Quarterly IJ Summary Report
July 2021 – September 2021

The following report presents information regarding all tags cited at the Immediate Jeopardy (IJ) level during licensing and certification surveys and complaint or incident investigations performed in nursing facilities during the third quarter of 2021 (07/01/2021 – 09/30/2021).

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

During this period, an IJ level tag was cited for fifty-three of the surveys and investigations conducted, resulting in seventy-three citations of twenty unique federal tags. The following tables provide the percentage at which each unique tag was cited (Table 1), the percent of IJs per nursing facility (NF) by region (Table 2) and the number of IJs per type of investigation (Table 3).

Descriptions of the situations and the deficient practices are derived from each event's *Form CMS-2567 - Statement of Deficiencies and Plan of Correction*, which is available to the public through a Freedom of Information Act (FOIA) request.

Table 1

F-Tag (Sorted by Tag Number)	**% Cited***	**F-Tag** (Sorted by Frequency Cited)	**% Cited***
578	1%	689	26%
600	14%	684	21%
603	1%	600	14%
606	1%	880	8%
609	1%	686	7%
610	1%	755	4%
622	1%	760	3%
684	21%	578	1%
686	7%	603	1%
689	26%	606	1%
692	1%	609	1%
698	1%	610	1%
755	4%	622	1%
760	3%	692	1%
773	1%	698	1%
805	1%	773	1%
812	1%	805	1%
835	1%	812	1%

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
880	8%	835	1%
925	1%	925	1%

*Rounded to the nearest tent

Table 2

Region	# of IJs	# of NFs	% of IJs/NF
1	2	88	2.27%
2	3	135	2.22%
3	14	229	6.11%
4	9	192	4.69%
5	8	188	4.26%
6	11	171	6.43%
7	6	223	2.69%
Total	**53**	**1226**	**4.32%**

Table 3
Number of IJs

from Complaints	from Incidents	from Surveys	From Other	Total
36	5	11	1	53

Tag References

483.10 – Resident Rights:

578 Request/Refuse/Discontinue Treatment; Formulate Adv. Directives
580 Notification of Changes (Injury/Decline/Room, Etc.)

483.12 - Freedom from Abuse, Neglect, and Exploitation:

600 Free from Abuse and Neglect
603 Free from Involuntary Seclusion
606 Not Employ/Engage Staff with Adverse Actions
609 Reporting of Alleged Violations
610 Investigate/Prevent/Correct Alleged Violation

483.15 – Admission, Transfer, and Discharge:

622 Transfer and Discharge Requirements

483.25 - Quality of Care:

684 Quality of Care

686 Treatment/Svcs to Prevent/Heal Pressure Ulcers
689 Free of Accident Hazards/Supervision/Devices
692 Nutrition/Hydration Status Maintenance
698 Dialysis

483.45 Pharmacy Services

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

483.50 – Laboratory, Radiology, and Other Diagnostic Services:

773 Lab Svcs Physician Order/Notify of Results

483.60 – Food and Nutrition Services:

805 Food in Form to Meet Individual Needs
812 Food Procurement, Store/Prepare/Serve - Sanitary

483.70 - Administration:

835 Administration

483.80 – Infection Control:

880 Infection Prevention & Control

483.90 – Physical Environment:

925 Maintains Effective Pest Control Program

Acronyms

CPR – Cardiopulmonary Resuscitation
LAR – Legally Authorized Representative
PPE – Personal Protective Equipment

Region 5
Exit Date: 07/02/2021
Purpose of Visit: Standard Survey; Focused Infection Control Survey
Tags: F684/N1446; F689/N1476; F805/N1580
Situations: The facility failed to provide food to six residents who were on altered diets that was appropriate for their condition and as ordered by a physician. The residents were provided whole popcorn and three of the residents displayed signs of aspiration. The facility failed to ensure the exit door alarms and WanderGuard system (system that helps prevent elopement) were active. Five residents were allowed to elope from the facility.

Deficient Practice: The facility failed to ensure that residents received treatment and care in accordance with the professional standards of practice and comprehensive person-centered care plan, failed to ensure the resident environment remained as free of accident hazards as is possible, and failed to assure residents received and consumed foods in the appropriate form as prescribed by a physician.

