Quarterly IJ Summary Report
January 2024 – March 2024

The following report presents information regarding all tags cited at the Immediate Jeopardy (IJ) level during licensing and certification surveys and complaint or incident investigations performed in nursing facilities during the first quarter of 2024 (01/01/2024 – 03/31/2024).

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 148 of the surveys and investigations conducted, resulting in 261 citations of forty 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*
551	0.4%	689	21.5%
552	0.4%	600	12.6%
578	1.5%	684	9.6%
580	8.4%	580	8.4%
584	1.5%	607	5.7%
600	12.6%	760	4.6%
602	0.4%	678	3.8%
607	5.7%	686	3.4%
609	1.9%	656	2.7%
610	1.5%	697	2.3%
635	0.4%	609	1.9%
655	0.4%	578	1.5%
656	2.7%	584	1.5%
657	0.4%	610	1.5%
660	0.4%	692	1.5%
678	3.8%	726	1.5%
684	9.6%	755	1.5%
686	3.4%	880	1.5%

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
689	21.5%	740	1.1%
692	1.5%	770	1.1%
693	0.8%	926	1.1%
695	0.8%	693	0.8%
697	2.3%	695	0.8%
698	0.8%	698	0.8%
725	0.4%	742	0.8%
726	1.5%	761	0.8%
740	1.1%	551	0.4%
742	0.8%	552	0.4%
755	1.5%	602	0.4%
757	0.4%	635	0.4%
760	4.6%	655	0.4%
761	0.8%	657	0.4%
770	1.1%	660	0.4%
776	0.4%	725	0.4%
805	0.4%	757	0.4%
835	0.4%	776	0.4%
839	0.4%	805	0.4%
880	1.5%	835	0.4%
921	0.4%	839	0.4%

*Rounded to the nearest tenth

Table 2

Region	# Of IJs	# Of NFs	% Of IJs/NF
1	2	82	2.44%
2	28	136	20.59%
3	35	221	15.84%
4	48	187	25.67%
5	42	187	22.46%
6	58	166	34.94%
8	36	142	25.35%
11	12	77	15.58%
Total	261	1198	21.79%

Table 3
Number of IJs

from Complaints	from Incidents	from Surveys	Total
98	17	33	148

Tag References

483.10 – Resident Rights:

551 Rights Exercised by Representative
552 Rights to be Informed/Make Treatment Decisions
578 Request/Refuse/Discontinue Treatment; Formulate Adv Dir
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
602 Free from Misappropriation/Exploitation
607 Develop/Implement Abuse/Neglect, etc. Policies
609 Reporting of Alleged Violations
610 Investigate/Prevent/Correct Alleged Violation

483.20 – Resident Assessments:

635 Admission Physician Orders for Immediate Care

483.21 – Comprehensive Resident Centered Care Plans:

655 Baseline Care Plan
656 Develop/Implement Comprehensive Care Plan
657 Care Plan Timing and Revision
660 Discharge Planning Process

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
698 Dialysis

483.35 Nursing Services

725 Sufficient Nursing Staff
726 Competent 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
757 Drug Regimen is Free from Unnecessary Drugs
760 Residents are Free of Significant Med Errors
761 Label/Store Drugs & Biologicals

483.50 – Laboratory, Radiology, and Other Diagnostic Services:

770 Laboratory Services
776 Radiology/Other Diagnostic Services

483.60 – Food and Nutrition Services:

805 Food in Form to Meet Individual Needs

483.70 – Administration:

835 Administration
839 Staff Qualifications

483.80 – Infection Control:

880 Infection Prevention & Control

483.90 Physical Environment

921 Safe/Functional/Sanitary/Comfortable Environment
926 Smoking Policies

Acronyms

AED – Automated External Defibrillator
CPR – Cardiopulmonary Resuscitation
PPE – Personal Protective Equipment

Region 3
Exit Date: 01/02/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F684/N3937; F760/N4600
Situations: The facility failed to ensure a resident was administered their blood pressure medication, did not effectively monitor and record the resident's blood pressure, and did not inform the resident's physician of the missed medication and multiple incidents of elevated blood pressure.

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 residents are free of any significant medication errors.

Region 4
Exit Date: 01/02/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N3946
Situations: The facility failed to perform weekly skin assessments on a resident who wore an immobilizing boot resulting in the resident developing 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 2
Exit Date: 01/05/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement effective supervision to prevent elopements. A resident eloped from the facility and was found two hours later in forty-four-degree weather and had fallen in a wet ditch. The resident was hospitalized with hypothermia.

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

Region 4
Exit Date: 01/08/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement effective supervision to prevent elopements. A resident, who was identified as at-risk for elopement, eloped from the facility without staff knowledge. The facility failed to ensure the resident's elopement monitoring bracelet was regularly checked for functionality.

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

Region 11
Exit Date: 01/08/2024
Purpose of Visit: Complaint Investigation
Tags: F635/N3712; F760/N4600
Situations: The facility failed to properly implement hospital discharge orders and to begin administering a resident's prescribed medications for eight days.

Deficient Practice: The facility

Region 8
Exit Date: 01/10/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to monitor a resident after they became unresponsive with low blood pressure and did not notify a physician of the resident's complaints of nausea, abdominal pain, and decreased appetite. The resident died 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 3
Exit Date: 01/11/2024
Purpose of Visit: Standard Survey
Tags: F584/N3628
Situations: The facility failed to ensure temperatures were maintained at a safe, comfortable level after the heater failed. Areas of the facility were measured below sixty degrees.

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

Region 5
Exit Date: 01/12/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure adequate supervision to prevent a resident from spilling hot coffee on themselves, resulting in the resident sustaining second-degree burns.

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

Region 5
Exit Date: 01/12/2024
Purpose of Visit: Standard Survey
Tags: F880/N4723

Situations: The facility failed to isolate a resident with scabies, resulting in five others developing rashes. The facility failed to administer and store medication and oxygen supplies in a sanitary manner.

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

Region 5
Exit Date: 01/12/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937
Situations: The facility failed to ensure a resident, with a diagnosis of pneumonia and requiring oxygen via an oxygen mask, was transferred to the hospital after a significant change in condition, including an altered mental status and abnormal vital signs. The resident was left unsupervised after receiving their meal and being left without their oxygen mask and was later found unresponsive. The resident died at the facility.

