Quarterly IJ Summary Report
April 2022 – June 2022

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 2022 (04/01/2022 – 06/31/2022).

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-two of the surveys and investigations conducted, resulting in sixty-nine citations of twenty 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	6%	689	22%
600	10%	684	17%
610	1%	600	10%
678	3%	686	7%
684	17%	580	6%
686	7%	755	6%
689	22%	760	6%
692	4%	692	4%
693	3%	678	3%
694	1%	693	3%
700	1%	880	3%
712	1%	610	1%
726	1%	694	1%
755	6%	700	1%
757	1%	712	1%
758	1%	726	1%
760	6%	757	1%
772	1%	758	1%

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
880	3%	772	1%
908	1%	908	1%

*Rounded to the nearest tent

Table 2

Region	# Of IJs	# Of NFs	% Of IJs/NF
1	3	86	3.49%
2	4	136	2.94%
3	19	229	8.30%
4	12	189	6.35%
5	9	189	4.76%
6	10	169	5.92%
8	10	141	7.09%
11	2	79	2.53%
Total	**69**	**1218**	5.67%

Table 3
Number of IJs

from Complaints	from Incidents	from Surveys	Total
37	10	5	52

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
610 Investigatre/Prevent/Correct Alleged Violation

483.25 - Quality of Care:

678 Cardio-Pulmonary Resuscitation
684 Quality of Care
686 Treatment/Svcs to Prevent/Heal Pressure Ulcers
689 Free of Accident Hazards/Supervision/Devices
692 Nutrition/Hydration Status Maintenance
693 Tube Feeding Management/Restore Eating Skills
694 Parenteral/IV Fluids
700 Bedrails

483.35 Physician Services

TEXAS
Health and Human
Services

712 Physician Visits – Review Care/Notes/Order

483.35 Nursing Services

726 Competent Nursing Staff

483.45 Pharmacy Services

755 Pharmacy Svcs/Procedures/Pharmacist/Records
757 Drug Regimen is Free from Unnecessary Drugs
758 Free From Unnec Psychotropic Meds/PRN Use
760 Residents Are Free of Significant Med Errors

483.50 – Laboratory, Radiology, and Other Diagnostic Services:

772 Lab Services Not Provided On-Site

483.80 – Infection Control:

880 Infection Prevention & Control

483.90 – Physical Environment:

908 Essential Equipment, Safe Operating Condition

Acronyms

CPR – Cardiopulmonary Resuscitation
HHS – Health and Human Services
ICU – Intensive Care Unit
PPE – Personal Protective Equipment

Region 11
Exit Date: 04/01/2022
Purpose of Visit: Incident Investigation
Tags: F684/N1446
Situations: The facility failed to provide a resident with a pureed meal as ordered by a physician. The resident experienced a change in condition and was sent to the hospital where they were diagnosed with aspiration pneumonia (inflammation or infection of the lungs that occurs when foreign substances, such as food, are breathed into the lungs).

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

Region 6
Exit Date: 04/01/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N1446
Situations: The facility failed to ensure adequate supervision for a resident when the resident was not observed performing their usual routines. The resident, who missed three smoke breaks that were a part of their daily routine, was not observed by the facility for over 12 hours. The resident was found in their room unresponsive, cold to the touch, and had developed mottling to their skin.

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

Region 8
Exit Date: 04/02/2022
Purpose of Visit: Complaint Investigation
Tags: F580/N1131; F684/N1446
Situations: The facility failed to provide necessary respiratory care to a resident during an episode of acute respiratory distress, failed to contact the resident's physician, and delayed contacting emergency services for more than three hours, resulting in the resident passing away at the facility.

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

Region 8
Exit Date: 04/05/2022
Purpose of Visit: Complaint Investigation
Tags: F689/N1476
Situations: The facility failed to properly secure a construction area in the facility. One resident entered the construction site in their wheelchair causing the ceiling to collapse and injure the resident.

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

Region 6
Exit Date: 04/05/2022
Purpose of Visit: Complaint Investigation
Tags: F686/N1450
Situations: The facility failed to provide weekly skin assessments to a resident and to document and obtain treatment for a pressure ulcer identified. Nearly one month later, the resident had developed five additional pressure ulcers.

