Quarterly IJ Summary Report
October 2024 – December 2024

The following report presents information regarding all tags cited at the Immediate Jeopardy (IJ) level during licensing and certification surveys and complaint or incident investigations performed in nursing facilities during the fourth quarter of 2024 (10/01/2024 – 12/30/2024).

Immediate Jeopardy is "a situation in which the provider's or supplier's non-compliance with one or more requirements, conditions of participation, conditions for coverage, or conditions for certification has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident or patient" (42 CFR 489.3).

During this period, an IJ level tag was cited for 106 of the surveys and investigations conducted, resulting in 164 citations of 29 unique federal tags. The following tables provide the percentage at which each unique tag was cited (Table 1), the percent of IJs per nursing facility (NF) by region (Table 2) and the number of IJs per type of investigation (Table 3).

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

Table 1

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
580	6.1%	689	34.8%
600	16.5%	600	16.5%
604	1.2%	684	7.3%
607	6.7%	607	6.7%
609	2.4%	580	6.1%
610	3.0%	610	3.0%
624	0.6%	609	2.4%
656	2.4%	656	2.4%
658	0.6%	695	2.4%
677	0.6%	686	1.8%
678	1.2%	760	1.8%
684	7.3%	604	1.2%
686	1.8%	678	1.2%
689	34.8%	692	1.2%
690	0.6%	694	1.2%
692	1.2%	806	1.2%
694	1.2%	919	1.2%
695	2.4%	624	0.6%

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
697	0.6%	658	0.6%
699	0.6%	677	0.6%
740	0.6%	690	0.6%
755	0.6%	697	0.6%
758	0.6%	699	0.6%
760	1.8%	740	0.6%
773	0.6%	755	0.6%
806	1.2%	758	0.6%
835	0.6%	773	0.6%
880	0.6%	835	0.6%
919	1.2%	880	0.6%

*Rounded to the nearest tenth

Table 2

Region	# Of IJs	# Of NFs	% Of IJs/NF
1	11	82	7.32%
2	6	132	8.21%
3	32	224	26.34%
4	32	187	16.58%
5	26	187	22.04%
6	30	165	16.46%
8	18	140	19.86%
11	9	77	9.09%
Total	164	1194	13.74%

Table 3
Number of IJs

from Complaints	from Incidents	from Surveys	Total
70	15	21	106

Tag References

483.10 – Resident Rights:

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

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:

624 Preparation for Safe/Orderly Transfer/Discharge

483.21 – Comprehensive Resident Centered Care Plans:

656 Develop/Implement Comprehensive Care Plan
658 Services Provided Meet Professional Standards

483.25 - Quality of Care:

677 ADL Care Provided for Dependent Residents
678 Cardio-Pulmonary Resuscitation
684 Quality of Care
686 Treatment/Svcs to Prevent/Heal Pressure Ulcers
689 Free of Accident Hazards/Supervision/Devices
690 Bowel/Bladder incontinence, Catheter, UTI
692 Nutrition/Hydration Status Maintenance
694 Parenteral/IV Fluids
695 Respiratory/Tracheostomy Care and Suctioning
697 Pain Management
699 {Phase-3} Trauma Informed Care

483.40 Behavioral Health Services

740 Behavioral Health Services

483.45 Pharmacy Services

755 Pharmacy Svcs/Procedures/Pharmacist/Records
758 Free from Unnec Psychotropic Meds/PRN Use
760 Residents are Free of Significant Med Errors

483.50 – Laboratory, Radiology, and Other Diagnostic Services:

773 Lab Svs Physician Order/Notify of Results

483.60 – Food and Nutrition Services:

806 Resident Allergies, Preferences, and Substitutes

483.70 – Administration:

835 Resident Records – Identifiable Information
880 Infection Prevention & Control

483.90 Physical Environment

919 Resident Call System

Acronyms

CPR – Cardiopulmonary Resuscitation
HHSC – Health and Human Services Commission
PICC – Peripherally Inserted Central Catheter
PPE – Personal Protective Equipment
PRN – Pro Re Nata (as needed)
UTI – Urinary Tract Infection

Region 6
Exit Date: 10/01/2024
Purpose of Visit: Complaint Investigation
Tags: F689/N4030
Situations: The facility failed to ensure two staff members were assisting during incontinence care resulting in a resident falling out of bed and sustaining a right femur fracture and requiring surgery.

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

Region 4
Exit Date: 10/02/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure a resident was properly secured in the facility van during transport resulting in the resident falling out of their wheelchair and onto their hands and knees and sustaining injuries.

