# *Quarterly IJ Summary Report*
# *October 2020 – December 2020*

The following report presents information regarding all tags cited at the Immediate Jeopardy (IJ) level during licensing and certification surveys and complaint or incident investigations performed in nursing facilities during the fourth quarter of 2020 (10/01/2020 – 12/30/2020).

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 fifty-nine of the surveys and investigations conducted, resulting in seventy citations of fifteen 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). Due to the COVID-19 crisis, recertification surveys were suspended by the Centers for Medicare and Medicaid Services (CMS) until September.

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*** |
|---|---|---|---|
| 580 | 3% | 880 | 51% |
| 600 | 7% | 684 | 9% |
| 610 | 1% | 686 | 9% |
| 678 | 4% | 600 | 7% |
| 684 | 9% | 689 | 6% |
| 686 | 9% | 678 | 4% |
| 689 | 6% | 580 | 3% |
| 692 | 1% | 610 | 1% |
| 726 | 1% | 692 | 1% |
| 760 | 1% | 726 | 1% |
| 773 | 1% | 760 | 1% |
| 835 | 1% | 773 | 1% |
| 842 | 1% | 835 | 1% |
| 880 | 51% | 842 | 1% |
| 886 | 1% | 886 | 1% |

*Rounded to the nearest tent

**Table 2**

| Region | # of IJs | # of NFs | % of IJs/NF |
|---|---|---|---|
| 1 | 4 | 89 | 4.49% |
| 2 | 0 | 136 | 0.00% |
| 3 | 14 | 232 | 6.03% |
| 4 | 13 | 193 | 6.74% |
| 5 | 13 | 188 | 6.91% |
| 6 | 7 | 174 | 4.02% |
| 7 | 6 | 231 | 2.60% |
| Total | 57 | 1243 | 4.59% |

**Table 3**
**Number of IJs**

| from Complaints | from Incidents | from Surveys | From Other | Total |
|---|---|---|---|---|
| 42 | 5 | 5 | 7 | 59 |

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**Tag References**

**483.10 - Resident Rights:**
580 Notify of Changes (Injury/Decline/Room, Etc.)

**483.12 - Freedom from Abuse, Neglect, and Exploitation:**
600 Free from Abuse and Neglect
610 Investigate/Prevent/Correct Alleged Violation

**483.24 - Quality of Life:**
678 – Cardio-Pulmonary Resuscitation

**483.25 - Quality of Care:**
684 Quality of Care
686 Treatment/Svcs to Prevent/Heal Pressure Ulcers
689 Free of Accident Hazards/Supervision/Devices
692 Nutrition/Hydration Status Maintenance

**483.35 Nursing Services**
726 Competent Nursing Staff

**483.45 - Pharmacy Services:**
760 Residents are Free of Significant Med Errors

**483.50 – Laboratory, Radiology, and Other Diagnostic Services:**
773 Lab Svcs Physician Order/Notify of Results

**483.70 - Administration:**
835 Administration
842 Resident Records – Identifiable Information
880 Infection Prevention & Control

**483.75 – Quality Assurance and Performance Improvement:**

**Acronyms**

**CPR** – Cardio-Pulmonary Resuscitation
**LAR** – Legally Authorized Representative
**PPE** – Personal Protective Equipment

**Region 4**
**Exit Date**: 10/01/2020
**Purpose of Visit:** Complaint Investigation
**Tags**: F580/N1131; F684/N1416
**Situations:** The facility failed to identify the resident's physician or LAR and did not assess and treat the resident when wounds were discovered on their toes. The resident was admitted to the hospital twenty-five days after the wounds were noted with gangrene.

**Deficient Practice:** The facility failed to notify a physician or family/LAR of significant changes in condition and failed to ensure that residents received treatment and care in accordance with the professional standards of practice and comprehensive person-centered care plan.

**Region 6**
**Exit Date**: 10/05/2020
**Purpose of Visit**: Standard Survey; Focused Infection Control Survey
**Tags**: F686/N1422/N1423
**Situations**: The facility failed to ensure three residents received effective treatment for pressure ulcers resulting in deterioration of the ulcers after they were identified.

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

**Region 3**
**Exit Date**: 10/05/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F686/N1423; F880/N1647
**Situations:** The facility failed to perform proper assessments to identify pressure ulcers on three residents and had failed to implement treatment plans as ordered by a physician for two of them. The facility failed to ensure staff were effectively utilizing PPE and did not effectively cohort residents based on their exposure to COVID-19.