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

Region 4
Exit Date: 04/06/2022
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F692/N1462; F758/N1627
Situations: The facility failed to develop and implement interventions when a resident experienced a decrease in appetite and developed a greater need for assistance with eating and drinking. The facility did not obtain orders from a physician or dietician to address these issues and the resulting weight loss, which totaled a decrease of seventeen percent within a month. The facility failed to provide the resident with nutritional supplements as ordered. The facility failed to properly assess and attempt interventions other than psychotropic medication administration when a resident began experiencing adjustment difficulties and negative behaviors.

Deficient Practice: The facility failed to ensure residents maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance unless the resident's clinical condition demonstrated that this was not possible, or the resident's preferences indicated otherwise, and failed to ensure residents who have not used psychotropic drugs are not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record.

Region 3
Exit Date: 04/12/2022
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F580/N1131; F686/N1450
Situations: The facility failed to effectively assess two resident’s for pressure ulcers, did not contact the residents’ physicians, and did not effectively treat the ulcers to ensure they did not deteriorate. Both residents were ultimately admitted to the hospital, one with necrotizing fasciitis (serious bacterial infection that destroys tissue under the skin), the other with a urinary tract infection and sepsis (a potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues).

Deficient Practice: The failed to consult with the physician regarding a change in condition and 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: 04/13/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N1446
Situations: The facility failed to properly transcribe a resident's admission orders for their medication to treat liver disease. The facility provided more medication that was ordered before the error was caught after three days. The facility failed to consult the resident's physician and obtain new orders and stopped administering the medication. The facility failed to obtain labs to determine the effect of over-administration and subsequent lack of administration.

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

Region 3
Exit Date: 01/14/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1476/N1477
Situations: The facility failed to adequately supervise a resident to ensure they did not elope. The resident eloped out of the front door of the facility and was found nearly a mile away after someone in the nearby neighborhood notified law enforcement.

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

Region 4
Exit Date: 04/15/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1283; F689/N1477; F726/N1488/N1500
Situations: The facility failed to implement interventions to protect one resident from being sexually assaulted by another, and to prevent another resident being verbally and physically abused. In the latter situation, one resident was found screaming and standing threateningly over another and both were left alone while help was requested.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect, failed to ensure adequate supervision was provided to prevent accidents, failed to ensure nursing staff demonstrated competencies and skill sets necessary to care for resident needs.

Region 1
Exit Date: 04/15/2022
Purpose of Visit: Complaint Investigation

Tags: F760/N1671
Situations: The facility failed to follow a resident's hospital discharge orders related to their insulin administration. The resident missed eight doses of insulin over the course of three days and was found unresponsive in their room. The resident was transferred to the hospital where they died.
Deficient Practice: The facility failed to ensure each resident's drug regimen was free of significant medication errors.

Region 6
Exit Date: 04/16/2022
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F689/N1477
Situations: The facility failed to ensure a resident, who had a diagnosis of dementia and lived on the facility's secure unit, was provided with supervision when they were attending a doctor's appointment. The resident eloped from the doctor's office and was later reported to be found at a family member's house.
Deficient Practice: The facility failed to ensure adequate supervision was provided to prevent accidents.

Region 4
Exit Date: 04/19/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N1451
Situations: The facility failed to perform effective skin assessments for a resident with a wound on their feet. The resident developed gangrene (death of body tissue due to a lack of blood flow or a serious bacterial infection) resulting in amputation of all five toes.
Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 3
Exit Date: 04/22/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F755/N1657; F760/N1666
Situations: The facility failed to update a resident's anticonvulsant medication administration as ordered by a physician. Instead of discontinuing the resident's previous order, the facility administered the updated dosage in addition to the old dosage, resulting in the resident having seizures and requiring hospitalization.
Deficient Practice: The facility failed to ensure residents were free of significant medication errors.

Region 2
Exit Date: 04/22/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F610/N1306

Situations: The facility failed to investigate an allegation of abuse made by a resident and to prevent further potential abuse by allowing the alleged perpetrator to remain in the facility and have direct contact with the residents.

