

Quarterly IJ Summary Report October 2021 – December 2021

The following report presents information regarding all tags cited at the Immediate Jeopardy (IJ) level during licensing and certification surveys and complaint or incident investigations performed in nursing facilities during the fourth quarter of 2021 (10/01/2021 – 12/31/2021).

Immediate Jeopardy is “a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident” (42 CFR 489.3).

During this period, an IJ level tag was cited for forty-three of the surveys and investigations conducted, resulting in fifty-seven citations of nineteen unique federal tags. The following tables provide the percentage at which each unique tag was cited (Table 1), the percent of IJs per nursing facility (NF) by region (Table 2) and the number of IJs per type of investigation (Table 3).

Descriptions of the situations and the deficient practices are derived from each event's *Form CMS-2567 - Statement of Deficiencies and Plan of Correction*, which is available to the public through a Freedom of Information Act (FOIA) request.

Table 1

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
578	2%	684	23%
580	7%	880	12%
600	7%	689	12%
607	4%	686	11%
610	2%	580	7%
678	4%	600	7%
684	23%	607	4%
686	11%	695	4%
689	12%	678	4%
692	2%	925	2%
695	4%	770	2%
726	2%	757	2%
740	2%	740	2%
741	2%	726	2%
757	2%	741	2%
770	2%	578	2%
801	2%	801	2%
880	12%	692	2%

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
925	2%	610	2%

*Rounded to the nearest tent

Table 2

Region	# of IJs	# of NFs	% of IJs/NF
1	1	88	1.14%
2	4	135	2.96%
3	14	230	6.09%
4	7	192	3.65%
5	8	188	4.26%
6	16	171	9.36%
7	7	223	3.14%
Total	57	1227	4.65%

**Table 3
Number of IJs**

from Complaints	from Incidents	from Surveys	Total
28	4	11	43

Tag References

483.10 – Resident Rights:

- 578 Request/Refuse/Discontinue Treatment; Formulate Adv. Directives
- 580 Notification of Changes (Injury/Decline/Room, Etc.)

483.12 - Freedom from Abuse, Neglect, and Exploitation:

- 600 Free from Abuse and Neglect
- 607 Develop/Implement Abuse/Neglect, etc. Policies
- 610 Investigate/Prevent/Correct Alleged Violation

483.25 - Quality of Care:

- 678 Cardio-Pulmonary Resuscitation
- 684 Quality of Care
- 686 Treatment/Svcs to Prevent/Heal Pressure Ulcers
- 689 Free of Accident Hazards/Supervision/Devices
- 692 Nutrition/Hydration Status Maintenance
- 695 Respiratory/Tracheostomy Care and Suctioning

483.35 Nursing Services

726 Competent Nursing Staff

483.40 Behavioral Health Services

740 Behavioral Health Services

741 Sufficient/Competent Staff-Behav Health Needs

483.45 Pharmacy Services

757 Drug Regimen is Free from Unnecessary Drugs

483.50 – Laboratory, Radiology, and Other Diagnostic Services:

770 Laboratory Services

483.60 – Food and Nutrition Services:

801 Qualified Dietary Staff

483.80 – Infection Control:

880 Infection Prevention & Control

483.90 – Physical Environment:

925 Maintains Effective Pest Control Program

Acronyms

CPR – Cardiopulmonary Resuscitation

HHS – Health and Human Services

PPE – Personal Protective Equipment



TEXAS
Health and Human
Services

Region 2**Exit Date:** 10/04/2021**Purpose of Visit:** Complaint/Incident Investigation; Focused Infection Control Survey**Tags:** F880/N1713**Situations:** The facility failed to screen staff and visitors for signs of COVID-19.**Deficient Practice:** The facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment.**Region 6****Exit Date:** 10/06/2021**Purpose of Visit:** Complaint Investigation**Tags:** F686/N1450**Situations:** The facility failed to provide appropriate wound care to five residents with pressure ulcers, and failed to ensure staff had adequate processes, training, and supplies to provide wound care.**Deficient Practice:** The facility failed to provide the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice to prevent development and worsening of pressure ulcers.**Region 3****Exit Date:** 10/06/2021**Purpose of Visit:** Complaint/Incident Investigation; Focused Infection Control Survey**Tags:** F880/N1713**Situations:** The facility failed to screen staff and visitors for symptoms of COVID-19, failed to quarantine residents with known exposure, and failed to ensure access to and proper use of PPE.**Deficient Practice:** The facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment.**Region 7****Exit Date:** 10/06/2021**Purpose of Visit:** Complaint Investigation**Tags:** F684/N1446**Situations:** The facility failed to inform a resident's physician of abnormal radiology test results after the resident developed nausea and vomiting and had been receiving anti-nausea medication for three days. The resident was transferred to the hospital where they died.**Deficient Practice:** The facility failed to provide treatment and care in accordance with the comprehensive person-centered care plan and in accordance with professional standards of practice.**Region 5****Exit Date:** 10/08/2021