Region 3
Exit Date: 07/02/2021
Purpose of Visit: Standard Survey; Focused Infection Control Survey
Tags: F689/N1476
Situations: The facility failed to implement monitoring and interventions for a resident with a history of drug use. The resident obtained and overdosed on heroine.

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

Region 6
Exit Date: 07/04/2021
Purpose of Visit: Complaint/Incident Investigation
Tags: F603/N1284
Situations: The facility placed two residents on a secure unit without documentation of the clinical criteria for placement in a secured unit by the residents' physicians and without information provided by members of the residents' interdisciplinary teams. Both residents reported feeling frightened about being on the secure unit.

Deficient Practice: The facility failed to ensure each resident had the right to be free from involuntary seclusion.

Region 4
Exit Date: 07/09/2021
Purpose of Visit: Standard Survey
Tags: F684/N1446
Situations: The facility failed to properly assess, monitor, and seek immediate medical intervention when a resident began to verbalize suicidal ideations, display increased agitation, and ingested an unknown quantity of pills.

Deficient Practice: The facility failed to ensure appropriate treatment and care was provided in accordance with professional standards, comprehensive person-centered care plan and choices.

Region 5
Exit Date: 07/11/2021
Purpose of Visit: Complaint Investigation
Tags: F684/N1446
Situations: The facility failed to monitor and provide care and services for a resident's catheter. The resident developed abdominal pain and was sent to the hospital where they were diagnosed with sepsis, urinary tract infection, and cystitis (bladder inflammation). The facility failed to have a system in place for the care and monitoring of four residents with catheters.

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

Region 6
Exit Date: 07/11/2021
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1283; F689/N1477
Situations: The facility failed to implement interventions to prevent a resident from engaging in non-consensual sexual behaviors toward others. The resident had incidents of inappropriate, non-consensual touching with five other residents. The facility failed to accurately document and investigate these incidents.

Deficient Practice: The facility failed to ensure residents were free from abuse and failed to ensure residents received adequate supervision to prevent sexually inappropriate incidents.

Region 7
Exit Date: 07/12/2021
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F684/N1488
Situations: The facility failed to provide appropriate care to a resident when they were pulled into a sitting position by their arm, resulting in a fracture.

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

Region 2
Exit Date: 07/13/2021
Purpose of Visit: Standard Survey
Tags: F600/N1283; F689/N1477

Situations: The facility failed to ensure that two residents' WanderGuard systems (system that helps prevent elopement) were active and working. Both residents eloped from the facility, one of whom was missing for nearly four hours and was found with abrasions on their leg.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect and failed to ensure the resident environment remained as free of accident hazards as is possible.

Region 6
Exit Date: 07/15/2021
Purpose of Visit: Emergency Preparedness Survey
Tags: F689
Situations: The facility failed to ensure that water temperatures in the facility were kept at a safe temperature. Temperatures were measured to be greater than 120 degrees in multiple halls of the facility.

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

Region 3
Exit Date: 07/15/2021
Purpose of Visit: Standard Survey; Focused Infection Control Survey
Tags: F689/N1476
Situations: The facility failed to implement effective interventions for a resident with cognitive impairment and a history of wandering. The resident eloped from the facility and was found in the rear parking lot by an employee coming into work with bruising to their left eye and a laceration to the elbow.

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

Region 3
Exit Date: 07/27/2021
Purpose of Visit: Standard Survey
Tags: F600/N1283; F686/N1450; F689/N1477; F880/N1713/N1719
Situations: The facility failed to staff a wound care nurse, resulting in the facility not providing adequate skin assessments and treatment for residents with skin conditions and pressure ulcers. The facility failed to ensure staff were adequately trained to provide appropriate skin care. The facility failed to ensure effective planning before discharging a resident, failed to know where the resident was discharged to, and failed to provide supervision to ensure the resident's safety and well-being. The facility failed to ensure that an instance of verbal abuse towards a resident was reported. The facility failed to store PPE properly and failed to use proper disinfection practices. Due to infection control failures, a resident's wounds deteriorated, and they developed sepsis. The facility failed to identify that a resident was readmitted with MRSA (staph infection).

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect, failed to provide the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice to prevent development and worsening of pressure ulcers, failed to provide adequate supervision to prevent accidents, and ailed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment.