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

Region 3
Exit Date: 10/02/2024
Purpose of Visit: Complaint Investigation
Tags: F689/N4030
Situations: The facility failed to ensure staff followed policy to use mechanical lifts when assisting residents unable to bear their own weight resulting in a resident falling and sustaining a broken tibia. For the same resident, the facility failed to obtain proper transfer orders and to perform an assessment to determine the extent of the resident's transfer assistance needs.

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

Region 4
Exit Date: 07/03/2024
Purpose of Visit: Standard Survey
Tags: F758/N4591
Situations: The facility failed to properly convey behavioral information to a resident's physician, asserting that the resident's behavioral issues were related to aggression rather than wandering, resulting in a likely inappropriate increase in the resident's antipsychotic medication. The facility failed to recognize and report the resident's negative side effects from changes to the resident's medication, including lethargy, increased falls, increased episodes of incontinence, behavioral changes, and severe weight loss. The facility failed to ensure a physician reviewed and affirmed rationale for the continued use of medications for three residents.

Deficient Practice: The facility failed to ensure, based on comprehensive assessments, residents who used psychotropic drugs received gradual dose reduction and behavioral interventions, the medication was necessary to treat a specific condition as diagnosed and documented in the clinical records, and/or that PRN orders for psychotropic drugs were limited to fourteen days unless the prescribing practitioner documented their rationale in the resident's medical records.

Region 3
Exit Date: 10/03/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F760/N4600
Situations: The facility failed to ensure a resident did not receive the incorrect medications when they were given another resident's medication order, which included a narcotic.

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

Region 5
Exit Date: 10/03/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure adequate supervision was provided to prevent a resident from eloping out of the front door of the facility.

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

Region 5
Exit Date: 10/03/2024
Purpose of Visit: Standard Survey
Tags: F689/N4027
Situations: The facility failed to properly secure a resident in the facility van during transport, resulting in the resident falling from their wheelchair and sustaining a head laceration and broken clavicle.

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

Region 4
Exit Date: 10/06/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F607/N3484
Situations: The facility failed to protect two residents from sexual abuse by another, who had a history of inappropriate sexual behaviors, when the latter touched them inappropriately.

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

Region 3
Exit Date: 10/08/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident from eloping. The resident was found two hours after elopement about a mile and a half from the facility.

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

Region 6
Exit Date: 10/10/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F656/N3784; F740/N4042
Situations: The facility failed to incorporate a resident's history of drug use into their care plan. The facility failed to inform the resident's physician when they were out on pass to the community, from which they were taken to the hospital. The facility failed to inform the resident's physician of two urine tests that indicated the presence of opiates, one of which was after the resident returned from hospital.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition, failed to develop and implement a comprehensive person-centered care plan for each resident, and failed to ensure each resident received the necessary behavioral health care and services to attain or maintain the highest practicable well-being.

Region 11
Exit Date: 10/10/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4027
Situations: The facility failed to provide adequate supervision to prevent a resident with a history of wandering behaviors from eloping.

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

Region 4
Exit Date: 07/11/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030

Situations: The facility failed to provide adequate supervision to prevent a resident from eloping. The facility was unaware of the elopement until they were contacted by emergency services that the resident was located and had fallen.

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

Region 3
Exit Date: 10/11/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F604/N3481; F607/N3484; F610/N3538
Situations: The facility failed to protect a resident from physical abuse when a staff member pinned the resident's arms to the bed and used their body weight to contain them while using threatening language. The facility administrator failed to report the incident according to policy.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect; failed to ensure the right to be free from physical restraints imposed for purpose of convenience and not required to treat the resident's medical symptoms; 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 2
Exit Date: 10/13/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F880/N4723
Situations: The facility failed to isolate resident's positive for COVID-19 from those who were not and failed to ensure staff used and changed PPE appropriately.

Deficient Practice: The facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

Region 5
Exit Date: 10/14/2024
Purpose of Visit: Standard Survey
Tags: F580/N3013; F689/N4030
Situations: The facility failed to ensure a resident's wheelchair was set up properly prior to a staff member attempting to transfer them, resulting in the resident sustaining a fractured kneecap. After the fall, the resident complained of pain to their knee, which was later observed to be swollen and hot, which the facility failed to timely report to the resident's physician.

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 6
Exit Date: 10/16/2024
Purpose of Visit: Standard Survey
Tags: F600/N3478; F677/N3580
Situations: The facility failed to provide hot water to residents for use in baths and showers for around a month resulting in residents going weeks without showers or baths.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to provide the necessary services to maintain grooming and personal care.

