Quarterly IJ Summary Report
April 2023 – June 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 second quarter of 2023 (04/01/2023 – 06/30/2023).

Immediate Jeopardy is "a situation in which the provider's or supplier's non-compliance with one or more requirements, conditions of participation, conditions for coverage, or conditions for certification has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident or patient" (42 CFR 489.3).

During this period, an IJ level tag was cited for ninety-six of the surveys and investigations conducted, resulting in 141 citations of thirty-one 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*
37	1%	689	26%
550	1%	684	17%
580	6%	600	16%
584	1%	580	6%
600	16%	607	5%
607	5%	686	4%
609	1%	760	4%
610	1%	777	2%
656	1%	610	1%
678	1%	678	1%
684	17%	697	1%
686	4%	921	1%
689	26%	37	1%
692	1%	550	1%
693	1%	584	1%
694	1%	609	1%
695	1%	656	1%

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
697	1%	692	1%
700	1%	693	1%
726	1%	694	1%
740	1%	695	1%
742	1%	700	1%
755	1%	726	1%
760	4%	740	1%
773	1%	742	1%
777	2%	755	1%
812	1%	773	1%
835	1%	812	1%
880	1%	835	1%
919	1%	880	1%
921	1%	919	1%

*Rounded to the nearest tenth

Table 2

Region	# Of IJs	# Of NFs	% Of IJs/NF
1	4	83	4.82%
2	4	136	2.94%
3	22	227	9.69%
4	24	187	12.83%
5	20	188	10.64%
6	11	167	6.59%
8	10	141	7.09%
11	1	78	1.28%
Total	96	1207	7.95%

Table 3
Number of IJs

from Complaints	from Incidents	from Surveys	Total
67	15	14	96

TEXAS
Health and Human
Services

Tag References

483.10 – Resident Rights:

- 550 Resident Rights/Exercise of Rights
- 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
- 607 Develop/Implement Abuse/Neglect, etc. Policies
- 609 Reporting of Alleged Violations
- 610 Investigate/Prevent/Correct Alleged Violation

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
- 692 Nutrition/Hydration Status Maintenance
- 693 Tube Feeding Management/Restore Eating Skills
- 695 Respiratory/Tracheostomy Care and Suctioning
- 697 Pain Management
- 700 Bedrails

483.35 Nursing Services

- 726 Sufficient Nursing Staff

483.40 Behavioral Health Services

- 740 Behavioral Health Services
- 742 Treatment/Svc for Mental/Psychosocial Concerns

483.45 Pharmacy Services

- 755 Pharmacy Svcs/Procedures/Pharmacist/Records
- 760 Residents are Free of Significant Med Errors

483.50 – Laboratory, Radiology, and Other Diagnostic Services:

- 770 Laboratory Services
- 773 Lav Svcs Physician Order/Notify of Results
- 777 Radiology/Diag. Svcs Ordered/Notify Results

483.60 – Food and Nutrition Services:

- 812 Food Procurement, Store/Prepare/Serve - Sanitary

483.70 – Administration:

- 835 Administration

483.80 – Infection Control:

- 880 Infection Prevention & Control

483.90 Physical Environment

- 919 Resident Call System
- 921 Safe/Functional/Sanitary/Comfortable Environment

Acronyms

ADL – Activities of Daily Living
CPR – Cardiopulmonary Resuscitation
EMS – Emergency Medical Services
PPE – Personal Protective Equipment
UTI – Urinary Tract Infection

Region 2
Exit Date: 04/01/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F695/N4003
Situations: The facility failed to ensure suction supplies were available when a resident required suctioning and was experiencing a decrease in oxygen. The resident was sent to the hospital where they died.

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

Region 4
Exit Date: 04/02/2023
Purpose of Visit: Incident Investigation
Tags: F760/N4600
Situations: The facility failed to follow medication orders and administered an excess of potassium to a resident, requiring the resident to be hospitalized.

Deficient Practice: The facility failed to ensure residents remained free of any significant medication errors.

Region 4
Exit Date: 04/03/2023
Purpose of Visit: Incident Investigation
Tags: F689/N4027
Situations: The facility failed to supervise a resident while they were smoking. While smoking unsupervised, the resident's oxygen tubing and catheter bag ignited on a discarded cigarette.

