Quarterly IJ Summary Report
January 2023 – March 2023

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 first quarter of 2023 (01/01/2023 – 03/30/2023).

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 seventy-one of the surveys and investigations conducted, resulting in 122 citations of thirty-two 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	1%	684	14%
580	11%	600	13%
584	1%	580	11%
600	13%	689	11%
604	1%	686	7%
607	1%	692	5%
609	1%	678	4%
610	1%	835	3%
635	1%	690	2%
656	1%	697	2%
678	4%	760	2%
684	14%	770	2%
686	7%	880	2%
689	11%	693	2%
690	2%	741	2%
692	5%	755	2%
693	2%	757	2%

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
695	1%	578	1%
697	2%	584	1%
700	1%	604	1%
740	1%	607	1%
741	2%	609	1%
742	1%	610	1%
755	2%	635	1%
757	2%	656	1%
760	2%	695	1%
770	2%	700	1%
777	1%	740	1%
803	1%	742	1%
812	1%	777	1%
835	3%	803	1%
880	2%	812	1%

*Rounded to the nearest tenth

Table 2

Region	# Of IJs	# Of NFs	% Of IJs/NF
1	3	83	6.02%
2	2	136	2.94%
3	13	229	6.99%
4	6	189	8.99%
5	12	188	9.04%
6	6	166	3.61%
8	3	142	3.52%
11	1	78	1.28%
Total	**46**	1211	5.86%

Table 3
Number of IJs

from Complaints	from Incidents	from Surveys	Total
39	9	24	71

Tag References

483.10 – Resident Rights:

578 Request/Refuse/Discontinue Treatment, Formulate Advanced Directives
580 Notification of Changes (Injury/Decline/Room, Etc.)
584 Safe/Clean/Comfortable/Homelike Environment

483.12 - Freedom from Abuse, Neglect, and Exploitation:

600 Free from Abuse and Neglect
604 Free from Involuntary Seclusion
607 Develop/Implement Abuse/Neglect, etc. Policies
609 Reporting of Alleged Violations
610 Investigate/Prevent/Correct Alleged Violation

483.20 – Resident Assessments:

635 Admission Physician Orders for Immediate Care

483.21 – Comprehensive Resident Centered Care Plans:

656 Develop/Implement Comprehensive Care Plan

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
690 Bowel/Bladder Incontinence, Catheter, UTI
692 Nutrition/Hydration Status Maintenance
693 Tube Feeding Management/Restore Eating Skills
695 Respiratory/Tracheostomy Care and Suctioning
697 Pain Management
700 Bedrails

483.40 Behavioral Health Services

740 Behavioral Health Services
741 Sufficient/Competent Staff – Behavioral Health Needs
742 Treatment/Svc for Mental/Psychosocial Concerns

483.45 Pharmacy Services

755 Pharmacy Svcs/Procedures/Pharmacist/Records
757 Drug Regimen is Free From Unnecessary Drugs
760 Residents are Free of Significant Med Errors

483.50 – Laboratory, Radiology, and Other Diagnostic Services:

770 Laboratory Services
777 Radiology/Diag. Svcs Ordered/Notify Results

483.60 – Food and Nutrition Services:

803 Menus Meet Res Needs/Prep in Advance/Followed
812 Food Procurement, Store/Prepare/Serve - Sanitary

483.70 – Administration:

835 Administration

483.80 – Infection Control:

880 Infection Prevention & Control

Acronyms

CPR – Cardiopulmonary Resuscitation
EMS – Emergency Medical Services
PPE – Personal Protective Equipment

Region 5
Exit Date: 01/02/2023
Purpose of Visit: Standard Survey
Tags: F584/N3643; F835/N4996
Situations: The facility failed to ensure the residents' living environment was kept at a comfortable temperature after the HVAC system stopped functioning properly. Temperatures in two units were measured from fifty-six to sixty-six degrees. The facility failed to ensure an emergency transfer agreement was in place when the facility was unable to regulate the temperature in those two halls.

Deficient Practice: The facility failed to ensure that residents had comfortable and safe temperature levels and facility administration failed to ensure effective use of resources.

Region 3
Exit Date: 01/05/2023
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control
Tags: F600/N3481
Situations: The facility failed to protect six residents from another resident who had a history of physical and verbal aggression.