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

Region 4
Exit Date: 01/12/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937; F740/N4042
Situations: The facility failed to provide care to a resident's wound after the resident refused treatment. The facility failed to evaluate the resident's ability to make decisions, failed to implement mental health care interventions, failed to inform the resident's physician of their refusal for treatment, and to identify other means of providing care.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice and failed to ensure each resident received necessary behavioral health care services to maintain the residents' highest practicable mental and psychosocial wellbeing.

Region 3
Exit Date: 01/12/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F600/N3484; F684/N3937
Situations: The facility failed to effectively assess and inform a resident's physician after they had a change in condition that included coughing up blood and critically low blood glucose levels. The resident was found unresponsive with no pulse around forty minutes after their critical blood glucose levels were identified and died the following day.

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 residents received treatment and care in accordance with professional standards of practice.

Region 8
Exit Date: 01/13/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to properly assess and inform a resident's physician after the resident was found bleeding at the bridge of their nose. The resident had a significant change in condition the following day and was transferred to the hospital where they were diagnosed with a subdural hematoma (a serious condition where blood collects between the skull and the surface of the brain).

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: 01/13/2024
Purpose of Visit: Standard Survey
Tags: F607/N3484; F610/N3511; F689/N4030
Situations: The facility failed to report and investigate a resident's unwitnessed fall that resulted in a serious injury. The facility failed to assess the resident for fall risks and did not implement a care plan to prevent falls.

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 incidents while the investigation was in progress; and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 3
Exit Date: 01/17/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to effectively assess and notify a physician to obtain treatment orders after a resident developed a wound to the foot.

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 6
Exit Date: 01/18/2024
Purpose of Visit: Complaint Investigation
Tags: F686/N3949

Situations: The facility failed to provide wound care to a resident with pressure ulcers, resulting in the wounds deteriorating significantly. The facility failed to ensure wound care materials were available.

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: 01/18/2024
Purpose of Visit: Incident Investigation
Tags: F580/N3013; F697/N4009
Situations: The facility failed to adequately assess a resident for pain and provide pain medication after the resident had a change in behavior and complained of pain. The facility failed to inform the resident's physician and health team and to continually monitor the resident for pain.

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

Region 8
Exit Date: 01/19/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F760/N4600
Situations: The facility failed to hold administering a resident's insulin based on the parameters established by the resident's physician, providing the medication despite the resident's blood sugar being below levels required for administration.

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

Region 5
Exit Date: 01/19/2024
Purpose of Visit: Standard Survey
Tags: F805/N4330
Situations: The facility failed to ensure two residents were provided pureed meals in accordance with their care plans during one meal service.

Deficient Practice: The facility failed to ensure residents received food prepared in a form designed to meet individual needs.

Region 3
Exit Date: 01/20/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F760/N4600

Situations: The facility failed to verify a resident's allergy to penicillin before administering an antibiotic containing penicillin. When staff became aware of the allergy the facility failed to ensure the antibiotic was reviewed for containing penicillin. The resident ultimately died eleven days after beginning the medication.

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

Region 2
Exit Date: 01/22/2024
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 facility, triggering an alarm to which facility staff did not respond. The resident was outside of the facility and was found with cuts and abrasions.

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

Region 6
Exit Date: 01/22/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F678/N3580
Situations: The facility failed to initiate CPR on a resident with a full code status (code status that allows all interventions to restart the heart) when they were found unresponsive. The facility failed to inform a resident's physician when the resident had critically low oxygen saturation levels.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to follow physician orders and the resident's advance directives.

Region 8
Exit Date: 01/22/2024
Purpose of Visit: Complaint Investigation
Tags: F584/N3628
Situations: The facility failed to ensure their heating systems were functioning on all halls, resulting in two halls dropping below sixty degrees Fahrenheit.

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

Region 8
Exit Date: 01/25/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3010; F684/N3937
Situations: The facility failed to report and effectively assess a resident after a fall and failed to inform the resident's physician that the x-ray machine was not available timely.

The resident waiting nearly sixteen hours before ultimately being transferred to the hospital and diagnosed with a broken hip.

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: 10/16/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F697/N4009
Situations: The facility failed to provide pain management to a resident on hospice who was found by non-facility hospice staff writhing in pain, thrashing, grimacing, and mouthing the words "help me."

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 11
Exit Date: 01/26/2024
Purpose of Visit: Complaint Investigation
Tags: F684/N3937; F692/N3985
Situations: The facility failed to provide services to prevent a resident from a nearly twenty percent weight loss. The facility failed to identify a resident's change in condition across multiple shifts.

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

Region 6
Exit Date: 01/26/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N3949
Situations: The facility failed to implement new interventions to prevent a resident from developing pressure ulcers after the resident refused to wear their protective equipment and be repositioned in bed, resulting in the development of multiple severe pressure ulcers to the groin and feet.

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 5
Exit Date: 01/26/2024

Purpose of Visit: Standard Survey
Tags: F600/N3478; F686/ N3949; F692/N3985; F726/N4063; F880/N4723
Situations: The facility failed to provide effective treatment to three residents with pressure ulcers, all of whom developed infections, two developed sepsis, and one ultimately died from complications related to the infections. The facility failed to provide sufficient nutrition to a resident who required a tube to intake food, resulting in greater than thirty percent weight loss over six months. The facility failed to ensure proper hand hygiene procedures were followed during wound care.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect; failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing; failed to ensure 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 resident preferences indicate otherwise; failed to ensure staff were competent and trained in their job responsibilities; and failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment.

Region 3
Exit Date: 01/26/2024
Purpose of Visit: Standard Survey
Tags: F880/N4723
Situations: The facility failed to effectively identify resident rooms with positive flu infections, failed to ensure PPE was available outside of those rooms, and failed to isolate infected residents from non-infected ones.

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

Region 5
Exit Date: 01/26/2024
Purpose of Visit: Standard Survey
Tags: F689/N4027
Situations: The facility failed to ensure that the water temperatures from the hot water dispenser were at safe levels. The water was recorded coming out of the dispenser at 188 degrees, resulting in a resident receiving second-degree burns when they spilled it on themselves.

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

Region 4
Exit Date: 01/27/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F880/N4723

Situations: The facility failed to ensure staff were trained on current COVID-19 protocols and failed to ensure effective use of PPE when providing care to residents positive for the illness.

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 1
Exit Date: 01/27/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F697/N4009
Situations: The facility failed to assess a resident and provide pain medication after they began to present with symptoms of pain.

