Quarterly IJ Summary Report
October 2022 – December 2022

The following report presents information regarding all tags cited at the Immediate Jeopardy (IJ) level during licensing and certification surveys and complaint or incident investigations performed in nursing facilities during the fourth quarter of 2022 (10/01/2022 – 12/31/2022).

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

During this period, an IJ level tag was cited for forty-six of the surveys and investigations conducted, resulting in sixty-six citations of twenty-four 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	2%	689	2%
580	9%	600	9%
600	12%	580	12%
603	2%	684	2%
607	3%	880	3%
609	2%	697	2%
610	2%	760	2%
635	2%	607	2%
678	2%	686	2%
684	9%	726	9%
686	3%	550	3%
689	24%	603	24%
692	2%	609	2%
693	2%	610	2%
695	2%	635	2%
697	5%	678	5%
726	3%	692	3%
741	2%	693	2%
755	2%	695	2%
760	5%	741	5%
803	2%	755	2%

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
805	2%	803	2%
835	2%	805	2%
880	6%	835	6%
925	1%	689	2%

*Rounded to the nearest tent

Table 2

Region	# Of IJs	# Of NFs	% Of IJs/NF
1	3	86	3.49%
2	2	135	1.48%
3	13	229	5.68%
4	6	189	3.17%
5	12	188	6.38%
6	6	169	3.55%
8	3	141	2.13%
11	1	79	1.27%
Total	**46**	**1216**	3.78%

Table 3
Number of IJs

from Complaints	from Incidents	from Surveys	Total
25	9	12	46

Tag References

483.10 – Resident Rights:

550

580 Notification of Changes (Injury/Decline/Room, Etc.)

483.12 - Freedom from Abuse, Neglect, and Exploitation:

600 Free from Abuse and Neglect

603 Free from Involuntary Seclusion

607 Develop/Implement Abuse/Neglect, etc. Policies

609 Reporting of Alleged Violations

610 Investigate/Prevent/Correct Alleged Violation

483.20 – Resident Assessments:

635 Admission Physician Orders for Immediate Care

483.25 - Quality of Care:

678 Cardio-Pulmonary Resuscitation

684 Quality of Care

686 Treatment/Svcs to Prevent/Heal Pressure Ulcers
689 Free of Accident Hazards/Supervision/Devices
692 Nutrition/Hydration Status Maintenance
693 Tube Feeding Management/Restore Eating Skills
695 Respiratory/Tracheostomy Care and Suctioning
697 Pain Management

483.35 Nursing Services

726 Competent Nursing Staff

483.40 Behavioral Health Services

741 Sufficient/Competent Staff – Behavioral Health Needs

483.45 Pharmacy Services

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

483.60 – Food and Nutrition Services:

803 Menus Meet Res Needs/Prep in Advance/Followed
805 Food in Form to Meet Individual Needs

483.70 – Administration:

835 Administration

483.80 – Infection Control:

880 Infection Prevention & Control

Acronyms

CPR – Cardiopulmonary Resuscitation
PPE – Personal Protective Equipment

Region 3
Exit Date: 10/01/2022
Purpose of Visit: Standard Survey
Tags: F580/N1131; F684/N1446
Situations: The facility failed to assess and implement interventions and to inform a physician when a resident had a change in appearance, became lethargic, and had multiple incidents of vomiting.

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

Region 1
Exit Date: 10/03/2022
Purpose of Visit: Incident Investigation; Focused Infection Control
Tags: F600/N1283; F689/N1477
Situations: The facility failed to implement interventions for a resident with a history of abusive behaviors who had multiple physical encounters with other residents.

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

Region 5
Exit Date: 10/05/2022
Purpose of Visit: Standard Survey
Tags: F684/N1321
Situations: The facility failed to provide a resident with a pureed diet, as ordered by a physician, resulting in the resident aspirating and dying.

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

Region 11
Exit Date: 10/07/2022
Purpose of Visit: Incident Investigation
Tags: F689/N1477
Situations: The facility failed to implement interventions to prevent a resident from eloping. The resident eloped from the facility and was missing for over two hours before the facility initiated a search and found the resident two miles from the facility.

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

Region 3
Exit Date: 10/07/2022
Purpose of Visit: Standard Survey
Tags: F580/N1132; F697/N1470
Situations: The facility failed to provide effective pain management to two residents and failed to inform the residents' physicians of ineffective treatment.

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

Region 8
Exit Date: 10/07/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F678/N1321

Situations: The facility failed to use a defibrillator on a resident with a full code status (code status that allows all interventions to restart the heart) and stopped providing CPR after thirty minutes due to erroneous information.