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

Region 5
Exit Date: 04/06/2023
Purpose of Visit: Incident Investigation
Tags: F600/N3481; F607/N3487
Situations: The facility failed to effectively address allegations of sexual abuse against a resident who had not been assessed for their ability to consent to sexual contact and who had a BIMS score that indicated sever cognitive impairment.

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

Region 4
Exit Date: 04/06/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3484; F684/N3937

Situations: The facility failed to follow physician orders to refer a resident to a vascular specialist. The resident ultimately required an above-the-knee amputation.

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 8
Exit Date: 04/06/2023
Purpose of Visit: Incident Investigation
Tags: F760/N4600
Situations: The facility failed to administer a resident's anti-coagulant medication for nine days, resulting in the resident developing blood clots and requiring hospitalization.

Deficient Practice: The facility failed to ensure residents remained free of any significant medication errors.

Region 8
Exit Date: 04/08/2023
Purpose of Visit: Standard Survey
Tags: F684/N3937
Situations: The facility failed to provide treatment to a resident with a severe urinary tract infection for over twenty-five days. The resident ultimately died after being hospitalized with a UTI and sepsis.

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

Region 6
Exit Date: 04/12/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure their hydraulic lift was in working condition during a transfer. The lift's strap broke resulting in the resident falling and sustaining head and hip injuries requiring hospitalization. The facility failed to ensure two-person assistance during incontinent care for a resident, resulting in the resident falling and sustaining a deep laceration to their leg requiring surgery. The resident died from complications after surgical treatment.

Deficient Practice: The facility failed to ensure adequate supervision and assistance devices were provided to prevent accidents.

Region 6
Exit Date: 04/12/2023
Purpose of Visit: Complaint Investigation
Tags: F684/N3937

Situations: The facility failed to properly assess and treat a resident who developed difficulty moving their bowels. The resident's condition deteriorated and ultimately required emergency hospitalization with small bowel obstruction, pancreatitis, and ileus (intolerance of oral intake due to inhibition of the gastrointestinal propulsion without signs of mechanical obstruction).

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

Region 4
Exit Date: 04/12/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4027
Situations: The facility failed to provide adequate supervision to prevent a resident from obtaining cigarettes from another and smoking in their room. The resident attempted to smoke in their room, catching a napkin on fire which ignited the resident's blanket. The resident obtained cigarettes again after the incident.

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

Region 5
Exit Date: 04/13/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F697/N4009; F760/N4600
Situations: The facility failed to provide a resident with pain medication, resulting in the resident experiencing severe pain. The facility failed to provide the resident with lactulose (medication to reduce ammonia levels) resulting in a rise of ammonia levels in the resident causing confusion and decreased cognition.

Deficient Practice: The facility failed to ensure that pain management is provided to residents who require such services and ensure that residents are free from any significant medication errors.

Region 4
Exit Date: 04/14/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F760/N4600
Situations: The facility failed to ensure a resident was free from medication errors after administering the resident their roommate's medication in addition to their own, requiring hospitalization.

Deficient Practice: The facility failed to ensure residents remained free of any significant medication errors.

Region 4
Exit Date: 04/14/2023
Purpose of Visit: Complaint/Incident Investigations

Tags: F600/N3484; F689/N4030
Situations: The facility failed to ensure two-person assistance while providing incontinent care to a resident. The resident fell out of bed during care and sustained multiple leg fractures.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 1
Exit Date: 04/16/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F684/N3937
Situations: The facility failed to effectively monitor a resident's blood glucose levels and failed to provide treatment when the resident's levels were elevated. The resident was hospitalized with metabolic acidosis (a condition in which too much acid accumulates in the body).

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 1
Exit Date: 04/17/2023
Purpose of Visit: Incident Investigation
Tags: F600/N3481
Situations: The facility failed to protect residents from abuse after a resident sustained a spiral fracture from the apparent use of unnecessary force. The facility allowed the alleged perpetrator to continue working at the facility while the incident was being investigated.

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

Region 8
Exit Date: 04/19/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F607/N3484
Situations: The facility failed to protect three residents, two of whom were cognitively impaired and unable to consent, from inappropriate sexual behaviors from another resident.