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

Region 5
Exit Date: 01/27/2024
Purpose of Visit: Standard Survey
Tags: F921/N3628
Situations: The facility failed to ensure there were no open flames near oxygen cylinders, to store cylinders in an upright position, and to secure the cylinders from residents and the public.

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

Region 6
Exit Date: 01/27/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent a resident, identified as at-risk for elopement, from eloping. The resident was sent to the doctor’s office unsupervised and was later found outside the office standing in the rain by a bystander.

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

Region 6
Exit Date: 01/29/2024
Purpose of Visit: Complaint Investigation
Tags: F684/N3937
Situations: The facility failed to provide adequate supervision to a resident who received medications through a tube after they were administered medications. The resident vomited and aspirated to death.

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

Region 5
Exit Date: 01/30/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F609/3532
Situations: The facility failed to report and investigate when a staff member brought a gun into the facility following a verbal altercation between staff members.

Deficient Practice: The facility failed to ensure that all alleged violations involving abuse are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.

Region 5
Exit Date: 01/31/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4027
Situations: The facility failed to follow a resident's care plan while attempting to assist the resident with a transfer, resulting in the resident having to be placed on the floor to prevent them from falling.

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

Region 6
Exit Date: 01/31/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3010; F684/N3937
Situations: The facility failed to identify, assess, and notify a resident's physician after the resident began to vomit over the course of several days and consistently had critically high blood glucose levels. The resident was ultimately transferred to the hospital where they 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 6
Exit Date: 02/01/2024
Purpose of Visit: Complaint Investigation
Tags: F686/N3949
Situations: The facility failed to effectively assess and treat a resident's pressure ulcers, resulting in the wounds deteriorating and the resident developing sepsis.

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 5
Exit Date: 02/01/2024
Purpose of Visit: Standard Survey
Tags: F689/N4027
Situations: The facility failed to ensure the locking devices on the doors to the secure unit were functioning and three residents were able to exit the secured unit into a courtyard under construction, which had significant hazards including sharp debris and trenches.

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

Region 6
Exit Date: 02/01/2024
Purpose of Visit: Complaint Investigation
Tags: F584/N3628
Situations: The facility failed to ensure staff were able to quickly access two residents in the event of an incident or emergency after the resident's door became wedged shut by the bathroom door for over fifty minutes.

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

Region 2
Exit Date: 02/01/2024
Purpose of Visit: Standard Survey
Tags: F656/N3790; F689/N4030
Situations: The facility failed to develop and implement a comprehensive person-centered care plan that included transfer goals and interventions for six residents. For one of these, the facility had no transfer assistance orders in place resulting in the resident falling during an attempted transfer and sustaining a leg fracture.

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: 02/02/2024
Purpose of Visit: Standard Survey
Tags: F580/N3013; F656/N3784; F689/N4030
Situations: The facility failed to inform a resident's physician when a resident was secreting away narcotic medications. The facility then failed to establish behavioral

interventions after the resident was readmitted from behavioral health inpatient care following a suicide attempt by drug overdose.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition, 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: 02/05/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4030; F926/N835
Situations: The facility failed to secure smoking items and supervise three residents while smoking, two of whom had a history of unsafe smoking behaviors and were on or exposed to others on oxygen, one of whom was paralyzed on one side and had a history of dropping their cigarette and burning holes their clothes and wheelchair.

Deficient Practice: The facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents and failed to follow their own established smoking policies.

Region 4
Exit Date: 02/06/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F678/N3484
Situations: The facility failed to initiate CPR and use an AED on a resident with a full code status (code status that allows all interventions to restart the heart) when they were found unresponsive.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to follow physician orders and the resident's advance directives.

Region 5
Exit Date: 02/07/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure food was provided to two residents at safe temperatures for their ability, resulting in one receiving second-degree burns and the other requiring medical attention from a burn.

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

Region 3
Exit Date: 02/07/2024
Purpose of Visit: Incident Investigation
Tags: F726/N4075; F760/N4600

Situations: The facility failed to ensure staff were trained to properly identify medication orders when a resident was given an entire bottle of nitroglycerin (medication used to prevent or relieve chest pain caused by coronary artery disease by relaxing blood vessels). The resident was transferred to the hospital with critically low blood pressure.

Deficient Practice: The facility failed to ensure staff were competent and trained in their job responsibilities and failed to ensure residents are free of any significant medication errors.

Region 3
Exit Date: 02/07/2024
Purpose of Visit: Complaint Investigation
Tags: F600/N3481
Situations: The facility failed to protect a resident who did not have the ability to consent to sexual activity from sexual abuse by a staff member.

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

Region 6
Exit Date: 02/08/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937; F689/N4027
Situations: The facility failed to provide timely transfer to the hospital after a resident on blood thinning medication had an unwitnessed fall resulting in a head injury. The facility failed to protect residents when two staff members got into a verbal altercation in front of residents. One of the staff members had an unsecured, loaded gun in their bag at the nurse's station, which they later pointed at a staff member and then discharged into the air outside of the facility near resident windows.

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 and assistive devices were provided to prevent accidents.

Region 4
Exit Date: 02/08/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F607/N3484; F689/N4030
Situations: The facility failed to ensure a resident's allegation of sexual abuse was reported and investigated. The facility failed to ensure a resident was transferred properly resulting in bruising to the arms from the resident's bed rails.

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 8

Exit Date: 02/09/2024
Purpose of Visit: Incident Investigation
Tags: F742/N4048
Situations: The facility failed to assess and implement interventions when a resident started to exhibit symptoms of depression, ultimately leading to the resident committing suicide with a firearm.

Deficient Practice: The facility failed to ensure a resident who displayed or was diagnosed with a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being.

Region 6
Exit Date: 02/09/2024
Purpose of Visit: Complaint Investigation
Tags: F678/N3580
Situations: The facility failed to initiate CPR on a resident with a full code status (code status that allows all interventions to restart the heart) when they were found unresponsive.

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

Region 11
Exit Date: 02/09/2024
Purpose of Visit: Standard Survey
Tags: F580/N3010; F692/N3985
Situations: The facility failed to ensure three residents did not experience significant weight loss of up to twenty-two percent. For one resident, the facility failed to inform the resident’s physician and implement recommendations from a registered dietician to increase the resident’s food intake.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to ensure 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 resident preferences indicate otherwise.

Region 6
Exit Date: 02/11/2024
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to implement interventions when a resident continued to experience falls, all of which resulted in injuries to the head.