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

Region 1
Exit Date: 10/10/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F760/N1671
Situations: The facility administered a resident's evening medication to the resident's roommate after they had already received their evening medication. The latter resident began to exhibit signs of an altered mental state and was admitted into the hospital where they were diagnosed with serotonin syndrome (an excess of serotonin that causes shivering, diarrhea, muscle rigidity, fever, seizures, and can cause death if untreated).

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

Region 2
Exit Date: 10/10/2022
Purpose of Visit: Standard Survey
Tags: F689/N1477
Situations: The facility failed to implement interventions to prevent a resident, who resided on a secure unit and had a history of exit-seeking behaviors, from eloping. The resident eloped from the facility and was found twenty minutes later after crossing a five-lane street.

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

Region 4
Exit Date: 10/13/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1477
Situations: The facility failed to implement interventions to prevent a resident, with a history of exit-seeking behaviors including breaking windows, from eloping. The resident eloped from the facility and was found several blocks away at a restaurant. The facility was unaware of the elopement until they were contacted by a neighbor.

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

Region 4
Exit Date: 10/13/2022
Purpose of Visit: Standard Survey
Tags: F635/N1365

Situations: The facility failed to ensure a newly admitted resident with diabetes was provided with a physician's order for insulin or blood glucose checks. The facility continued in this failure until the resident's family intervened six days after admission. The resident's blood glucose levels were critically high. The facility failed to ensure a resident's hospital discharge medication order for their heart medication was transcribed and followed. The resident's medication was omitted six days after admission.

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

Region 5
Exit Date: 10/16/2022
Purpose of Visit: Standard Survey
Tags: F600/N1284
Situations: The facility failed to provide a safe environment for residents when two residents alleged abuse by a staff member. One resident alleged that while a staff member was changing their brief, the staff member hit the resident in the mouth and twisted their arm. It was later revealed the resident had a wrist fracture. Another resident alleged that a staff member ran into the room and screamed at them for talking to their roommate's family about the roommate's lack of care. The resident was shaken by the encounter and began to experience chest pain which was not alleviated by medication and was sent to the hospital.

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

Region 6
Exit Date: 10/18/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1284; F741/N1497
Situations: The facility failed to ensure a resident who was cognitively impaired and had a history of combative behaviors was free from abuse. The resident was dragged, kicked, punched, and thrown into their bed by two staff members and sustained a laceration to the left eye, and bruising around and burst blood vessels in both eyes.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to ensure staff who provide direct services to residents had the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable well-being.

Region 6
Exit Date: 10/19/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1446
Situations: The facility failed to implement interventions to prevent a resident with dementia and a history of exit-seeking behaviors from eloping. The resident eloped from the facility and was found several hours later lying on the ground. The resident was transferred to the hospital where they died from a heat stroke.

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

Region 3
Exit Date: 10/21/2022
Purpose of Visit: Incident Investigation
Tags: F880/N1713
Situations: The facility failed to effectively maintain isolation procedures when a resident from the COVID-positive unit was transferred through the COVID-negative unit. The facility failed to ensure effective use of PPE.

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

Region 5
Exit Date: 10/22/2022
Purpose of Visit: Standard Survey
Tags: F689/N1476
Situations: The facility failed to comply with their policy and residents care plans of securing all smoking materials in the designated area at the nursing station. All the resident's care plans stated smoking materials would be kept at the nursing station.

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

Region 5
Exit Date: 10/22/2022
Purpose of Visit: Standard Survey
Tags: F697/N1470
Situations: The facility failed to ensure pain medication was provided to a resident who sustained a femur fracture. The resident was not assessed and monitored for pain upon returning from the hospital. The facility failed to assess a resident admitted with terminal cancer and did not realize the resident’s fentanyl patch was not in place. The resident was not provided the medication for seventeen hours after admission.

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 3
Exit Date: 11/02/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1477
Situations: The facility failed to ensure a resident was properly fitted for the mechanical lift during a two-person transfer, resulting in the resident falling.

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

Region 6
Exit Date: 11/03/2022

Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N1446; F686/N1450
Situations: The facility failed to identify and treat a resident's pressure ulcer, which deteriorated causing the resident to develop a bone infection. The facility failed to obtain stat lab orders for a resident who began to complain of burning when urinating. The resident was found unresponsive and was sent to the hospital where they ultimately died. The resident was diagnosed with acute community cardiac arrest (sudden loss of heart function, breathing, and consciousness), MRSA carrier (a bacteria resistant to treatment with usual antibiotics), chronic right lower lobe infiltrate (substance denser than air such as blood, pus, protein within the lungs), chronic left hydronephrosis (excess fluid in a kidney due to a backup of urine) and hydroureter (abnormal enlargement of the ureter caused by any blockage that prevents urine from draining into the bladder), and chronic prostatomegaly (prostate enlargement).