Region 5
Exit Date: 10/16/2024
Purpose of Visit: Complaint Investigation
Tags: F684/N3937
Situations: The facility failed to adhere to a resident's hospital discharge orders to follow up with a physician regarding a urethral stent (a thin tube placed between the kidney and bladder to help urine flow), resulting in the resident having a change in condition, including weakness, fever, and low blood pressure, related to complications with the stent.

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

Region 6
Exit Date: 10/16/2024
Purpose of Visit: Incident Investigation
Tags: F678/N3580; F689/N4030
Situations: The facility failed to immediately initiate CPR on a resident with a full code status (code status that allows all interventions to restart the heart) when they were found unresponsive behind the building with blood coming from their mouth. CPR was not initiated until emergency services arrived. The resident ultimately died in the hospital.

Deficient Practice: The facility failed to follow physician orders and the resident's advance directives and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 3
Exit Date: 10/17/2024
Purpose of Visit: Standard Survey
Tags: F776/N5059
Situations: The facility failed to promptly notify a physician when a resident's urinary analysis results indicated the presence of bacteria in their urine. The resident

subsequently experienced a change in condition and was transferred to the hospital where they were diagnosed with sepsis due to UTI.

Deficient Practice: The facility failed to provide radiology or other diagnostic services to meet the needs of its residents in a timely manner.

Region 8
Exit Date: 10/18/2024
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to ensure staff followed a resident's care plan to have more than one person assist with transfers, resulting in the resident falling and sustaining a broken leg, requiring surgery.

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

Region 5
Exit Date: 10/18/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478/N3481; F656/N3487
Situations: The facility failed to implement comprehensive care plans and protect two residents from abuse following documented history of verbal and physical altercations between the two, culminating in one hitting the other over the head with a cane and causing a laceration that required stitches.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

Region 4
Exit Date: 10/23/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F607/N3484; F609/N3532; F610/N3538
Situations: The facility failed to protect a resident from abuse when a staff member recorded a video of the resident naked from the waist down, while laughing, and sent it to other staff members. The facility failed to investigate and report the incident and failed to protect the resident from further abuse by allowing the staff member to continue working for nearly a month after the event.

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 3
Exit Date: 10/23/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F604/N3514
Situations: The facility failed to ensure a resident was free from restraint when a staff member restricted their head and mouth by force.

Deficient Practice: The facility failed to ensure the right to be free from physical restraints imposed for purpose of convenience and not required to treat the resident's medical symptoms.

Region 6
Exit Date: 10/24/2024
Purpose of Visit: Standard Survey
Tags: F694/N4000
Situations: The facility failed to remove a resident's PICC line (a tube inserted through a vein in the arm which passes to the larger veins near the heart and used to deliver medications, liquid nutrition, or other treatments), as ordered by a physician after the resident completed their series of antibiotics.

Deficient Practice: The facility failed to ensure parenteral fluids were administered consistent with professional standards of practice.

Region 3
Exit Date: 10/25/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F600/N3484; F684/N3937
Situations: The facility failed to effectively monitor a resident who had diabetes and was no longer taking hyperglycemic medication. Following a reduction in appetite, the resident's lab indicated elevated blood glucose levels and the facility failed to inform the physician and implement interventions and monitoring, resulting in the resident's condition deteriorating, culminating in hospitalization with blood glucose levels measuring over one thousand (well-controlled levels are expected to be below one hundred).

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

Region 6
Exit Date: 10/25/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F600/N3481; F607/N3484; F609/N3535; F610/N3538; F684/N3937

Situations: The facility failed to protect a resident from sexual abuse. The resident was assessed during incontinence care with blood in their urine and they complained of pain, refused cleaning, and requested not to be touched, appearing fearful. The facility failed to inform a physician, to initiate an abuse investigation, and to report possible abuse. The resident was ultimately sent to the hospital where semen was found in their urine sample.

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 that all alleged violations involving abuse are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury; failed to provide evidence that all alleged violations of neglect, abuse, or misappropriation of property were thoroughly investigated to prevent further potential incidents while the investigation was in progress; and failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 4
Exit Date: 10/25/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481
Situations: The facility failed to protect residents from sexual abuse when one, who had severe cognitive impairments and was unable to make informed decisions, was observed in the dining room engaging in sexual activities with another resident, who had a history of sexually inappropriate behaviors.

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

Region 3
Exit Date: 10/25/2024
Purpose of Visit: Standard Survey
Tags: F600/N3478; F607/N3484; F609/N3532
Situations: The facility failed to protect a resident from verbal abuse when a staff member yelled at them in front of others. The facility failed to protect the resident from retaliation when the staff member, after getting suspended, went to the resident's room and blamed them for causing the dismissal. The facility failed to ensure staff immediately reported the incident to the abuse coordinator.

