Quarterly IJ Summary Report
July 2022 – September 2022

The following report presents information regarding all tags cited at the Immediate Jeopardy (IJ) level during licensing and certification surveys and complaint or incident investigations performed in nursing facilities during the third quarter of 2022 (07/01/2022 – 09/31/2022).

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

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

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

Table 1

F-Tag (Sorted by Tag Number)	**% Cited***	**F-Tag** (Sorted by Frequency Cited)	**% Cited***
580	10%	689	19%
584	1%	684	15%
600	14%	600	14%
607	3%	580	10%
609	1%	610	6%
610	6%	686	5%
622	1%	695	5%
626	1%	880	4%
656	1%	607	3%
678	2%	678	2%
684	15%	692	2%
686	5%	584	1%
689	19%	609	1%
692	2%	622	1%
694	1%	626	1%
695	5%	656	1%
725	1%	694	1%
740	1%	725	1%

TEXAS
Health and Human Services

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
741	1%	740	1%
757	1%	741	1%
758	1%	757	1%
776	1%	758	1%
835	1%	776	1%
880	4%	835	1%
925	1%	925	1%

*Rounded to the nearest tent

Table 2

Region	# Of IJs	# Of NFs	% Of IJs/NF
1	3	86	3.49%
2	2	135	1.48%
3	20	229	8.73%
4	18	189	9.52%
5	7	188	3.72%
6	6	169	3.55%
8	4	141	2.84%
11	1	79	1.27%
Total	**61**	**1216**	5.02%

Table 3
Number of IJs

from Complaints	from Incidents	from Surveys	Total
41	5	15	61

Tag References

483.10 – Resident Rights:

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
607 Develop/Implement Abuse/Neglect, etc. Policies
609 Reporting of Alleged Violations
610 Investigate/Prevent/Correct Alleged Violation

483.15 – Admission, Transfer, and Discharge:

622 Transfer and Discharge Requirements
626 Permitting Residents to Return to Facility

483.21 – Comprehensive Resident Centered Care Plans:

656 Develop/Implement Comprehensive Care Plan

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
694 Parenteral/IV Fluids
695 Respiratory/Tracheostomy Care and Suctioning

483.35 Nursing Services

725 Sufficient Nursing Staff

483.40 Behavioral Health Services

740 Behavioral Health Services
741 Sufficient/Competent Staff – Behavioral Health Needs

483.45 Pharmacy Services

757 Drug Regimen is Free from Unnecessary Drugs
758 Free From Unnec Psychotropic Meds/PRN Use

483.50 – Laboratory, Radiology, and Other Diagnostic Services:

776 Radiology/Other Diagnostic Services

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
ER – Emergency Room
PPE – Personal Protective Equipment

Region 8
Exit Date: 07/01/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N1131; F684/N1446
Situations: The facility failed to perform a complete skin assessment on a resident who was newly admitted and failed to inform the resident's physician when they experienced a change in condition to their left great toe, which required amputation two days later.

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: 07/11/2022
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control
Tags: F610/N1294
Situations: The facility failed to investigate allegations of abuse of a resident and continued to allow the alleged perpetrator to have direct contact with residents.

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

Region 3
Exit Date: 07/14/2022
Purpose of Visit: Standard Survey
Tags: F757/N1666
Situations: The facility failed to monitor a resident's labs while they were taking antibiotics. The resident ultimately required hospitalization and was diagnosed with acute kidney failure.

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

Region 6
Exit Date: 07/17/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1477
Situations: The facility failed to provide adequate supervision and assistive devices to prevent three residents from eloping from the facility in a span of less than three months.

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

Region 5
Exit Date: 07/18/2022

Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N1446
Situations: The facility failed to ensure adequate staffing to ensure incontinence care was provided appropriately to two residents who were left in urine-soaked linens for extended periods of time, one of whom developed a pressure ulcer to the buttocks.

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

Region 6
Exit Date: 07/20/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F725/N1490
Situations: The facility failed to provide adequate staff to assign to the designated COVID-19 unit where four residents, with cognitive impairments and histories of falls and exit-seeking behaviors, were regularly left unattended. One resident fell and sustained a head injury requiring staples.