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

Region 2
Exit Date: 04/21/2023
Purpose of Visit: Complaint/Incident Investigation

Tags: F580/N3010; F684/N3937; F686/N3946
Situations: The facility failed to effectively assess and implement interventions to prevent two residents from developing pressure ulcers. One resident developed ulcers under their knee immobilizer, the other developed one under their arm splint. The facility failed to inform the latter resident's physician and the resident required hospitalization for treatment.

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 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: 04/21/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure adequate supervision to prevent a resident from eloping. The resident eloped from the secured unit and fell out of their wheelchair, sustaining a head laceration.

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

Region 6
Exit Date: 04/22/2023
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to implement effective supervision to prevent a resident from eloping. A resident in the memory care unit eloped out of a courtyard gate that was left unlocked. The facility failed to provide supervision during smoke breaks for four residents.

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

Region 3
Exit Date: 04/22/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement effective supervision to prevent a resident, who was identified as at-risk for eloping, did not elope from the facility. The resident eloped and was found by staff two blocks from the facility. The facility failed to ensure staff were trained to inspect the anti-elopement devices for three residents.

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

Region 3
Exit Date: 04/25/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F607/N3484; F610/N3538
Situations: The facility failed to investigate reported incidents of abuse of three residents by a staff member, failed to report the allegations to Health and Human Services, and failed to suspend the alleged perpetrator pending investigations into the allegations.

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 6
Exit Date: 04/28/2023
Purpose of Visit: Complaint Investigation
Tags: F684/N3937
Situations: The facility failed to immediately assess and call an ambulance when a resident was found excreting blood through vomit, feces, and urine. The facility waited over three hours to call EMS after discovering the resident's condition. The resident died at 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 5
Exit Date: 04/29/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement effective supervision and interventions to prevent a resident, who had a history of wandering into others' rooms, from wandering into the room of a resident with a history of aggressive behaviors. The former resident wandered into the latter's room and was assaulted by the latter, ultimately dying from the injuries sustained.

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

Region 8
Exit Date: 04/30/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937
Situations: The facility failed to report that a resident had not had a bowel movement in over seventy-two hours to their physician, per policy and the resident's physician orders. The resident was found vomiting and with abnormal vital signs and was sent to

the hospital where they required a colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall to bypass a damaged part of the colon).

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

Region 6
Exit Date: 05/01/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F812/N3628; F835/N4363; F921/N4996
Situations: The facility failed to ensure that foods were sealed, labeled, and dated; failed to ensure that equipment was cleaned and in good operating condition; railed to ensure that kitchen floors were cleaned; failed to ensure that plates with dried food particles were not stored with clean plates; failed to ensure that chipped plates were not stored with unchipped plates; failed to ensure that menu items on the steam table were maintained at, minimally, 135 degrees; failed to ensure the expired food was not stored with foods that are not expired; failed to ensure that groceries received were not store directly on the floor; and failed to ensure that the dish machine had soap and was properly sanitizing. Facility administration failed to immediately act when staff and residents reported a smell of gas in the facility for three days. The facility failed to evacuate or move the residents which resulted in prolonged exposure to carbon monoxide.

Deficient Practice: The facility failed to serve food in accordance with professional standards for food service safety and failed to provide a safe, functional, and sanitary environment for residents, staff, and the public. Facility administration failed to ensure effective use of resources.

Region 8
Exit Date: 05/01/2023
Purpose of Visit: Complaint Investigation
Tags: F684/N3937
Situations: The facility failed to provide effective wound treatment to a resident with a severe foot wound. The resident had not been seen by the wound care team for over two weeks. The resident was found with maggots in their wound, which was draining and had a strong foul odor. The resident was ultimately sent to the hospital where they underwent emergency amputation of the lower extremity.

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

Region 4
Exit Date: 05/01/2023
Purpose of Visit: Incident Investigation
Tags: F689/N4030

Situations: The facility failed to ensure a resident was not connected to and using supplemental oxygen while smoking. The resident received second-degree burns to the face when a staff member attempted to help them light their cigarette while the oxygen was still on and the cannulas were still in place on the resident's head.

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

Region 5
Exit Date: 05/02/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481
Situations: The facility failed to implement effective interventions to prevent four different instances of abuse amongst residents during a two-week period.

