Quarterly IJ Summary Report
July 2023 – September 2023

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 2023 (07/01/2023 – 09/30/2023).

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 133 of the surveys and investigations conducted, resulting in 284 citations of forty-one 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*
550	0.4%	689	16.5%
558	0.4%	600	14.8%
580	8.5%	684	9.2%
584	1.1%	580	8.5%
600	14.8%	607	7.4%
604	1.4%	686	4.9%
607	7.4%	610	3.9%
609	2.5%	726	3.5%
610	3.9%	755	3.2%
622	0.4%	760	2.8%
624	1.1%	609	2.5%
626	0.4%	656	2.1%
655	0.4%	678	2.1%
656	2.1%	835	2.1%
658	0.4%	880	2.1%
660	0.4%	697	1.8%
661	0.4%	604	1.4%
678	2.1%	584	1.1%

TEXAS
Health and Human
Services

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
684	9.2%	624	1.1%
686	4.9%	687	0.7%
687	0.7%	690	0.7%
689	16.5%	695	0.7%
690	0.7%	740	0.7%
693	0.4%	742	0.7%
695	0.7%	550	0.4%
697	1.8%	558	0.4%
710	0.4%	622	0.4%
726	3.5%	626	0.4%
740	0.7%	655	0.4%
742	0.7%	658	0.4%
755	3.2%	660	0.4%
760	2.8%	661	0.4%
773	0.4%	693	0.4%
777	0.4%	710	0.4%
812	0.4%	773	0.4%
825	0.4%	777	0.4%
835	2.1%	812	0.4%
880	2.1%	825	0.4%
919	0.4%	919	0.4%
921	0.4%	921	0.4%
550	0.4%	689	16.5%

*Rounded to the nearest tenth

Table 2

Region	# Of IJs	# Of NFs	% Of IJs/NF
1	5	82	6.10%
2	5	137	3.65%
3	24	224	10.71%
4	28	187	14.97%
5	27	187	14.44%
6	28	168	16.67%
8	7	141	4.96%
11	9	78	11.54%

TEXAS
Health and Human
Services

Total	133	1204	11.05%

Table 3
Number of IJs

from Complaints	from Incidents	from Surveys	Total
100	9	24	133

Tag References

483.10 – Resident Rights:

550 Resident Rights/Exercise of Rights
558 Reasonable Accommodations of Needs/Preferences
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
604 Right to be Free from Physical Restraints
607 Develop/Implement Abuse/Neglect, etc. Policies
609 Reporting of Alleged Violations
610 Investigate/Prevent/Correct Alleged Violation

483.15 – Admission, Transfer, and Discharge:

622 Transfer and Discharge Requirements
624 Preparation for Safe/Orderly Transfer/Discharge
626 Permitting Residents to Return to Facility

483.21 – Comprehensive Resident Centered Care Plans:

655 Baseline Care Plan
656 Develop/Implement Comprehensive Care Plan
658 Services Provided Meet Professional Standards
660 Discharge Planning Process
661 Discharge Summary

483.25 - Quality of Care:

678 Cardio-Pulmonary Resuscitation
684 Quality of Care
686 Treatment/Svcs to Prevent/Heal Pressure Ulcers
687 Foot Care
689 Free of Accident Hazards/Supervision/Devices
690 Bowel/Bladder Incontinence, Catheter, UTI
693 Tube Feeding Management/Restore Eating Skills
695 Respiratory/Tracheostomy Care and Suctioning
697 Pain Management

483.30 Nursing Services

710 Resident's Care Supervised by a Physician

483.35 Nursing Services

726 Sufficient 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
760 Residents are Free of Significant Med Errors

483.50 – Laboratory, Radiology, and Other Diagnostic Services:

773 Lav Svcs Physician Order/Notify of Results
777 Radiology/Diag. Svcs Ordered/Notify Results

483.60 – Food and Nutrition Services:

812 Food Procurement, Store/Prepare/Serve - Sanitary

483.65 – Specialized Rehabilitative Services:

825 Provide/Obtain Specialized Rehab Services

483.70 – Administration:

835 Administration

483.80 – Infection Control:

880 Infection Prevention & Control

483.90 Physical Environment

919 Resident Call System
921 Safe/Functional/Sanitary/Comfortable Environment

Acronyms

ADL – Activities of Daily Living
AED – Automated External Defibrillator
CPR – Cardiopulmonary Resuscitation
EMS – Emergency Medical Services
HHS – Health and Human Services
PPE – Personal Protective Equipment

Region 6
Exit Date: 07/05/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N3949
Situations: The facility failed to effectively assess a resident's wound and obtain treatment orders when they were admitted to the facility, resulting in the resident missing six days of wound care. The facility failed to provide wound care to three other residents resulting in deterioration of the wounds of one resident.

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

Region 1
Exit Date: 07/05/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481
Situations: The facility failed to protect a resident from physical abuse when a staff member struck them on the arm. The facility failed to properly report and investigate the incident and the staff member was allowed to continue working after a half-day suspension.

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

Region 5
Exit Date: 07/06/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F660/N3838
Situations: The facility failed to ensure a plan of care was in place before discharging a resident to a motel. The resident required hospitalization three days after discharge.

Deficient Practice: The facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

Region 4
Exit Date: 07/11/2023
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to develop a system for residents to sign themselves out for smoking or traveling on their own. The facility did not have a designated smoking area with ash trays and a fire extinguisher and did not ensure a system of supervision while residents smoked. One resident signed themselves out of the facility and traveled in their wheelchair to a nearby convenience store and neighborhood.

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

Region 5
Exit Date: 07/11/2023
Purpose of Visit: Complaint Investigation
Tags: F742/N4042
Situations: The facility failed to monitor a resident and begin interventions after the resident expressed the desire to die to multiple staff members. The resident attempted suicide that same day and was sent to the ER.

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

Region 3
Exit Date: 07/12/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure staff provided appropriate supervision and care to a resident with advanced Alzheimer's. A staff member redirected the resident out of another resident's room inappropriately, which resulted in the resident falling backwards and sustaining a femur fracture.

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

Region 2
Exit Date: 07/12/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to respond when a resident, who had a history of wandering behaviors, triggered a door alarm as they left the facility. The resident was found wandering in 103-degree heat in a nearby neighborhood.

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

Region 4
Exit Date: 07/12/2023
Purpose of Visit: Standard Survey
Tags: F689/N4027
Situations: The facility failed to ensure a resident, with a history of elopement, did not elope from the facility through their window. Following the elopement, the facility failed to ensure all windows in the secured unit were fitted with alarms. Three windows remained without alarms, two of which were screwed shut. The facility failed to establish a system to monitor alarms and to have sufficient staff to monitor residents on the secured unit.

