prevent unauthorized persons from access to resident medications for 1 of 3 med carts used.
A	431	E	Failed to ensure that the medication room was secured with access only to authorized personnel.
A	441	D	Failed to store resident care equipment in a manner to reduce the risk of contamination for 1 of 9 sampled.
A	441	D	Failed to ensure that infection control practices were followed during transfer of 1 resident.
A	441	D	Failed to clean the sit to stand lift between use by 3 residents.
A	441	E	Failed to ensure that whirlpool tubs were cleaned and sanitized in accordance with facility policy and mfg guidelines.
A	441	E	Failed to provide perineal care in a manner to reduce the risk of contamination for 4 of 12 sampled.
A	441	E	Failed to ensure that whirlpool tubs were cleaned according to Mfg recommendations.
A	441	E	Failed to assure blood glucose testing equipment was sanitized between resident use for 3 of 11 sampled.
A	441	F	Failed to clean and sanitize 2 whirlpool tubsfollowing baths. Potential to affect 34 residents.
A	442	D	Failed to ensure treatment and dressing changes for pressure ulcers was completed to prevent potential infections and that ulcers were assessed to determine degree of tunneling for progress of healing.

Type	Tag	S/S	Description
A	442	D	Failed to identify residents personal hygiene items with specific information to prevent potential cross-contamination for 2 residents.
A	442	D	Failed to follow infection control guidelines for 1 resident who had MRSA infection of the urine.
A	444	D	Failed to follow clean technique for hand washing hygiene to prevent spread of potential infections for 2 residents.
A	444	D	Failed to ensure care items were not contaminated by staff during pericare for 1 resident.
A	444	D	Failed to 1) wash hands after providing personal care, 2) to wash hands after administering a medication and 3) failed to change gloves when providing treatment for 1 resident.
A	444	D	Failed to utilize hand washing and gloving techniques to prevent cross-contamination during personal care for 2 residents.
A	444	E	Failed to ensure nursing staff washed their hands or used gel when ice water was passed to the residents in water pitchers and failed to follow infection controls by storing distilled water on the floor.
A	444	E	Failed to 1) thoroughly wash hands before and after providing personal cares for 4 residents and 2) to perform hand hygiene during medication administration for 1 resident.
A	444	E	Failed to that staff washed hands when indicated during administration of medications.
A	444	E	Failed to ensure that staff performed hand washing when required after resident contact for 3 of 11 sampled.
A	445	E	Failed to ensure that residents' personal laundry was processed in a sanitary manner.
A	445	F	Failed to ensure that residents' personal clothing was processed in a sanitary manner.
A	445	F	Failed to process residents' personal laundry in a sanitary manner.
A	455	J	Failed to identify the need for and obtain an emergency power source to ensure that 1 resident requiring deep suctioning would receive procedure in event of power outage.
A	460	E	Failed to ensure that full visual privacy curtains were provided in 6 or 15 sampled multi-bed rooms.
A	460	E	Failed to ensure that 4 of 8 sampled semi-private rooms were equipped to afford full visual privacy for residents.
A	465	C	Failed to maintain a functional environment as there was excess frost on 2 freezers and not on routine cleaning schedule.
A	465	D	Failed to ensure that the device used to crush medication was clean prior to usage.
A	465	D	Failed to maintain 3 medication crushers in a clean manner.
A	465	E	Failed to ensure handrails on wall next to nurses station were in good repair, failed to ensure tub room floor was clean and in good repair and to ensure wheelchair armrest were in good repair.
A	465	E	Failed to maintain the cleanliness of 2 medication carts and 1 treatment cart of 4 total carts used.
A	465	E	Failed to maintain in a sanitary/orderly condition, floors, vents, doors in, MDS Office, Service Closet, Staff Restroom, Oxygen supply closet and Boiler Room and the outside parameter of the building.
A	465	F	Failed to keep kitchen floor free of build up of black and brown debris in a food prep and dish clean up areas.
A	465	F	Failed to maintain facility in a functional, sanitary & comfortable manner. Dust/soil buildup on vent covers, gouged walls and exposed corner beading, laundry linen table broken, debris & water on storage room floor.
A	490	G	Administrator failed to utilize facility recourses to achieve/maintain highest practical well-being of each resident by failure to implement plan to correct previous deficiencies; to identify & develop plans of action to identify multiple deficiencies.