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

Region 11
Exit Date: 01/06/2023
Purpose of Visit: Complaint Investigation
Tags: F678/N3580
Situations: The facility failed to attempt resuscitative measures on a resident with a full code status (code status that allows all interventions to restart the heart). The resident died at the facility. The facility failed to ensure all staff had current CPR certifications.

Deficient Practice: The facility failed to ensure personnel provided basic life support, which included CPR to a resident who required such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directive.

Region 5
Exit Date: 01/06/2023
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent two residents, who resided on a secure unit and had a history of exit-seeking behaviors, from eloping.

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

Region 5
Exit Date: 01/09/2023
Purpose of Visit: Standard Survey
Tags: F600/N3481; F812/N493
Situations: The facility failed to protect a resident from abuse when the resident was physically forced to take their medication by mouth, which resulted in a bleeding cut to their lip. The facility failed to ensure that dishes used during mealtimes were properly sanitized.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and failed to serve food in accordance with professional standards for food service safety.

Region 4
Exit Date: 01/10/2023
Purpose of Visit: Incident Investigation; Focused Infection Control
Tags: F580/N3010; F760/N4600
Situations: The facility administered a resident's medication to their roommate, resulting in the latter resident experiencing an altered mental status requiring transfer to the hospital. The facility failed to inform the resident's physician that they had received the incorrect medication.

Deficient Practice: The facility failed to consult with the resident's physician when there was a significant change in the resident's status and failed to ensure residents remained free of any significant medication errors.

Region 6
Exit Date: 01/11/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F678/N3580
Situations: The facility failed to attempt resuscitative measures on a resident with a full code status (code status that allows all interventions to restart the heart). The resident died at the facility.

Deficient Practice: The facility failed to ensure personnel provided basic life support, which included CPR to a resident who required such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directive.

Region 5
Exit Date: 01/12/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F697/N4009
Situations: The facility failed to obtain a resident's pain medication for five days after the resident was admitted to the facility following a toe amputation.

Deficient Practice: The facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Region 3
Exit Date: 01/12/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937; F777/N4723; F880/N5041
Situations: The facility failed to ensure a resident received medications according to physician orders for pain management when the resident experienced a fall with injury that resulted in a fracture to the left hip. The resident was in pain for three days before being sent to the hospital. The facility failed to obtain diagnostic services for the resident after the fall. The facility failed to ensure effective use of PPE and that effective infection control measures were followed when going between rooms with residents positive for COVID-19 and those with residents who were not.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice, failed to promptly notify the ordering physician of results that fell outside of clinical procedures for notification of the ordering physician, and failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment.

Region 1
Exit Date: 01/13/2023
Purpose of Visit: Standard Survey
Tags: F684/N3937; F697/N4009
Situations: The facility failed to coordinate and create a plan to manage and treat a resident’s pain. The facility failed to have another resident’s anti-anxiety and UTI medication available.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice and failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences

Region 3
Exit Date: 01/13/2023
Purpose of Visit: Complaint Investigation
Tags: F693/N3997
Situations: The facility failed to ensure a tool used for unclogging feeding tubes was used correctly when two residents’ feeding tubes became clogged.

Deficient Practice: The facility failed to ensure a resident receiving enteral feeding received appropriate care and services to prevent complications.

Region 5
Exit Date: 01/13/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1477
Situations: The facility failed to ensure a safe and practical room move for a resident, who was visually impaired, when they were moved from a room to which they were acclimated to a room on a different hallway. The following day the resident fell in the threshold of the new room resulting in a wrist fracture and a traumatic subarachnoid hemorrhage (bleeding within the area between the brain and the tissue covering the brain).

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

Region 5
Exit Date: 01/13/2023
Purpose of Visit: Standard Survey
Tags: F600/N3481
Situations: The facility failed to implement interventions when a resident physically assaulted another resident on two separate occasions, and verbally assaulted another resident.