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

Region 3
Exit Date: 07/13/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F656/N3784; F689/N4030
Situations: The facility failed to implement monitoring and interventions to prevent a resident with severe cognitive impairment and assessed as being at moderate risk for elopement from eloping from the facility unsupervised. At the time of the investigation the resident's whereabouts were still unknown.

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 4
Exit Date: 07/13/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F600/N3481; F607/N3484N/N3487/N3511; F610/N3538; F684/N3937
Situations: The facility failed to protect four residents from physical abuse by another resident on multiple occasions. The facility failed to fully investigate the incidents and did not implement interventions to prevent the behaviors. The facility failed to effectively assess a resident after they had an unwitnessed fall and did not notify the resident's physician of changes in their condition, resulting in the resident's death.

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

Region 4
Exit Date: 07/13/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N3949
Situations: The facility failed to provide the prescribed treatment and nutritional interventions to a resident with pressure ulcers, resulting in the ulcers deteriorating. The facility failed to identify and treat newly developed ulcers on another resident's foot.

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 11
Exit Date: 07/14/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F604/N3484; F607/N3514; F609/N3532
Situations: The facility failed to protect three residents from undergoing involuntary restraint. One resident was tied to a chair with clothes, one was held down by force, and a third was held with their hands above their head and mouth covered. The facility failed to ensure the incidents were reported and fully investigated.

Deficient Practice: The facility failed to ensure residents were treated with respect and dignity, including the right to be free from any physical restraints imposed for purposes of discipline or convenience; 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 4
Exit Date: 07/14/2023
Purpose of Visit: Standard Survey
Tags: F580/N3013; F684/N3937
Situations: The facility failed to inform a resident's physician and implement interventions when the resident, who was taking anticoagulant medication, began to display increased bruising.

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: 07/14/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F697/N4009
Situations: The facility failed to provide a resident with their prescribed pain medication for twenty hours after the resident expressed having severe 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 6
Exit Date: 07/17/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F607/N3484; 656/N3784; F689/N4030; F835/N4996
Situations: The facility failed to implement interventions for a resident who was admitted to the facility on two separate occasions following suicide attempts. The resident continued to express suicidal ideations resulting in another attempt. The facility failed to ensure the ostomy bags for two residents were in proper working condition.

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 ensure adequate supervision and assistive devices were provided to prevent accidents. Facility administration failed to ensure effective use of resources.

Region 11
Exit Date: 07/17/2023
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent elopement, resulting in two residents eloping from the facility within five days.

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

Region 11
Exit Date: 07/17/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3643; F689/N4027
Situations: The facility failed to ensure the temperatures throughout the building were maintained at safe, comfortable levels. The temperature in residents' rooms was measured at 88.5 degrees. The facility failed to implement interventions to prevent elopement, resulting in two residents eloping from the facility within two weeks.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 5
Exit Date: 07/17/2023
Purpose of Visit: Complaint Investigation
Tags: F600/N3481
Situations: The facility failed to implement interventions to protect five residents from verbal and physical abuse from another resident.

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

Region 4
Exit Date: 07/20/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F607/N3484; F609/N3532
Situations: The facility failed to ensure intervention and investigation after staff heard two incidents of what sounded like slapping sounds while another staff member provided care to a resident. The facility failed to ensure incidents of suspected abuse were reported to the administrator.

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, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than two hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury.

Region 1
Exit Date: 07/21/2023
Purpose of Visit: Incident Investigation
Tags: F600/N3481; F607/N3487
Situations: The facility failed to protect multiple residents from being verbally abused by a staff member for a prolonged period of time, resulting in residents feeling insecure and unsafe.

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

Region 3
Exit Date: 07/21/2023
Purpose of Visit: Incident Investigation
Tags: F600/N3484
Situations: The facility failed to prevent a resident from eloping when a staff member opened a locked door on a secured unit at the request of the resident. As of the investigation, the resident had not been located.

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

Region 5
Exit Date: 07/21/2023
Purpose of Visit: Complaint Investigation
Tags: F684/N3937
Situations: The facility failed to monitor a resident after they were put on anticoagulants to ensure the medication was appropriate and effective.

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

Region 3
Exit Date: 07/21/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937; F695/N4003
Situations: The facility failed to monitor a resident’s vital signs and provide them with supplemental oxygen after they ingested an unknown combination of prescription medications and were awaiting the arrival of EMS. The resident’s carbon dioxide levels were significantly elevated when they arrived at the hospital.

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 who needed respiratory care was provided such care, consistent with professional standards of practice.

Region 3 **Exit Date**: 07/21/2023 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F684/N3937 **Situations:** The facility failed to ensure staff were trained to provide proper wound care. A resident's wound began to bleed uncontrollably during wound care, requiring emergency transfer to the hospital for a blood transfusion.
Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 3 **Exit Date**: 07/22/2023 **Purpose of Visit**: Complaint Investigation **Tags**: F580/N3013; F684/N3937; F773/N5059 **Situations:** The facility failed to inform a resident's physician and obtain treatment orders for a resident with significantly high blood glucose levels. The resident was sent to the hospital where they died three days later.
Deficient Practice: The facility failed to consult with the resident's physician when there was a significant change in the resident's status, failed to ensure residents received treatment and care in accordance with professional standards of practice, and failed to promptly notify the physician of laboratory results in accordance with facility policy and procedures.

Region 6 **Exit Date**: 07/23/2023 **Purpose of Visit**: Standard Survey **Tags**: F600/N3481; F610/N3541 **Situations:** The facility failed to protect a resident from abuse when the resident displayed agitation and yelled as they were being twisted around naked in their wheelchair. The facility failed to thoroughly investigate the incident.
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 incidents while the investigation was in progress.

Region 3 **Exit Date**: 07/27/2023 **Purpose of Visit**: Complaint Investigation **Tags**: F686/N3946; F690/N3967

Situations: The facility failed to provide care to prevent the development of pressure ulcers on a resident and failed to treat the wounds effectively after they developed. The facility failed to provide effective care to a resident's indwelling catheter, resulting in the resident developing a severe urinary tract infection that required hospitalization.

Deficient Practice: The facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing and failed to ensure residents who are incontinent of bladder received appropriate treatment and services to prevent urinary tract infections.

Region 4
Exit Date: 07/27/2023
Purpose of Visit: Standard Survey
Tags: F584/N3481; F600/N3484; F607/N3643; F689/N4030; F919/N4951
Situations: The facility failed to protect a resident from physical abuse by staff members and failed to thoroughly investigate the incident. The facility failed to ensure building temperatures were at safe, comfortable levels, with temperatures reaching eighty-one degrees in multiple common areas of the building. The facility failed to respond to a door alarm, resulting in a resident eloping in their wheelchair before being returned to the facility by a community member. The facility failed to ensure their call light system was functioning for all residents.

Deficient Practice: The facility failed to provide a safe, functional, sanitary, and comfortable environment; 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 be adequately equipped to allow resident to call for assistance.