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

Region 4
Exit Date: 11/08/2022
Purpose of Visit: Standard Survey
Tags: F686/N1450; F697/N1470
Situations: The facility failed to assess and obtain treatment orders for a resident who was admitted with a pressure ulcer. The facility failed to effectively treat the wound, did not use pressure ulcer prevention devices effectively, and the wound deteriorated. The facility failed to ensure that the resident received adequate pain management when they received wound care treatment.

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 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: 11/09/2022
Purpose of Visit: Complaint Investigation
Tags: F726/N1497; F803/N1580
Situations: The facility failed to provide a resident with a modified textured diet, as ordered by the resident's physician, putting the resident at risk for harm or death. The facility failed to provide training to staff related to dietary modifications.

Deficient Practice: The facility failed to ensure agency staff were competent and trained in their job responsibilities and failed to meet the nutritional menu for residents.

Region 4
Exit Date: 11/09/2022
Purpose of Visit: Complaint/Incident Investigation

Tags: F580/N1130; F684/N1446; F755/N1657
Situations: The facility failed to monitor a resident's surgical wound which was found to have reopened and had become infected. The facility failed to provide the resident with their antibiotics as ordered by a physician and did not inform the resident's physician of these failures.

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 provide pharmaceutical services, including procedures that assured accurate administering of all drugs to meet the needs of the residents.

Region 3
Exit Date: 11/09/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F550/N1100; F684/N1446
Situations: The facility failed to effectively assess a resident who requested to be sent to the hospital after they had a change in condition. The facility failed to act, and the resident was later found unresponsive and had to be revived.

Deficient Practice: The facility failed to treat each resident with a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 3
Exit Date: 11/10/2022
Purpose of Visit: Complaint Investigation; Focused Infection Control Survey
Tags: F880/N1713
Situations: The facility failed to identify the source and implement measures timely to respond to legionella after a resident was diagnosed in August with the disease while at the hospital. The facility completed testing of the water in late October and received information in early November that the facility had three areas positive for legionella.

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

Region 3
Exit Date: 11/10/2022
Purpose of Visit: Incident Investigation
Tags: F880/N1713
Situations: The facility failed to cohort residents based on their COVID-19 status.

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

Region 3
Exit Date: 11/14/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1284; F607/N1285; F609/N1294; F610/N1303; F835/N1808

Situations: The facility failed to report and investigate allegations of verbal abuse from four residents against a staff member. The alleged perpetrator was allowed to continue working after facility administration became aware of the allegations.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to ensure that all alleged violations involving abuse or mistreatment, 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, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials, including the State Agency, in accordance with State law through established procedures, and failed to ensure that all alleged violations of neglect were thoroughly investigated and to prevent further neglect while the investigation was in progress. Facility administration failed to ensure effective use of resources.

Region 5
Exit Date: 11/17/2022
Purpose of Visit: Incident Investigation
Tags: F689/N1477
Situations: The facility failed to ensure adequate supervision to prevent a resident from attempting to ingest a decorative bead. The resident received the Heimlich Maneuver, which dislodged the item, and was sent to the hospital as a precautionary measure. An x-ray indicated the resident had moderate lower lobe airspace disease (when alveolar air is replaced by fluid, pus, blood, cells, or other material), atelectasis (partial or complete collapse of the lung). The resident died at the hospital several days later.

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

Region 6
Exit Date: 11/23/2022
Purpose of Visit: Standard Survey
Tags: F692/N1462
Situations: The facility failed to fully assess a resident upon admission and establish a baseline weight to monitor. The facility failed to recognize a nearly fifteen percent weight loss over a three-month period. The facility failed to consult with a speech language pathologist to determine what changes were needed to the resident's diet texture.

Deficient Practice: The facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, unless the resident's clinical condition demonstrates that it is not possible.

Region 6
Exit Date: 11/23/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N1132; F760/N1671
Situations: The facility failed to administer a resident's anticoagulant medication for a total of four days and administered the incorrect dosage of another resident's heart medication. The facility failed to inform the former resident's physician of the missed medication doses.

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

Region 4
Exit Date: 11/23/2022
Purpose of Visit: Incident Investigation
Tags: F689/N1477
Situations: The facility failed to provide supervision to a resident when they were off the secured unit. The resident eloped from the facility and was found across the street at a nearby grocery store.

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

Region 5
Exit Date: 12/01/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F760/N1671
Situations: The facility failed to administer the correct form of insulin to a resident.