Deficient Practice: The facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable well-being.

Region 3
Exit Date: 07/20/2022
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F600/N1284; F607/N1286; F610/N1303/N1305/N1306
Situations: The facility failed to report, investigate, and protect four residents from abuse by two staff members.

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

Region 4
Exit Date: 07/22/2022
Purpose of Visit: Standard Survey
Tags: F695/N1468
Situations: The facility failed to properly set up a resident’s ventilator. The ventilator did not sound an alarm to notify the facility when the resident’s pulse stopped. The resident was sent to the hospital where they died.

Deficient Practice: The facility failed to ensure that a resident who needed respiratory care, which included tracheostomy care and tracheal suctioning, was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Region 3

Exit Date: 07/22/2022
Purpose of Visit: Standard Survey
Tags: F880/N1713
Situations: The facility failed to ensure all staff and residents were tested for COVID-19 after one resident tested positive and continued in this failure until after the sixth resident tested positive, resulting in over half the facility resident's developing COVID-19. The facility failed to ensure effective donning and doffing of protective gear, failed to ensure shared medical devices were sanitized properly between uses, 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 11
Exit Date: 07/22/2022
Purpose of Visit: Complaint Investigation
Tags: F686/N1450
Situations: The facility failed to provide effective wound care to a resident who was admitted with a pressure ulcer, resulting in deterioration of the wound.

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: 07/24/2022
Purpose of Visit: Standard Survey
Tags: F656/N1393; F689/N1476/N1477
Situations: The facility failed to ensure two residents received effective supervision and assistive devices to prevent falls. One resident fell twenty-seven times, the other twenty, within a year, resulting in multiple injuries to both.

Deficient Practice: The facility failed to develop a comprehensive fall prevention care plan that addressed resident-specific risk factors for falls and failed to ensure adequate supervision was provided to prevent accidents.

Region 2
Exit Date: 07/28/2022
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F600/N1284; F689/N1477
Situations: The facility failed to ensure the secured unit was adequately staffed to prevent elopement. One resident, with a history of wandering behaviors, eloped from the secure unit and was found on the ground outside the facility after being unaccounted for nearly two hours.

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

Region 4
Exit Date: 07/28/2022
Purpose of Visit: Incident Investigation
Tags: F689/N1476
Situations: The facility failed to provide adequate supervision to prevent a resident with a history of exit-seeking behaviors from eloping. The resident exited their window and wandered from the facility in nearly one-hundred-degree weather.

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

Region 3
Exit Date: 07/29/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1477
Situations: The facility failed to ensure policies were followed to abstain from cell phone use while providing care. A resident fell during a transfer while a staff member talked on their cell phone, sustaining a laceration to the forehead that required stitches, a fractured upper arm, and a subarachnoid hemorrhage (bleeding within the subarachnoid space located between the brain and the tissue covering the brain).

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

Region 3
Exit Date: 08/03/2022
Purpose of Visit: Standard Survey
Tags: F689/N1476
Situations: The facility failed to ensure a resident being transported back to the facility after outside treatment was effectively supervised. The resident was left in the van with no air-conditioning or open windows for over thirty minutes in ninety-eight-degree weather.

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

Region 3
Exit Date: 08/04/2022
Purpose of Visit: Complaint Investigation; Focused Infection Control Survey
Tags: F880/N1713
Situations: The facility failed to cohort residents based on the COVID-19 infection statuses.

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 2

Exit Date: 08/05/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1283; F689/N1477; F741/N1482
Situations: The facility failed to protect residents from abuse when two residents were abused by others, one of whom was abused by four others. The facility failed to ensure supervision to prevent a resident, who required a specialized consistency of food in their diet, from obtaining food inconsistent with their needs, resulting in the resident choking.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect, failed to ensure adequate supervision was provided to prevent accidents, and failed to have enough qualified staff to provide adequate care for residents with mental and psychosocial disorders.