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

Region 4
Exit Date: 02/12/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure to secure a resident's wheelchair wheels during a transfer, resulting in the resident sliding out of the chair and sustaining a severe femur fracture.

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

Region 3
Exit Date: 02/12/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F684/N3937; F755/N4561
Situations: The facility failed to ensure blood thinning medication was available and provided to three residents and failed to inform the residents' physicians of the missed doses.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to implement policies and procedures to prevent abuse and neglect.

Region 6
Exit Date: 02/12/2024
Purpose of Visit: Standard Survey
Tags: F600/N3481; F689/N4030; F697/N4009; F755/N4675
Situations: The facility failed to protect a resident from physical abuse by a staff member when the staff member used their foot to prohibit the resident from getting themselves up after an unwitnessed fall. The facility failed to implement effective intervention and ensure a resident's anti-elopement device was functioning to keep them from eloping. The facility failed to provide a resident with pain medication for two days after they requested it.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect; failed to consult with the physician regarding a change in condition; 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; and failed to provide pharmaceutical services, including procedures that assured accurate administering of all drugs to meet the needs of the residents.

Region 3
Exit Date: 02/13/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030

Situations: The facility failed to provide adequate supervision to prevent a resident from eloping. The resident left through an exit door down a hallway which triggered the alarm. The facility failed to conduct a thorough search after the alarm went off and failed to realize the resident was missing.

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

Region 5
Exit Date: 02/14/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F693/N3997
Situations: The facility failed to provide proper care to two residents who were given medication and food through feeding tubes. One resident was transferred to the hospital where fungus was found growing in their feeding tube.

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

Region 4
Exit Date: 02/14/2024
Purpose of Visit: Standard Survey
Tags: F760/N4600; F770/N5041
Situations: The facility failed to provide a resident with the proper dose of potassium resulting in critically high potassium levels that required hospitalization. The facility failed to obtain blood test results for the resident for five days.

Deficient Practice: The facility failed to ensure residents are free of any significant medication errors and failed to obtain timely laboratory services.

Region 6
Exit Date: 02/14/2024
Purpose of Visit: Complaint Investigation
Tags: F755/N4561
Situations: The facility failed to provide a resident with their insulin when they left the facility on a two-day pass. The resident returned to the facility with critically high blood glucose levels.

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: 02/14/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478/N3484; F697/N4009

Situations: The facility failed to ensure a resident was evaluated and treated for urinary retention, resulting in the resident requiring hospitalization to empty their bladder. The facility failed to ensure the same resident was provided with their prescribed pain medication for the pain caused by fractures to both ankles.

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

Region 2
Exit Date: 02/15/2024
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident, with a history of eloping previous facilities, from eloping. The resident left the facility and was missing for over two hours.

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

Region 4
Exit Date: 02/15/2024
Purpose of Visit: Complaint Investigation
Tags: F600/N3484; F6859/N4030
Situations: The facility failed to ensure a resident was not transferred incorrectly by a non-staff "sitter" resulting in the resident sustaining a hip fracture. The facility was aware of the untrained "sitters" providing similar care to residents and allowed the practice to continue.

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 4
Exit Date: 02/15/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478/N3481; F607/N3484; F689/N4030; F926/N835
Situations: The facility failed to protect three residents from abuse by another. One resident, who was the alleged perpetrator's roommate, requested to be moved after the alleged perpetrator took money from them, which the facility failed to honor. The facility failed to supervise residents or provide them with smoking aprons, failed to ensure residents did not store their smoking materials in their room, and failed to reassess a resident for smoking safety after they lit a cigarette inside the building.

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 follow their own established smoking policies.

Region 4
Exit Date: 02/16/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F678/N5545/N5548
Situations: The facility failed to use an AED to revive a resident who was found unresponsive and not breathing due to being unable to find parts of the device. The facility failed to ensure staff were trained to check the "crash cart" to make sure it was assembled and ready for use.

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

Region 8
Exit Date: 02/16/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure a resident's new bed had side rails for bed mobility and positioning, resulting in the resident falling out of bed, sustaining spinal fractures, broken ribs, and ultimately dying.

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

Region 8
Exit Date: 02/16/2024
Purpose of Visit: Incident Investigation
Tags: F600/N3478; F607/N3484; F609/N3532
Situations: The facility failed to protect residents from abuse when three staff members shared videos they took of three different residents, two in the shower and one who had fallen on the floor while naked and shared them to a group chat. The facility failed to ensure staff were trained to report suspected abuse after four other staff members learned about the videos but did not report them.

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 are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.

Region 2
Exit Date: 02/17/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F607/N3484; F609/N3532; F610/N3538; F689/N4030
Situations: The facility failed to report and investigate a resident's allegations of sexual abuse by a staff member. The facility failed to implement effective intervention to

prevent elopements. One resident eloped through the back patio and was found over half an hour later walking near a ravine and busy street.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect; failed to ensure that all alleged violations involving abuse are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury; failed to provide evidence that all alleged violations of neglect, abuse, or misappropriation of property were thoroughly investigated to prevent further potential incidents while the investigation was in progress; and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 6
Exit Date: 02/17/2024
Purpose of Visit: Standard Survey
Tags: F698/N4012
Situations: The facility failed to provide a resident with their hemodialysis treatment resulting in the resident developing an altered mental state, increased confusion, lethargy, and requiring hospitalization.

Deficient Practice: The facility failed to ensure that a resident who requires dialysis receive such services, consistent with professional standards of practice.

Region 6
Exit Date: 02/18/2024
Purpose of Visit: Standard Survey
Tags: F470/N4042
Situations: The facility failed to ensure that a resident had individualized behavioral health needs addressed through a person-centered care plan after they began to exhibit suicidal ideations.

Deficient Practice: The facility failed to ensure each resident received necessary behavioral health care services to maintain the residents' highest practicable mental and psychosocial wellbeing.

Region 6
Exit Date: 02/19/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent elopement. A resident eloped from the facility and was gone for over two hours before staff from a local hospital informed the facility of the resident's elopement.

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

Region 6
Exit Date: 02/19/2024

Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3484; F656/N3784; F657/N3808
Situations: The facility failed to provide effective supervision to prevent residents from getting into physical alterations. Two residents engaged in an unwitnessed altercation resulting in one resident being hit in the head with a trashcan and requiring hospitalization. The facility failed to update a resident's care plan after they began to exhibit aggressive behaviors.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect, failed to develop and implement a comprehensive person-centered care plan for each resident, and failed to review and revise person-centered care planning.