Region 3
Exit Date: 07/27/2023
Purpose of Visit: Incident Investigation
Tags: F580/N3013; F600/N3481; F607/N3484; F610/N3538; F684/N3937; F697/N4009
Situations: The facility failed to ensure a resident who fell while being assisted back into bed was properly assessed and treated after the fall. The resident cried out in pain when their leg was moved and the facility failed to conduct an assessment, consult the resident's physician, or provide pain management for seventeen hours after the incident, after which the resident was transported to the hospital and diagnosed with a fractured femur.

Deficient Practice: The facility failed to consult with the resident's physician when there was a significant change in the resident's status; 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 incidents while the investigation was in progress; failed to ensure that residents received treatment and care in accordance with professional standards of practice; 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: 07/28/2023
Purpose of Visit: Standard Survey
Tags: F760/N4600
Situations: The facility failed to effectively assess a resident before giving them a dose of insulin. The resident’s blood glucose levels were below the threshold to hold the dose and the resident required hospitalization after the insulin was administered.

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

Region 4
Exit Date: 07/28/2023
Purpose of Visit: Standard Survey
Tags: F755/N4561
Situations: The facility failed to ensure a resident received the correct combination of antiviral medications, as ordered by a physician, to treat the resident’s viral infection, resulting in the resident requiring hospitalization.

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 2
Exit Date: 07/28/2023
Purpose of Visit: Complaint Investigation
Tags: F600/N3481; F609/N3532; F610/N3538
Situations: The facility failed to protect two residents from abuse by a staff member. The staff member was found by another cleaning blood from one resident’s ear and denied knowing what happened. The resident was transferred to the hospital and found to have multiple injuries, including a left ear laceration, left shoulder abrasion, bruising on the abdomen and legs, and a bruise on their genitals. The staff member was observed abusing the second resident on video during incontinent care. The facility failed to ensure all allegations were reported and failed to fully investigate the incidents.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect; failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than two hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury to the administrator of the facility and to other officials; and failed to provide evidence that all alleged violations of neglect, abuse, or misappropriation of property were thoroughly investigated to prevent further potential neglect, abuse, or misappropriation while the investigation was in progress.

Region 5
Exit Date: 07/31/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F689/N4030
Situations: The facility failed to ensure a resident received transfer assistance from at least two people, resulting in the resident falling during a single person transfer and sustaining a minor head injury.

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

Region 5
Exit Date: 08/01/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N3949
Situations: The facility failed to ensure a resident was properly assessed upon admission and regularly thereafter to identify and treat current or 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 6
Exit Date: 08/02/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481
Situations: The facility failed to protect a resident from physical abuse by a staff member when the staff member yelled at and slapped the resident in the face twice.

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

Region 3
Exit Date: 08/02/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4027; F760/N4600
Situations: The facility failed to implement interventions to prevent a resident from eloping. The resident left the facility through the front and was gone for three days. The facility initially assumed the resident was out on a pass and failed to inform the resident’s family that they did not have their medication. The resident was without critical medications while they were missing.

Deficient Practice: The facility failed to provide adequate supervision and assistive devices were provided to prevent accidents and failed to ensure residents are free of any significant medication errors.

Region 6
Exit Date: 08/03/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F600/N3478; F684/N3937
Situations: The facility failed to assess and inform a physician when a resident, who was dependent on staff for all ADLs, was identified with an injury of unknown origin in the form of a bruise on their arm. The resident was ultimately transported to the hospital where they were diagnosed with an arm and rib fractures. The facility failed to ensure incontinence care was provided by two staff members as required by a resident's care plan.

Deficient Practice: The facility failed to consult with the resident's physician when there was a significant change in the resident's status, failed to implement policies and procedures to prevent abuse and neglect, and failed to provide adequate supervision and assistive devices were provided to prevent accidents.

Region 5
Exit Date: 08/03/2023
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to obtain orders to monitor a resident's blood sugar when the resident was admitted. The facility failed to notify the physician when the resident became increasingly lethargic, unresponsive, experienced elevated blood glucose levels and required emergency transfer to the hospital.

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

Region 3
Exit Date: 08/04/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions after a resident attempted to elope from the facility. The resident later successfully exited the same door because the alarm was not reset after the first attempt. The resident was found outside on facility property in greater than 100-degree temperatures.

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

Region 8
Exit Date: 08/05/2023
Purpose of Visit: Complaint Investigation
Tags: F689/N4060

Situations: The facility failed to implement interventions to prevent a resident from eloping. A resident eloped from the facility and was found over a mile away and required emergency medical attention for low potassium levels and low blood pressure.

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

Region 2
Exit Date: 08/07/2023
Purpose of Visit: Complaint Investigation
Tags: F580/N3016; F600/N3484; F607/N3937; F684/N3946; F686/N3949
Situations: The facility failed to perform proper skin assessments and follow treatment orders for six residents resulting in the development of new and deterioration of existing pressure ulcers. The facility failed to obtain post-amputation treatment orders for a resident and failed to ensure the resident attended follow-up appointments for the wound. The facility failed to consult with residents' physicians when treatments were missed and wounds deteriorated.

Deficient Practice: The facility failed to consult with the resident's physician when there was a significant change in the resident's status; 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 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: 08/08/2023
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to ensure all residents had safety evaluations for handling hot liquids prior to being served them. One resident, who had not been assessed for their ability to handle hot liquids, was given two cups of hot coffee which they spilled on their legs, sustaining second degree burns.

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

Region 6
Exit Date: 08/08/2023
Purpose of Visit: Complaint Investigation
Tags: F755/N4561
Situations: The facility failed to administer antibiotics to a resident as ordered by a physician when the resident's insurance did not cover the medication.

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 8
Exit Date: 08/09/2023
Purpose of Visit: Standard Survey
Tags: F678/N3580; F726/N4063
Situations: The facility failed to effectively perform CPR on a resident who was found unresponsive. The facility had an available AED and failed to use the device until emergency services arrived.

Deficient Practice: The facility failed to follow physician orders and the resident's advance directives and failed to ensure agency staff were competent and trained in their job responsibilities.

Region 5
Exit Date: 08/09/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481/N3484; F684/N3937; F686/N3946/N3949; F689/4030; F880/N4795
Situations: The facility failed to provide effective supervision to a resident as they went out of the facility on a pass. The facility failed to have the resident sign out and did not initiate a search when the resident had not returned by the expected time. The facility failed to assess a resident and inform a physician when they began to exhibit significant changes in condition, resulting in the resident being transferred to the emergency room where they were diagnosed with Acute Hypercapnic Respiratory Failure (usually caused by defects in the central nervous system, impairment of neuromuscular transmission, mechanical defect of the ribcage and fatigue of the respiratory muscles). The facility failed to follow treatment orders for a resident with a pressure ulcer, resulting in the wound deteriorating. The resident ultimately required emergency transfer to the hospital and was diagnosed with sepsis. The facility failed to maintain accurate records of residents with communicable diseases and failed to monitor two residents for signs and symptoms of communicable diseases.