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: 10/27/2024
Purpose of Visit: Complaint/Incident Investigation

Tags: F689/N4030
Situations: The facility failed to implement effective supervision to prevent a resident from eloping. The facility remained unaware of the elopement until a community member contacted them and reported seeing the resident walking through a field nearby.

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

Region 11
Exit Date: 10/28/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement effective supervision to prevent a resident from eloping. The facility remained unaware of the elopement until local law enforcement found them several blocks from the facility.

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

Region 5
Exit Date: 10/30/2024
Purpose of Visit: Complaint Investigation
Tags: F689/N4030; F697/N4009
Situations: The facility failed to have consistent documentation reflecting a resident's transfer status, which required more than one person assisting. The resident was transferred by one person resulting in the resident breaking both lower leg bones. The facility failed to provide effective pain management and did not further assess when a resident complained of increased abdominal pain. The resident was ultimately sent to the hospital where they were diagnosed with a UTI, sepsis, and a blood clot in their bladder.

Deficient Practice: The facility failed to provide adequate supervision and assistive devices were provided to prevent accidents 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 3
Exit Date: 10/31/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F689/N4030
Situations: The facility failed to protect a resident from abuse when a staff member, failing to wear a gait-belt, moved them roughly from the bed to a chair and slapped their hand when they tried to hold onto the bedrail.

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 4
Exit Date: 11/01/2024
Purpose of Visit: Standard Survey
Tags: F600/N3478/N3481; F689/N4027; F699/N4015
Situations: The facility failed to protect a resident from abuse when four staff members held them down to perform incontinence care while the resident was yelling for them to stop. The facility failed to include trauma informed care practices into the resident's care plan to address severe traumatic events the resident had experienced. The facility failed to ensure coffee was kept at temperatures safe to handle before offering it to residents, resulting in one resident spilling and sustaining second-degree burns to their legs and lower abdomen.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect, failed to ensure adequate supervision and assistive devices were provided to prevent accidents, and failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

Region 3
Exit Date: 11/01/2024
Purpose of Visit: Complaint Investigation
Tags: F689/N4030
Situations: The facility failed to ensure effective supervision was provided to a resident in a wheelchair who had been assessed as at high risk for falls. The resident was left unattended in the dining room and fell out of their wheelchair, resulting in a subdural hematoma (a collection of blood that accumulates between the inner layer of the skull and the surface of the brain).

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

Region 8
Exit Date: 11/01/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F689/N4030
Situations: The facility failed to implement interventions to prevent two residents with severe cognitive impairments, one of whom had a history of aggressive behaviors, from physical conflict.

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

Region 6
Exit Date: 11/02/2024
Purpose of Visit: Standard Survey
Tags: F686/N3946
Situations: The facility failed to implement effective treatment and monitoring to prevent a resident's pressure ulcers from deteriorating, causing severe worsening of the wounds. The facility failed to obtain the results of the same resident's lab tests, which indicated MRSA and osteomyelitis (bone infection), until over three weeks after the sample was collected. Following receipt of the results, the facility failed to begin treatment for another five days.

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

Region 4
Exit Date: 11/02/2024
Purpose of Visit: Complaint Investigation
Tags: F695/N4003
Situations: The facility failed to ensure staff used sterile practices and proper technique when cleaning a resident's tracheostomy site.

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

Region 3
Exit Date: 11/05/2024
Purpose of Visit: Complaint Investigation
Tags: F600/N3481
Situations: The facility failed to protect a resident from sexual abuse when another resident engaged them in nonconsensual sexual activity.

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

Region 4
Exit Date: 11/06/2024
Purpose of Visit: Standard Survey
Tags: F694/N4000
Situations: The facility failed to provide effective wound care to a resident's midline catheter site, resulting in the site becoming infected and the catheter requiring replacement.

Deficient Practice: The facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

Region 5
Exit Date: 11/07/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F607/N3481/N3484; F835/N4996
Situations: The facility failed to protect a resident from sexual abuse by another resident who was a registered sex offender. The facility failed to thoroughly investigate the incident and did not report it to HHSC.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect. Facility administration failed to ensure effective use of their resources.

Region 6
Exit Date: 11/07/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F695/N4003
Situations: The facility failed to ensure a resident was provided increased oxygen while they were showering, as indicated by the resident's care plan, resulting in a severe decrease in the resident's oxygen saturation levels, requiring hospitalization where the resident ultimately died.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice.