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

Region 3
Exit Date: 04/23/2022
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F760/N1657
Situations: The facility failed to ensure medications were administered to the correct residents, resulting in one resident receiving the medication of another, in addition to their own. The resident was admitted to the hospital due to an overdose that resulted in nausea and vomiting.

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

Region 4
Exit Date: 04/23/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1283
Situations: The facility failed to implement interventions to protect residents from sexual abuse from a resident on the dementia care unit. The facility failed to inform the perpetrators physician of the ongoing issue of inappropriate sexual behaviors and did not implement changes in the plan of care or effective monitoring.

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

Region 6
Exit Date: 40/25/2022
Purpose of Visit: Complaint Investigation
Tags: F600/N1283; F678/N1321
Situations: The facility failed to protect one resident from sexual abuse and three others from physical and verbal abuse by a resident with a history of such behaviors. The facility failed to provide CPR to a resident with a full code status (allowing all interventions to restart the heart) after the resident was found unresponsive.

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

Region 11
Exit Date: 04/26/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1284

Situations: The facility failed to ensure a resident, who was on a pureed diet, was provided the correct diet and supervision when they were fed a regular diet on which resulted the resident choking, losing consciousness, and requiring abdominal and back thrusts and CPR before being revived and receiving treatment at the hospital

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

Region 1
Exit Date: 04/27/2022
Purpose of Visit: Standard Survey
Tags: F689/N1477
Situations: The facility failed to provide multiple people to assist with transferring a resident, per the resident's care plan. The resident fell during a single-person transfer, sustaining a leg and elbow fracture.

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

Region 3
Exit Date: 04/27/2022
Purpose of Visit: Incident Investigation
Tags: F689/N1477
Situations: The facility failed to provide adequate supervision to a resident who eloped from the facility and was observed by a staff member crossing a road and falling at a median almost half a mile from the facility.

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

Region 5
Exit Date: 04/27/2022
Purpose of Visit: Standard Survey
Tags: F678/N1234
Situations: The facility failed to ensure a resident's directives were followed when the resident's EMR reflected them to have a DNR status while the resident wished to have a full code (allowing all interventions to restart the heart) status. The facility failed to ensure all direct-care staff members had current CPR certifications.

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

Region 2
Exit Date: 04/29/2022
Purpose of Visit: Incident Investigation
Tags: F689/N1477

Situations: The facility to ensure a resident was safely assisted out of the facility van after returning to the facility. The resident was dropped during exit resulting in multiple rib fractures and a compression fracture to their lower back.

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

Region 3
Exit Date: 04/30/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1477
Situations: The facility failed to provide adequate supervision to a resident who eloped from the facility because the elopement alert system could not be heard from the nurse's station. The resident was located over fifteen hours later more than three miles from the facility.

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

Region 4
Exit Date: 05/02/2022
Purpose of Visit: Incident Investigation
Tags: F684/N1446
Situations: The facility failed to monitor and assess a resident's foot after discoloration was documented. The resident developed gangrene (death of body tissue due to a lack of blood flow or a serious bacterial infection) and had to have their leg removed above the knee.

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

Region 5
Exit Date: 05/03/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N1449
Situations: The facility failed to ensure a resident received care to prevent the development of pressure ulcers and, once developed, to provide care to prevent deterioration. The facility failed to implement interventions when a resident began experiencing significant weight loss, resulting in a greater than eleven percent decrease over the course of two months.

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

Region 8
Exit Date: 05/05/2022
Purpose of Visit: Complaint/Incident Investigation

Tags: F689/N1477
Situations: The facility failed to provide adequate supervision to prevent two residents from eloping. Both eloped from the facility which was near a busy highway.

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

Region 8
Exit Date: 05/05/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1283
Situations: The facility failed to implement interventions to protect a resident from being sexually assaulted by another. The facility continued in this failure when they moved another resident into the same room as the perpetrator.

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

Region 6
Exit Date: 05/10/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N1450
Situations: The facility failed to adequately assess and treat a resident's pressure ulcers when they were admitted to the facility. The resident ultimately required hospitalization and was diagnosed with bilateral lower extremity cellulitis (a common and potentially serious bacterial skin infection), osteomyelitis (inflammation of bone caused by infection, generally in the legs, arm, or spine), and required partial foot amputation.