Purpose of Visit: Standard Survey

Tags: F686/N1449/N1450

Situations: The facility failed to ensure a resident admitted without pressure ulcers and at low risk for them received care to prevent the development of pressure ulcers. After the resident developed a pressure ulcer, the facility failed to provide adequate care and the wound deteriorated. The facility failed to provide adequate wound care for another resident assessed with a pressure ulcer, resulting in deterioration of the wound.

Deficient Practice: The facility failed to provide the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice to prevent development and worsening of pressure ulcers.

Region 3

Exit Date: 10/08/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F880/N1713

Situations: The facility failed to isolate residents who tested positive for COVID-19, leaving them in their rooms with residents who were negative for the disease.

Deficient Practice: The facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment.

Region 5

Exit Date: 10/09/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F925/N1804

Situations: The facility failed to ensure the building was free of pests. One resident was found with ants crawling on them, sustaining multiple ant bites, and developing cellulitis (bacterial skin infection that causes redness, swelling, and pain in the infected area).

Deficient Practice: The facility failed to maintain an effective pest control program.

Region 7

Exit Date: 10/11/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F607/N1286

Situations: The facility failed to investigate multiple incidents of abuse alleged against a staff member. The facility failed to do an adequate review of the staff member prior to employing them.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect.

Region 4

Exit Date: 10/14/2021

Purpose of Visit: Standard Survey

Tags: F580/N1131; F770/N1823



Situations: The facility failed to immediately inform a resident's physician after the resident had severe, prolonged seizures. The facility failed to monitor the resident's levels of anti-seizure medications, as ordered by a physician. The resident's stat labs were outside of the therapeutic range for the medications to be effective.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to ensure laboratory services were obtained to meet the needs of residents.

Region 2

Exit Date: 10/15/2021

Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey

Tags: F600/N1285; F686/N1449/N1450

Situations: The facility failed to properly assess, document, and treat a resident who developed pressure ulcers, resulting in deterioration of the wounds.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to provide the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice to prevent development and worsening of pressure ulcers.

Region 3

Exit Date: 10/16/2021

Purpose of Visit: Standard Survey; Focused Infection Control Survey

Tags: F686/N1450

Situations: The facility failed to properly assess, document, and treat pressure ulcers for four residents, resulting in deterioration of the wounds.

Deficient Practice: The facility failed to provide the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice to prevent development and worsening of pressure ulcers.

Region 3

Exit Date: 10/16/2021

Purpose of Visit: Complaint Investigation; Focus Infection Control Survey

Tags: F684/N1446

Situations: The facility failed to administer a resident's medication to treat their Parkinson's disease and to administer their ordered antibiotic medication for over forty hours after admission. The facility failed to properly care for the resident's PICC line (used to deliver medications and other treatments directly to the large central veins near the heart) which resulted in the resident needing a replacement PICC line.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 4

Exit Date: 10/21/2021

Purpose of Visit: Standard Survey



Tags: F695/N1468

Situations: The facility failed to ensure a resident had replacement tracheostomy supplies (inner cannulas or tracheostomy tubes) in the facility or at the bedside and a bag valve mask (handheld device used to provide rescue breaths during cardiac pulmonary resuscitation) at the bedside. The facility failed to ensure four residents oxygen concentrator filters were cleaned for 4 days.

Deficient Practice: The facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice.