Region 5
Exit Date: 08/05/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F584/N1342
Situations: The facility failed to provide relief to ten residents when the air conditioner in their wing went out. The facility did not monitor the residents for dehydration or heat-related illnesses as the temperatures in the hall approached ninety degrees.

Deficient Practice: The facility failed to maintain a safe, clean, sanitary, comfortable, and homelike environment for residents.

Region 5
Exit Date: 08/08/2022
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F600/N1284
Situations: The facility failed to put interventions into place to address a resident's history of sexually inappropriate behaviors, resulting in the resident sexually assaulting another.

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

Region 3
Exit Date: 08/08/2022
Purpose of Visit: Complaint/Incident Investigation; Focused Infection Control Survey
Tags: F580/N1131; F684/N1446
Situations: The facility failed to provide treatment and notify a physician when a resident developed chest pain and had unusually low blood pressure. The resident died the day after developing these symptoms.

Deficient Practice: The facility failed to consult with the resident's physician when there was a significant change in the resident's physical status and failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 8 **Exit Date**: 08/11/2022 **Purpose of Visit**: Complaint Investigation **Tags**: F600/N1283; F684/N1446; F686/N1450 **Situations:** The facility failed to ensure effective wound treatment for four residents, resulting in all experiencing deterioration of their wounds. One resident developed a bone infection, which required hospitalization and amputation of a portion of their foot.
Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to ensure residents received treatment and care in accordance with professional standards of practice, and failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

Region 1 **Exit Date**: 08/12/2022 **Purpose of Visit**: Standard Survey **Tags**: F600/N1283 **Situations:** The facility failed to protect one resident from sexual abuse, witnessed by two staff members, failed to protect four residents from mental abuse, and one from physical abuse. The facility failed to report these allegations of abuse.
Deficient Practice: The facility failed to implement policies and procedures to prevent abuse.

Region 2 **Exit Date**: 04/29/2022 **Purpose of Visit**: Licensed-only Complaint/Incident Investigation **Tags**: N1284 **Situations:** The facility failed to implement interventions to prevent a resident attacking others.
Deficient Practice: The facility failed to implement policies and procedures to prevent abuse.

Region 6 **Exit Date**: 08/15/2022 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F580/N1130/N1131; F600/N1283; F684/N1446; F835; F925/N1804 **Situations:** The facility failed to inform a resident’s physician and provide medical care after the resident was found covered in hundreds of ant bites. Facility administration failed to provide guidance and coordinate with other providers after receiving notification, including footage, of the injuries the resident sustained to the face, eyes, inside the mouth, and across their body from the bites. The resident died four hours after sustaining the bites. The facility failed to ensure an effective pest control program.
Deficient Practice: The facility failed to consult with the resident's physician when there was a significant change in the resident's physical status, failed to implement

policies and procedures to prevent neglect, failed to ensure residents received treatment and care in accordance with professional standards of practice, and failed to maintain an effective pest control program. Facility administration failed to ensure effective use of its resources.

Region 3
Exit Date: 08/17/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N1130; F607/N1285; F610/N1305; F684/N1446
Situations: The facility failed to investigate and inform a resident's physician when they were found to have a significant injury to the left hand, the source of which could not be identified by the facility. The resident was sent to the ER the following day when they became unresponsive, and the blisters had tripled in size and was diagnosed with second degree thermal burns to the whole left hand, sepsis (the body's extreme reaction to an infection), and a urinary tract infection. The hospital notified the facility that there was a concern that the resident had been burned.

Deficient Practice: The facility failed to consult with the resident's physician when there was a significant change in the resident's physical status, failed to implement policies and procedures to prevent neglect, failed to ensure that all alleged violations of neglect were thoroughly investigated and to prevent further neglect while the investigation was in progress, and failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 3
Exit Date: 08/18/2022
Purpose of Visit: Standard Survey
Tags: F695/N1468
Situations: The facility failed to ensure emergency respiratory interventions for a resident with a tracheostomy, such as oxygen, suction, and replacement cannula, were at their bedside and failed to assess the resident when they went into respiratory distress.