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 6
Exit Date: 05/11/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F755/N1657
Situations: The facility failed to ensure a resident received accurate medications. The resident was misidentified and given another resident's medication for six days, resulting in an altered mental status.

Deficient Practice: The facility failed to provide pharmaceutical services to meet the needs of the residents.

Region 3
Exit Date: 05/15/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N1449

Situations: The facility failed to ensure effective assessments and treatment for two residents who developed pressure ulcers. Both residents experienced deterioration of the wounds, one of whom subsequently required 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 1
Exit Date: 05/16/2022
Purpose of Visit: Incident Investigation
Tags: F689/N1477
Situations: The facility failed to provide adequate supervision to prevent resident altercations between residents with a history of violence and residents who wandered into others' rooms. Alterations between five different residents were noted.

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

Region 4
Exit Date: 05/19/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1284
Situations: The facility failed to perform sexual assessments on any residents and to determine their capacity for engaging in consensual sexual activity. The facility failed to develop plans of care that targeted residents' needs and to protect those without the mental capacity to determine the consequences of their actions. The facility failed to notify physicians of residents' inappropriate sexual behaviors.

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

Region 2
Exit Date: 05/23/2022
Purpose of Visit: Complaint Investigation
Tags: F689/N1476/N1477; F908/N1776
Situations: The facility failed to adequately supervise a resident with a history of wandering and at-risk for elopement. The resident eloped from the facility and fell, sustaining a forehead laceration that required twenty sutures and fractures in their spine. The facility failed to maintain battery operated door alarms on exit doors in multiple halls.

Deficient Practice: The facility failed to ensure that each resident received adequate supervision to prevent accidents and failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition.

Region 4
Exit Date: 05/25/2022

Purpose of Visit: Incident Investigation
Tags: F880/N2220
Situations: The facility failed to effectively screen staff for symptoms of COVID-19 and allowed a staff member who presented symptoms the previous day return to work without a negative COVID-19 test.

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 3
Exit Date: 05/27/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N1131/N1132; F684/N1446; F693/N1565; F694/N1467
Situations: The facility failed to ensure three residents with feeding tubes were provided with an adequate amount of water. Two of those residents required hospitalization. The facility failed to inform one of the resident's physicians that they had been without water for over seventy-two hours. The facility failed to assess a resident, who was on anticoagulant medication, when they began to present with blood in their urine and did not consult with the resident's physician.

Deficient Practice: The facility failed to consult with the resident's physician when there was a significant change in the resident's physical status, failed to ensure residents received treatment and care in accordance with professional standards of practice, failed to ensure that a resident who was fed by enteral feeding received the appropriate treatment and services to prevent complications, and failed to ensure parenteral fluids were administered consistent with professional standards.

Region 8
Exit Date: 06/04/2022
Purpose of Visit: Incident Investigation
Tags: F689/N1477
Situations: The facility failed to provide adequate supervision to prevent a resident from eloping. The resident eloped from the facility and traveled fifteen miles before they were found.

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

Region 3
Exit Date: 06/05/2022
Purpose of Visit: Incident Investigation; Focused Infection Control Survey
Tags: F700/N1473
Situations: The facility failed to assess a resident for risk of entrapment from bed rails and did not obtain informed consent for their use. The resident lodged their arm in the bed rail, resulting in a fracture.

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.

Region 5
Exit Date: 06/09/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F692/N1462
Situations: The facility failed to provide a resident with dietitian recommended and physician ordered diet for morning and noon meals, providing the resident with cereal for all three meals for about one year. The resident lost fourteen pounds over the course of four months.

Deficient Practice: The facility failed to ensure that acceptable parameters of nutritional status were maintained.

Region 4
Exit Date: 06/10/2022
Purpose of Visit: Standard Survey
Tags: F757/N1666
Situations: The facility failed to regularly obtain labs and monitor a resident's blood clotting ability while they were on anticoagulant medication, resulting in the facility being unaware when medication needed to be held.

Deficient Practice: The facility failed to ensure each resident's drug regimen was free from unnecessary drugs.

Region 4
Exit Date: 06/14/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1477
Situations: The facility failed to ensure a resident was properly secured in the facility van during transportation. The resident fell out of their wheelchair during transport, sustaining a lower back injury.

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

Region 8
Exit Date: 06/17/2022
Purpose of Visit: Complaint Investigation
Tags: F600/N1283
Situations: The facility failed to ensure a resident's environment was free of pests when they did not repair a damaged window screen. The resident was found with flies and maggots on them.

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

Region 6 **Exit Date**: 06/20/2022 **Purpose of Visit**: Standard Survey **Tags**: F693/N1465 **Situations:** The facility failed to ensure a resident was provided with their prescribed diet.
Deficient Practice: The facility failed to ensure that a resident who was fed by enteral feeding received the appropriate care, treatment, and services to prevent complications.

Region 3 **Exit Date**: 06/23/2022 **Purpose of Visit**: Incident Investigation **Tags**: F689/N1477 **Situations:** The facility failed to provide adequate supervision to prevent a resident from eloping. The resident eloped from the facility and was located by law enforcement at an apartment complex near the facility.
Deficient Practice: The facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

Region 3 **Exit Date**: 06/23/2022 **Purpose of Visit**: Complaint Investigation **Tags**: F684/N1446; F689/N1476 **Situations:** The facility failed to administer insulin to twelve residents and failed to administer pain medication to two residents. The facility failed to provide adequate supervision to prevent a resident from eloping. The resident eloped from the facility and was gone for an indeterminate amount of time without staff knowledge.
Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice and failed to ensure adequate supervision was provided to prevent accidents.

Region 5 **Exit Date**: 06/25/2022 **Purpose of Visit**: Standard Survey **Tags**: F580/N1131; F684/N1446; F712/N1609 **Situations:** The facility failed to provide treatment and care to a resident who had a forty-two-pound weight gain with a diagnosis of chronic kidney disease and who reported increased swelling in their limbs. The facility failed to notify the resident’s physician when they exhibited abnormally high blood pressure levels.
Deficient Practice: The facility failed to consult with the resident's physician when there was a significant change in the resident's physical status, failed to ensure residents received treatment and care in accordance with professional standards of

practice, and failed to ensure the medical care of each resident was supervised by a physician.

Region 8
Exit Date: 06/27/2022
Purpose of Visit: Complaint Investigation
Tags: F692/N1462
Situations: The facility failed to address a resident's weight loss after they lost over thirty pounds in a two-month period.

Deficient Practice: The facility failed to ensure that acceptable parameters of nutritional status were maintained.

Region 3
Exit Date: 06/27/2021
Purpose of Visit: Incident Investigation; Focused Infection Control Survey
Tags: F880/N1713
Situations: The facility failed to cohort residents based on their COVID-19 status and failed to ensure effective use of PPE.

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

Region 3
Exit Date: 06/27/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N1446
Situations: The facility failed to ensure a resident's admission orders including medications, were verified with the physician and transcribed correctly into the electronic medical records.

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

Region 8
Exit Date: 06/27/2022
Purpose of Visit: Complaint Investigation
Tags: F684/N1446; F772/N1823
Situations: The facility failed to assess and obtain a physician-ordered STAT blood test following a change in condition. The resident was admitted to the ICU where they were put on a breathing tube and diagnosed with a brain infection.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice and failed to provide laboratory services to meet the needs of the residents.

Region 5
Exit Date: 06/29/2022

Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F684/N1446; F755/N1656; F760/N1671
Situations: The facility failed to administer a resident's life-sustaining medication, tacrolimus (anti-rejection medication), as ordered by the physician. The resident missed fifty-seven doses of tacrolimus medication in a 105-day period. This failure likely contributed to the resident developing multi-organ failure and ultimately their death.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice, failed to ensure residents were free of significant medication errors, and failed to ensure each resident's drug regimen was free of significant medication errors.

Region 6
Exit Date: 06/30/2022
Purpose of Visit: Complaint Investigation
Tags: F755/N1657
Situations: The facility failed to ensure a resident received a scheduled dose of an anti-seizure medication through gastrostomy tube as ordered by the physician. The resident sustained a seizure lasting ten minutes and was transferred to the hospital while still seizing, requiring acute hospital evaluation and treatment.

Deficient Practice: The facility failed to provide pharmaceutical services that ensured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of residents.