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

Region 3
Exit Date: 12/01/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1477
Situations: The facility failed to ensure a resident received two-person assistance for all mobility needs, resulting in the resident falling and sustaining a femur fracture.

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

Region 3
Exit Date: 12/02/2022
Purpose of Visit: Standard Survey
Tags: F580/N1132; F684/N1446
Situations: The facility failed to properly assess a resident who was complaining of difficulty breathing and requesting a breathing treatment, despite the resident not having a history of such issues. The resident was later found unresponsive in their room and was ultimately pronounced dead at the facility. The facility failed to properly assess, monitor, and consult a physician when a resident, who had a history of strokes, complained of significant pain to both arms and said they felt the same as they did when they last had a stroke. The resident was later found difficult to rouse, with slurred speech and hand tremors. The resident had two seizures within two days.

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

Region 3
Exit Date: 12/03/2022
Purpose of Visit: Incident Investigation; Focused Infection Control Survey
Tags: F689/N1477
Situations: The facility failed to ensure coffee was maintained at a safe temperature and to provide adequate supervision to prevent burns from spills. One resident spilled hot coffee and sustained burns on two separate occasions.

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

Region 5
Exit Date: 12/03/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1477
Situations: The facility failed to provide adequate supervision to prevent a resident from eloping. The resident eloped from the facility and was found sixteen hours later near a busy highway five miles from the facility.

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

Region 5
Exit Date: 12/04/2022
Purpose of Visit: Standard Survey
Tags: F600/N1283
Situations: The facility failed to implement interventions to prevent a resident from assaulting others. The resident had two incidents of physical assault against two separate residents.

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

Region 3
Exit Date: 12/06/2022
Purpose of Visit: Complaint Investigation
Tags: F693/N1466; F726/N1488
Situations: The facility failed to properly assess the placement of a resident's replacement feeding tube. The facility did not obtain an x-ray to ensure correct placement, resulting in the resident being hospitalized with severe abdominal wall pain with induration (area of hardness or deep thickening of the skin, that can result from edema, inflammation, or infiltration) and cellulitis (common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin of the abdominal wall).

Deficient Practice: The facility failed to ensure a resident receiving enteral feeding received appropriate care and services to prevent complications and failed to ensure nurses had the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable well-being.

Region 4
Exit Date: 12/08/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1477
Situations: The facility failed to provide adequate supervision to prevent residents from eloping. Two residents from the secure unit eloped through the facility's courtyard.

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

Region 5
Exit Date: 12/12/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1283
Situations: The facility failed to implement interventions to prevent a resident with a history of sexually inappropriate behavior from sexually assaulting another resident. The facility failed to recognize the act as sexual assault.

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

Region 5
Exit Date: 12/13/2022
Purpose of Visit: Incident Investigation
Tags: F805/N1580
Situations: The facility failed to provide a resident with their physician-ordered mechanically softened diet resulting in the resident choking.

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

Region 6
Exit Date: 12/16/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F603/N3481
Situations: The facility placed a resident into a secured unit upon admission without a directive from a doctor, recommendation from an interdisciplinary team, or proof of medical or behavioral need, causing the resident for feel fear and isolation.

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

Region 8
Exit Date: 12/21/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3010; F695/N4003
Situations: The facility failed to ensure a resident received supplemental oxygen as ordered by a physician, resulting in the resident dying.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and to ensure that a resident who needed respiratory care, which included tracheostomy care and tracheal suctioning, was provided such care consistent with

professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Region 5
Exit Date: 12/23/2022
Purpose of Visit: Incident Investigation
Tags: F600/N3481; F607/N3538; F689/N4030
Situations: The facility failed to protect a resident from abuse when a staff member deliberately placed a urine-soaked towel against the resident's face. The facility failed to provide adequate supervision to prevent a resident from eloping.

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

Region 2
Exit Date: 12/24/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to supervise a resident who had a diagnosis of dysphagia (difficulty swallowing) and required an altered diet. The resident had two choking incidents, the second of which resulted in the resident's death.

Deficient Practice: The facility failed to provide adequate supervision to prevent accidents.

Region 8
Exit Date: 12/29/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4027
Situations: The facility failed to implement interventions to prevent a resident from eloping.

Deficient Practice: The facility failed to provide adequate supervision to prevent accidents.

Region 3
Exit Date: 12/30/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F880/N4027
Situations: The facility failed to follow-up on a resident's positive COVID-19 self-test and did not implement infection control protocols.

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

Region 1
Exit Date: 12/31/2022
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481

Situations: The facility failed to implement interventions after a resident alleged abuse by a staff member. The staff member was allowed to continue working directly with residents after the allegations were made.
Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect.