

Quarterly IJ Summary Report April 2021 – June 2021

The following report presents information regarding all tags cited at the Immediate Jeopardy (IJ) level during licensing and certification surveys and complaint or incident investigations performed in nursing facilities during the second quarter of 2021 (04/01/2021 – 06/31/2021).

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

During this period, an IJ level tag was cited for twenty-four of the surveys and investigations conducted, resulting in forty citations of eighteen 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*
580	8%	600	20%
600	20%	684	15%
602	3%	689	10%
604	5%	580	8%
607	3%	604	5%
609	3%	610	5%
610	5%	686	5%
656	3%	755	5%
678	3%	835	5%
684	15%	602	3%
686	5%	607	3%
689	10%	609	3%
693	3%	656	3%
700	3%	678	3%
755	5%	693	3%
760	3%	700	3%
835	5%	760	3%
921	3%	921	3%

*Rounded to the nearest tent



Table 2

Region	# of IJs	# of NFs	% of IJs/NF
1	2	88	2.27%
2	3	135	2.22%
3	3	229	1.75%
4	9	192	4.69%
5	2	188	1.06%
6	1	171	0.58%
7	3	223	1.35%
Total	23	1226	1.88%

Table 3
Number of IJs

from Complaints	from Incidents	from Surveys	Total
15	4	5	24

Tag References

483.10 – Resident Rights:

580 Notification of Changes (Injury/Decline/Room, Etc.)

483.12 – Freedom from Abuse, Neglect, and Exploitation:

600 Free from Abuse and Neglect

602 Free from Misappropriation/Exploitation

604 Right to be Free from Physical Restraints

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

483.24 – 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

693 Tube Feeding Management/Restore Eating Skills

700 Bedrails



483.45 Pharmacy Services

755 Pharmacy Svcs/Procedures/Pharmacist/Records

760 Residents Are Free of Significant Med Errors

483.70 - Administration:

835 Administration

483.90 – Physical Environment:

921 Safe/Functional/Sanitary/Comfortable Environment

Acronyms

CDC – Centers for Disease Control

HHS – Health and Human Services



TEXAS
Health and Human
Services

Region 4**Exit Date:** 04/01/2021**Purpose of Visit:** Standard Survey**Tags:** F678/N1321**Situations:** The facility failed to immediately provide CPR and call emergency services for a resident who was full code (code status that allows full interventions to restart the heart) when the resident was found without a pulse. The resident was pronounced dead on arrival at the hospital.**Deficient Practice:** The facility failed to ensure that a resident's CPR orders were followed.**Region 2****Exit Date:** 04/10/2021**Purpose of Visit:** Complaint/Incident Investigation; Focused Infection Control Survey**Tags:** F600/N1283; F684**Situations:** The facility failed to provide a timely assessment of a resident when they were found with blood pooling beneath their head on their bed. The resident was not assessed for nearly seven hours and was ultimately transferred to the hospital presenting with widespread infection causing organ failure, dangerously low blood pressure, and fracture of the cervical nerves.**Deficient Practice:** The facility failed to implement policies and procedures to prevent neglect 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 3****Exit Date:** 04/10/2021**Purpose of Visit:** Standard Survey**Tags:** F684/N1446**Situations:** The facility failed to identify a change in condition for a resident after they experienced several falls and did not recognize when the resident exhibited behavioral changes. The resident was transferred to the hospital and was diagnosed with a traumatic subdural hematoma.**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 5****Exit Date:** 04/13/2021**Purpose of Visit:** Complaint Investigation**Tags:** F600/N1283; F684/N1446; F755/N1657**Situations:** The facility failed to ensure that four residents with pressure ulcers were monitored and effectively treated to ensure the wounds did not deteriorate and failed to ensure staff were trained in proper wound care. The facility failed to have a system in

place to ensure residents received medication, including insulin, in the even there was a power outage, disaster, or computer system failure, resulting in four residents missing their scheduled doses of medication.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect and failed to ensure that residents received treatment and care in accordance with the professional standards of practice and comprehensive person-centered care plan, and failed to provide pharmaceutical services, including procedures that assure the accurate acquiring and administering of all drugs to meet the needs of the residents.

Region 4

Exit Date: 04/13/2021

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

Tags: F656/N1399; F684/N1446

Situations: The facility failed to accommodate a resident's desire to see their spouse and to address the resident's unrealistic expectations to leave the facility to do so. The facility failed to ensure that the resident's medications were provided prior to the resident signing out of the facility and failed to assess the resident's ability to care for themselves while out of the facility. The resident left the facility with another family to visit their spouse three hours away. The resident went into cardiac arrest while traveling and died.