Region 3
Exit Date: 07/30/2021
Purpose of Visit: Incident Investigation; Focus Infection Control Survey
Tags: F689/N1477
Situations: The facility failed to ensure that all facility doors were properly secured. A resident with a history of exit-seeking behavior eloped from the facility through an unlocked door and was found hours later walking on a service road along a highway.

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

Region 6
Exit Date: 08/03/2021
Purpose of Visit: Complaint Investigation
Tags: F684/N1446
Situations: The facility failed to properly assess a resident and notify their physician when they began to complain about not feeling well, developed an elevated heart rate, and had continuous loose stool. The resident was left in this condition for over four hours after the symptoms were noted and was ultimately transferred to the hospital and diagnosed with sepsis and dehydration and required IV antibiotics for seventeen days. The facility failed to transfer a resident to their dialysis treatment for two consecutive appointments, causing them to go six days without hemodialysis. The facility failed to inform the resident's physician of this lapse in treatment after they had a change in condition manifesting as nausea, vomiting, low blood pressure, and complaints of feeling unwell after the second missed appointment. The resident was found unresponsive six hours after their changes in condition were first noted and was pronounced dead at the facility.

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

Region 4
Exit Date: 08/05/2021
Purpose of Visit: Complaint Investigation; Focused Infection Control Survey
Tags: F684/N1446
Situations: The facility failed to inform a resident's physician and family/LAR when the resident continued to pocket food and medication in their mouth and exhibited

swallowing difficulties. The facility failed to have therapy staff assess the resident for their swallowing issues. The resident was admitted to the hospital with aspiration/hypoxia and was intubated and placed on a ventilator.

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

Region 6
Exit Date: 08/07/2021
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1283; F689/N1477
Situations: The facility failed to implement interventions to ensure two residents with a history of sexually inappropriate behaviors were unable to sexually abuse another resident.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and failed to ensure adequate supervision was provided to prevent accidents.

Region 3
Exit Date: 08/09/2021
Purpose of Visit: Standard Survey
Tags: F689/N1476
Situations: The facility failed to ensure a resident at-risk for elopement, with impaired cognitive functions, and with a history of falls received adequate supervision to ensure they did not elope from the facility. The resident eloped and was found by a staff member laying in the grass behind the rear parking lot.

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

Region 4
Exit Date: 08/10/2021
Purpose of Visit: Complaint Investigation
Tags: F755/N1657; F760/N1671
Situations: The facility failed to implement medication administration procedures to prevent adverse reactions to medication. A resident was provided an inappropriate mix of medications that caused the resident to become lethargic and require hospitalization.

Deficient Practice: The facility failed to provide pharmaceutical services to include procedures that assured the accurate dispensing and administering of all drugs to meet the needs of residents and failed to ensure residents were free from significant medication errors.

Region 7
Exit Date: 08/11/2021
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N1446

Situations: The facility failed to properly assess and administer CPR to a resident with a full-code status (code status that allows all interventions to restart the heart).

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

Region 4
Exit Date: 08/11/2021
Purpose of Visit: Incident Investigation
Tags: F760/N1671
Situations: The facility failed to administer a resident's anticoagulant medication for six days. The resident was sent to the hospital with chest pain and was diagnosed with a heart attack secondary to micro-embolisms (small blood clots) as a result of being off of their anticoagulant medication for days.

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

Region 3
Exit Date: 08/13/2021
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F692/N1462
Situations: The facility failed to ensure a resident who received all their nutrition through a gastronomy tube (tube inserted through the belly that brings nutrition directly to the stomach) had physician orders for enteral feeding when they returned from the hospital. The resident did not receive regular enteral feedings for over twenty days and lost a total of thirteen pounds.

Deficient Practice: The facility failed to ensure that residents maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range.

Region 3
Exit Date: 08/13/2021
Purpose of Visit: Incident Investigation
Tags: F686/N1450
Situations: The facility failed to ensure that residents received effective wound care. One resident with a sacral pressure ulcer present on admission was not assessed and did not receive wound care for thirty-two days after admission when the wound had significantly deteriorated. The resident required hospitalization and was diagnosed with sepsis (infection in the blood), acute kidney failure, and five additional pressure ulcers.