Deficient Practice: The facility failed to provide respiratory care consistent with professional standards of practice.

Region 4
Exit Date: 08/18/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1477
Situations: The facility failed to implement interventions to prevent a resident with a history of exit-seeking behaviors from eloping. The resident eloped from the facility and was found walking around an adjacent neighborhood. The facility was unaware of the elopement until it was time for the resident's medication administration.

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

Region 4
Exit Date: 08/19/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N1449
Situations: The facility failed to provide effective skin assessments to three residents who developed pressure ulcers which continued to deteriorate. One resident developed a stage four ulcer (very deep wound involving skin, muscle, and bone) to their sacrum (the bone between the spine and tailbone). The resident required hospitalization due to sepsis (the body's extreme reaction to an infection) and osteomyelitis (an infection of the bone).

Deficient Practice: The facility failed to ensure residents 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: 08/19/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/F607/N1284; F610/N1306
Situations: The facility failed to protect a resident from abuse after a witnessed physical and verbal abuse event was not reported and investigated.

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

Region 6
Exit Date: 08/20/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1283; F689/N147; F740/N1481
Situations: The facility failed to implement interventions to protect a resident from multiple incidents of abuse by their roommate, who had a history of violence and death threats. The resident was found dead in their room and the autopsy determined the likely cause of death was ligature strangulation. The facility failed to provide behavioral health assessments on the perpetrator of the abuse.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable well-being of residents.

Region 4
Exit Date: 08/20/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1477
Situations: The facility failed to implement interventions to prevent a resident with a history of exit-seeking behaviors from eloping. The resident eloped from the facility and

was found five days later. The resident required hospitalization due to an altered mental status, acute hypokalemia (low potassium), a urinary tract infection, sepsis (the body's extreme reaction to an infection), protein malnutrition, and alcoholism.

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

Region 4
Exit Date: 08/22/2022
Purpose of Visit: Standard Survey
Tags: F600/N1283; F695/N1468
Situations: The facility failed to protect residents from abuse when they allowed a staff member to return to work after an altercation with a resident during which the staff member bit the resident on the thigh. After returning from suspension, the staff member verbally abused another resident. The staff member remained in employment until they quit. The facility failed to ensure staff were knowledgeable in how to provide effective care to a resident with a tracheostomy (surgical airway management procedure which consists of making an incision on the anterior aspect of the neck and opening a direct airway through an incision in the trachea).

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and failed to provide respiratory care consistent with professional standards of practice.

Region 3
Exit Date: 08/22/2022
Purpose of Visit: Incident Investigation; Focused Infection Control Survey
Tags: F678/N1321; F684/N1446
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). The resident died at the facility.

Deficient Practice: The facility failed to ensure personnel provided basic life support, which included CPR to a resident who required such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directive and failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 3
Exit Date: 08/24/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N1446; F686/N1450
Situations: The facility failed to effectively assess and treat four residents with pressure ulcers, all of whom experienced 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 4
Exit Date: 08/25/2022
Purpose of Visit: Standard Survey
Tags: F695/N1468
Situations: The facility failed to ensure a resident had replacement respiratory care devices at their bedside, putting them at risk of delayed rescue efforts.

Deficient Practice: The facility failed to ensure that a resident who needed respiratory care, which included tracheostomy care and tracheal suctioning, was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Region 3
Exit Date: 08/25/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1477
Situations: The facility failed to provide adequate supervision to prevent a resident with a history of exit-seeking behaviors from eloping. The resident eloped from the facility and was returned to the facility by law enforcement.

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

Region 4
Exit Date: 08/26/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1477
Situations: The facility failed to coordinate with their transportation department when a resident’s outside appointment was canceled. The resident was transferred to their appointment and left at the treatment facility. The resident was away from the facility for over twenty-four hours and was found by law enforcement lying on their back in a wooded area behind an empty lot.