Deficient Practice: The facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and timeframes to meet residents mental and psychological needs and failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive, person-centered care plan.

Region 3

Exit Date: 04/15/2021

Purpose of Visit: Standard Survey; Focused Infection Control Survey

Tags: F684/N1446

Situations: The facility failed to put a plan in place and monitor a resident with a history of falls. The resident fell and the facility failed to report the incident. An x-ray revealed that the resident sustained a hip fracture.

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 4

Exit Date: 04/16/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F580/N1130; F600/N1284; F610/N1305; F684/N1446; F686/N1449

Situations: The facility failed to ensure that a resident received necessary care and services to address their diabetes. The resident routinely had blood glucose levels below seventy (normal blood glucose levels are between seventy and 130), and the facility did



not continue to monitor to ensure the levels became normal and did not inform the resident's physician. The resident was ultimately found unresponsive, with a blood glucose level of thirty-nine. The facility failed to ensure the same resident received care and treatment for their pressure ulcers. The resident's pressure ulcers continued to deteriorate, became infected, and eventually the resident required amputation of the right leg below the knee. The facility failed to ensure that two residents who alleged emotional and physical abuse by a staff member were protected and failed to fully investigate the allegations, resulting in emotional distress.

Deficient Practice: The facility failed to consult with the physician/LAR regarding a change in condition, failed to implement policies and procedures to prevent neglect or abuse, failed to ensure all alleged violations involving abuse were thoroughly investigated and failed to prevent further potential abuse, failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive, person-centered care plan, 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 2

Exit Date: 04/24/2021

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

Tags: F693/N1466

Situations: The facility failed to provide effective care to a resident with a gastrostomy tube (tube inserted through the belly that brings nutrition directly to the stomach). The resident was left flat during enteral feeding. The resident was found gurgling and unable to respond verbally. The resident was transferred to the hospital where they were diagnosed with aspiration pneumonia and had approximately fifty CCs of secretions suctioned out of their lungs. The resident ultimately died in the hospital.

Deficient Practice: The facility failed to ensure that a resident who was fed by enteral feeding received the appropriate treatment and services to prevent complications.

Region 3

Exit Date: 05/03/2021

Purpose of Visit: Standard Survey

Tags: F604/N1295; F700/N1743/1474

Situations: The facility, prior to installation of bed rails for all residents, failed to assess entrapment risks and attempt less restrictive measures, failed to obtain physician orders, and failed to obtain consent. The facility failed to develop a care plan related to bed rails for forty-seven of their eight-eight residents.

Deficient Practice: The facility failed to ensure that residents were free from physical restraints imposed for convenience and that are not required to treat the residents medical symptoms, failed to use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints, and failed to attempt to use appropriate alternatives prior to installing a side or bed rail, 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 of bed rails

Region 7

Exit Date: 05/06/2021

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

Tags: F689/N1476

Situations: The facility failed to protect residents with cognitive impairments. The facility left a bleach mix in one resident's room, which the resident drank, inducing vomiting, loose stool, and requiring intravenous fluids. The facility left prescription medication, nasal spray, and a skin ointment in another resident's room.

Deficient Practice: The facility failed to ensure the resident environment remained as free of accident hazards as is possible.

Region 1

Exit Date: 05/11/2021

Purpose of Visit: Incident Investigation

Tags: F760/N1671

Situations: The facility failed to monitor and assess a resident who was receiving antibiotics. The resident reacted poorly and developed respiratory failure requiring mechanical ventilation, acute kidney failure requiring dialysis, and required hospitalization.

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

Region 4

Exit Date: 05/14/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F689/N1477

Situations: The facility failed to supervise a resident after they were placed in their wheelchair and buckled into a harness. The resident was discovered dead with the harness around their neck approximately fifteen minutes later.

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

Region 4

Exit Date: 05/14/2021

Purpose of Visit: Complaint Investigation; Focused Infection Control Survey

Tags: F580/N1131; F686/N1449

Situations: The facility failed to consult a resident's physician and schedule wound care for a resident's pressure ulcer on their foot after it was recommended by a podiatrist. The resident was transferred to the hospital nine days after the recommendation and was diagnosed with osteomyelitis (bone infection) and had their great toe amputated.