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

Region 5
Exit Date: 05/03/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F89/N4030
Situations: The facility failed to implement interventions to prevent a resident from eloping. The resident eloped from the facility and fell, sustaining fractured ribs.

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

Region 5
Exit Date: 05/03/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F689/N4030
Situations: The facility failed to implement interventions to prevent a resident with a history of aggressive behaviors from attacking two others on three separate occasions.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 3
Exit Date: 05/04/2023
Purpose of Visit: Complaint Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent a resident, who was cognitively impaired, from eloping in the early hours of the morning. The resident was found by EMS and taken to the hospital for assessment.

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

Region 6
Exit Date: 05/04/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937; F686/N3946
Situations: The facility failed to follow up with physician for a resident's legs that were observed to be swollen, red, flaky with drainage. The facility failed to accurately assess the resident's skin weekly, as ordered by the physician, failed to establish wound care services as ordered, and failed to provide pain medication as needed. The facility failed to perform proper wound care techniques for all three residents needing wound care, resulting in two developing severe pressure ulcers after admission to the facility. The facility failed to provide colostomy care so a resident.

Deficient Practice: The facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and 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 5
Exit Date: 05/04/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F697/N4009
Situations: The facility failed to properly assess and provide effective pain management to a resident after they fell and injured their hip, resulting in uncontrolled pain and a decline in health. The resident subsequently died.

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: 05/04/2023
Purpose of Visit: Complaint Investigation
Tags: F686/N3949
Situations: The facility failed to document a wound assessment, notify the physician, and obtain wound care orders for six days after a resident was admitted with pressure ulcers. The wounds deteriorated, becoming necrotic (dead tissue).

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: 05/05/2023
Purpose of Visit: incident Investigation
Tags: F880/N4723

Situations: The facility failed to implement and maintain contact precautions and ensure staff utilized PPE appropriately to prevent cross contamination between residents positive for COVID-19 and residents who were not positive for the virus and failed to ensure effective social distance practices for those residents exposed to the virus.

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: 05/06/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937
Situations: The facility failed to develop a plan of care for a resident's contracted hand, and failed to provide skin assessments of the area, resulting in the resident developing a wound on the hand.

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

Region 4
Exit Date: 05/07/2023
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure two staff members were used when bathing a resident, as dictated by the resident's care plan. The resident fell during bathing, sustaining two brain bleeds.

Deficient Practice: The facility failed to provide adequate supervision and assistive devices were provided to prevent accidents.

Region 8
Exit Date: 05/0/2023
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent a resident, who was at-risk for elopement, from eloping. The resident eloped from the facility and was not found for over ten hours.

Deficient Practice: The facility failed to provide adequate supervision and assistive devices were provided to prevent accidents.

Region 5
Exit Date: 05/08/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure that coffee heated up for a resident in a microwave was a safe temperature when given to the resident. The resident spilled the coffee, sustaining second and third degree burns to the abdomen and thighs.

Deficient Practice: The facility failed to provide adequate supervision and assistive devices were provided to prevent accidents.

Region 5
Exit Date: 05/08/2023
Purpose of Visit: Complaint Investigation
Tags: F694/N4000
Situations: The facility failed to change the covering of a central venous catheter (thin, flexible tube that is placed into a large vein above the heart) when they returned from the hospital. The failure continued for thirty-seven days.

Deficient Practice: The facility failed to provide care according to professional standard of practice and in accordance with physician orders.

Region 4
Exit Date: 05/10/2023
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to ensure that coffee served to residents was served at a safe temperature, resulting in two residents receiving burns from spilled coffee.

Deficient Practice: The facility failed to provide adequate supervision and assistive devices were provided to prevent accidents.

Region 5
Exit Date: 05/10/2023
Purpose of Visit: Complaint Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to a resident in the memory care unit. The resident scaled the courtyard fence and fell over the other side to the asphalt, sustaining two fractured vertebrae.

Deficient Practice: The facility failed to provide adequate supervision and assistive devices were provided to prevent accidents.

Region 3
Exit Date: 05/12/2023
Purpose of Visit: Complaint/Incident
Tags: F684/N3937; F777/N5059
Situations: The facility failed to retrieve the results of a hip x-ray ordered by a resident's physician following a fall, resulting in delayed treatment of a hip dislocation.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice and failed to promptly notify the ordering physician of results that fall outside of clinical reference ranges.