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

Region 3
Exit Date: 01/17/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N3949; F690/N3967; F760/N4600
Situations: The facility failed to provide wound care to two residents, as ordered by their physicians, one of whom developed an infection and was sent to the hospital where they were diagnosed with sepsis. The facility failed to provide treatment for a resident with a severe pressure ulcer. The resident eventually required hospitalization with sepsis. The facility failed to provide effective care to three residents with catheters, resulting in two of them being hospitalized with catheter-related complications. The facility administered a resident's insulin outside of physician parameters, resulting in the resident becoming unresponsive and requiring hospitalization.

Deficient Practice: The facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing; failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections; and failed to ensure residents remained free of any significant medication errors.

Region 8
Exit Date: 01/20/2023

Purpose of Visit: Complaint Investigation
Tags: F684/N3937
Situations: The facility failed to follow physician orders and weigh a resident daily and failed to notify the resident's physician when they began to gain weight.

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

Region 4
Exit Date: 01/20/2023
Purpose of Visit: Standard Survey
Tags: F580/N3013; F692/N3988; F770/N5041
Situations: The facility failed to monitor a resident's fluid intake and output and to obtain a urinary analysis as ordered by a physician. The resident was admitted to the hospital due to dehydration.

Deficient Practice: The facility failed to consult with the resident's physician when there was a significant change in the resident's status, failed to maintain acceptable parameters of hydration status, and failed to ensure laboratory services were obtained.

Region 1
Exit Date: 01/20/2023
Purpose of Visit: Standard Survey
Tags: F600/N3481
Situations: The facility failed to fully investigate after two residents reported another being physically and verbally aggressive towards them.

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

Region 5
Exit Date: 01/23/2023
Purpose of Visit: Standard Survey
Tags: F686/N3949
Situations: The facility failed to provide effective treatment to a resident with a pressure ulcer, resulting in deterioration of the ulcer. Following the worsening of the ulcer, the facility failed to inform the resident's physician of x-ray results that indicated osteomyelitis (bone infection) at the site of the ulcer.

Deficient Practice: The facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing.

Region 8
Exit Date: 01/24/2023
Purpose of Visit: Standard Survey
Tags: F684/N3937; F835/N4996

Situations: The facility failed to ensure a resident received skin care, bathing, ostomy and wound care, and weekly wound measurements. The resident had pressure ulcers to eight different parts of their body.

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

Region 3
Exit Date: 01/24/2023
Purpose of Visit: Incident Investigation
Tags: F880/N4723
Situations: The facility failed to ensure visitors who entered rooms with residents positive for COVID-19 were aware of the status and used proper PPE, failed to ensure effective us of PPE amongst staff and residents, and failed to cohort residents based on their infection status.

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: 01/24/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F700/N4024
Situations: The facility failed to ensure full length bed rails were securely fastened to a resident's bed. The resident became entrapped between the bed rail and their mattress, sustaining a femur fracture.

Deficient Practice: The facility failed to assess the resident for risk of entrapment from bed rails prior to installation.

Region 6
Exit Date: 01/26/2023
Purpose of Visit: Standard Survey
Tags: F692/N3985
Situations: The facility failed to obtain regular weight measurements for ten residents over the course of four months. One resident experienced a greater than thirty-nine percent weight loss during that period.

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 demonstrated that it was not possible or resident preferences indicated otherwise.

Region 5
Exit Date: 01/26/2023
Purpose of Visit: Complaint Investigation
Tags: F689/N4030

Situations: The facility failed to implement interventions to keep a resident from eloping from the facility. The resident exited the facility through another resident's room window and was found by law enforcement nearly one mile from the facility.

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

Region 4
Exit Date: 01/26/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to follow physician orders for antibiotics and an imaging test to treat and diagnose a resident's wound. The resident was admitted to the hospital and required surgery. The facility failed to follow-up on the resident's MRSA-positive test results.

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: 01/27/2023
Purpose of Visit: Standard Survey
Tags: F600/N3481; F607/N3487; F609/N3532
Situations: The facility failed to implement interventions after a resident reported that a family member had grabbed their face and shook it during an altercation. The family member returned days after the resident reported this incident and started a verbal confrontation with the resident in their room with the door closed. When facility staff intervened, the resident was visibly upset and afraid.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury to the administrator of the facility and to other officials.

Region 5
Exit Date: 01/30/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident from eloping. The resident left the facility and was found seven hours later in the internal courtyard of a facility near their own.