Deficient Practice: The facility 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; 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 adequate supervision and assistive devices were provided to prevent accidents; 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: 08/09/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F607/N3487

Situations: The facility failed to implement interventions after an altercation between two residents where one hit another twice on the arm and, thirty minutes later, spit and hit another resident.

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

Region 4
Exit Date: 08/10/2023
Purpose of Visit: Standard Survey
Tags: F550/N2902; F600/N3484; F689/N4030
Situations: The facility failed to protect residents' privacy when a staff member took videos of two residents engaging in negative behaviors and posted them on social media. The facility failed to implement interventions to prevent a resident from eloping. A resident eloped from the secure unit through a door for which the lock had not been engaged and was found by a community member two blocks from the facility.

Deficient Practice: The facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of their quality of life, 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: 08/10/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3010; F684/N3937; F697/N4009
Situations: The facility failed to effectively treat a resident after a fall that resulted in injury and reports of pain. The facility failed to inform a physician of the fall and injury and to have the resident's prescribed pain medication available.

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 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: 08/10/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent a resident from eloping. The facility remained unaware of the resident's elopement until they were notified that the resident had been delivered to the hospital with facial abrasions, fractured teeth, and an intercranial hemorrhage.

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

Region 6
Exit Date: 08/11/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3016; F600/N3478; F686/N3949
Situations: The facility failed to ensure that a resident received a doppler study (ultrasound to assess circulatory functioning) as recommended by the wound care consultant on six occasions over four months. The facility failed to ensure the resident saw a specialist for their wound, as recommended by the wound care consultant on five occasions over four months. Four months after the date the recommendations were first made the resident required a below-the-knee amputation.

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 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: 08/11/2023
Purpose of Visit: Standard Survey
Tags: F580/N3013; F684/N3937
Situations: The facility failed to consult with a resident's physician and obtain treatment orders for a resident who developed a urinary tract infection. The facility failed to inform a physician when the resident developed low blood pressure, fever, and weakness requiring hospitalization.

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 1
Exit Date: 08/11/2023
Purpose of Visit: Standard Survey
Tags: F880/N4723
Situations: The facility failed to ensure residents positive for COVID-19 were practicing social distancing and wearing PPE, failed to ensure effective sanitation procedures between areas with positive cases and those without, and failed to ensure all staff were trained in 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 5
Exit Date: 08/11/2023

Purpose of Visit: Complaint/Incident Investigation
Tags: F755/N4561; F760/N4600
Situations: The facility failed to provide a resident with their chemotherapy medication for seventeen days after the medication was delivered to the facility. The facility continued in this failure until the resident's family inquired about the need for a refill. The facility failed to have a policy in place to follow-up on medications brought into the facility from an outside pharmacy.

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 and failed to ensure residents remained free of any significant medication errors.

Region 6
Exit Date: 08/15/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3484; F656/N3580; F678/N3784; F686/N3949; F689/N4030
Situations: The facility failed to immediately provide CPR to a resident who was found unresponsive and who had a full code status (code status that allows all interventions to restart the heart) and waited fifteen minutes after finding the resident unresponsive before contacting emergency services. The facility failed to follow physician orders and provide treatment to seven residents with pressure ulcers and failed to provide one of those residents, who was non-ambulatory, with weekly skin assessments. The facility failed to adequately supervise a resident during wound care and the resident was left unattended in the mechanical lift swing for over forty-five minutes, resulting in an unwitnessed fall. The facility failed to provide neurological checks to the resident for three days after the fall and did not inform the resident's physician of the incident.

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; 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; and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 6
Exit Date: 08/16/2023
Purpose of Visit: Standard Survey
Tags: F580/N3010/N3013; F600/N3478; F610/N3511; F684/N3937; F697/N4009; F726/N4075; F755/N4561; F777/N4996; F835/N5080
Situations: The facility failed to properly assess and review the x-rays of a resident after they fell, did not identify a resulting femur fracture, and did not inform the resident's physician of the fall and injury. The facility did not thoroughly investigate the incident as an injury of unknown origin and did not report the results to HHS. The facility failed to provide multiple residents with their prescribed pain medications and did not

perform daily assessments, resulting in one resident describing pain that was unbearable and which felt "worse than having a baby." The facility failed to acquire prescribed medications for three other residents in a timely manner.

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 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 residents received treatment and care in accordance with professional standards of practice; 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; failed to ensure agency staff were competent and trained in their job responsibilities; failed to provide pharmaceutical services, including procedures that assured accurate administering of all drugs to meet the needs of the residents; failed to promptly notify the ordering physician of results that fall outside of clinical reference ranges. Facility administration failed to ensure effective use of resources.

Region 4
Exit Date: 08/16/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F607/N3481; F610/N3511; F689/N4030
Situations: The facility failed to fully investigate and immediately report to HHS after a resident was found dead on the floor of their bathroom with injuries of unknown origin. The resident had been left unattended in the bathroom prior to the incident.

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

Region 4
Exit Date: 08/16/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N6484; F687/N3952
Situations: The facility failed to provide weekly skin assessments to a resident who was diabetic and was at-risk for foot injuries due to poor circulation. The resident developed a foot injury requiring removal of their toenails and debridement.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to ensure a resident received proper treatment and care to maintain good foot health.

Region 5
Exit Date: 08/16/2023

Purpose of Visit: Complaint/Incident Investigation
Tags: F0755/N4030
Situations: The facility failed to ensure a resident was taking their pills after they were given to the resident. It was determined that the resident would put pills in their pocket and it is unknown if the resident took any of the medications provided.

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 11
Exit Date: 08/17/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4027
Situations: The facility failed to ensure that a resident's soup was not too hot before serving it to the resident. The resident spilled the soup and sustained second degree burns.

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

Region 11
Exit Date: 08/17/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3010; F689/N4030; F755/N4561; F760/N4600
Situations: The facility failed to follow a physician's order for administering morphine to a resident. The facility administered 1 ml instead of the ordered 0.1 ml and failed to inform the resident's physician of the error. The facility failed to use a mechanical lift to help transfer a resident resulting in the resident falling and sustaining a broken femur.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition; failed to ensure adequate supervision and assistive devices were provided to prevent accidents; failed to provide pharmaceutical services, including procedures that assured accurate administering of all drugs to meet the needs of the residents; and facility failed to ensure residents are free of any significant medication errors.

Region 3
Exit Date: 08/17/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent a resident from eloping. A resident eloped from the facility and was found by a community member near a busy intersection and was returned to the facility by law enforcement.