Deficient Practice: The facility failed to ensure residents with a pressure ulcer received 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: 08/14/2021

Purpose of Visit: Standard Survey
Tags: F880/N1713/N1719
Situations: The facility failed to review a resident's hospital discharge documents and was unaware the resident had a diagnosis of MRSA (bacterial staph infection resistant to several antibiotics) and failed to implement contact isolation procedures. The facility failed to implement effective infection control procedures and did not properly identify areas for residents with unknown COVID status, failed to ensure effective use of PPE, and failed to ensure proper sanitization practices.

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 7
Exit Date: 08/16/2021
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F606/N1287/N1290
Situations: The facility failed to not employ a staff member with an inactive license due to disciplinary actions for resident abuse and failed to ensure all staff had background checks in their employee files.

Deficient Practice: The facility failed to not employ individuals who have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

Region 3
Exit Date: 08/19/2021
Purpose of Visit: Complaint Investigation
Tags: F600; F880
Situations: The facility failed to implement interventions to protect residents from abuse by a resident with a history of physical violence resulting in physical abuse of six residents. The facility failed to implement isolation precautions for newly admitted residents with unknown COVID status, failed to implement social distancing, and failed to ensure effective use of PPE.

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

Region 4
Exit Date: 08/19/2021
Purpose of Visit: Standard Survey; Focus Infection Control Survey
Tags: F689/N1476
Situations: The facility failed to effectively secure a resident in a wheelchair in the facility van prior to transport. The resident fell during transport, sustaining a head injury and was sent to a hospital where they died.

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

Region 2
Exit Date: 08/24/2021
Purpose of Visit: Complaint Investigation; Focused Infection Control Survey
Tags: F600/N1283
Situations: The facility failed to protect three residents who were unable to consent to sexual activity from being sexually abused by another resident.

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

Region 1
Exit Date: 08/25/2021
Purpose of Visit: Complaint Investigation; Focused Infection Control Survey
Tags: F684/N1446
Situations: The facility failed to provide wound care to a resident's surgical site for 14-days. The facility failed to obtain the physician's orders when the resident was returned from surgery and did not follow-up with the physician. The resident's surgical incision site became infected and, at the time of the survey, it was reported that the resident's leg may require amputation.

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

Region 4
Exit Date: 08/26/2021
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1476; F755/N1657
Situations: The facility failed to ensure their WanderGuard system (system that helps prevent elopement) was functioning properly throughout the facility. Five residents were able to elope from the facility through a door in the south wing which had a button installed that would allow anyone to bypass the alarm. The facility failed to ensure that a new medication administration policy would not contradict medication orders or cause negative side effects and failed to train staff and inform residents of the new procedures before implementing them.

Deficient Practice: The facility failed to ensure adequate supervision was provided to prevent accidents and failed to provide pharmaceutical services to include procedures that assured the accurate dispensing and administering of all drugs to meet the needs of residents.

Region 3
Exit Date: 08/27/2021
Purpose of Visit: Complaint/Incident Investigation

Tags: F689/N1477
Situations: The facility failed to ensure adequate supervision of all residents during a power outage. A resident was able to elope from the facility and was gone more than ten hours before the facility became aware that they were missing.

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

Region 2
Exit Date: 09/01/2021
Purpose of Visit: Complaint Investigation
Tags: F880
Situations: The facility failed to quarantine two unvaccinated residents with unknown COVID status.

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: 09/01/2021
Purpose of Visit: Complaint Investigation
Tags: F880
Situations: The facility failed to quarantine three residents exposed to COVID by their COVID-positive roommates, to monitor symptoms, and failed to ensure effective use of PPE.

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

Region 7
Exit Date: 09/01/2021
Purpose of Visit: Incident Investigation
Tags: F689/N1477
Situations: The facility failed to provide adequate supervision during the evening shift to ensure a resident did not elope. A resident eloped from the facility and was gone for more than two hours before a community member found them on the side of the road.

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

Region 5
Exit Date: 09/02/2021
Purpose of Visit: Complaint Investigation
Tags: F689/N1477
Situations: The facility failed to supervise a resident while they were out during transport. The resident was left unattended in the facility van at a convenience store and went into the store to buy cigarettes.