Region 6
Exit Date: 02/20/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F695/N4003; F726/N4063
Situations: The facility failed to ensure tracheostomy care was provided effectively and sanitarily. The staff member failed to reconnect the resident's tracheostomy to oxygen when they left to gather more supplies, failed to properly secure it, and failed to clean it.

Deficient Practice: The facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice and failed to ensure staff were competent and trained in their job responsibilities.

Region 5
Exit Date: 02/20/2024
Purpose of Visit: Incident Investigation
Tags: F578/N3340; F655/N3580; F678/N3781
Situations: The facility failed to follow the advanced directives of a resident with a OOHDNR (out of hospital do not resuscitate) order and began performing CPR on the resident when they were found unresponsive.

Deficient Practice: The facility failed to protect the residents right to request, refuse, and/or discontinue treatment, failed to develop and implement a baseline care plan to include the minimum healthcare information necessary, and failed to follow physician orders and the resident's advance directives.

Region 6
Exit Date: 02/20/2024
Purpose of Visit: Incident Investigation
Tags: F600/N3478; F689/N3481
Situations: The facility failed to implement interventions to prevent a resident with a history of falls from experiencing multiple falls, one of which resulted in a head injury and the resident's death. Three months prior, the facility failed to assess the resident after they screamed in pain following a fall and did not transfer the resident to the

hospital as recommended by a physician until after the family called emergency services. The resident had sustained a broken leg.

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

Region 2
Exit Date: 02/20/2024
Purpose of Visit: Standard Survey
Tags: F607/N3478; F839/N5023
Situations: The facility failed to ensure a staff member hired as a licensed nurse had the proper credentialing with the Texas Board of Nursing and allowed the staff member to provide nursing and medical staff supervisory services without the legal authority to do so.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to ensure professional staff were licensed in accordance with applicable state laws.

Region 2
Exit Date: 02/21/2024
Purpose of Visit: Complaint Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent two residents from multiple falls that resulted in injuries.

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

Region 11
Exit Date: 02/23/2024
Purpose of Visit: Complaint Investigation
Tags: F600/N3481; F607/N3484/N3511/3541; F684/N3937
Situations: The facility failed to protect two residents from another after they were attacked in bed and hit in the face, causing injuries. The facility failed to perform effective assessments on the residents after their injuries were reported. The facility failed to report the allegations to HHSC.

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 2
Exit Date: 02/23/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4030

Situations: The facility failed to provide adequate supervision to prevent a resident from choking. The resident found a staff member's lunch bag unsupervised in a hallway and attempted to eat a granola bar before choking and losing consciousness.

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

Region 4
Exit Date: 02/24/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F607/N3484; F609/N3532/N3538
Situations: The facility failed to protect six residents from verbal and physical abuse by a staff member, who caused injuries while assisting with activities of daily living and communicated in rude, threatening, and unprofessional ways to residents.

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 are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.

Region 8
Exit Date: 02/25/2024
Purpose of Visit: Standard Survey
Tags: F578/N2983; F678/N3580
Situations: The facility failed to follow the advanced directives of a resident with a OOHDNR (out of hospital do not resuscitate) order and began performing CPR on the resident when they were found unresponsive.

Deficient Practice: The facility failed to protect the residents right to request, refuse, and/or discontinue treatment and failed to follow physician orders and the resident's advance directives.

Region 5
Exit Date: 02/25/2024
Purpose of Visit: Standard Survey
Tags: F760/N4600
Situations: The facility failed to properly transcribe a resident's medication orders resulting in the resident receiving a significant overdose and requiring hospitalization.

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

Region 8
Exit Date: 02/26/2024
Purpose of Visit: Incident Investigation
Tags: F580/N3013; F684/N3937

Situations: The facility failed to assess, inform a physician, and treat a resident who had multiple days of critically high blood glucose levels. The resident was ultimately transferred to the hospital where they 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 6
Exit Date: 02/26/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937
Situations: The facility failed to assess a resident who was on daily anticoagulant medication before lifting them off the floor following a fall that resulted in facial injuries and a hematoma to the head.

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

Region 3
Exit Date: 02/28/2024
Purpose of Visit: Standard Survey
Tags: F684/N3937; F776/N5068
Situations: The facility failed to order an x-ray for a resident who fell and complained of pain in their side until the next day, which revealed two broken ribs. The facility failed to assess a resident who had a reported "audible sound" when they attempted to put their shoe back on. The resident was later diagnosed with an ankle fracture.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice and failed to provide radiology or other diagnostic services to meet the needs of its residents in a timely manner.

Region 3
Exit Date: 02/29/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478/N6484; F689/N4027
Situations: The facility failed to implement interventions for a resident with a history of falls resulting in injury. The facility failed to equip the resident's room with a fall mat as ordered. The resident had a seizure which resulted in them falling and sustaining injuries.

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: 02/29/2024
Purpose of Visit: Complaint/Incident Investigation

Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident from eloping after residents from the secure unit were temporarily moved to non-secure units during construction projects.

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

Region 6
Exit Date: 02/29/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F307/N3484; F610/N3538/N3541
Situations: The facility failed to protect a resident from abuse by a staff member and failed to investigate and report the incident after another staff member noted bruising to the resident's face.

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 incidents while the investigation was in progress.

Region 3
Exit Date: 02/29/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F757/N4585
Situations: The facility failed to monitor a resident's lithium levels while they were on a lithium supplement to ensure therapeutic levels were maintained. The resident was admitted to the hospital and diagnosed with acute toxic encephalopathy secondary to lithium toxicity.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to ensure each resident's drug regimen did not have an excessive dose, for an excessive duration, with inadequate monitoring.

Region 2
Exit Date: 03/01/2024
Purpose of Visit: Standard Survey
Tags: F578/N3328; F600/N3484; F607; F678
Situations: The facility failed to determine and transcribe a resident's advanced directives when they were admitted into hospice at the facility. Facility staff initiated CPR when the resident was found unresponsive due to being unable to locate the resident's DNR (do no resuscitate) order.

Deficient Practice: The facility failed to protect the residents right to request, refuse, and/or discontinue treatment; failed to implement policies and procedures to prevent abuse and neglect; and failed to follow physician orders and the resident's advance directives.

Region 2
Exit Date: 03/01/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F578/N3328; F600/N3484; F607; F678
Situations: This was a second event performed in conjunction with the one above. The events above apply here.