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

Region 5

Exit Date: 08/17/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement effective interventions to prevent a resident from falling and sustaining injuries. The resident had fourteen falls in the twelve months prior to the investigation, the last of which resulted in the resident lying in a pool of blood around their head due to a laceration, as well as bruises, skin tears, and three fractured ribs.

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

Region 4
Exit Date: 08/18/2023
Purpose of Visit: Complaint Investigation
Tags: F600/N3478; F604/N3481; F607/N3484; F609/N3532
Situations: The facility failed to protect a resident from abuse when a staff member made the resident get out of bed against their wishes and stay seated in their wheelchair all night. The same staff member, and another, allegedly threatened and emotionally abused the resident who posited that they were being "punished for hollering out." The facility failed to ensure that staff reported allegations of abuse to the administrator. The administrator was unaware of the allegations until investigating another allegation of abuse.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect, failed to ensure residents were treated with respect and dignity, including the right to be free from any physical restraints imposed for purposes of discipline or convenience, 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 4
Exit Date: 08/18/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4027
Situations: The facility failed to provide adequate supervision to prevent a resident from leaving the facility with a stranger. The resident was taken approximately twenty-five miles from the facility to their old residence and dropped off.

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

Region 4
Exit Date: 08/18/2023
Purpose of Visit: Standard Survey
Tags: F600/N3478; F607/N3487; F610/N3511

Situations: The facility failed to protect two residents from verbal abuse by a staff member and failed to investigate the allegations, allowing the staff member to continue working directly with residents.

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 incidents while the investigation was in progress.

Region 4
Exit Date: 08/18/2023
Purpose of Visit: Standard Survey
Tags: F580/N3010; F760/N4600
Situations: The facility failed to provide twelve doses of a resident's medication used to treat their edema caused by congestive heart failure. The facility failed to inform the resident's physician of the error.

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 8
Exit Date: 08/19/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F600/N3484; F684/N3937; F726/N4063
Situations: The facility failed to effectively treat a resident's arterial wound to their great toe for nearly three months and did not inform the resident's physician or a wound care doctor that the injury was worsening, resulting in the resident developing gangrene, necrosis (tissue death), and requiring amputation.

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 ensure agency staff were competent and trained in their job responsibilities.

Region 8
Exit Date: 08/19/2023
Purpose of Visit: Complaint Investigation
Tags: F624/N3448
Situations: The facility failed to ensure a resident was safely discharged to a homeless shelter and was unaware of the resident's whereabouts for three days, after which they were found in a park.

Deficient Practice: The facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility.

Region 5
Exit Date: 08/21/2023

Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3484; F678/N5542
Situations: The facility failed to check their AED unit to ensure it had an active status, was cleaned, without visible defects, did not have a low battery, and was properly functioning before using it on a resident prior to the arrival of emergency services. The resident passed away at the facility.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders follow physician orders and the resident's advance directives.

Region 5
Exit Date: 08/21/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481
Situations: The facility failed to protect a resident from physical and verbal abuse by staff members during routine care, as revealed by video footage provided by the family. Staff members were observed using foul, intimidating language with the resident and being physically aggressive during incontinence care.

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

Region 6
Exit Date: 08/22/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure more than one staff member assisted a resident during transfer resulting in the resident falling and sustaining a femur fracture.

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

Region 11
Exit Date: 08/23/2023
Purpose of Visit: Complaint Investigation
Tags: F600/N3481; F607/N3487
Situations: The facility failed to ensure a witnessed incident of verbal abuse by a staff member toward a resident was reported and investigated.

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

Region 3
Exit Date: 08/23/2023
Purpose of Visit: Complaint/Incident Investigation

Tags: F656/N3784; F689/N4030
Situations: The facility failed to ensure three residents were properly assessed upon admission and that their care plans included interventions to address the residents' high elopement risk. One resident eloped from the facility and was found nearly five miles from the facility by law enforcement.
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: 08/23/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to make timely repairs to a resident's closet door when the resident reported issues with it, resulting in the door falling on the resident which resulted in injuries that required hospitalization.
Deficient Practice: The facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 3
Exit Date: 08/24/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F607/N3484; F689/N4030
Situations: The facility failed to implement interventions to prevent a resident from eloping. A resident eloped and was found the next day nearly twelve miles from the facility after a Silver Alert had been issued.
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: 08/24/2023
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to implement changes after a resident eloped from the facility through the courtyard gate. The facility failed to lock the gate following this incident and failed to provide adequate supervision in the courtyard when residents who were deemed at-risk for elopement were there.
Deficient Practice: The facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 5
Exit Date: 08/24/2023
Purpose of Visit: Complaint/Incident Investigation

Tags: F600/N3484; F689/N4030
Situations: The facility failed to implement interventions to prevent a resident, who began to display exit-seeking behaviors shortly after admission, from eloping. The resident eloped from the facility and was discharged without consulting a physician or obtaining an order.

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: 08/24/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F558/N2902; F600/N3481
Situations: The facility failed to protect a resident from sexual assault by their roommate after they were moved into a new room temporarily. The facility failed to provide the resident with their communication device and did not hear the resident yelling for help.

Deficient Practice: The facility failed to ensure the rights to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents and failed to implement policies and procedures to prevent abuse and neglect.

Region 5
Exit Date: 08/25/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F626/N3463
Situations: The facility failed to provide or document sufficient preparation for an orderly discharge when they did not allow a resident to return to the facility after being sent to a behavioral health hospital. The resident was discharged to the family’s home where they had two falls, were not bathed, experienced deterioration of their wounds, and ultimately required hospitalization.

Deficient Practice: The facility failed to establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave.

Region 4
Exit Date: 08/25/2023
Purpose of Visit: Standard Survey
Tags: F600/N3481; F607/N3484; F610/N3511; F835/N4996
Situations: The facility failed to protect multiple residents from abuse. The facility did not thoroughly investigate or implement interventions when one resident attempted to stab another with a fork, when one resident was yelled at and had their belongings thrown outside their room, and when a staff member allegedly abused a resident. The staff member was allowed to continue working with residents after the alleged incident.

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 incidents while the investigation was in progress. Facility administration failed to ensure effective use of resources.

Region 3
Exit Date: 08/25/2023
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F686/N3946
Situations: The facility failed to notify a physician and obtain treatment orders for a resident who developed a pressure ulcer which deteriorated and began to exhibit signs of infection. The resident was transferred to the hospital where they were diagnosed with sepsis.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition 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 5
Exit Date: 08/26/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F755/N4561
Situations: The facility failed to follow physician orders while administering a resident's medications, resulting in the resident aspirating, developing labored breathing, and requiring hospitalization.

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: 08/27/2023
Purpose of Visit: Incident Investigation
Tags: F600/N3478; F689/N4030
Situations: The facility failed to protect two residents from abuse by a staff member when the staff member was allowed continued access to the residents after allegations of abuse. The facility failed to implement effective interventions to prevent a resident from eloping. The resident left the facility and was outside for an indeterminate amount of time without facility knowledge.