Type	Tag	S/S	Description
A	497	F	Failed to assure that 18 nursing assistants had a minimum of 12 hours of continuing in-service education.
A	498	F	Failed to assure that nursing assistants demonstrated competency in the skills necessary to provide care to residents.
A	502	D	Failed to obtain a blood sample for lab review timely when ordered by the physician for 1 sampled resident.
C	514	D	Failed to have documentation of a physical assessment after an incident of resident (1) being found in bed of resident (2) at 4:00 AM.
A	514	D	Failed to ensure medical record charts were accurately documented and complete related to the weight of 1 resident.
A	514	D	Failed to chart the effect of PRN medications used for pain control and anxiety for 1 of 20 sampled.
A	514	D	Failed to ensure the medical chart documentation was accurate and complete for 2 of 10 sampled.
C	514	D	Failed to document 1) administration of insulin and blood glucose testing for 1 resident. 2) accurately document placement of a wander guard device for 1 resident.
A	514	E	Failed to ensure complete documentation relating to individual narcotic count records for 6 residents of 22 sampled.
A	514	E	Failed to provide completed documentation for 9 of 23 sampled residents.
A	514	E	Failed to complete documentation related to refusals of a skin treatment for 1 resident of 9 sampled.
A	514	E	Failed to provide completed documentation for 6 of 12 sampled residents.
A	514	E	Failed to ensure clinical records for 4 residents were complete, legible & systematically organized.
A	514	E	Failed to assure clinical records were accurately documented for 5 of 14 sampled.
A	514	E	Failed to ensure that residents' medical records contained accurate documentation of skin issues and physicians' orders for 3 of 11 sampled.
A	514	E	Failed to accurately document medication on record for 3 of 10 sampled. Staff failed to obtain doctor order to release the body of an expired resident. Failed to complete the RAP for 1 of 10 sampled.
A	520	E	Failed to identify quality deficiencies and failed to implement a quality improvement program for repeat deficiencies.
A	520	F	Failed to ensure that repeated deficiencies at F279, F250, F314, F323, F365, F371 and F325 were corrected and the corrections maintained.
A	520	G	Failed to ensure that previously cited deviancies at F157, F164, F166, F280, F309, F323, F325, F327, F490, F514 and F520 were corrected during past year and corrections maintained.
A	K017	E	Failed to provide proper corridor separation for the physical therapy rooms.
A	K025	E	Failed to maintain proper smoke barriers i.e. self closing doors etc.
A	O127	O	Failed to ensure that the dietary manager had the required qualifications.
A	O128	O	Failed to ensure that the director of food service had the qualified job requirements.
A	O128	O	Failed to ensure that the dietary manager had the required qualifications.
A	O194	O	Failed to ensure that medications were documented immediately after being given for 6 or 10 sampled.
A	O212	O	Failed to ensure 2 staff members initial separate medication control count sheets for each scheduled II and III controlled substance with each change in shift/staff.
A	O215	O	Failed to ensure that outdated medications were not available for use for 3 residents of 22 sampled.
A	O219	O	Failed to ensure medications were disposed of according to policy for 2 residents.

Type	Tag	S/S	Description
A	O231	O	Failed to obtain resident or responsible party acknowledgment that personal items of inventory had been accounted for at admission and/or discharge for 4 residents of 20 sampled.
A	O231	O	Failed to maintain an inventory of residents personal items.
A	O231	O	Failed to have evidence that the possessions were accounted for upon discharge for 2 residents.
A	O260	O	Failed to ensure water delivered to bathing fixtures and beauty shop did not exceed 110 degrees.
A	O260	O	Failed to maintain the hot water temperature at hand washing sinks in 3 resident rooms.
A	O293	O	Failed to arrange the furniture providing a minimum of three feet between the heads of the beds in 7 resident rooms.