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

Region 3
Exit Date: 08/26/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N1132; F692/N1462/N1463
Situations: The facility failed to ensure a resident was provided an appropriate nutrition and hydration program and failed to consult with a physician when the resident experienced significant weight loss and changes in their mental status. The resident was ultimately hospitalized with dehydration, metabolic encephalopathy (an acute condition

of global cerebral dysfunction encompassing delirium and confusion), acute kidney injury, and significant weight loss.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to ensure residents maintained acceptable parameters of nutritional status.

Region 3
Exit Date: 08/27/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N1446
Situations: The facility failed to monitor a resident's lower extremities for blood flow and oxygen despite the resident's known poor circulation. The resident required hospitalization due to developing gangrene and had to have their leg amputated.

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

Region 6
Exit Date: 08/29/2022
Purpose of Visit: Standard Survey
Tags: F689/N1477
Situations: The facility failed to provide adequate supervision and to ensure their anti-elopement systems were functioning to prevent a resident from eloping. The resident eloped from the facility after admitting EMS personnel and was found two days later, four miles from the facility.

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

Region 4
Exit Date: 08/30/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1284
Situations: The facility failed to implement interventions to prevent a resident with a history of falls from falling. After the resident fell, the facility failed to provide neurological checks, to assess the resident for injuries, and to inform the resident's physician of the incident.

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

Region 4
Exit Date: 08/30/2022
Purpose of Visit: Complaint Investigation
Tags: F580/N1132; F695/N1468
Situations: The facility failed to inform a resident's physician when the resident refused to use their BIPAP machine with a tracheostomy tube due to discomfort and did not

obtain alternate or additional monitoring orders. The resident began to have trouble breathing and had decreased oxygen levels.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to ensure that a resident who needed respiratory care, which included tracheostomy care and tracheal suctioning, was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Region 5
Exit Date: 08/30/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N1131; F684/N1446; F686/N1449
Situations: The facility failed to assess and report a change in skin condition when a resident developed a pressure ulcer, resulting in deterioration of the wound.

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 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: 09/01/2022
Purpose of Visit: Standard Survey
Tags: F580/N1131; F609/N1294; F610/N1303; F684/N1446; F776/N1832
Situations: The facility failed to report and investigate an allegation of sexual abuse reported by a resident. The facility failed to obtain a CT scan per physician orders after a resident had a change in condition. The resident was ultimately hospitalized with a subdural hematoma (which occurs when a blood vessel in the space between the skull and the brain is damaged).

Deficient Practice: The facility failed to consult with the physician regarding a change in condition, failed to ensure that all alleged violations involving sexual abuse are reported immediately or not later than two hours, failed to ensure that all alleged violations of abuse were thoroughly investigated and to prevent further abuse while the investigation was in progress, 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 residents.

Region 3
Exit Date: 09/01/2022
Purpose of Visit: Incident Investigation
Tags: F689/N1477
Situations: The facility failed to ensure a resident with cognitive impairments had adequate supervision during an appointment outside the facility. The resident left the

facility to go to their appointment on their own and was missing for thirty-five hours before being returned to the facility.

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

Region 8
Exit Date: 09/02/2022
Purpose of Visit: Complaint Investigation
Tags: F600/N1283; F678/N1321
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).

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to ensure personnel provided basic life support, which included CPR to a resident who required such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directive.

Region 4
Exit Date: 09/04/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1283; F689/N1477
Situations: The facility failed to implement interventions to prevent a resident with a history of sexually inappropriate behaviors from sexually assaulting 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 4
Exit Date: 09/04/2021
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N1446
Situations: The facility failed to inform a resident's physician and implement treatment and monitoring when they developed cracked lips, poor skin turgor, thirst, decreased output, lethargy, elevated temperature, low blood pressure with increased pulse, and weight loss. The resident was ultimately sent to the hospital and diagnosed with acute kidney failure and septic shock.

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

Region 4
Exit Date: 09/09/2022
Purpose of Visit: Complaint Investigation
Tags: F580/N1130; F684/N1446

Situations: The facility failed to implement interventions and obtain clarification of their physician's orders for treatment after abnormal lab levels. The resident became unresponsive and 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 4
Exit Date: 09/15/2022
Purpose of Visit: Complaint Investigation
Tags: F689/N1477
Situations: The facility failed to a resident was properly secured in their wheelchair during transport, resulting in the resident falling from their wheelchair and sustaining fractures to their femur and clavicle.