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: 08/27/2023
Purpose of Visit: Incident Investigations
Tags: F760/N4600
Situations: The facility failed to follow procedures to ensure residents received the correct medication. One resident was erroneously given an intravenous medication to which they were allergic.

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

Region 11
Exit Date: 08/28/2023
Purpose of Visit: Complaint Investigation
Tags: F921/N3628
Situations: The facility failed to provide a safe, sanitary living environment for residents. Several rooms among three halls were observed with water damaged ceiling tiles, trash cans collecting brown liquid, and mold growth.

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

Region 4
Exit Date: 08/28/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F656/N3784; F689/N4030
Situations: The facility failed to ensure a resident's care plan included supervision and fall prevention interventions to prevent them from falling from their geri-chair (chairs useful for those with mobility issues and can also be used for bedridden patients who have difficulty sitting upright in a conventional wheelchair) and sustaining hip and pelvic fractures.

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 5
Exit Date: 08/28/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3484; F684/N3937
Situations: The facility failed to ensure a resident was assessed and treated for a disseminated rash (rash on several parts of the body). The facility subsequently failed to ensure the resident was taken to their dermatology appointment on time, resulting in it being rescheduled for nearly a month later, at which time they were diagnosed with scabies and treatment was initiated.

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 6 **Exit Date**: 08/29/2023 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F661/N3877 **Situations:** The facility failed to provide a resident with a post-discharge plan of care before dropping them off at a hotel and discharged another resident without documentation of any pre-discharge planning or a discharge summary.
Deficient Practice: The facility failed to ensure all residents were provided with a discharge summary for an anticipated discharge.

Region 6 **Exit Date**: 08/30/2023 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F580/N3013; F684/N3937 **Situations:** The facility failed to provide an adequate assessment when a resident had an unwitnessed fall that resulted in a bleeding head injury. The facility failed to provide neurological checks, did not continue to monitor the resident, and did not inform the resident's physician of the incident or injury.
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**: 08/30/2023 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F689/N4027 **Situations:** The facility failed to properly secure a resident's side rail to their bed, causing it to rotate and expose a metal rod. During a transfer, the resident's leg was punctured by the metal rod and required ten staples.
Deficient Practice: The facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 1 **Exit Date**: 08/30/2023 **Purpose of Visit**: Complaint Investigation **Tags**: F600/N3481; F607/N3484; F609/N3532; F610/N3538 **Situations:** The facility failed to protect a resident from verbal and physical abuse by a staff member. The facility failed to ensure the abuse was reported after it was observed and failed to ensure it was investigated. The alleged perpetrator was allowed to continue working directly with residents after the observed incident.
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; 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 4
Exit Date: 08/31/2023
Purpose of Visit: Complaint Investigation
Tags: F689/N4030; F740/N4042
Situations: The facility failed to implement interventions to protect a resident who began to exhibit self-injurious behavior, attempted to strangle themselves with the call light cord, and attempted to throw themselves out of their wheelchair. The facility failed to remove harmful items from the resident's room, failed to update the resident's care plan, and failed to inform the resident's physician of the self-injurious behaviors.

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 highest practicable mental and psychosocial wellbeing of residents.

Region 3
Exit Date: 08/31/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F880/N4723
Situations: The facility failed to have an effective protocol in place to prevent the spread of COVID-19 that followed nationally accepted standards for contact tracing or broad-based testing after a resident, who was mobile and regularly moved around the facility, tested positive.

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: 09/01/2023
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F684/N3937; F726/N4063
Situations: The facility failed to effectively assess a resident and inform a physician when the resident began to exhibit changes in condition, including lethargy and decreased appetite, and when they were ultimately found unresponsive. Upon finding the resident unresponsive, the resident was first moved to a wheelchair and prompted to take water despite not responding to any stimulus except pain. The resident was transferred to the hospital where they subsequently died.

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 agency staff were competent and trained in their job responsibilities.

Region 3
Exit Date: 09/01/2023
Purpose of Visit: Standard Survey
Tags: F695/N4003
Situations: The facility failed to ensure they had a plan to provide four residents with emergency oxygen if they needed it in case of a power outage.

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

Region 6
Exit Date: 09/01/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F607/N3484; F689/N4027
Situations: The facility failed to prevent a resident at high risk for falls from falling. The resident sustained a broken femur which required surgical repair. The resident died at the facility a week after the operation. The facility failed to provide a physician with accurate x-ray results and failed to implement changes to the resident's care plan after they had experienced multiple falls.

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 2
Exit Date: 09/01/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to inform a resident's physician when they had multiple episodes of emesis (vomiting). The facility did not obtain the resident's vital signs after the first episode and did not establish a baseline to make determinations from. The facility continued in the failure to inform a physician when vital signs were taken after the fifth episode of emesis and the resident's blood pressure was critically low. The facility contacted the family to request a decision on transporting to the hospital. The resident ultimately died in the hospital.

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: 09/01/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F760/N4600

Situations: The facility failed to administer a residents potassium chloride supplement for four days.

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

Region 8
Exit Date: 09/01/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N348; F604/N3514; F689/N4030; F740/N4042
Situations: The facility failed to implement effective, appropriate interventions when a resident began to exhibit aggressive and exit-seeking behaviors. The facility failed to ensure staff were trained to handle the level of behaviors exhibited by the resident and resorted to physical restraints and antipsychotic medication to help control the resident. The resident had five elopements over the course of three months.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect; failed to ensure residents were treated with respect and dignity, including the right to be free from any physical restraints imposed for purposes of discipline or convenience; 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 highest practicable mental and psychosocial wellbeing of residents.

Region 5
Exit Date: 09/03/2023
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to implement effective interventions after a resident eloped, permitting the resident to elope again three months later.

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

Region 6
Exit Date: 09/07/2023
Purpose of Visit: Standard Survey
Tags: F686/N3946; F835/N4996
Situations: The facility failed to perform adequate skin assessments to identify two severe pressure ulcers on a resident who was non-ambulatory. The facility failed to have policies in place to ensure staff were performing regular skin assessments and routine hygiene practices.

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. Facility administration failed to ensure effective use of resources.

Region 11 **Exit Date**: 09/07/2023 **Purpose of Visit**: Complaint Investigation **Tags**: F684/N3937; F710/N5086; F726/N4405 **Situations**: The facility failed to establish an order for a resident's blood glucose monitoring considering the resident's daily administration of three medications for treating diabetes. The resident became lethargic and presented an altered mental status and was transported to the hospital where they were found to have exceptionally high blood glucose levels and required positive pressure ventilation to assist with breathing.
Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice, failed to ensure a physician supervised the care of residents, and failed to ensure agency staff were competent and trained in their job responsibilities.