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

Region 3
Exit Date: 09/03/2021
Purpose of Visit: Complaint Investigation; Focused Infection Control Survey
Tags: F686/N1450
Situations: The facility failed to ensure a newly admitted resident received wound care for a deep tissue injury. The facility did not assess the wound for five days after admission. The resident was sent to the hospital five days after the first assessment and diagnosed with necrotizing fasciitis (flesh-eating bacteria) and septic shock. The resident died in the hospital. The facility failed to document a stage three pressure ulcer found on a resident.

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

Region 6
Exit Date: 09/03/2021
Purpose of Visit: Complaint/Incident Survey
Tags: F684/N1446
Situations: The facility failed to implement a physician's order for medication after a resident had a critical ammonia lab level of 165 (normal range is between fifteen and forty-five). The resident was found unresponsive sixteen hours after the critical lab levels.

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

Region 7
Exit Date: 09/05/2021
Purpose of Visit: Complaint/Incident Investigation
Tags: F812/N1591
Situations: The facility failed to maintain a clean, sanitary kitchen environment and had their kitchen operating license suspended by the local health inspector due to a roach infestation.

Deficient Practice: The facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety.

Region 6
Exit Date: 09/06/2021
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F686/N1449

Situations: The facility failed to identify, assess, and treat two pressure ulcers on both of a resident's heels. The ulcers deteriorated and developed into necrosis of the bone (the death of bone tissue due to a lack of blood supply).

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: 09/07/2021
Purpose of Visit: Complaint Investigation
Tags: F684/N1446; F755/N1657
Situations: The facility failed to ensure that a resident's intravenous vitamin therapy was complete and to monitor the resident for adverse reactions.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice and failed to provide pharmaceutical services to include procedures that assured the accurate dispensing and administering of all drugs to meet the needs residents.

Region 4
Exit Date: 09/10/2021
Purpose of Visit: Complaint Investigation
Tags: F684/N1446
Situations: The facility failed to ensure that two residents were thoroughly assessed over a period of three days. The facility did not obtain the residents vital signs, instead documenting vital signs from previous assessments. The facility failed to report one of the resident's change in condition when they began vomiting. Both residents died on the same day at the facility.

Deficient Practice: The facility failed to ensure treatment and care was provided based on the comprehensive assessment and in accordance with professional standards of practice.

Region 5
Exit Date: 09/11/2021
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N1446
Situations: The facility failed to provide effective supervision for a resident who was unable to move on their own. The resident was found with ants crawling on their body with numerous bites, causing pain and swelling. The facility failed to ensure that two residents who required assistance to eat received assistance resulting in them missing meals for multiple days.

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

Region 5
Exit Date: 09/11/2021
Purpose of Visit: Complaint Investigation
Tags: F689/N1476
Situations: The facility failed to implement interventions to address residents' risks for falls, resulting in three residents falling. The facility failed to perform a neurological check for one of the residents after they fell.

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

Region 5
Exit Date: 09/15/2021
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1477
Situations: The facility failed to provide effective supervision to ensure residents could not elope. A resident eloped from the facility through a window in the dining area and got a ride from a stranger and was found thirty miles from the facility.

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

Region 3
Exit Date: 09/16/2021
Purpose of Visit: Complaint Investigation; Focused Infection Control Survey
Tags: F684/N1446; F925/N1804
Situations: The facility failed to ensure residents safety when ants were found in resident rooms. Two residents were attacked by ants, causing bites all over their bodies. The facility failed to properly assess one of the residents and did not offer assistance to change the resident's clothes, shower, and offer them a different room after the incident.

Deficient Practice: The facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices and failed to maintain an effective pest control program to ensure the facility was free of pests.

Region 4
Exit Date: 09/20/2021
Purpose of Visit: Complaint Investigation
Tags: F600/N1284; F609/N1303/N1307; F610/N1294
Situations: The facility failed to protect residents from abuse after one staff member was observed choking a resident and punching another in the stomach. Another resident had alleged that a different staff member was regularly "rough" with them. Both staff members were allowed to continue working with residents after these allegations were presented. The facility failed to investigate the allegations timely and effectively.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse, failed to ensure that all alleged violations involving abuse or mistreatment were reported to the administrator and State Survey Agency immediately, but no later than 2 hours after the allegation was made for allegations that involved abuse, and failed to ensure that all violations involving abuse were thoroughly investigated and to take corrective actions and prevent further potential abuse.

Region 6
Exit Date: 09/21/2021
Purpose of Visit: Complaint Investigation; Focused Infection Control Survey
Tags: F684/N1446
Situations: The facility failed to ensure two residents received their prescribed doses of insulin for four days, resulting in elevated blood glucose levels and for one resident, increased confusion.

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

Region 5
Exit Date: 09/21/2021
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1209; F622/N1271
Situations: The facility failed to follow their discharge policy when they locked a resident out of the building after the resident left on a day pass. The resident was locked out of the facility and was not allowed reentry. The resident remained outside for over fifteen hours.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare, the safety of individuals in the facility, and the resident's needs could not be met in the facility.

Region 6
Exit Date: 09/22/2021
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F600/N1284; F689/N1477
Situations: The facility failed to effectively supervise a resident with a history of aggressive behavior and protect other residents from abuse when the resident hit another and pushed them, causing them to fall and sustain a head injury requiring hospitalization.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and failed to ensure that each resident received adequate supervision to prevent accidents.

Region 3

Exit Date: 09/24/2021
Purpose of Visit: Complaint Investigation; Focused Infection Control Survey
Tags: F684/N1446
Situations: The facility failed to assess, monitor, and treat a resident's surgical site to ensure there were no complications. The resident was sent to the hospital after the resident's family noticed drainage, redness, and a mass on the back of the resident's head where the surgical site was located. The resident was diagnosed with a wound infection that required surgical incision and drainage.

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

Region 6
Exit Date: 09/25/2021
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F689/N1477
Situations: The facility failed to implement interventions for a resident with exit-seeking behaviors after multiple elopement attempts. The resident eloped from the facility and was found approximately one mile away and unresponsive. The resident was transferred to the hospital where they died.

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

Region 7
Exit Date: 09/28/2021
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F600/N1209; F835/N1808
Situations: The facility failed to respect a resident's rights when the resident was placed in a shower while their clothes were on to encourage them to remove them and force them to bathe. The facility administration had written a policy directing such actions when a resident refused to bathe. The facility took away the resident's comfort items despite the resident's objections.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and administration failed to administer resources to attain or maintain the highest practicable physical, mental, and psychosocial well-being for residents.

Region 3
Exit Date: 09/29/2021
Purpose of Visit: Standard Survey; Focus Infection Control Survey
Tags: F578/N1121; F686/N1449
Situations: The facility failed to ensure a resident's updated DNR status was correctly documented. The resident had an OOH-DNR (out-of-hospital, do not resuscitate), which the facility received and had on file. The resident had a change in condition requiring a transfer to the hospital via ambulance. The facility provided the previous, outdated full code status (code status that allows all interventions to restart the heart). During the

transfer to the hospital the resident went into cardiac arrest and the paramedics provided treatment to restart the resident's heart. The resident was pronounced dead at the hospital after the family informed them of the resident's code status. The facility failed to implement wound care as ordered by a physician to treat the resident's pressure ulcer. The facility failed to identify a separate pressure ulcer on the resident's right arm.

Deficient Practice: The facility failed to honor the resident's right to refuse treatment and failed to provide care and treatments, consistent with professional standards, to promote healing of pressure ulcers and to prevent development of new pressure ulcers.

Region 6
Exit Date: 09/29/2021
Purpose of Visit: Standard Survey
Tags: F698/1471; F773/N1823
Situations: The facility failed to assess resident's requiring dialysis to ensure their equipment was sufficient to perform the treatment effectively. The facility failed to recheck three residents' hemoglobin levels, all of whom received dialysis, after all three had low/abnormal levels, as directed by a nurse practitioner. The residents all required transfer to the hospital for evaluation and treatment.

Deficient Practice: The facility failed to ensure residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences and failed to obtained laboratory services as ordered by the physician and report results in accordance with facility policy and procedures for notification.

Region 1
Exit Date: 09/30/2021
Purpose of Visit: Incident Investigation; Focused Infection Control Survey
Tags: F880/N1713/N1717
Situations: The facility failed to screen staff members for symptoms of COVID prior to them starting their shifts.

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