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

Region 4
Exit Date: 02/03/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to consult a resident's physician and effectively assess and treat a resident after they fell and hit their head, leading the resident to begin vomiting three hours after the fall. The resident was on anticoagulant therapy and was admitted to the hospital with an intracranial bleed and ultimately died.

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 4
Exit Date: 02/04/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3010; F684/N3937; F770/N5041
Situations: The facility failed to obtain a urinary analysis test for a resident suspected of a urinary tract infection (UTI). The resident was admitted to the hospital and was diagnosed with sepsis due to a UTI.

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

Region 4
Exit Date: 02/08/2023
Purpose of Visit: Standard Survey
Tags: F678/N5536
Situations: The facility failed to provide staff certified for CPR during the overnight shift for five days.

Deficient Practice: The facility failed to ensure personnel provided basic life support, which included CPR to a resident who required such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directive.

Region 4
Exit Date: 02/08/2023
Purpose of Visit: Standard Survey
Tags: F600/N3484; F686/N3949; F692/N3985
Situations: The facility failed to implement admission orders for twenty-two residents. The facility did not provide effective wound care to multiple residents with pressure ulcers. The facility failed to follow dietary orders for multiple residents and failed to ensure weekly weight measurements. The facility failed to obtain routine lab tests for a

resident and failed to ensure that residents medications were on hand and administered properly.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect; failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing; and failed to maintain acceptable parameters for nutritional status such as usual body weight or desirable body weight range by failing to provide nutritional and hydration care and services to residents consistent with the resident's comprehensive assessment.

Region 3
Exit Date: 02/10/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F757/N4585
Situations: The facility failed to effectively administer a resident's antiseizure medication, resulting in the resident being sent to the hospital three times in a month with symptoms consistent with complications due to seizures. The facility failed to inform the resident's physician of the pharmacist's recommendations about changes to the resident's medication.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to ensure each resident's drug regimen was free from unnecessary drugs and included adequate monitoring for high-risk medications.

Region 4
Exit Date: 02/10/2023
Purpose of Visit: Complaint Investigation
Tags: F755/N4675/N4678
Situations: The facility failed to ensure a resident had physician orders for five mediations they were administered. The facility failed to provide the resident with their correct dosage of their diabetic medication.

Deficient Practice: The facility failed to provide pharmaceutical services, including procedures to ensure the accurate administering of all drugs and biologicals, to meet the needs of each resident.

Region 4
Exit Date: 02/10/2023
Purpose of Visit: Standard Survey
Tags: F684/N3937
Situations: The facility failed to follow a physician's orders for a diagnostic imaging scan for a resident with an undiagnosed abscess, which ultimately required surgery.

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

Region 4

Exit Date: 02/15/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F600/N3484; F656/N3802; F686/N3946; F692/N3991
Situations: The facility failed to provide effective treatment to two residents with pressure ulcers, both of whom experienced deterioration of the ulcers. The facility failed to inform a resident's physician of the development of a new pressure ulcer. The facility failed to ensure a resident's nutritional interventions were followed to promote the resident's health in accordance with their care plan.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition; failed to implement policies and procedures to prevent abuse and neglect; failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs; failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing; and 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 demonstrated that it was not possible or resident preferences indicated otherwise.

Region 4
Exit Date: 02/15/2023
Purpose of Visit: Standard Survey
Tags: F740/N4042
Situations: The facility failed to implement interventions when a resident began to express suicidal ideations. The facility did not implement suicidal precautions as outlined in their policy, failed to ensure nurse observation and documentation every four hours, failed to update the resident's care plan, and failed to inform all relevant staff of the concerns.

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

Region 6
Exit Date: 02/15/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F695/N1468
Situations: The facility failed to ensure a resident with a tracheostomy had emergency equipment at their bedside at all times, failed to order sufficient tracheostomy/respiratory equipment, and failed to ensure all staff were trained on caring for residents with tracheostomies.

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

Region 6

Exit Date: 02/15/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N3937; F689/N3946; F692/N3985
Situations: The facility failed to effectively treat a resident's pressure ulcers and failed to provide skin assessments to identify new ones. The resident's ulcers deteriorated, and they ultimately required hospitalization due to sepsis. The facility failed to provide adequate supervision and psychiatric intervention to prevent a resident's further falls and injurious behaviors, failed to implement hourly observations, and failed to ensure staff were trained on caring for residents with self-harming behaviors. The facility failed to implement nutritional interventions when a resident began to experience significant weight loss.