Region 5 **Exit Date**: 09/07/2023 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F580/N3010; F684/3937 **Situations:** The facility failed to notify a resident's physician when the resident fell and sustained a head injury. The facility did not perform the first neurological check for over six hours after the fall. The resident ultimately had a change in condition requiring hospitalization.
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**: 09/11/2023 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F689/N4030 **Situations:** The facility failed to ensure multiple staff were provided to perform incontinence care for a resident who required at least two staff members. The resident fell out of bed and sustained a fractured femur.
Deficient Practice: The facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 6 **Exit Date**: 09/12/2023 **Purpose of Visit**: Complaint Investigation **Tags**: F686/N3949 **Situations:** The facility failed to ensure a resident, who was admitted with multiple severe pressure ulcers, was provided with a treatment plan to promote healing. The resident's wounds were not assessed by a wound care physician until twenty-six days after admission and were not consistently measured prior to then. The resident missed

multiple days of wound care treatment. All these failures resulted in the wound deteriorating.

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

Region 6
Exit Date: 09/13/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F607/N3484; F609/N3532; F610/N3538; F689/N4030; F835/N4996
Situations: The facility failed to report and investigate an injury of unknown origin after a resident sustained a severe femur fracture that required surgical repair. The facility failed to ensure all staff were trained on proper reporting procedures for injuries of unknown origin.

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; 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. Facility administration failed to ensure effective use of resources.

Region 4
Exit Date: 09/13/2023
Purpose of Visit: Complaint/Incident Investigation
Tags:F689/N4027
Situations: The facility failed to implement interventions to prevent a resident, who had begun exhibiting exit-seeking behaviors, from eloping. The resident left through a door for which the alarm did not activate and was found in the roadway by law enforcement. The facility failed to ensure coffee was served at safe temperatures. A resident spilled coffee on their arms and legs, sustaining burns which the facility did not properly assess until two days after the incident.

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

Region 3
Exit Date: 09/15/2023
Purpose of Visit: Standard Survey
Tags: F600/N3484
Situations: The facility failed to ensure all staff were trained in deescalating situations of aggression from residents. A resident and staff member got into an altercation and the staff member responded with derogatory name calling and threatening to spit on the resident.

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

Region 4
Exit Date: 09/15/2023
Purpose of Visit: Standard Survey
Tags: F689/N4030; F825/N4057; F835/N4723; F880/N4996
Situations: The facility failed to ensure coffee temperatures were effectively monitored and that all residents were assessed for risk in handling hot liquids, resulting in two residents spilling coffee and burning themselves. The facility failed to implement interventions to prevent two residents from eloping, both of whom eloped multiple times. The facility failed to consistently provide the ordered physical therapy to fourteen residents. The facility failed to ensure processes were followed and all staff were effectively trained to perform incontinence care in a safe, hygienic manner. Thirteen residents developed urinary tract infections in a month.

Deficient Practice: The facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents, failed to provide specialized rehabilitative services, and failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment. Facility administration failed to ensure effective use of resources.

Region 4
Exit Date: 09/15/2023
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement effective interventions after a resident began to express suicidal ideations.

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

Region 5
Exit Date: 09/15/2023
Purpose of Visit: Incident Investigation
Tags: F678/N3580
Situations: The facility failed to provide CPR to a resident with a full code status (code status that allows all interventions to restart the heart) continually until emergency services arrived.

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

Region 3
Exit Date: 09/15/2023
Purpose of Visit: Complaint/Incident Investigation

Tags: F687/N3952
Situations: The facility failed to ensure a resident with multiple diagnoses that impacted their circulatory system received regular foot assessments, as ordered by a physician, resulting in the resident developing a severe wound to their foot.

Deficient Practice: The facility failed to ensure a resident received proper treatment and care to maintain good foot health.

Region 6
Exit Date: 09/18/2023
Purpose of Visit: Incident Investigations
Tags: F580/N3013; F658/N3826; F684/N3937; F693/N3994/N3997; F697/N4009; F726/N4075; F755/N4561
Situations: The facility failed to inform a resident's physician that a g-tube was deemed non-functional for over five months resulting in multiple infections at the site of the tube. The resident was ultimately hospitalized when the tube became dislodged and caused a partial bowel obstruction. The facility failed to provide a resident their medication when their blood glucose was measured at critically low levels. The facility failed to assess and document the pain levels of three residents and failed to administer one resident's ordered pain medication, resulting in what the resident described as ten out of ten in severity.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition; failed to ensure services provided met professional standards of quality; failed to ensure residents received treatment and care in accordance with professional standards of practice; failed to ensure enteral feeding physician orders were followed; 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; failed to ensure agency staff were competent and trained in their job responsibilities; failed to provide pharmaceutical services, including procedures that assured accurate administering of all drugs to meet the needs of the residents.

Region 6
Exit Date: 09/19/2023
Purpose of Visit: Standard Survey
Tags: F686/N3949
Situations: The facility failed to effectively assess a resident upon admission and identify wounds for which to provide care. The facility failed to provide wound care to the existing wounds for eight days after admission. The resident was ultimately transferred to the hospital resulting in a wound evaluation that revealed severe erythema (redness of the skin), edema (swelling caused by excess fluid accumulation in the body tissues), necrosis (tissue death), induration (an increase in the fibrous elements in tissue, usually due to inflammation or swelling, making the tissue less elastic and pliable) and the wound required debridement.

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

Region 6 **Exit Date**: 09/19/2023 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F686/N3949 **Situations:** The facility failed to follow physician orders and provide effective treatment to three residents with pressure ulcers, resulting in deterioration of the wounds and one resident requiring a foot amputation.
Deficient Practice: The facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing.

Region 6 **Exit Date**: 09/21/2023 **Purpose of Visit**: Complaint Investigation **Tags**: F580/N3013; F684/N3937; F726/N4063 **Situations:** The facility failed to assess a resident, consult a physician, and provide treatment when the resident began to have trouble breathing and ultimately required hospitalization.
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 agency staff were competent and trained in their job responsibilities.

Region 5 **Exit Date**: 09/21/2023 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F584/N3484; F600/N3643; F755/N4561 **Situations:** The facility failed to ensure all residents rooms had access to air conditioning and were in rooms with safe, comfortable temperatures. One resident had a measured rectal temperature of 108 degrees and went into cardiac arrest and died at the facility. Another resident had a measured rectal temperature of ninety-nine and was sent to the hospital where they were placed in the ICU due to septic shock and heat exhaustion. The facility failed to provide one resident with thirteen doses of their antibiotic medication. The facility failed to ensure that clean linens and towels were available for incontinence care.
Deficient Practice: The facility failed to provide a safe, functional, sanitary, and comfortable environment, failed to implement policies and procedures to prevent abuse and neglect, and failed to provide pharmaceutical services, including procedures that assured accurate administering of all drugs to meet the needs of the residents.