Deficient Practice: The facility failed to protect the residents right to request, refuse, and/or discontinue treatment; failed to implement policies and procedures to prevent abuse and neglect; and failed to follow physician orders and the resident's advance directives.

Region 6
Exit Date: 03/01/2024
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent elopements and failed to ensure staff were properly trained in elopement procedures. A resident eloped from the facility and staff assumed they had left with a family member and failed to initiate a search.

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

Region 4
Exit Date: 03/02/2024
Purpose of Visit: Complaint Investigation
Tags: F600/N3478/N3481; F607/N3484/N3487; F610/N3511; F689/N4027; F725/N4069; F755/N4561; F760/N4600; F835/N4996
Situations: The facility failed to protect a resident from abuse by another resident and failed to further assess the victim after bruising appeared on their leg, later being diagnosed with a fracture and hip dislocation. The resident was allowed alone with another resident after the incident. The facility failed to protect two residents from verbal abuse by a staff member and failed to ensure staff were trained to report allegations of abuse. The facility failed to thoroughly investigate the incidents. The facility failed to accurately provide medications to nine residents. The facility administration failed to ensure adequate staff were available and aware of job functions to provide for residents needs when the facility's administrator position experienced four changes within six months. The facility failed to ensure the abuse coordinator was aware that they were the abuse coordinator in absence of the administrator.

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 incidents while the investigation was in progress; failed to ensure adequate supervision and assistive devices were provided to prevent accidents; failed to provide sufficient number of nursing staff on a twenty-four-hour basis to provide nursing care to

all residents in accordance with resident care plans and the facility assessments; failed to provide pharmaceutical services, including procedures that assured accurate administering of all drugs to meet the needs of the residents and failed to ensure residents are free of any significant medication errors. Facility administration failed to ensure effective use of their resources.

Region 5
Exit Date: 03/03/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure five residents were assessed for their ability to handle hot liquids without assistance, resulting in one resident spilling coffee and sustaining second-degree burns.

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

Region 2
Exit Date: 03/05/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3010; F684/N3937
Situations: The facility failed to immediately inform a resident's physician when the resident began exhibiting signs of cyanosis (bluish color in the skin, lips, and nail beds caused by a shortage of oxygen in the blood), waiting over fourteen hours after the resident began to experience the change in 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: 03/06/2024
Purpose of Visit: Complaint Investigation
Tags: F770/N5041
Situations: The facility failed to ensure a resident's blood tests were run weekly for five weeks, as ordered by a physician. The resident ultimately had a change in condition and requested to be sent to the hospital where they were diagnosed with hyponatremia (decreased sodium with symptoms including fatigue, lethargy, and mental confusion), dehydration and acute kidney injury.

Deficient Practice: The facility failed to obtain timely laboratory services.

Region 5
Exit Date: 03/07/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030

Situations: The facility failed to provide supervision to a resident during a meal after the resident's care plan changed to require supervision. The resident choked while eating, resulting in hospitalization with aspiration pneumonia.

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

Region 4
Exit Date: 03/07/2024
Purpose of Visit: Incident Investigation
Tags: F600/N3478
Situations: The facility failed to protect a resident from abuse when a staff member slapped them on the arm with a washcloth while telling the resident to stop complaining while assisting with a shower.

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

Region 1
Exit Date: 03/07/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4027
Situations: The facility failed to ensure staff used proper technique when assisting a resident with transferring, resulting in the resident sustaining a broken ankle.

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

Region 5
Exit Date: 03/07/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F607/N3484; F697/N4009
Situations: The facility failed to effectively assess a resident after they fell and complained of pain to the arm and hip. The resident did not receive an x-ray for two days after the fall. The facility failed to provide the same resident, and another, with their prescribed pain medication when the facility ran out.

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

Region 6
Exit Date: 03/07/2024
Purpose of Visit: Complaint Investigation
Tags: F600/N3481; F689/N4027
Situations: The facility failed to protect a resident when a staff member brought their partner into the facility and took them to the resident's room where the partner verbally

abused the resident and pointed a gun at them. The facility failed to provide staff with a workplace violence training.

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 6
Exit Date: 03/07/2024
Purpose of Visit: Standard Survey
Tags: F686/N3946
Situations: The facility failed to monitor and treat five residents for their pressure ulcers resulting in all of them experiencing worsening wounds. One resident was not provided wound care for thirty-eight days.

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: 03/08/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481
Situations: The facility failed to protect seven residents from verbal and physical abuse by a staff member who used fowl language with them, pinched and pulled on three, and was generally physically aggressive with one.
Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect.

Region 2
Exit Date: 03/08/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F760/N4600
Situations: The facility failed to ensure a resident received the correct medication, administering the medications of another resident for which the former did not have orders and included a narcotic, a blood pressure medication, and a diuretic.
Deficient Practice: The facility failed to ensure residents are free of any significant medication errors.

Region 6
Exit Date: 03/08/2024
Purpose of Visit: Complaint Investigation
Tags: F695/N4003
Situations: The facility failed to provide supplemental oxygen to a resident while they were transported to an outside appointment resulting in the resident's oxygen saturation levels becoming dangerously low and causing difficulty breathing.

Deficient Practice: The facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice.

Region 5
Exit Date: 03/08/2024
Purpose of Visit: Complaint Investigation
Tags: F684/N3937
Situations: The facility failed to identify and treat two new skin injuries to a resident's feet.

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

Region 6
Exit Date: 03/11/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F678/N3580
Situations: The facility failed to immediately initiate CPR on a resident who was found unresponsive and and had a full code status (code status that allows all interventions to restart the heart).

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

Region 4
Exit Date: 03/12/2024
Purpose of Visit: Incident Investigation
Tags: F600/N3484
Situations: The facility failed to protect a resident from abuse by a staff member who struck the resident in the face and caused them to fall.

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

Region 11
Exit Date: 03/12/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent elopements. A resident eloped from the facility after removing their anti-elopement bracelet on two separate occasions.
Deficient Practice: The facility failed to ensure adequate supervision and assistance devices were provided to prevent accidents.

Region 5
Exit Date: 03/13/2024

Purpose of Visit: Standard Survey
Tags: F689
Situations: The facility failed to ensure hot water temperatures were kept at safe levels (between 100 and 110 degrees) with some areas being measured at 145 degrees.
Deficient Practice: The facility failed to ensure adequate supervision and assistance devices were provided to prevent accidents.

Region 6
Exit Date: 03/13/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F602; F761/N4603
Situations: The facility failed to ensure effective supervision to a resident who was left unattended in their bathroom for over seven hours. The facility failed to ensure that a resident received the correct medication after the labels were switched and failed to ensure discontinued controlled substance medication was discarded according to protocols, resulting in nine medication packages being altered by an unknown staff member.
Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect; failed to ensure residents were free from misappropriation of property; and failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

Region 3
Exit Date: 03/13/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F656/N3784
Situations: The facility failed to protect a resident from sexual abuse by another, who had a history of non-consensual sexual behaviors towards residents, when the latter came into the former resident's room, removed their briefs, and attempted to have non-consensual intercourse.
Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to develop and implement a comprehensive person-centered care plan for each resident.

Region 5
Exit Date: 03/13/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478/N3481
Situations: The facility failed to protect a resident from abuse by a staff member when the staff member recorded instances of pouring water on the resident's face, verbally taunting and striking them, and sitting on their arm.
Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect.

Region 8
Exit Date: 03/13/2024
Purpose of Visit: Complaint/Incident Investigations
Tags: F584/N3628; F689/N4027
Situations: The facility failed to ensure a safe environment after a staff member brought a handgun into the facility, broke a window, then hid in a closet before emerging and pointing the gun at two maintenance staff members. The facility failed to implement effective interventions to prevent elopements. A resident eloped from the facility when a visitor held the door open for them and another individual pushed the resident across the street in their wheelchair.

Deficient Practice: The facility failed to provide a safe, functional, sanitary, and comfortable environment and failed to ensure adequate supervision and assistance devices were provided to prevent accidents.

Region 4
Exit Date: 03/13/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3010; F684/N3937; F760/N4600
Situations: The facility failed to assess and inform a physician when a resident experienced a change in condition that included low oxygen saturation levels, vomiting dark substances, later becoming lethargic and ultimately unresponsive later in the day. The resident was transferred to the hospital where they were diagnosed with sepsis secondary to pneumonia, requiring intubation. The facility failed to hold medication administration to two residents when their vital signs were below the established parameters that required the medication.

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 residents are free of any significant medication errors.

Region 6
Exit Date: 03/14/2024
Purpose of Visit: Complaint Investigation
Tags: F551/N2935; F580/N3013; F684/N3937
Situations: The facility failed to assess, notify a physician, and secure transportation of a resident to a hospital at the request of their representative when the resident began to complain of trouble breathing, abdominal pain, and diarrhea. The resident was ultimately transported to a local hospital in their wheelchair and died the next day.

Deficient Practice: The facility failed to extend to the resident representative ' s the right to make decisions on behalf of the resident, failed to consult with the physician regarding a change in condition and failed to ensure residents received treatment, and care in accordance with professional standards of practice.

Region 8
Exit Date: 03/16/2024
Purpose of Visit: Standard Survey (CHOW)
Tags: F580/N3016; F760/N4600
Situations: The facility failed to hold blood pressure medication administration to four residents when their vital signs were below the established parameters that required the medication.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to ensure residents are free of any significant medication errors.

Region 4
Exit Date: 03/18/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure two staff members assisted a resident with incontinent care, as required, resulting in the resident rolling out of the bed and sustaining a hematoma to the top of the forehead.

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

Region 8
Exit Date: 03/18/2024
Purpose of Visit: Standard Survey
Tags: F552/N3980; F580/N3010; F600/N3484; F689/N1030
Situations: The facility failed to obtain the consent of a resident or their representative before administering them medroxyprogesterone (used to treat amenorrhea, or unusual stopping of menstrual periods, and abnormal uterine bleeding), and failed to inform both parties for the rationale and educate them on the risks. The facility failed to protect residents from abuse when a resident was left in a locked, dark shower room alone, when a resident was allowed access to another resident's bathroom while the latter was in the shower, and when the same resident wandered into another's room, resulting in the latter hitting the former in the head.

Deficient Practice: The facility failed to ensure residents had the right to be informed of, and participate in, their treatment, including the right to be informed, in advance, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option the resident prefers; 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 assistance devices were provided to prevent accidents.

Region 5
Exit Date: 03/19/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F600/N3478; F684/N3937; F770/N5041

Situations: The facility failed to collect and test a urine sample, as ordered by a physician, from a resident who subsequently died of sepsis related to complications due to a urinary tract infection.

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

Region 5
Exit Date: 03/19/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N3949
Situations: The facility failed to provide adequate wound care to a resident's pressure ulcers, resulting in the wounds deteriorating and becoming septic.

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: 03/20/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent elopements. A resident left the facility without staff knowledge and was found walking down the street from the facility.

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

Region 4
Exit Date: 03/20/2024
Purpose of Visit: Complaint Investigation
Tags: F660/N3838
Situations: The facility failed to effectively plan for a resident's safe discharge resulting in the resident being hospitalized with threats of suicide.

Deficient Practice: The facility failed to provide and document an effective discharge planning process that focused on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.

Region 6
Exit Date: 03/20/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F607/N3484; F656/F3784

Situations: The facility failed to implement interventions to prevent resident-to-resident violence resulting in a resident physically attacking three others on different dates.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to develop and implement a comprehensive person-centered care plan for each resident.

Region 6
Exit Date: 03/21/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to use two staff members and a lift to assist a resident with transferring, resulting in the resident falling and sustaining a broken leg.

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

Region 3
Exit Date: 03/22/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3484; F686/N3949
Situations: The facility failed to provide adequate wound care to a resident's pressure ulcers, resulting in the resident developing lethargy, disorientation, loss of appetite, and low blood pressure. The resident was transferred to the hospital where they were diagnosed with sepsis.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect 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: 03/23/2024
Purpose of Visit: Incident Investigation
Tags: F600/N3478/N3484; F689/N4027
Situations: The facility failed to implement effective intervention to prevent elopements. Two residents were able to elope from the facility without staff knowledge. One resident was returned to the facility by police and the whereabouts of the other were still unknown at the time of the survey.

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

Region 4
Exit Date: 03/23/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937; F686/N3949

Situations: The facility failed to assess and treat two residents' facility acquired pressure ulcers, resulting in both experiencing deterioration of the wounds.

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: 03/24/2024
Purpose of Visit: Complaint Investigation
Tags: F684/N3937
Situations: The facility failed to hold a resident's heart and blood pressure medications when their vital signs indicated that parameters were below the threshold to require the medications, per physician orders.