Deficient Practice: The facility failed to ensure the physician/LAR was consulted for a change of condition 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 7

Exit Date: 05/20/2021

Purpose of Visit: Complaint Investigation; Focused Infection Control Survey

Tags: F600/N1283; F607/N1285; F609/N1303/N1304; F610/N1294/N1306; F835/N1808

Situations: The facility failed to protect nine residents from verbal and physical abuse from multiple staff members. The residents reported physical and verbal aggression and rough treatment during care. The facility failed to report the incidents to HHS within two hours of the allegations and failed to thoroughly investigate the allegations and allowed the alleged perpetrators continued access to residents.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse, failed to ensure that all allegations involving abuse and neglect, were reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials including the State Survey agency (HHS), in accordance with State law through established procedures, failed to ensure all alleged violations involving abuse were thoroughly investigated and failed to prevent further potential abuse, and failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Region 2

Exit Date: 05/21/2021

Purpose of Visit: Incident Investigation

Tags: F580/N1131

Situations: The facility failed to notify a resident's physician when they had three hypoglycemic (low blood glucose levels) episodes. After the third episode the resident became unresponsive and had no respirations or heart beat. The resident had a do-not-resuscitate order and was pronounced dead.

Deficient Practice: The facility failed to immediately consult with resident's physician/LAR when there was a significant change in condition.

Region 4

Exit Date: 05/27/2021

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

Tags: F600/N1284

Situations: The facility failed to address a resident's inappropriate sexual behaviors following an incident of non-consensual sexual contact with another resident.



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

Region 5

Exit Date: 05/29/2021

Purpose of Visit: Complaint Investigation

Tags: F602/N1283

Situations: The facility failed to ensure a staff member who was barred from access to narcotics per the Texas Peer Assistance Program for Nurses did not have access to a resident's narcotic medication.

Deficient Practice: The facility failed to have safeguards in place to ensure residents' medications were not misappropriated.

Region 7

Exit Date: 06/08/2021

Purpose of Visit: Standard Survey

Tags: 755/N1657; F835/N1811

Situations: The facility failed to ensure the residents received appropriate pharmaceutical services. Twenty-one residents missed multiple doses of their medication.

Deficient Practice: The facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, and administering of medications and was not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

Region 6

Exit Date: 06/14/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F689/N1477

Situations: The facility failed to implement intervention for a resident who was cognitively impaired and unable to walk due to a previous fall that resulted in fractures. The resident sustained multiple unwitnessed falls and injuries of unknown origin in the facility which included head/face lacerations, subdural hematoma, skin tears, and a fractured clavicle. The resident was observed crawling out of their room on the floor and the facility failed to intervene. The resident crawled across a living area and then outside into a courtyard area unseen by staff until they were found outside crawling on their hands and knees approximately forty-five minutes later. The facility failed to promptly assist due to staff members recording the resident for approximately one minute before aiding. The facility failed to investigate the event and continued to fail to implement interventions. The resident was subsequently found out of their bed attempting to stand up from a crawling position by the bathroom door with blood stains. The resident was transferred to the hospital where they were diagnosed with a subdural hematoma and a fractured clavicle.



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

Region 4

Exit Date: 06/16/2021

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

Tags: F600/N1283; F604/N1295

Situations: The facility failed to ensure a resident was free from unnecessary physical restraints when a bed sheet was tied around the resident and then tied to their wheelchair. The resident attempted to walk and fell. The resident was sent to the hospital where they were diagnosed with a collapsed lung, head laceration, and closed fractures of two ribs. The resident required a chest tube and died three days later.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect and failed to ensure the right to be free from physical restraints imposed for purpose of convenience and not required to treat the resident's medical symptoms.

Region 1

Exit Date: 06/17/2021

Purpose of Visit: Incident Investigation

Tags: F600/N1284

Situations: The facility failed to ensure a safe environment for a resident when they were threatened with a taser after they exhibited negative behaviors.

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

Region 3

Exit Date: 06/18/2021

Purpose of Visit: Incident Investigation; Focused Infection Control Survey

Tags: F921/N1220

Situations: The facility failed to protect residents after the facility had confirmation of mold and asbestos and failed to ensure temperatures in two halls did not rise above 81 degrees.

Deficient Practice: The facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

Region 4

Exit Date: 06/18/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F600/N1284

Situations: The facility failed to implement interventions for a resident who exhibited inappropriate physical and sexual behaviors. The resident continuously entered two residents rooms while they slept, in one instance blocking the door with furniture to prevent staff from entering while they were in the room with the sleeping resident,



inappropriately touched another resident, and pulled another resident from their wheelchair.

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

Region 4

Exit Date: 06/21/2021

Purpose of Visit: Complaint/Incident Investigation

Tags: F689/N; F/N

Situations: The facility failed to implement interventions for a resident with exit-seeking behaviors. The resident eloped from the facility and was found approximately seventeen miles away.

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