Count 343

Nursing Home Survey Data (2008-09)

CUMULATIVE FOR MONTHS SHOWN

Month	Annual	Revisit	Complaint	Total
<i>Prior-08</i>	1	0	0	1
<i>Sept-08</i>	11	1	5	17
<i>Oct-08</i>	17	0	4	21
<i>Nov-08</i>	14	0	4	18
<i>Dec-08</i>	15	0	4	19
<i>Jan-09</i>	14	1	6	21
<i>Feb-09</i>	19	0	6	25
<i>Mar-09</i>	20	0	6	26
<i>April-09</i>	16	0	4	20
<i>May-09</i>	5	0	3	8
<i>June-09</i>	0	0	1	1
TOTALS	132	2	43	177

QTR 3 TOTALS

S & S	Frequency
B	1
C	5
D	185
E	94
F	34
G	8
H	2
J	1
O	13
Total	343

Nursing Home Survey Data (2008-2009)

Quarter 3

Scope and Severity	Tag	Freq.	Scope and Severity	Tag	Freq.
E	157	2	F	156	2
	164	1		278	1
	166	1		362	1
	225	1		363	1
	241	1		368	1
	246	1		371	20
	248	1		441	1
	253	9		445	2
	254	1		465	2
	272	2		497	1
	278	2		498	1
	279	3		520	1
	280	2		Total F Tags	34
	281	5		G	309
	312	2	323		2
	315	2	325		1
	322	1	333		1
	323	4	490		1
	327	1	520		1
	329	2	Total G Tags		8
	332	2	H		314
	333	1		325	1
	363	5	Total H Tags	2	
	364	4	J	455	1
	365	1		Total J Tags	1
	366	1	Total Tags	137	
	367	2			
	371	5			
	425	1			
	431	3			
441	4				
444	4				
445	1				
460	2				
465	3				
514	8				
520	1				
Total E Tags	92				

Qtr 3 Federal Fiscal Year 2009 Nebraska Nursing Home Survey Data

Top 20					
Total Citations:	343				
Total Surveys:	56				
Rank	Tag #	Regulation Text	Reg Grouping	# Cites	Frequency of Cite
1	371	Procure food from sources approved and store, prepare, distribute and serve food under sanitary conditions.	Dietary Services	25	45%
2	281	Services must meet professional standards of quality	Resident Assessment	23	41%
3	309	Highest practicable physical, mental, and psychosocial well-being care.	Quality of Care	18	32%
4	253	Housekeeping & maintenance to maintain sanitary, orderly & comfortable environment	Quality of Life	14	25%
4	315	No indwelling catheter unless unavoidable; incontinent treatment & services to prevent UTI's & restore function	Quality of Care	14	25%
5	514	Clinical records by SOP & are complete, accurately documented, readily accessible & systematically organized	Administration	13	23%
6	280	CCP developed within 7 days after comprehensive assessment; periodically reviewed and revised	Resident Assessment	12	21%
7	329	Each resident's drug regimen must be free from unnecessary drugs	Quality of Care	12	21%
8	323	Resident environment remains as free from accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.	Quality of Care	11	20%
9	157	Facility must immediately inform the resident, their physician and resident's legal representative or an interested family member when there is any changes.	Resident Rights	10	18%
9	225	Not employ staff guilty of abuse; ensure all alleged violations reported	Resident Behavior and Facility Practices	8	14%
9	279	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	Resident Assessment	8	14%
10	314	Pressure sore treatment & services	Quality of Care	8	14%
10	325	Based on a comprehensive assessment, facility must ensure resident maintains acceptable parameters of nutritional status or receives therapeutic diet.	Quality of Care	8	14%
10	327	The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	Quality of Care	8	14%
11	441	Establish and maintain an infection control program	Infection Control	8	14%
11	444	Staff wash hands after each direct resident contact	Infection Control	8	14%
12	465	Safe, functional, sanitary, and comfortable environment	Physical Environment	8	14%
12	363	Meet the nutritional needs of residents in accordance w/ RDA	Dietary Services	7	13%
12	278	The assessment must accurately reflect the resident's status.	Resident Assessment	6	11%
12	322	A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to avoid complications.	Quality of Care	6	11%