Region 8
Exit Date: 11/08/2024
Purpose of Visit: Incident Investigation
Tags: F684/N3937
Situations: The facility failed to implement interventions when a resident was readmitted from hospice care and was reported to have attempted self-harm while at home, resulting the resident committing suicide via self-strangulation four months after admission.

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

Region 5
Exit Date: 11/08/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030

Situations: The facility failed to implement interventions after a resident broke their window and attempted to elope. The resident broke their repaired window again three days later and successfully eloped.

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

Region 2
Exit Date: 11/08/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F658/N3826; F684/N3937
Situations: The facility failed to assess a resident after their family reported that, while eating, they had stopped talking spit out their food. The responding staff did not assess the resident for possible issues swallowing or eating and told the family they could call EMS if they wanted. The resident was transferred to the emergency room where they were intubated and ultimately died due, in part, to food aspiration.

Deficient Practice: The facility failed to ensure services provided or arranged by the facility met professional standards of quality and failed to ensure residents received treatment and care in accordance with professional standards of practice.

Region 1
Exit Date: 11/08/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3010; F689/N4030
Situations: The facility failed to ensure more than one staff were used when assisting a resident with transfers, resulting in the resident sustaining a fractured femur. The facility failed to timely report the incident to a physician and the resident's family.

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 4
Exit Date: 11/11/2024
Purpose of Visit: Incident Investigation
Tags: F580/N3013; F686/N3946
Situations: The facility failed to ensure a resident did not develop a pressure ulcer and once developed, did not provide adequate treatment to prevent deterioration, ultimately resulting in the resident being admitted to the hospital with sepsis and osteomyelitis (bone infection).

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 4

Exit Date: 11/13/2024
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident from eloping from the facility. The facility had not checked the resident's anti-elopement device which did not function when they left the facility.

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

Region 6
Exit Date: 11/13/2024
Purpose of Visit: Complaint Investigation
Tags: F692/N3985
Situations: The facility failed to monitor a resident for weight loss resulting in a nearly twenty percent loss in three months. The resident was sent to the hospital where they were diagnosed with hypernatremia (high concentration of sodium in the blood) and had lost forty-three pounds since their last visit.

Deficient Practice: The facility failed to ensure acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible, or resident preferences indicate otherwise.

Region 6
Exit Date: 11/13/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4027
Situations: The facility failed to ensure coffee was kept at temperatures safe to handle before offering it to residents, resulting in one resident spilling and burning their hands.

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

Region 5
Exit Date: 11/14/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to assess a resident and inform a physician when a resident with severe kidney failure complained of being unable to urinate. The facility failed to assess and inform a physician when the same resident, who was on blood thinners, presented with bruises all over their body and began hitting themselves, falling to the floor, and yelling. The resident ultimately contacted EMS for transport to the hospital on their own.

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: 11/14/2024
Purpose of Visit: Complaint Investigation
Tags: F695/N4003
Situations: The facility failed to ensure a resident received consistent oxygen therapy. The resident removed their oxygen cannula, which was not replaced until the resident was found unresponsive approximately five hours later. Video shows the resident calling for help multiple times before becoming unresponsive.

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

Region 8
Exit Date: 11/15/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030; F806/N4339
Situations: The facility failed to provide adequate supervision to prevent a resident, who was at-risk for wandering, from eloping from the facility. The facility provided a resident with food that contained egg, to which the resident had a documented allergy, resulting in a severe allergic reaction.

Deficient Practice: The facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents and failed to provide food that accommodates resident allergies, intolerances, and preferences.

Region 3
Exit Date: 11/19/2024
Purpose of Visit: Standard Survey
Tags: F684/N3937
Situations: The facility failed to identify and treat pressure ulcers on two residents until they were identified during the survey. One resident reported their wounds had been open and draining for over a month.

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

Region 6
Exit Date: 11/19/2024
Purpose of Visit: Complaint Investigation
Tags: F919/N4954
Situations: The facility failed to replace the call light system after inclement weather damaged it and failed to provide other means for residents to communicate with staff, for over five months. The facility failed to have interventions in place to allow a resident who was quadriplegic to communicate with staff, resulting in delays to the resident's care when they began to experience shortness of breath.

Deficient Practice: The facility failed to have a functional communication system for residents to call staff for assistance.

Region 4
Exit Date: 11/20/2024
Purpose of Visit: Standard Survey
Tags: F689/N4027
Situations: The facility failed to ensure coffee was kept at temperatures safe to handle before offering it to residents, resulting in one resident spilling and sustaining second-degree burns to their legs.