Region 3
Exit Date: 05/12/2023

Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937; F777/N5080
Situations: The facility failed to retrieve the results of an x-ray ordered by a resident's physician in a timely manner after the resident was noted to be grimacing in pain and unable to move their right arm, which resulted in delayed treatment of a fractured clavicle.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice and failed to promptly notify the ordering physician of results that fall outside of clinical reference ranges.

Region 8
Exit Date: 05/13/2023
Purpose of Visit: Standard Survey
Tags: F580; F684
Situations: The facility failed to inform a resident's physician of their change in condition that included significantly decreased oxygen saturation levels and continuous verbal reactions to pain and requests for help. The facility continued in this failure for over nine hours after assessment of the symptoms, resulting in eventual emergency discharge to the hospital where the resident died.

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 3
Exit Date: 05/14/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3484; F689/N4030
Situations: The facility failed to provide supervision to a resident, who required extensive assistance with ADL's, during a shower. The resident was left alone and fell, resulting in a fractured femur.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 11
Exit Date: 05/15/2023
Purpose of Visit: Standard Survey
Tags: F760/N4600
Situations: The facility failed to ensure medications administered through g-tubes were administered correctly and based on physician orders for three residents over the course of nearly two months.

Deficient Practice: The facility failed to ensure residents are free of any significant medication errors.

Region 5 **Exit Date**: 05/15/2023 **Purpose of Visit:** Complaint/Incident Investigation **Tags**: F600/N3481 **Situations:** The facility failed to implement effective supervision and interventions to prevent a resident, who had a history of wandering into others’ rooms, from wandering into the room of a resident with a history of aggressive behaviors. The former resident wandered into the latter’s room and was assaulted by the latter, sustaining fractures.
Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect.

Region 2 **Exit Date**: 05/17/2023 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F684/N3937 **Situations**: The facility failed to provide skin assessments timely to a resident who was admitted to the facility with diagnoses of skin and bone infection and an open wound from a toe amputation. Seven days after admission, an open wound was found on the resident’s foot, which was not treated for over twenty-four hours until the resident was admitted to the hospital.
Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 3 **Exit Date**: 05/18/2023 **Purpose of Visit**: Incident Investigation **Tags**: F689/N4030 **Situations:** The facility failed to implement interventions after a resident had an unwitnessed fall that resulted in large subdural hematoma (a collection of blood that forms on the surface of the brain).
Deficient Practice: The facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 4 **Exit Date**: 05/18/2023 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F755/N4561 **Situations:** The facility failed to have a resident’s anti-seizure medication on hand, resulting in the resident missing multiple doses, having multiple seizures, and being hospitalized.
Deficient Practice: The facility failed to provide pharmaceutical services, including procedures that assured accurate administering of all drugs to meet the needs of the residents.

Region 5
Exit Date: 05/18/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure staff used assistive devices when assisting a resident with ambulation, causing the resident to fall and sustain a fractured wrist.

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

Region 5
Exit Date: 05/19/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481
Situations: The facility failed to protect two residents from verbal and physical abuse by two staff members.

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

Region 3
Exit Date: 05/19/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F609/N3532
Situations: The facility failed to protect a resident from continued verbal abuse by a staff member. The facility allowed the alleged perpetrator to continue working with the resident for seven days after another staff member witnessed and reported verbal abuse, resulting in continued abuse of the resident.

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 3
Exit Date: 05/20/2023
Purpose of Visit: Standard Survey
Tags: F692/N3985; F693/N3997
Situations: The facility failed to ensure that two residents who required enteral (tube) feeding received sufficient nutrition resulting in significant weight loss for both residents. The facility failed to update the resident’s nutrition plans following the assessment of weight loss and failed to notify the residents’ physicians.

Deficient Practice: The facility failed to ensure that residents maintained acceptable parameters of nutritional status and failed to ensure enteral feeding physician orders were followed.

Region 3
Exit Date: 05/2/2023
Purpose of Visit: Complaint Investigation
Tags: F686/N3949
Situations: The facility failed to ensure a resident with pressure ulcers received effective assessment and treatments, including eight days of missed wound care, resulting in the pressure ulcer deteriorating and the resident 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.