**Deficient Practice:** The facility failed to provide the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice to prevent development and worsening of pressure ulcers and failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 4**
**Exit Date**: 10/07/2020
**Purpose of Visit**: Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to ensure a staff member who tested positive for COVID-19 did not return to work and expose staff and residents who were negative and failed to cohort staff.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 6**
**Exit Date**: 10/08/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to screen employees, failed to keep a log of staff and visitor screening results, and failed to ensure effective use of PPE.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 7**
**Exit Date**: 10/09/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F600/N1284; F610/N1292
**Situations:** The facility failed to protect a resident from non-consensual sexual acts with another resident. The facility failed to effectively investigate when two other residents were found in a potentially non-consensual sexual act.

**Deficient Practice:** The facility failed to implement policies and procedures to prevent abuse and failed to ensure that all alleged violations involving abuse were thoroughly investigated, failed to take corrective action and prevent further potential abuse and failed to report results of investigations in accordance with state law.

**Region 3**
**Exit Date**: 10/10/2020
**Purpose of Visit**: Standard Survey; Focused Infection Control Survey
**Tags**: F689/N1432
**Situations:** The facility failed to contact emergency services when a resident had a choking episode that lasted approximately thirty minutes and became unresponsive as staff were unable to remove the obstruction. The resident was pronounced dead at the facility.

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

**Region 1**
**Exit Date**: 10/11/2020
**Purpose of Visit**: Focused Infection Control Survey
**Tags**: F880/N1647

**Situations:** The facility failed to separate residents who were positive for COVID-19 from those who were negative, failed to designate staff accordingly, and failed to ensure effective use of PPE.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 3**
**Exit Date**: 10/14/20
**Purpose of Visit**: Complaint/Incident Investigation
**Tags**: F678; F684/N1416
**Situations:** The facility failed to effectively assess and treat a resident who had a change in condition and was discovered with a "gurgling" sound coming from their gastronomy tube, was lethargic, and had a reduced level of responsiveness. The resident eventually became unresponsive and did not have a pulse or respirations. The facility, due to confusion over the resident's code status, did not immediately initiate CPR. The resident died at the facility.

**Deficient Practice:** The facility failed to ensure CPR was provided in accordance with professional standards and failed to ensure residents received treatment and care in accordance with professional standards.

**Region 4**
**Exit Date**: 10/15/2020
**Purpose of Visit**: Complaint Investigation
**Tags**: F880/N1647
**Situations:** The facility failed to ensure effective use of PPE, failed to cease communal dining and did not implement social distancing, did not have an infection control preventionist on staff, failed to perform resident assessments three times a day, and did not cohort residents and staff.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 4**
**Exit Date**: 10/16/2020
**Purpose of Visit**: Standard Survey; Focused Infection Control Survey
**Tags**: F689/N1433
**Situations:** The facility failed to ensure a resident with exit-seeking behavior did not elope from the facility. The resident was found on a high-traffic bridge on a street which crossed multiple railroad tracks.

**Deficient Practice:** The facility failed to ensure residents received appropriate supervision to prevent accidents.

**Region 6**
**Exit Date**: 10/18/2020
**Purpose of Visit**: Complaint Investigation
**Tags**: F600/N1284; F686/N1422/N1423
**Situations:** The facility failed to implement their wound management procedures on the COVID-designated unit, resulting in two residents developing pressure ulcers. The facility failed to effectively treat the ulcers causing them to deteriorate.

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

**Region 5**
**Exit Date**: 10/19/2020
**Purpose of Visit**: Complaint Investigation
**Tags**: F684/N1130
**Situations:** The facility failed to effectively assess and treat two residents who had significant changes in condition. One resident experienced significant decreases in oxygen levels and was ultimately transferred to the hospital where they died. The other resident began to have blood in their stool and severely low blood pressure and was found dead in their room two hours after the symptoms were first identified.

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

**Region 5**
**Exit Date**: 10/19/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F880/N1647/N1653
**Situations:** The facility failed to perform resident assessments three times a day, failed to ensure staff were able to identify and report symptoms of COVID-19, failed to implement effective sanitation practices and effective use of PPE, and failed to ensure residents were regularly tested for COVID-19.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 3**
**Exit Date**: 10/20/2020
**Purpose of Visit**: Complaint/Incident Investigation
**Tags**: F600/N1285; F684/N1416; F760/N1442; F842/N1784
**Situations:** The facility failed to ensure two residents received proper care and medication when their documentation was assigned to the other resident upon

admission. The residents did not receive their prescribed medication, instead receiving the other's medication for two days after admission.

**Deficient Practice:** The facility failed to implement policies and procedures to prevent neglect, failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive, person-centered care plan, failed to ensure residents were free of significant medication errors, and failed to ensure medical records were complete, accurately documented, readily accessible, and systematically organized.