Deficient Practice: The facility failed to ensure residents with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing; failed to provide adequate supervision to prevent accidents; and failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, unless the resident's clinical condition demonstrates that it is not possible.

Region 3
Exit Date: 02/16/2023
Purpose of Visit: Incident Investigation
Tags: F689/N4027
Situations: The facility failed to ensure adequate supervision and to provide a hazard free environment in the memory care unit when a resident ingested body wash which they found left out in another resident's room.

Deficient Practice: The facility failed to provide adequate supervision to prevent accidents.

Region 4
Exit Date: 02/16/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937; F803/N4330
Situations: The facility did not ensure a resident was provided the proper therapeutic diet during an activity which resulted in them choking, having CPR performed, and being sent to the hospital where they ultimately died. The facility failed to keep the dietary documentation up to date with the resident's diet orders.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice and failed to follow the menu for a resident on a mechanically softened diet.

Region 2
Exit Date: 02/16/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030

Situations: The facility failed to ensure a resident's anti-elopement devices were in working order, resulting in the resident eloping from the facility.

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

Region 3
Exit Date: 02/17/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to inform a physician when a resident complained of numbness to the side of the face and did not obtain care and treatment orders. The resident's symptoms grew to include slurred speech and drooling three days later, and they were sent to the hospital where they were diagnosed as having had an acute stroke.

Deficient Practice: The facility failed 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: 02/22/2023
Purpose of Visit: Incident Investigation
Tags: F600/N3484; F689/N4030
Situations: The facility failed to implement interventions and update a resident's care plan after they eloped from the facility and expressed their desire to go home. The resident eloped again from the facility three months later and was missing for four days in temperatures that dropped below freezing.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to provide adequate supervision to prevent accidents.

Region 3
Exit Date: 02/23/2023
Purpose of Visit: Standard Survey
Tags: F693/N3997
Situations: The facility failed to ensure the staff were not using a de-clogger to unclog a residents gastrostomy tube (tube inserted through the abdomen that brings nutrition directly to the stomach) without physician orders, without notifying the physician and without training.

Deficient Practice: The facility failed to ensure a resident receiving enteral feeding received appropriate care and services to prevent complications.

Region 2
Exit Date: 02/23/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N3946

Situations: The facility failed to effectively apply and monitor a resident's knee stabilizing device, resulting in the resident developing multiple pressure ulcers.

Deficient Practice: The facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

Region 3
Exit Date: 02/23/2023
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to provide continuous supervision to residents while they were smoking, resulting in one resident burning their hair and scalp.

Deficient Practice: The facility failed to provide adequate supervision to prevent accidents.

Region 2
Exit Date: 02/24/2023
Purpose of Visit: Standard Survey
Tags: F600/N3484; F686/N3946; F690/N3949; F741/N3967; F835/N4045
Situations: The facility failed to ensure care was provided to a resident with an indwelling catheter to prevent complications or infections. The facility failed to ensure a resident with pressure ulcers received treatment sufficient to prevent deterioration. The facility failed to implement interventions to prevent a resident with aggressive behaviors from harming other residents. The facility failed to provide adequate supervision to a resident in a secure unit to prevent them from being abused by others.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect; failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing; failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections; failed to ensure staff who provide direct services to residents had the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable well-being. Facility administration failed to ensure effective use of resources.

Region 2
Exit Date: 02/24/2023
Purpose of Visit: Standard Survey
Tags: F600/N3484; F686/N3946; F690/N3949; F741/N3967; F835/N4045
Situations: This was a second investigation event worked in tandem with that directly above. The details are the same as above.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect; failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to

promote healing, prevent infection and prevent new ulcers from developing; failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections; failed to ensure staff who provide direct services to residents had the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable well-being. Facility administration failed to ensure effective use of resources.

Region 5
Exit Date: 02/25/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3484
Situations: The facility failed to protect a resident from assault when they were choked by a staff member.