Region 2
Exit Date: 05/22/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F700/N4906
Situations: The facility failed to assess a resident for entrapment from bedrails or contact their representative to obtain informed consent, assess risk for entrapment or physician's orders. The resident's left arm became lodged in between the bedrails, resulting in bruising to the chest and psychosocial harm.

Deficient Practice: The facility failed to assess the resident for risk of entrapment from bed rails prior to installation, review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation or physician's orders.

Region 6
Exit Date: 03/03/2023
Purpose of Visit: Incident Investigation
Tags: F0037/N0001; F921/N4972
Situations: The facility failed to ensure all staff were trained over their Emergency Preparedness Plan (EPP), including active shooter/armed intruder and safety in the workplace before an incident involving an armed intruder entering the facility in May 2023. The facility failed to ensure the lock for the emergency exit door was functioning correctly resulting in an armed intruder gaining access into the facility.

Deficient Practice: The facility failed to provide initial and periodic training in emergency preparedness policies and procedures to all new and existing staff and failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.

Region 4

Exit Date: 05/24/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N3946; F760/N4600
Situations: The facility failed to ensure a resident with pressure ulcers received effective assessment and treatments resulting in the pressure ulcer deteriorating. The facility failed to properly transcribe a resident's narcotic pain medication order, resulting in the resident receiving a dose significantly higher than that ordered by the resident's physician.

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 and failed to ensure residents remained free of any significant medication errors.

Region 1
Exit Date: 05/24/2023
Purpose of Visit: Complaint Investigation
Tags: F600/N3481
Situations: The facility failed to ensure residents were protected from verbal abuse by a staff member who yelled and cursed at staff in front of residents and yelled and cursed at residents.

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

Region 3
Exit Date: 05/25/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident from eloping.

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

Region 3
Exit Date: 05/25/2023
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident, at-risk for wandering behaviors, did not elope from the facility. The resident eloped from the facility and fell, sustaining a hip fracture.

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

Region 4
Exit Date: 05/26/2023

Purpose of Visit: Complaint Investigation
Tags: F684/N3937; F686/N3949
Situations: The facility failed to assess a resident after they complained of pain and did not ask or document where the pain was. The facility failed to ensure the resident's bowel movements were documented, as required by the resident's care plan. The resident was ultimately transferred to the hospital where they were diagnosed with fecal impaction. The facility failed to ensure a resident with pressure ulcers received effective assessment and treatments resulting in the pressure ulcer deteriorating.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice and 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: 05/27/2023
Purpose of Visit: Standard Survey
Tags: F678/N3580
Situations: The facility failed to follow a resident's advance directives when CPR was initiated despite the resident's "do not resuscitate" (DNR) code status.

Deficient Practice: The facility failed to follow physician orders and the resident's advance directives.

Region 6
Exit Date: 05/29/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F777/N5080
Situations: The facility failed to have an effective system in place to monitor for STAT diagnostic/laboratory results, to ensure staff were trained on where to check for and follow up on diagnostic/laboratory results, and to have a communication system in place to ensure timely continuity of care and interventions. The facility failed to report a resident's stat x-ray results of a fracture to the right hip, femur, and pelvis in a prompt manner.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to promptly notify the ordering physician of results that fall outside of clinical reference ranges.

Region 3
Exit Date: 05/30/2023
Purpose of Visit: Complaint Investigation
Tags: F773/N5059
Situations: The facility failed to check the laboratory portal containing a resident's stat lab results causing a delay in the physician ordering necessary interventions to treat the resident's infection

Deficient Practice: The facility failed to promptly notify the physician of laboratory results in accordance with facility policy and procedures.

Region 5
Exit Date: 06/02/2023
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to ensure that coffee served to residents was served at a safe temperature, resulting in a resident receiving second-degree burns from spilled coffee.

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

Region 4
Exit Date: 06/03/2023
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure their assistive devices were well maintained and safe for use. A resident fell, sustaining a fractured femur when the hydraulic lift's strap broke, dropping the resident. The facility failed to provide adequate supervision to a resident while they bathed in the shower. The resident fill, sustaining fractures to both lower leg bones.

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

Region 8
Exit Date: 06/04/2023
Purpose of Visit: Standard Survey
Tags: F684/N3937
Situations: The facility failed to administer insulin to eleven residents over the course of a month following an update to the facility's electronic medication system. The facility failed to have procedures in place to account for issues with the system and ensure residents received their medication as ordered. The facility failed to consult with the residents physicians during the failure.