**Region 4**
**Exit Date**: 10/23/2020
**Purpose of Visit**: Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to quarantine a resident after their roommate tested positive for COVID-19, did not monitor the resident's temperature, did not communicate the resident's unknown COVID status to the staff, and did have signage outside of the resident's room indicating their unknown status.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 1**
**Exit Date**: 10/23/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to ensure effective use and disposal of PPE and failed to quarantine residents with symptoms of COVID-19.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 3**
**Exit Date**: 10/27/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to ensure staff were tested for COVID-19 and that they did not come to work while exhibiting symptoms of the disease.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 7**
**Exit Date**: 10/28/2020
**Purpose of Visit**: Complaint/Incident Investigation; Focused Infection Control Survey

**Tags**: F678/N1307
**Situations:** The facility failed to be aware of a resident's code status and to immediately initiate CPR on a resident who was found unresponsive with no pulse or respirations.

**Deficient Practice:** The facility failed to ensure CPR was provided in accordance with professional standards.

**Region 3**
**Exit Date**: 10/30/2020
**Purpose of Visit**: Focused Infection Control Survey
**Tags**: F880
**Situations:** The facility failed to ensure effective use of PPE and failed to remove residents from the quarantine unit after they had completed a 14-day quarantine. The facility provided therapy to the potentially re-exposed residents in the communal therapy department.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 7**
**Exit Date**: 10/30/2020
**Purpose of Visit**: Complaint/Incident Investigation
**Tags**: F600/N1284
**Situations:** The facility failed to protect a resident from abusive threats from a staff member, who shouted at the resident, used offensive language, and threatened to kill the resident. The facility allowed the staff member to continue working following the altercation with the resident.

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

**Region 7**
**Exit Date**: 11/01/2020
**Purpose of Visit**: Complaint/Incident Investigation; Focused Infection Control Survey
**Tags**: F686/N1423
**Situations:** The facility failed to provide wound care as ordered by a physician for five residents to ensure pressure ulcers were properly treated and did not deteriorate.

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

**Region 4**
**Exit Date**: 11/02/2020
**Purpose of Visit**: Complaint/Incident Investigation; Focused Infection Control Survey
**Tags**: F886/N2201

**Situations:** The facility failed to test staff based on the county's COVID-19 positivity rate.

**Deficient Practice:** The facility failed to ensure testing parameters set forth by the Secretary of State related to COVID-19.

**Region 5**
**Exit Date**: 11/02/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to screen employees, failed to ensure effective use of PPE, failed to cohort staff and residents, and failed to implement effective sanitation practices.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 4**
**Exit Date**: 11/04/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F880/N1647; F835/N1742
**Situations:** The facility failed to quarantine a resident after their roommate tested positive for COVID-19. The facility failed to ensure a resident moved to the COVID-positive unit was cared for effectively. The facility failed to review and update their policies to mitigate staffing shortages due to COVID-19.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained, failed to ensure resources were utilized effectively and efficiently to attain or maintain the highest practicable well-being.

**Region 3**
**Exit Date**: 11/05/2020
**Purpose of Visit**: Incident Investigation; Focused Infection Control Survey
**Tags**: F689/N1432
**Situations:** The facility failed to ensure that a resident's oxygen and nasal cannula (plastic tube that supplies the oxygen from the oxygen storage device/generator) prior to being allowed into the smoking area. The resident received burns when the oxygen ignited while trying to light a cigarette and required transfer to a hospital.

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

**Region 5**
**Exit Date**: 11/06/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F880/N1647

**Situations:** The facility failed to cohort staff, failed to screen essential visitors prior to entry, failed to ensure effective use of PPE, and failed to implement effective sanitation practices.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 3**
**Exit Date**: 11/12/2020
**Purpose of Visit**: Complaint/Incident Investigation
**Tags**: F678/N1307
**Situations:** The facility failed to ensure CPR was provided to a resident with a full code status (status that allows all interventions to restart the heart). CPR was not initiated for thirteen minutes after the resident was found unresponsive with no pulse or respirations. The resident was pronounced dead at the hospital.

**Deficient Practice:** The facility failed to ensure CPR was provided in accordance with professional standards.

**Region 3**
**Exit Date**: 11/12/2020
**Purpose of Visit**: Complaint/Incident Investigation
**Tags**: F880/N1621
**Situations:** The facility failed to ensure staff who displayed symptoms of COVID-19 did not provide direct care to non-positive residents, failed to ensure staff and visitors were screened prior to entrance, and failed to track the spread of COVID-19 within the facility.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 3**
**Exit Date**: 11/15/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F686/N1423
**Situations:** The facility failed to assess and treat a resident's pressure ulcers, resulting in the resident requiring hospitalization due to an altered mental state and low blood pressure. The resident was diagnosed with sepsis and the ulcer had become necrotic (death of tissue). The facility failed to identify, assess, and treat the pressure ulcers of two other residents, resulting in the ulcers deteriorating.