Region 4

Exit Date: 10/22/2021

Purpose of Visit: Complaint Investigation

Tags: F600/N1283; F684/N1446

Situations: The facility failed to ensure that a resident received appropriate bathing and hygiene resulting in areas of irritation and inflammation, later diagnosed as yeast infections. The resident experienced extreme pain when moved resulting in a further lack of bathing, treatments, and incontinent care.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 5

Exit Date: 10/27/2021

Purpose of Visit: Standard Survey

Tags: F695/N1468

Situations: The facility failed to have a system in place for residents who utilized oxygen concentrators should the facility lose power, to have a contract with an oxygen company or have a designee that inventoried their oxygen tanks and ordered as needed and to ensure all staff were educated on where oxygen tanks were stored. The facility failed to educate staff to be aware of where the crash cart was at all times and to ensure all necessary supplies and a full oxygen tank were available on the crash cart.

Deficient Practice: The facility failed to ensure that residents who needed respiratory care were provided with such care, consistent with professional standards of practice.

Region 6

Exit Date: 10/30/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F580/N1132; F684/N1446

Situations: The facility failed to assess a resident after they had a change in condition experiencing low blood pressure, low oxygen levels, and lethargy. The facility failed to ensure all were aware of the resident's missed dose of blood pressure medications. The facility failed to perform comprehensive assessments for two residents who developed



elevated blood pressure. The facility failed to notify a resident's physician after they had a seizure.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 3

Exit Date: 11/05/2021

Purpose of Visit: Standard Survey; Focused Infection Control Survey

Tags: F686/N1449/N1450

Situations: The facility failed to properly assess, document, and treat a resident who developed pressure ulcers, resulting in deterioration of the wound, which developed necrosis (death of tissue). The facility failed to provide the physician ordered pressure ulcer treatments to two other residents.

Deficient Practice: The facility failed to provide the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice to prevent development and worsening of pressure ulcers.

Region 7

Exit Date: 11/05/2021

Purpose of Visit: Complaint Investigation

Tags: F678/N1321

Situations: The facility failed to immediately initiate CPR when a resident was found unresponsive. The resident was left unattended for more than four minutes. The facility failed to arrive with the AED and crash cart for fourteen minutes. The resident died at the facility.

Deficient Practice: The facility failed to provide basic life support, including CPR, to residents requiring such emergency care and subject to related physician orders and the residents' advance directives.

Region 6

Exit Date: 11/06/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F684/N1446

Situations: The facility failed to identify a resident's change in condition when they experienced lethargy and impaired communication and motor functions. The facility failed to address the resident's increased seizure activity.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 5

Exit Date: 11/08/2021

Purpose of Visit: Complaint Investigation; Focused Infection Control Survey

Tags: F757/N1666



Situations: The facility failed to take appropriate action in response to a critical lithium serum level for a resident who was receiving lithium (medication for bipolar disorder), had a recent increase in lithium dose, had a change in condition, and had an order that was not completed to repeat the test of lithium serum levels to validate the critical result prior to resuming the psychotropic medication. The resident was admitted to the hospital and was diagnosed with acute encephalopathy (damage or disease that affects the brain), altered mental state, hypercalcemia (a condition in which the calcium level in your blood is above normal), and lithium toxicity.

Deficient Practice: The facility failed to ensure each resident's drug regimen did not have an excessive dose, for an excessive duration, with inadequate monitoring

Region 6

Exit Date: 11/10/2021

Purpose of Visit: Standard Survey

Tags: F740/N1481

Situations: The facility failed to implement timely interventions after a resident expressed suicidal ideations. The failure continued until surveyor intervention.

Deficient Practice: The facility failed to provide the necessary behavioral health care and services to attain or maintain the residents highest practicable well-being.

Region 7

Exit Date: 11/12/2021

Purpose of Visit: Standard Survey; Focused Infection Control Survey

Tags: F689/N1476

Situations: The facility failed to implement interventions to prevent a resident with a history of exit-seeking behaviors from eloping from the facility. The facility failed to repair a malfunctioning door on the secured unit.

Deficient Practice: The facility failed to ensure adequate supervision was provided to prevent accidents.

Region 5

Exit Date: 11/24/2021

Purpose of Visit: Incident Investigation

Tags: F600/N1283

Situations: The facility failed to ensure a resident admitted from a psychiatric hospital with a history of violent behaviors received adequate supervision and did not engage in physical contact with others, including pushing, slapping, kicking, and choking.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect.