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

Region 1
Exit Date: 11/20/2024
Purpose of Visit: Incident Investigation
Tags: F600/N3481; F607/N3484; F610/N3538
Situations: The facility failed to protect a resident from multiple instances of inappropriate sexual touching and failed to investigate and report the incidents when a staff member alleged witnessing the abuse.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to provide evidence that all alleged violations of neglect, abuse, or misappropriation of property were thoroughly investigated to prevent further potential incidents while the investigation was in progress.

Region 3
Exit Date: 11/21/2024
Purpose of Visit: Complaint Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent two residents from eloping. The facility remained unaware of the elopement until the following shift.

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

Region 4
Exit Date: 11/21/2024
Purpose of Visit: Complaint Investigation
Tags: F600/N3478/N3481; F656 /N3784
Situations: The facility failed to protect a resident from sexual abuse on two separate occasions by another resident who had an active warrant for sexual abuse of a child.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes

measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

Region 5
Exit Date: 11/21/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident from eloping. The resident left through the front door and walked to a local grocery store.

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

Region 6
Exit Date: 11/21/2024
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident from eloping. The resident eloped through a window twenty minutes after a previous failed elopement attempt.

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

Region 11
Exit Date: 11/21/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident from eloping. The resident left through a dining hall door and was found two hours later across the street.

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

Region 8
Exit Date: 11/23/2024
Purpose of Visit: Incident Investigation
Tags: F580/N3010; F684/N3937; F689/N4030
Situations: The facility failed to implement interventions and adequately supervise a resident with a history of bringing medications, including narcotics, into the facility without notifying staff. The resident had an unknown visitor after which they were not observed until the following morning shift where they were found unresponsive and twitching, with bottles of sedatives.

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 adequate supervision and assistive devices were provided to prevent accidents.

Region 8
Exit Date: 11/23/2024
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to a resident after they were suspected of being under the influence of illicit substances and failed to ensure all means of ingress and egress that weren't locked were monitored, resulting in four residents testing positive for amphetamines.

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

Region 8
Exit Date: 11/24/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4027
Situations: The facility failed to ensure coffee was kept at temperatures safe to handle before offering it to residents, resulting in one resident spilling and sustaining second-degree burns to their thigh and first degree burns to their hands.

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

Region 5
Exit Date: 11/24/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure the mechanical lift was used properly while helping a resident transfer resulting in the resident fracturing their femur.

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

Region 4
Exit Date: 11/26/2024
Purpose of Visit: Complaint Investigation
Tags: F600/N3481; F609/N3535; F689/N4030
Situations: The facility failed to protect a resident from physical abuse by a staff member and failed to immediately investigate and report the incident, allowing the staff member to continue working in the facility for three hours after other staff witnessed the incident. The facility failed to ensure multiple staff members were provided while assisting a resident with transferring, resulting in the resident falling out of the sling of the mechanical lift.

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

Region 11
Exit Date: 11/26/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident from eloping out of the front door. The resident was out for around eight minutes before they were witnessed re-entering the facility and were assessed to have fallen, sustaining multiple cranial fractures.

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

Region 3
Exit Date: 11/26/2024
Purpose of Visit: Complaint/Investigations Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident from eloping with the assistance of another.

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

Region 1
Exit Date: 11/27/2024
Purpose of Visit: Complaint Investigation
Tags: F600/N3481; F607/N3484
Situations: The facility failed to protect two residents from physical abuse by another who had been displaying aggressive behaviors. The facility failed to protect the same resident from abuse by an unknown overnight staff member. The facility failed to investigate and report the allegations.

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

Region 3
Exit Date: 11/27/2024
Purpose of Visit: Standard Survey
Tags: F580/N3010; F684/N3937

Situations: The facility failed to obtain treatment orders to care for a resident's surgical wound after they were readmitted to the facility and failed to assess and treat the wound, resulting in the resident developing an infection.

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: 11/27/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937; F689/N4030
Situations: The facility failed to respond effectively and transfer a resident, who was on blood thinning medication, to a higher level of care after an unwitnessed fall resulted in a head injury, later diagnosed as a subdural hematoma (a collection of blood that accumulates between the inner layer of the skull and the surface of the brain).

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 8
Exit Date: 11/27/2024
Purpose of Visit: Complaint Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions when a resident became confused and required assistance to ambulate. The facility failed to add a fall mat and lower the resident's bed, resulting in a hip fracture when the resident fell out of their bed.