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

Region 1
Exit Date: 02/27/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N3946
Situations: The facility failed to identify pressure ulcers developing on three residents. The facility failed to provide a resident at-risk for pressure ulcers with a skin assessment upon admission and did not develop a care plan to prevent pressure ulcers forming.

Deficient Practice: The facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

Region 1
Exit Date: 02/27/2023
Purpose of Visit: Incident Investigation
Tags: F580/N3016; F760/N4600
Situations: The facility failed to administer a resident’s insulin when their blood glucose levels became elevated beyond normal parameters, resulting in continued increases in the resident’s blood glucose levels.

Deficient Practice: The facility failed to consult with the resident's physician when there was a significant change in the resident's status and failed to ensure residents remained free of any significant medication errors.

Region 5
Exit Date: 02/27/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F697/N4009
Situations: The facility failed to administer pain medication to two residents.

Deficient Practice: The facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Region 5
Exit Date: 02/28/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F578/N2983; F684/N3937
Situations: The facility failed to honor the DNR order for a resident who was found unresponsive and the facility initiated CPR on the resident.

Deficient Practice: The facility failed to protect the residents right to request, refuse, and/or discontinue treatment and failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 3
Exit Date: 02/28/2023
Purpose of Visit: Complaint Investigation
Tags: F678/N3580
Situations: The facility failed to provide CPR to a resident who had a full code status (code status that allows all interventions to restart the heart) and was found unresponsive with no pulse. CPR was not provided for approximately six minutes until EMS arrived. The resident died at the facility.

Deficient Practice: The facility failed to ensure personnel provided basic life support, which included CPR to a resident who required such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directive.

Region 6
Exit Date: 03/01/2023
Purpose of Visit: Standard Survey
Tags: F600/N3478
Situations: The facility failed to protect a resident from being abused by a staff member and subsequently failed to report the incident to the facility’s abuse coordinator.

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

Region 8
Exit Date: 03/03/2023
Purpose of Visit: Standard Survey
Tags: F600/N3481; F610/N3538
Situations: The facility failed to protect four residents from verbal abuse by a staff member. The facility failed to thoroughly investigate the allegations of abuse against the staff member.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to provide evidence that all alleged violations of neglect, abuse, or misappropriation of property were thoroughly investigated to prevent further potential neglect, abuse, or misappropriation while the investigation was in progress.

Region 5
Exit Date: 03/03/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident from eloping. The resident eloped from the facility and was found several blocks away after falling and sustaining a hip fracture.

Deficient Practice: The facility failed to ensure adequate assistive devices were provided to prevent accidents.

Region 4
Exit Date: 03/03/2023
Purpose of Visit: Standard Survey
Tags: F580/N3016; F684/N3937; F880/N4723
Situations: The facility failed to obtain physician-ordered medical tests for two residents and failed to inform their physicians of worsening symptoms. The facility failed to initiate infection control procedures when two residents were diagnosed with communicable illnesses.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition, failed to ensure residents received treatment and care in accordance with professional standards of practice, and failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment.

Region 4
Exit Date: 03/03/2023
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure a resident in a wheelchair was properly secured before being transported. The resident fell out of their wheelchair during transport, which caused injuries that resulted in the resident's death.

Deficient Practice: The facility failed to ensure adequate assistive devices were provided to prevent accidents.

Region 4
Exit Date: 03/04/2023
Purpose of Visit: Standard Survey
Tags: F692/N3985; F755/N4561

Situations: The facility failed to follow physician-ordered diets and nutritional supplements for two residents, resulting in one resident losing weight and one experiencing a drop in albumin levels.

Deficient Practice: The facility failed to ensure residents maintained acceptable parameters of nutritional status and failed to provide pharmaceutical services, including procedures that assured accurate administering of all drugs to meet the needs of the residents.

Region 3
Exit Date: 03/07/2023
Purpose of Visit: Standard Survey
Tags: F580/N3013; F600/N3484; F635/N3712; F684/N3937
Situations: The facility failed to reconcile hospital discharge orders for a resident and failed to provide the resident with their blood glucose medication. The facility failed to inform the resident's physician and provide treatment when the resident's blood glucose levels became elevated.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition, failed to implement policies and procedures to prevent abuse and neglect, failed to ensure residents had admission physician orders for their immediate care, and failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 5
Exit Date: 03/09/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure adequate supervision to prevent a resident from eloping when the alarm on an external door was temporarily turned off. The resident eloped from the facility and was not found until they called a family member and provided their location, over five miles from the facility.