Region 7

Exit Date: 11/29/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F684/N1446; F726/N1492



Situations: The facility failed to ensure that a resident received wound care on their surgical wound, as ordered by a physician, which resulted in the resident requiring rehospitalization. The facility failed to provide the resident with their narcotic pain medication.

Deficient Practice: The facility failed to ensure that residents received treatment and care in accordance with the professional standards of practice and comprehensive person-centered care plan and failed to ensure the nursing staff had the competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain their highest practicable well-being.

Region 3

Exit Date: 12/01/2021

Purpose of Visit: Complaint/Incident Investigation; Focus Infection Control Survey

Tags: F880/N1713

Situations: The facility failed to isolate residents who tested positive for COVID-19, failed to ensure effective use of PPE, and failed to have a system in place for transporting residents who were positive for the disease.

Deficient Practice: The facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment.

Region 6

Exit Date: 12/06/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F689/N1477; F741/N1482

Situations: The facility failed to provide adequate supervision to residents in the memory care unit. One resident was not protected from physical and emotional harm after another resident physically assaulted them on two different occasions causing pain and fear of leave their room.

Deficient Practice: The facility failed to ensure adequate supervision was provided to prevent accidents and failed to ensure that staff who provided direct services to residents had the appropriate competencies and skills sets to assure resident safety and attain or maintain their highest practicable well-being.

Region 5

Exit Date: 12/06/2021

Purpose of Visit: Complaint Investigation

Tags: F684/N1446

Situations: The facility failed to ensure that staff were trained to properly monitor and care for a resident's Life Vest (device designed to detect certain life-threatening rapid heart rhythms and automatically deliver a treatment shock to save the patient's life). The facility did not perform proper assessments and upkeep with the device and failed to remove it when the resident was bathed, which could have resulted in electric shock.



Deficient Practice: The facility failed to ensure that residents received treatment and care in accordance with the professional standards of practice and comprehensive person-centered care plan.

Region 3

Exit Date: 12/09/2021

Purpose of Visit: Standard Survey

Tags: F689/N1477

Situations: The facility failed to implement effective interventions to prevent a resident from eloping. The resident eloped from a facility through a door in the kitchen and was not found for over eight hours.

Deficient Practice: The facility failed to ensure adequate supervision was provided to prevent accidents.

Region 6

Exit Date: 12/09/2021

Purpose of Visit: Complaint Investigation

Tags: F684/N1476

Situations: The facility failed to allow a resident back into the facility after they returned from their doctor's appointment. The resident attempted to reenter the facility but was denied. The facility made the resident sit outside in a wheelchair from eight in the evening until they were sent to the hospital on at two in the morning, during which time the facility refused them access to their personal belongings, food, medications, or incontinence care.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 6

Exit Date: 12/10/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F689/N1476

Situations: The facility failed to implement effective interventions to prevent a resident from eloping. The resident eloped from the secure unit and was found by law enforcement three days later along a busy highway many miles from the facility.

Deficient Practice: The facility failed to ensure adequate supervision was provided to prevent accidents.

Region 6

Exit Date: 12/13/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F580/N11321; F600/N1283; F607/N1285; F684/N1446; F689/N1477

Situations: The facility failed to protect residents from abuse when two residents were given a bath using bleach and water. The facility failed to inform the residents' physicians and failed to report the incident to HHS in the time required. The facility



failed to implement effective interventions to prevent a resident from eloping. The resident eloped from the facility and was found by a community member near a busy intersection. The facility was unaware of the elopement until the resident's family called the facility after they were unable to reach the resident.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition, failed to implement policies and procedures to prevent abuse, failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices, and failed to ensure residents received adequate supervision and assistance devices to prevent accidents.

Region 5

Exit Date: 12/14/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F684/N1476

Situations: The facility failed to ensure sufficient care to prevent a resident from sustaining a spiral fracture to their femur, failed to determine the cause of the fracture, and did not provide appropriate treatment after the injury was discovered.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 3

Exit Date: 12/51/2021

Purpose of Visit: Incident Investigation

Tags: F880/N1713/N2220

Situations: The facility failed to screen staff for symptoms of COVID-19 and allowed a staff member, who attested to being exposed to and having symptoms of COVID-19, to work at the facility. A week later, seven residents and two other staff members tested positive for the disease.