Region 4
Exit Date: 09/21/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F690/N3967; F880/N4723
Situations: The facility failed to provide adequate training related to sanitary processes during incontinence care and failed to ensure those processes were followed. Five residents who received incontinence care developed urinary tract infections.

Deficient Practice: The facility failed to ensure residents who are incontinent of bladder received appropriate treatment and services to prevent urinary tract infections 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: 09/21/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F607/N3484; F609/N3532
Situations: The facility failed to report and investigate injuries of unknown origin when a resident reported bruising to their upper and inner thigh, buttocks, groin area, and right knee. Three months later, the resident provided a staff member with a video that showed the resident being sexually assaulted by a care provider.

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 11
Exit Date: 09/22/2023
Purpose of Visit: Complaint Investigation
Tags: F580/N3010; F684/N3937; F726/N4075
Situations: The facility failed to assess a resident, document, and inform a physician of the resident's abnormal skin discoloration for approximately thirty-nine hours. The resident was transferred to the hospital with acute ischemia (a condition in which blood flow and thus oxygen is restricted or reduced in a part of the body), putting the resident at risk for amputation.

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 agency staff were competent and trained in their job responsibilities.

Region 5
Exit Date: 09/23/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F812/N4363; F880/N4723

Situations: The facility failed to ensure that wastewater from the toilet in the kitchen bathroom did not leak into the kitchen, failed to ensure that a bucket of waste material in the facility kitchen was disposed of properly, and failed to ensure that the area around the ice machine was free of wastewater.

Deficient Practice: The facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety and failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment.

Region 8
Exit Date: 09/24/2023
Purpose of Visit: Complaint Investigation
Tags: F622/N3442; F624/N3448
Situations: The facility failed to have a valid reason to discharge a resident, failed to ensure they were discharged to a safe homelike environment, and failed to permit them to remain in the facility while their discharge appeal was pending. The resident broke their leg and was hospitalized while out of the facility.

Deficient Practice: The facility failed to ensure residents were permitted to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge was necessary and failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility.

Region 6
Exit Date: 09/25/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3484; F684/N3937; F689/N4030
Situations: The facility failed to effectively assess and treat a resident, who was receiving blood thinning medication, after they had an unwitnessed fall. The resident was ultimately transferred to the hospital where they required surgery due to a brain bleed. The facility failed to protect two other residents from preventable falls, one of whom displayed improper neck alignment on x-rays following the fall, which were later revealed to indicate two fractured neck vertebrae.

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 6
Exit Date: 09/25/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F655/N3778; F689/N4030
Situations: The facility failed to care plan and implement interventions to address a resident's history of hallucinations, need for enhanced supervision, and behavioral interventions which resulted in the resident attempting suicide.

Deficient Practice: The facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality and failed to ensure adequate supervision and assistance devices were provided to prevent accidents.

Region 1
Exit Date: 09/27/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3643; F604/N3487; F607/N3514; F610/N3538
Situations: The facility failed to protect two residents from abuse when a staff member was witnessed by another using force to hold down combative residents. Five residents in total alleged abuse by the same staff member. The facility failed to fully investigate and report the allegations of abuse.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect; failed to ensure residents were treated with respect and dignity, including the right to be free from any physical restraints imposed for purposes of discipline or convenience; 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: 09/27/2023
Purpose of Visit: Complaint Investigation
Tags: F678/N3580
Situations: The facility failed to review a resident's code status to reveal a full code (code status that allows all interventions to restart the heart) when they were found unresponsive with no pulse and did not initiate CPR.

Deficient Practice: The facility failed to follow physician orders and the resident's advance directives and failed to ensure agency staff were competent and trained in their job responsibilities.

Region 3
Exit Date: 09/27/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F600/N3478; F607/N3484; F624/N3448; F742/N4048
Situations: The facility failed to provide prescribed psychotropic medications to a resident with dementia and other cognitive diagnoses and moved them to several different rooms in a week's time which resulted in increased behaviors and two separate unwitnessed altercations with other residents. The facility failed to inform the resident's physician of their refusal to take the medication. The facility failed to provide sufficient preparation for the room transfers.

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 provide and document sufficient preparation and orientation to residents to

ensure safe and orderly discharge from the facility; and failed to ensure adequate supervision and assistive devices were provided to prevent accidents, and failed to ensure a resident who displayed, or is diagnosed with, mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, 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: 09/28/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937; F686/N3946
Situations: The facility failed to provide effective treatment to a resident with diabetes and a foot wound upon admission. The resident's existing wounds deteriorated, and new wounds formed while the resident was at the facility. The resident ultimately required two leg amputations due to infection.

Deficient Practice: The facility failed to ensure adequate supervision and assistance devices were provided to prevent accidents 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: 09/28/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to properly use their mechanical lift while assisting with bed transfers, resulting in one resident tipping out of the lift and breaking a lower leg bone. The facility was observed two additional times using the lift improperly.

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

Region 6
Exit Date: 09/29/2023
Purpose of Visit: Complaint Investigation
Tags: F678/N3580; F726/N4075
Situations: The facility failed to immediately initiate CPR and contact emergency services when a resident with a full code status (code status that allows all interventions to restart the heart) was found unresponsive. When CPR was initiated, the facility failed to follow policy and perform the procedure on a cardiac board to maximize its effectiveness.

Deficient Practice: The facility failed to follow physician orders and the resident's advance directives and failed to ensure agency staff were competent and trained in their job responsibilities.

Region 5
Exit Date: 09/29/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3580; F689/N4030; F726/N4063
Situations: The facility failed to implement effective interventions to prevent a resident from falling a day after an initial unwitnessed fall. The facility failed to adequately assess and notify the resident's physician after the second unwitnessed fall, after which the resident slept for over twenty-five hours. The resident was ultimately admitted to the hospital with two subdural hematomas (a collection of blood that forms on the surface of the brain), underwent two craniotomies (surgical operation via the skull) and required intubation.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition, failed to ensure adequate supervision and assistance devices were provided to prevent accidents, and failed to ensure agency staff were competent and trained in their job responsibilities.

Region 3
Exit Date: 09/29/2023
Purpose of Visit: Complaint/Incident Investigation
Tags: F760/N4600
Situations: The facility failed to accurately transcribe the medication list when a resident was discharged from the hospital back to the facility, resulting in the resident receiving the incorrect medications for two days.

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

Region 6
Exit Date: 09/30/2023
Purpose of Visit: Standard Survey
Tags: F656/N3784; F689/N4027
Situations: The facility failed to implement interventions to prevent a resident with history of falling from having continued falls. The resident had fifteen documented falls in a year and no revisions were made to the care plan until the time of the survey.

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.

TEXAS
Health and Human
Services