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

Region 2
Exit Date: 03/25/2024
Purpose of Visit: Standard Survey
Tags: F580/N3016; F726/N4063; F760/N4600
Situations: The facility exhibited widespread medication errors related to insulin administration to two residents resulting in dozens of missed doses over the course of three months. For the same two residents, the facility regularly failed to inform a physician when the resident's blood glucose levels were above acceptable established parameters.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition, failed to ensure staff were competent and trained in their job responsibilities, and failed to ensure residents are free of any significant medication errors.

Region 6
Exit Date: 03/25/2024
Purpose of Visit: Complaint Investigation
Tags: F689/N4030; F926/N4987
Situations: The facility failed to implement effective supervision and assistive devices to prevent injuries while resident's, who were identified as needing supervision and protective equipment, were smoking. All were observed smoking without supervision and those whose care plan required protective equipment were observed without it.

Deficient Practice: The facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents and failed to follow their own established smoking policies.

Region 5
Exit Date: 03/26/2024
Purpose of Visit: Incident Investigation
Tags: F656/N3784; F692/N3985; F742/N4048
Situations: The facility failed to follow physician orders for monthly weight checks for a resident who subsequently lost sixteen percent of their body weight after a change in diet. The facility failed to implement interventions when a resident refused to see the psychiatric nurse practitioner after displaying signs of depression and failed to report the resident's expressions of negative emotions.

Deficient Practice: The facility failed to develop and implement a comprehensive person-centered care plan for each resident; failed to ensure 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 resident preferences indicate otherwise; and failed to ensure a resident who displayed or was diagnosed with a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being.

Region 4
Exit Date: 03/26/2024
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to ensure a resident was adequately supervised while using the mechanical lift into the facility van, resulting in the resident falling from the lift.

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

Region 3
Exit Date: 03/26/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F698/N4012
Situations: The facility failed to ensure two residents were transported to their dialysis appointments and failed to consult with a physician regarding the missed appointments. Both residents required hospitalization.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to ensure that a resident who requires dialysis receive such services, consistent with professional standards of practice.

Region 5
Exit Date: 03/27/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030

Situations: The facility failed to complete an elopement risk assessment within twenty-four hours of the resident being admitted. The resident eloped from the facility and was located three hours later nearly two miles from the facility.

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

Region 5
Exit Date: 03/27/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4027
Situations: The facility failed to implement effective intervention to prevent a resident from eloping. The resident eloped from the facility and was found nearly an hour and over a mile away. The resident was transported to the hospital where they were diagnosed with a fracture above the left eye.

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

Region 4
Exit Date: 03/27/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F607/N3484; F609/N3532
Situations: The facility failed to protect a resident from abuse when a staff member witnessed another hitting the resident on the head during incontinent care. The facility failed to ensure staff reported incidents of abuse timely resulting in the staff member continuing to work with residents after the abuse.

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 are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.

Region 3
Exit Date: 03/28/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4027
Situations: The facility failed to ensure a resident was transferred with the assistance of two staff members, resulting in the resident falling and breaking their femur.

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

Region 2
Exit Date: 03/28/2024
Purpose of Visit: Complaint Investigation
Tags: F678/N3580

Situations: The facility failed to immediately initiate CPR on a resident with a full code status (code status that allows all interventions to restart the heart).

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

Region 5
Exit Date: 03/28/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement effective interventions to prevent elopements. A resident eloped from the facility after a staff member remotely unlocked the door and was gone for over twenty-four hours before being found at a bus stop twelve miles from the facility.

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

Region 8
Exit Date: 03/28/2024
Purpose of Visit: Incident Investigation
Tags: F656/N3787; F689/N4030
Situations: The facility failed to ensure a resident was assisted with transferring using two staff members and a mechanical lift, per the resident's care plan, resulting in the resident breaking their foot.

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: 03/29/2024
Purpose of Visit: Standard Survey
Tags: F580/N3010; F693/N3994
Situations: The facility failed to implement physician's orders for an abdominal binder to prevent complications of a resident's gastrostomy tube (g-tube), resulting in the resident requiring hospital for a g-tube replacement. The facility failed to ensure all staff were trained to properly administer medication through a g-tube.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to ensure a resident who is fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding.

Region 2
Exit Date: 03/29/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030

Situations: The facility failed to ensure four residents were provided supervision when smoking. The residents were allowed to sign out and go outside to smoke unsupervised in an area with flammable objects. Two residents were observed crossing the street in front of the facility to the picnic table at the park to smoke in their wheelchairs near a creek with an eight-foot drop off. The facility failed to ensure smoking materials were checked in and out at the nurse's station.

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

Region 3
Exit Date: 03/29/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure a resident was provided with adequate supervision to prevent falls and elopements. One resident had an unwitnessed fall that resulted in a fractured sacrum, another resident eloped from the secured unit. The facility failed to ensure the staff break room was locked and not accessible by residents resulting in one resident using the microwave and spilling the contents, receiving burns to their feet.

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

Region 4
Exit Date: 03/29/2024
Purpose of Visit: Standard Survey
Tags: F689/N4030; F740/N4042
Situations: The facility failed to ensure a resident was further assessed after a counseling evaluation and psychiatric referral were signed by the resident. The facility failed to comprehensively address the resident's behaviors and mental distress and to update their care plan to increase antianxiety medications. The facility failed to remove dangerous items from the residents room. The resident attempted to commit suicide with the call light cord and a pair of scissors on separate occasions.

Deficient Practice: The facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents and failed to ensure each resident received necessary behavioral health care services to maintain the residents' highest practicable mental and psychosocial wellbeing.

Region 11
Exit Date: 03/30/2024
Purpose of Visit: Complaint Investigation
Tags: F684/N3937; F689/N4030
Situations: The facility failed to provide a resident, with a gastronomy tube and an order to take nothing buy mouth, with adequate supervision to prevent them from

obtaining another resident's food. The resident attempted to eat another resident's food in the dining room resulting in them choking to death.

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 and assistive devices were provided to prevent accidents.

Region 8
Exit Date: 03/31/2024
Purpose of Visit: Standard Survey
Tags: F689/N4027; F761/N4603
Situations: The facility failed to ensure three residents did not overuse alcohol, resulting in falls. The facility failed to implement interventions when residents were found with unprescribed narcotics. The facility failed to properly store a resident's medications, leaving them in the resident's room and resulting in an overdose and hospitalization due to self-administration of the medication.

Deficient Practice: The facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents and failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.