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

Region 4
Exit Date: 06/06/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident, at-risk for wandering behaviors, did not elope from the facility.

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

Region 4
Exit Date: 06/06/2023
Purpose of Visit: Incident Investigation
Tags: F580/N3010; F684/N3937
Situations: The facility failed to notify a resident's physician of abnormal lab and x-ray results that indicated dehydration, kidney failure, and possible pneumonia to obtain treatment interventions after a change of condition.

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: 06/06/2023
Purpose of Visit: Complaint Investigation
Tags: F689/N4030
Situations: The facility failed to ensure a resident was secure and safely positioned during incontinence care. The resident fell from their bed, sustaining a hip fracture.

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

Region 3
Exit Date: 06/08/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3010; F684/N3937
Situations: The facility failed to assess and inform a resident's physician after the resident suffered two falls. The resident sustained a subdural hematoma (a collection of blood that forms on the surface of the brain) 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 5
Exit Date: 06/09/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478
Situations: The facility failed to ensure a safe environment when a staff member pointed a taser at a resident to scare them.

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

Region 3
Exit Date: 06/09/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F656/N3805; F689/N4027
Situations: The facility failed to ensure a resident, who resided in the memory care unit, had a comprehensive care plan identifying reasons for aggression, appropriate supervision, and interventions to prevent them from eating non-edible items. The resident was left unsupervised and ingested the contents of a deodorant stick.

Deficient Practice: The facility failed to develop and implement a comprehensive person-centered care plan for each resident and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 6
Exit Date: 06/10/2023
Purpose of Visit: Standard Survey
Tags: F689/N4027
Situations: The facility failed to develop interventions after a resident suffered a fall. The resident fell again ten days later, sustaining traumatic head injuries that resulted in the resident's death.

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

Region 5
Exit Date: 06/12/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure a resident was assessed for their ability to smoke independently and failed to supervise them while they smoked, resulting in the resident starting a fire in their room.

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

Region 4
Exit Date: 06/14/2023
Purpose of Visit: Standard Survey
Tags: F684/N3937
Situations: The facility failed to obtain informed written consent or document verbal consent, including risks, benefits, and potential adverse reactions, prior to IV vitamin and hydration infusions. The facility failed to monitor residents for adverse reactions for seventy-two hours following infusion. The facility failed to ensure staff were trained in IV therapy, including post-care assessments and monitoring.

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

Region 4
Exit Date: 06/14/2023
Purpose of Visit: Standard Survey
Tags: F580/N3013; F684/N3937
Situations: The facility failed to inform a physician and follow medication orders to hold doses of insulin when a resident had critically low blood glucose levels.

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 5
Exit Date: 06/14/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F726/N4075
Situations: The facility failed to properly clean and flush a resident's g-tube, resulting in the device not functioning correctly.

Deficient Practice: The facility failed to provide care, including but not limited to assessing, evaluating, and responding to residents' care needs.

Region 6
Exit Date: 06/15/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F607/N3484; F610/N3538; F689/N4030
Situations: The facility failed to properly supervise and implement interventions to prevent physical altercations among residents. Four residents were allegedly injured during separate altercations with three other residents. The facility failed to thoroughly investigate the incidents and implement procedures to prevent continued abuse.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect, 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, and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 3
Exit Date: 06/16/2023
Purpose of Visit: Complaint Investigation
Tags: F684/N3937; F919/N4951/N4954/N4957
Situations: The facility failed to be adequately equipped to allow residents to call for staff assistance when needing help due to call light malfunction.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice and failed to be adequately equipped to allow resident to call for assistance.

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Region 4 **Exit Date**: 06/16/2023 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F550/N2902; F600/N3481; F607/N3484 **Situations:** The facility failed to protect four residents from emotional distress and humiliation when a staff member refused to assist, threw medication at a resident, was rude while providing care, intimidated residents and threatened retaliation.
Deficient Practice: The facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of their quality of life and failed to implement policies and procedures to prevent abuse and neglect.