Deficient Practice: The facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment.

Region 4

Exit Date: 12/16/2021

Purpose of Visit: Standard Survey

Tags: F580/N1130; F684/N1446

Situations: The facility failed to monitor two residents after they experience seizures and failed to notify one of the resident's physician of their sub-therapeutic levels of anti-seizure medication.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices.



Region 7**Exit Date:** 12/20/2021**Purpose of Visit:** Complaint Survey**Tags:** F689/N1477**Situations:** The facility removed a resident's fall mat that was placed beside their bed to help reduce the risk of injury in the event of a fall. The resident fell out of their bed and sustained a nose fracture, fractures to two vertebrae, and a forehead laceration, requiring hospitalization.**Deficient Practice:** The facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents.**Region 5****Exit Date:** 12/20/2021**Purpose of Visit:** Complaint/Incident Investigation**Tags:** F684/N1446**Situations:** The facility failed to assess, monitor, and provide a resident with appropriate medical intervention after they sustained unwitnessed falls on two occasions and had a change in condition.**Deficient Practice:** The facility failed to ensure residents received treatment and care in accordance with professional standards of practice.**Region 1****Exit Date:** 12/20/2021**Purpose of Visit:** Incident Investigation**Tags:** F678/N1321**Situations:** The facility failed to immediately initiate CPR on a resident while the resident's code status was determined, per facility policy. The resident had a full code status (allowing all interventions to restart the heart) and died at the facility.**Deficient Practice:** The facility failed to provide basic life support, including CPR, to residents requiring such emergency care and subject to related physician orders and the residents' advance directives.**Region 3****Exit Date:** 12/21/2021**Purpose of Visit:** Standard Survey**Tags:** F578/N1233; F684/N1446; F686/N1450; F801/N1551**Situations:** The facility failed to follow a resident's DNR order and initiated CPR immediately when the resident was found unresponsive. The facility failed to properly assess and monitor a resident's pressure ulcers and follow up on related physician orders. The facility failed to ensure three residents were assessed by a qualified nutrition professional.**Deficient Practice:** The facility failed to honor the resident's right to refuse treatment and failed to provide care and treatments, consistent with professional standards, failed to ensure treatment and care was provided based on the comprehensive assessment

and in accordance with professional standards of practice, failed to provide care and treatments, consistent with professional standards, to promote healing of pressure ulcers and to prevent development of new pressure ulcers, and failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service.

Region 3

Exit Date: 12/23/2021

Purpose of Visit: Incident Investigation

Tags: F689/N1476

Situations: The facility failed to implement effective interventions to prevent a resident from eloping. The resident eloped from the facility and was located at a nearby police station.

Deficient Practice: The facility failed to ensure residents received adequate supervision to prevent accidents

Region 6

Exit Date: 12/29/2021

Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey

Tags: F880/N1713/N2222

Situations: The facility failed to isolate residents who tested positive for COVID-19 and failed to ensure effective use of PPE.

Deficient Practice: The facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment.

Region 2

Exit Date: 12/29/2021

Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey

Tags: F880/N1713

Situations: The facility failed to isolate residents who tested positive for COVID-19 and failed to ensure effective use of PPE.

Deficient Practice: The facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment.

Region 6

Exit Date: 12/30/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F692/N1462

Situations: The facility failed to assess a resident after they lost twenty-one pounds in around two weeks. The resident's labs reflected high creatine levels, indicating issues with the kidneys. The facility failed to assess another resident who lost ten pounds in less than a month.

Deficient Practice: The facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte



balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise.

Region 3

Exit Date: 12/31/2021

Purpose of Visit: Complaint Investigation

Tags: F610/N1305/N1306

Situations: The facility failed to identify an allegation of abuse and allowed the alleged perpetrator to continue working at the facility for nine days after the alleged abuse was made known.

Deficient Practice: The facility failed to ensure that all alleged abuse violations were thoroughly investigated and to prevent further abuse from occurring while the investigation was in progress.