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

Region 4
Exit Date: 09/15/2022
Purpose of Visit: Complaint Investigation
Tags: F689/N1477
Situations: The facility failed to establish policies to ensure a resident was not left outside in direct exposure to high heat and the sun for long periods of time.

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

Region 5
Exit Date: 09/16/2022
Purpose of Visit: Incident Investigation
Tags: F880/N1713
Situations: The facility failed to screen staff for symptoms of COVID-19, failed to ensure effective use of PPE, and failed to ensure proper donning and doffing of PPE between COVID-positive and -negative units.

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 4
Exit Date: 09/19/2022
Purpose of Visit: Standard Survey
Tags: F580/N1131; F758/N1666
Situations: The facility failed to monitor a resident and recognize serious side effects of a newly prescribed antipsychotic medication, resulting in the resident developing extrapyramidal symptoms (serious side effects that develop after taking antipsychotic medication), decreased activity of daily living capabilities and a decreased quality of life.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to ensure that resident PRN orders for psychotropic drugs are limited to fourteen days and, if prescribing practitioner believed it is appropriate for PRN order to be extended beyond 14 days, then document rationale in resident's medical record.

Region 3
Exit Date: 09/19/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N1446
Situations: The facility failed to assess and respond to a resident after they had a significant change in condition. The facility waited over six hours before responding and sending the resident to the hospital after they became unresponsive.

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

Region 5
Exit Date: 09/22/2022
Purpose of Visit: Complaint Investigation
Tags: F694/N1446
Situations: The facility failed to ensure that a central venous line site was kept clean. The resident was sent to the hospital and diagnosed with septic shock.

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

Region 8
Exit Date: 09/22/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N1446
Situations: The facility failed to receive and act on a resident’s ordered laboratory services and failed to assess and treat an injury to the resident’s genitalia.

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

Region 3
Exit Date: 90/23/2022
Purpose of Visit: Standard Survey
Tags: F692/N1571
Situations: The facility failed to follow the dietician’s orders for a resident resulting in a greater-than eighteen percent weight loss, about which the facility failed to consult with the resident’s physician.

Deficient Practice: The facility failed to provide a therapeutic diet that considers the resident's clinical condition and preferences to ensure residents maintained acceptable parameters of nutritional status when there was a nutritional problem.

Region 3
Exit Date: 09/23/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F880/N1713
Situations: The facility failed to cohort residents based on their COVID-19 status, failed to ensure proper sanitization practices, 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 6
Exit Date: 09/25/2022
Purpose of Visit: Standard Survey
Tags: F600/N1283; F610/N1294/N1303
Situations: The facility failed to protect residents from threatening, abusive behavior by a staff member and failed to thoroughly investigate and correct the issue.

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

Region 1
Exit Date: 09/28/2022
Purpose of Visit: Incident Investigation
Tags: F689/N1476
Situations: The facility failed to ensure a resident's anti-elopement device was working properly to prevent the resident from eloping from the facility.

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

Region 4
Exit Date: 09/28/2022
Purpose of Visit: Complaint Investigation
Tags: F622/N1278; F515/N1419
Situations: The facility failed to allow a resident to return to the facility. The resident was sent to the hospital for evaluation due to a possible overdose. The facility refused to take them back after the hospital cleared them for readmission. The resident went to a gas station where they began to experience non-radiating chest pain and was sent to the hospital where they required intubation.

Deficient Practice: The facility failed to permit each resident to remain in the facility and not transfer or discharge the resident from the facility and failed to ensure the written policy for returning to the facility after a hospitalization was followed.

Region 1
Exit Date: 09/29/2022

Purpose of Visit: Standard Survey
Tags: F689/N1477
Situations: The facility failed to provide adequate supervision to prevent a resident with a history of exit-seeking behaviors from eloping. The facility failed to store chemicals in a safe manner, leaving them accessible to residents in common areas.

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