Deficient Practice: The facility failed to ensure adequate assistive devices were provided to prevent accidents.

Region 3
Exit Date: 03/09/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to inform a resident's physician and obtain treatment orders for a developing wound on the resident's leg and failed to inform the physician of the wound's deterioration several days later. The facility failed to provide effective treatment for the wound which resulted in the resident developing gangrene and requiring above-the-knee amputation of the leg.

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 4
Exit Date: 03/09/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F757/N4690
Situations: The facility failed to review a resident's physician orders and medication record before giving them a new medication to which their clinical records indicated they were allergic. The resident had a severe allergic reaction to the medication.

Deficient Practice: The facility failed to ensure each resident's drug regimen was free from unnecessary drugs and included adequate monitoring for high-risk medications.

Region 5
Exit Date: 03/13/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481
Situations: The facility failed to ensure four residents were protected from verbally aggressive behavior such as screaming, cursing, insults to race or ethnic group and intimidation from one resident, and sexually lewd behavior from another.

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

Region 4
Exit Date: 03/17/2023
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to intervene timely when a resident on anticoagulant medication fell and hit their head, resulting in a raised area on their head. The resident began to experience low blood pressure and hallucinations and the facility did not intervene until a family member had the resident sent to the hospital. The facility failed to inform the physician that the injury was reported to of the resident's use of anticoagulants.

Deficient Practice: The facility failed to consult with the resident's physician when there was a significant change in the resident's status and failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 8
Exit Date: 03/19/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481
Situations: The facility failed to implement interventions when a resident became prone to wandering into others' rooms. The resident was ultimately pushed by another resident

when the former entered the latter's room, resulting in a broken hip and permanent loss of ambulation. The facility failed to implement adequate interventions to ensure another resident felt safe after they were pushed by a fellow resident.

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

Region 3
Exit Date: 03/22/2023
Purpose of Visit: Complaint Investigation
Tags: F689/N4030
Situations: The facility failed to ensure adequate supervision to prevent a resident from eloping. The resident eloped from the facility and was found at a convenience store five miles from the facility by EMS and was transported to the hospital due to an altered mental state and an unprovenanced infection.

Deficient Practice: The facility failed to ensure adequate assistive devices were provided to prevent accidents.

Region 6
Exit Date: 03/22/2023
Purpose of Visit: Standard Survey
Tags: F604/N3514; F742/N4051
Situations: The facility failed to ensure physical restraints were not used during medication administration through a gastrostomy tube (tube inserted through the abdomen that brings nutrition and medication directly to the stomach), resulting in emotional distress.

Deficient Practice: The facility failed to ensure that residents were free from physical restraints imposed for the purposes of convenience, and not required to treat the resident's medical symptoms and failed to ensure a resident who displays, or was diagnosed with, a mental illness or psychosocial adjustment difficulty, or who had a history of trauma and/or post-traumatic stress disorder, received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being.

Region 5
Exit Date: 03/24/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F678/N4204
Situations: The facility failed to attempt resuscitative measures on a resident with a full code status (code status that allows all interventions to restart the heart). The resident died at the facility.

Deficient Practice: The facility failed to ensure personnel provided basic life support, which included CPR to a resident who required such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directive.

Region 1
Exit Date: 03/24/2023
Purpose of Visit: Complaint Investigation
Tags: F580/N3016; F684/N3937
Situations: The facility failed to contact the physician or emergency services after a resident was found to have a decrease in oxygen saturation levels. The facility failed to send the resident to the hospital until a family member intervened and requested the intervention because of the resident's decreased and unstable oxygen saturation levels. The resident ultimately died in the hospital.

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 8
Exit Date: 03/26/2023
Purpose of Visit: Incident Investigation
Tags: F684/N3937
Situations: The facility failed to ensure a resident's dentures were properly cared for and effectively secured. The resident experienced multiple meals where they aspirated while trying to eat due to the dentures being poorly secured in place. During one of those meals the resident's dentures became lodged in their throat.

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