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

Region 3
Exit Date: 12/02/2024
Purpose of Visit: Complaint Investigation
Tags: F695/N4003
Situations: The facility failed to obtain orders to administer oxygen to a resident readmitted with multiple respiratory illnesses and did not administer effective treatment. The facility failed to assess the resident when they had a respiratory change in condition and requested to go to the hospital. Subsequently, the facility failed to monitor the resident over six hours, ultimately finding them unresponsive prior to being pronounced dead. The facility failed to employ proper sanitary practices when providing tracheostomy care to a resident, placing the tubing on the floor then failing to replace or disinfect it.

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: 12/03/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure staff followed a resident's care plan to have more than one person assist with transfers, resulting in the resident falling and sustaining a broken leg, requiring surgery.

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

Region 4
Exit Date: 12/03/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4027/N4030
Situations: The facility failed to ensure a resident's free-standing cabinet was secured to the wall resulting in them pulling the cabinet down on top of themselves when they fell.

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

Region 1
Exit Date: 12/04/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure residents were effectively supervised and provided proper safety equipment while smoking.

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

Region 5
Exit Date: 12/05/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N3949; F760/N4690
Situations: The facility failed to implement effective treatment to prevent a resident's pressure ulcers, present on admission, from deteriorating. The facility failed to ensure accurate medication orders for the resident, failing to provide their insulin and administering anti-seizure medications for which the resident had no order, resulting in a change in condition requiring 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 are free of any significant medication errors.

Region 4
Exit Date: 12/05/2024
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent two residents from eloping, one of whom left the facility twice within a week.

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

Region 3
Exit Date: 12/06/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478
Situations: The facility failed to protect a resident with severe cognitive impairments from being sexually assaulted by an unknown visitor.

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

Region 8
Exit Date: 12/06/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478
Situations: The facility failed to protect a resident from sexual abuse when another resident, who was intoxicated and aggressive, was left alone in their room. The resident went into another resident's room and sexually assaulted them.

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

Region 2
Exit Date: 12/09/2024
Purpose of Visit: Standard Survey
Tags: F600/N3478; F607/N3484; F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident with a history of exit seeking behaviors from eloping. The resident eloped from the facility without facility knowledge despite their anti-elopement device triggering when they left. The facility failed to ensure a resident's smoking materials were stored appropriately.

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 1
Exit Date: 12/09/2024
Purpose of Visit: Standard Survey

Tags: F919/N4951
Situations: The facility failed to have a functioning call light in all residents' rooms.

Deficient Practice: The facility failed to have a functional communication system for residents to call staff for assistance.

Region 5
Exit Date: 12/10/2024
Purpose of Visit: Complaint Investigation
Tags: F684/N3937
Situations: The facility failed to assess and document a resident's unwitnessed fall and failed to ensure the incident was communicated to oncoming staff. The resident was ultimately transferred to the hospital after multiple reports of pain and was diagnosed with a hip fracture.

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

Region 6
Exit Date: 12/11/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F610/N3538/N3541
Situations: The facility failed to ensure two residents were protected from abuse by a staff member when the staff member shoved one on top of the other. The facility failed to report and investigate the incident and permitted the perpetrator to continue having access to 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 potential incidents while the investigation was in progress.

Region 4
Exit Date: 12/12/2024
Purpose of Visit: Complaint Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent two residents from eloping, one of whom left through a window, the other through a locked door, both from the secure unit.

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

Region 1
Exit Date: 12/12/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4030

Situations: The facility failed to provide adequate supervision to a resident while they were out smoking, allowing the resident to elope through the gate and leave the grounds.

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

Region 4
Exit Date: 12/12/2024
Purpose of Visit: Complaint Investigation
Tags: F624/N3448; F689/N4030
Situations: The facility failed to ensure two residents had safe and orderly discharges. One resident was discharged with no place to go, sat outside the facility for over seven hours before being transported to the hospital with irregular heart rhythm and high blood pressure. The other, who required assistance with some ADLs and was at-risk for falls, was discharged to a motel where they experienced multiple falls. The facility failed to act when a door alarm sounded allowing a resident with severe dementia to leave the facility and begin to leave the grounds before being intercepted by an oncoming staff member.

Deficient Practice: The facility 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.

Region 4
Exit Date: 12/12/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to follow a resident's care plan for transfers when a staff member attempted to transfer them without assistance, resulting in the resident sustaining a fractured tibia.

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

Region 8
Exit Date: 12/13/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to a resident who was found unresponsive with a bottle of acetaminophen at their bedside. The resident was transferred to the hospital where they were assessed with 12,000 milligrams of acetaminophen in their blood (harm threshold is 4,000 milligrams over twenty-four hours).