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

**Region 5**

**Exit Date**: 11/16/2020
**Purpose of Visit**: Incident Investigation; Focused Infection Control Survey
**Tags**: F880/N1647/N2179/N2185
**Situations:** The facility failed to cohort staff, failed to ensure effective use and storage of PPE, and failed to monitor residents for symptoms of COVID-19.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 5**
**Exit Date**: 11/16/2020
**Purpose of Visit**: Complaint/Incident Investigation; Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to regularly assess residents for symptoms of COVID-19 and failed to have designated COVID-positive areas of the facility.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 1**
**Exit Date**: 11/16/2020
**Purpose of Visit**: Complaint Investigation
**Tags**: F880/N1647
**Situations:** The facility failed to cohort staff, failed to ensure effective use of PPE, and failed to implement effective sanitation practices.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 5**
**Exit Date**: 11/17/2020
**Purpose of Visit**: Complaint/Incident Investigation; Focused Infection Control survey
**Tags**: F880/N1647
**Situations:** The facility failed to cohort residents and staff, failed to screen staff for symptoms of COVID-19 prior to entrance, and failed to ensure effective use of PPE.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 5**
**Exit Date**: 11/18/2020
**Purpose of Visit**: Incident Investigation; Focused Infection Control Survey
**Tags**: F880/N1647

**Situations:** The facility failed to screen employees for symptoms of COVID-19 and failed to cohort staff.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 6**
**Exit Date**: 11/20/2020
**Purpose of Visit**: Incident Investigation; Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to quarantine newly admitted residents until their COVID-19 status was determined, failed to report a positive COVID-19 test result, and failed to ensure effective use of PPE.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 5**
**Exit Date**: 11/22/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to cohort staff and residents based on COVID-19 status and failed to ensure adequate supply and effective use of PPE.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 5**
**Exit Date**: 11/23/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to screen employees prior to entrance, failed to ensure effective use of PPE, and failed to ensure residents who tested positive for COVID-19 were moved to an isolation unit.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 3**
**Exit Date**: 11/24/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F880/N1647

**Situations:** The facility failed to ensure adequate supply and effective use of PPE and failed to cohort residents based on COVID-19 status.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 7**
**Exit Date**: 11/25/2020
**Purpose of Visit**: Complaint/Incident Investigation; Focused Infection Control Survey
**Tags**: F580/N1130
**Situations:** The facility failed to inform two residents' physicians when the residents had a change in condition. One resident displayed increased shortness of breath and anxiety and developed bilateral upper extremity edema (swelling due to excess fluid). The resident was transferred to the hospital where they died. Another resident was diagnosed with pneumonia and increasingly displayed abnormal breathing, developed cyanosis (discoloration of skin due to low oxygen delivery to the tissue), and abnormal lung sounds. The resident died at the facility two days following the diagnosis.