Region 3 **Exit Date**: 06/17/2023 **Purpose of Visit**: Complaint/Incident Investigations **Tags**: F580/N3010; F600/N3013; F607/N3478; F689/N4030 **Situations:** The facility failed to assess, treat, and inform a resident's physician when they were exposed to extreme heat and became unresponsive.
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, and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 4 **Exit Date**: 06/19/2023 **Purpose of Visit**: Complaint Investigation **Tags**: F600/N3481 **Situations:** The facility failed to protect a resident from abuse when a staff member hit them in the face, causing their nose to bleed.
Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect.

Region 6 **Exit Date**: 06/20/2023 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F600/N3481; F689/N4030; F742/N4042 **Situations:** The facility failed to initiate safety interventions or provide psychiatric services for a resident who had a documented history of depression and suicidal ideations. The facility failed to follow a physician's order for an urgent psychiatric consultation after they expressed suicidal ideations and attempted to elope from the facility several times, resulting in an eventual suicide attempt
Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect, failed to ensure adequate supervision and assistive devices were

provided to prevent accidents, and failed to ensure a resident who displayed, or is diagnosed with, mental disorder or psychosocial adjustment difficulty, or who has 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 8
Exit Date: 06/20/2023
Purpose of Visit: Complaint Investigation
Tags: F678/N3580
Situations: The facility failed to provide CPR to a resident with a full code status (code status that allows all interventions to restart the heart) after they were found unresponsive with no pulse or respirations.

Deficient Practice: The facility failed to provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders follow physician orders and the resident's advance directives.

Region 3
Exit Date: 06/23/2023
Purpose of Visit: Incident Investigation
Tags: F580/N3010; F684/N3937
Situations: The facility failed to assess and inform a physician after a resident's leg was documented to be swollen and painful, resulting in a lack of treatment and continued pain for the resident. The resident was ultimately diagnosed with a knee fracture.

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: 06/23/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F584/N3643
Situations: The facility failed to ensure the building was kept at a safe, comfortable temperature after a power outage, resulting in internal temperatures of up to ninety-two degrees. The failure continued for four days. One resident was hospitalized after exhibiting signs of heat exhaustion.

Deficient Practice: The facility failed to provide a safe, functional, sanitary, and comfortable environment.

Region 5
Exit Date: 06/26/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030

Situations: The facility failed to implement interventions to prevent a resident from eloping. The resident left the facility and was found dead near the facility by staff members.
Deficient Practice: The facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 4 **Exit Date**: 06/28/2023 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F600/N3481; F607/N3484; F689/N4030; F740/N4042 **Situations:** The facility failed to protect two residents from abuse by a third who grabbed one resident's arm hard enough to cause bleeding and stabbed the other with a pen and pushed them out of their wheelchair.
Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect, failed to ensure adequate supervision and assistive devices were provided to prevent accidents and failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of residents.

Region 5 **Exit Date**: 06/28/2023 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F689/N4030 **Situations:** The facility failed to implement interventions to prevent a resident from eloping. The resident left the facility and was found near a busy highway a mile from the facility.
Deficient Practice: The facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 5 **Exit Date**: 06/29/2023 **Purpose of Visit**: Standard Survey **Tags**: F689/N4030 **Situations:** The facility failed to ensure a resident was assessed upon admission to determine if they were safe to smoke independently. The resident was found smoking in the building on two separate occasions, smoking outside the building unsupervised on one occasion and was found with cigarette and drug paraphernalia in their room.
Deficient Practice: The facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 4 **Exit Date**: 06/29/2023 **Purpose of Visit**: Complaint Investigation **Tags**: F684/N3937

Situations: The facility failed to assess and treat a resident, who was on anti-coagulant medication, suffered a fall resulting in a raised area on their head. The facility continued in the failure for thirty-four hours before the resident had a change in condition and was sent to the hospital where they ultimately died.

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

Region 3
Exit Date: 06/29/2023
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to ensure a resident with diagnoses including atherosclerosis (thickening or hardening of the arteries) and cellulitis (a common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin) to their left leg received scheduled daily wound care per physician order, causing the resident's wounds to worsen. The facility failed to notify a physician of the resident's deteriorating wounds, which became malodorous and had live maggots embedded in a wound with no dressing.

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: 06/30/2023
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent a resident from eloping. The resident left the facility and was found a half mile from the facility.

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

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