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

Region 4
Exit Date: 12/13/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to use a mechanical lift to help transfer a resident resulting in the resident falling and sustaining a severe laceration to the head.

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

Region 5
Exit Date: 12/13/2024
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident with a history of exit seeking behavior from eloping from the secure unit twice in less than two months.

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

Region 3
Exit Date: 12/18/2024
Purpose of Visit: Complaint Investigation
Tags: F755/N4561; F760/N4600
Situations: The facility failed to follow hospital discharge orders to administer blood thinning medication to a resident, resulting in thirty days of missed 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 and failed to ensure residents are free of any significant medication errors.

Region 3
Exit Date: 12/18/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure all doors had alarms to alert staff when they were opened, resulting in a resident eloping through a side door, leaving the facility for over fifteen hours before they were found by local law enforcement.

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

Region 1
Exit Date: 12/18/2024
Purpose of Visit: Incident Investigation
Tags: F806/N4339

Situations: The facility failed to ensure a resident was given the correct meal tray, resulting in the resident consuming a known allergen and developing symptoms of anaphylaxis.

Deficient Practice: The facility failed to provide food that accommodates resident allergies, intolerances, and preferences.

Region 8
Exit Date: 12/20/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to provide adequate supervision to prevent a resident from eloping through their window. The resident remained missing until the following day.

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

Region 6
Exit Date: 12/20/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F678/N3580
Situations: The facility failed to ensure CPR was initiated immediately when a resident was found unresponsive, failed to ensure the crash cart was properly set up for use, and failed to ensure staff were trained to perform CPR properly.

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

Region 8
Exit Date: 12/21/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent a resident from having seven falls within a month.

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

Region 8
Exit Date: 12/22/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478/N3481
Situations: The facility failed to protect multiple residents from physical and sexual abuse by another, who had a history of aggressive, sexually inappropriate behaviors.

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

Region 11
Exit Date: 12/23/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F607/N3484; F689/N4030; F690/N3967
Situations: The facility failed to ensure staff were trained to properly insert a foley catheter resulting in a resident, who had cried out in pain, sustaining an injury during the procedure, and requiring hospitalization. The facility failed to provide adequate supervision to prevent a resident with severe cognitive impairments and wandering behaviors from eloping.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect, failed to ensure adequate supervision and assistance devices were provided to prevent accidents, and failed to consult with the physician when the resident experienced a change in condition or a need to alter treatment significantly.

Region 4
Exit Date: 12/27/2024
Purpose of Visit: Complaint Investigation
Tags: F600; F607/N3484
Situations: The facility failed to protect a resident from physical abuse by a staff member, failed to investigate the incident, and failed to suspend the alleged perpetrator. The facility failed to implement interventions to prevent two residents from physically and, in one case, sexually abusing five other residents.

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

Region 3
Exit Date: 12/27/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure coffee was at temperatures safe to handle and in a secure vessel before offering it to a resident, resulting in them spilling and sustaining burns to their arm, hip, and waist.

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

Region 3
Exit Date: 12/30/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F689/N4030
Situations: The facility failed to protect a resident from abuse by a staff member who aggressively repositioned the resident and hit them twice in the face. The facility failed to ensure adequate supervision to prevent a resident with severe cognitive impairments from eloping.

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: 12/30/2024
Purpose of Visit: Complaint Investigation
Tags: F600/N3478
Situations: The facility failed to protect a resident with advanced dementia from sexual abuse by another resident.

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

Region 5
Exit Date: 12/31/2024
Purpose of Visit: Incident Investigation
Tags: F684/N3937; F689/N4030
Situations: The facility failed to ensure a resident was transferred via a mechanical lift, as required by their care plan, resulting in them being dropped and sustaining two femur fractures requiring surgery, during which the resident died.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice and failed to ensure adequate supervision and assistance devices were provided to prevent accidents.

Region 5
Exit Date: 12/31/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure sufficient staff were provided during care resulting in a resident rolling out of bed and hitting their face, causing a severe laceration to the forehead, a subdural hematoma (a collection of blood that accumulates between the inner layer of the skull and the surface of the brain), and possible neck fractures.

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

Region 5
Exit Date: 12/31/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F656/N3787; F692/N3985
Situations: The facility failed to effectively monitor, record, and track a resident's weight loss, resulting in the resident losing nearly thirty percent of their body weight in six months.

Deficient Practice: The facility failed to develop and implement a comprehensive person-centered care plan for each resident and failed to ensure acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible, or resident preferences indicate otherwise.