**Deficient Practice:** The facility failed to notify a physician or family/LAR of significant changes in condition.

**Region 3**
**Exit Date**: 11/25/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to cohort residents based on their COVID-19 status and failed to ensure proper use of PPE.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 3**
**Exit Date**: 11/27/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to isolate residents after they tested positive for COVID-19, failed to ensure residents were assessed for symptoms of COVID-19, and failed to ensure hospice providers provided negative COVID-19 results prior to working with residents. Those residents who were cared for by hospice staff later tested positive for COVID-19. The facility allowed a resident's parent, who was not an essential caregiver and had not been trained in infection control and use of PPE, to transport the resident to a doctor's visit.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 5**
**Exit Date**: 11/28/2020
**Purpose of Visit**: Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to screen employees prior to entrance and failed to ensure residents with an unknown COVID-19 status were isolated from those who were negative.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 5**
**Exit Date**: 12/01/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to have policies in place to test staff and residents who were possibly exposed to COVID-19, failed to cohort staff, and failed to utilize effective isolation techniques.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 4**
**Exit Date**: 12/02/2020
**Purpose of Visit**: Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to isolate a resident after their roommate tested positive for COVID-19, failed to cohort staff, and failed to ensure effective use of PPE.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 4**
**Exit Date**: 12/02/2020
**Purpose of Visit**: Complaint/Incident Investigation; Focused Infection Control Survey
**Tags**: F880/N2171
**Situations:** The facility failed to screen staff for symptoms of COVID-19 prior to entrance and failed to ensure staff who tested positive for COVID-19 did not provide care to residents who were negative.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 4**
**Exit Date**: 12/04/2020
**Purpose of Visit**: Standard Survey
**Tags**: F880/N16477/N1658/N1701
**Situations:** The facility failed to effectively isolate residents who were positive for COVID-19.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 7**
**Exit Date**: 12/05/2020
**Purpose of Visit**: Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to remove a resident who was negative for COVID-19 after the unit in which they resided was converted to the COVID-positive unit and failed to ensure effective use of PPE.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 5**
**Exit Date**: 12/07/2020
**Purpose of Visit**: Complaint/Incident Investigation; Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to ensure residents were regularly tested for COVID-19, failed to cohort staff, failed to designate an entrance and exit to the COVID-positive unit, and failed to ensure effective use of PPE.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 1**
**Exit Date**: 12/08/2020
**Purpose of Visit**: Complaint/Incident Investigation
**Tags**: F692/N1434; F726/N1446
**Situations:** The facility failed to implement a plan of care after a resident had an unexplained forty-eight-pound weight loss. The facility failed to obtain a doctor's order for removal of the resident's post-surgery staples, which stayed in place for almost two months until the resident went into cardiac arrest at the facility and subsequently died at the hospital.

**Deficient Practice:** The facility failed to ensure a resident maintained acceptable parameters of nutritional status and failed to have sufficient nursing staff with the

appropriate competencies and skills sets to provide nursing and related services to assure resident safety and maintain the highest practicable well-being of residents.

**Region 4**
**Exit Date**: 12/09/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to protect residents from exposure to COVID-19 when a staff member who was exposed to the disease provided direct care to residents and failed to ensure effective use of PPE.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 4**
**Exit Date**: 12/11/2020
**Purpose of Visit**: Complaint Investigation
**Tags**: F773/N1774
**Situations:** The facility failed to inform a resident's nurse practitioner of critical lab values. The resident ultimately required hospitalization and died.

**Deficient Practice:** The facility failed to promptly consult the nurse practitioner of critical lab results.

**Region 6**
**Exit Date**: 12/13/2020
**Purpose of Visit**: Complaint/Incident Investigation
**Tags**: F684/N1416
**Situations:** The facility failed to complete weekly labs for a resident as recommended by the resident's physician to monitor the resident's need for dialysis, and failed to follow up with their abnormal kidney filtration lab result which indicated kidney failure and a need to continue previously discontinued dialysis therapy. The facility failed to accurately assess the resident and treat their deteriorating condition.

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

**Region 1**
**Exit Date**: 12/14/2020
**Purpose of Visit**: Incident Investigation
**Tags**: F689/N1433

**Situations:** The facility failed to supervise a resident during the evening shift change and allowed the resident to elope from the facility.

**Deficient Practice:** The facility failed to ensure that each resident received adequate supervision to prevent accidents.

**Region 4**
**Exit Date**: 12/19/2020
**Purpose of Visit**: Complaint/Incident Investigation; Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to screen staff and visitors for symptoms of COVID-19 prior to entrance prior to entrance, failed to ensure effective use of PPE, and failed to cohort staff.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 3**
**Exit Date**: 12/20/2020
**Purpose of Visit**: Standard Survey; Focused Infection Control Survey
**Tags**: F880/N1647
**Situations:** The facility failed to screen staff for symptoms of COVID-19 prior to entrance and failed to implement effective sanitation practices.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.

**Region 6**
**Exit Date**: 12/21/2020
**Purpose of Visit**: Complaint Investigation
**Tags**: F600/N1284; F686/N1422/N1423
**Situations:** The facility failed to have a system in place to identify and treat pressure ulcers, resulting in five residents developing new and worsening pressure ulcers. The facility failed to inform the residents' physicians.

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

**Region 6**
**Exit Date**: 12/22/2020
**Purpose of Visit**: Complaint Investigation

**Tags**: F684/N1416
**Situations:** The facility failed to assess a resident's vital signs three times a day, as ordered by the resident's physician. The facility failed to inform the resident's physician or alert emergency services when the resident exhibited shortness of breath and increased blood pressure.

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

**Region 4**
**Exit Date**: 12/30/2020
**Purpose of Visit**: Complaint Investigation; Focused Infection Control Survey
**Tags**: F880/N1647/N2158
**Situations:** The facility failed to protect residents from exposure to COVID-19 when eleven staff members who reported symptoms of COVID-19 were allowed to provide care to residents.

**Deficient Practice:** The facility failed to ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained.