Quarterly IJ Summary Report
July 2024 – September 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 third quarter of 2024 (07/01/2024 – 09/30/2024).

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 131 of the surveys and investigations conducted, resulting in 210 citations of 35 unique federal tags. The following tables provide the percentage at which each unique tag was cited (Table 1), the percent of IJs per nursing facility (NF) by region (Table 2) and the number of IJs per type of investigation (Table 3).

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

Table 1

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
550	0.5%	689	24.3%
578	0.5%	600	12.9%
580	9.0%	684	9.5%
584	0.5%	580	9.0%
600	12.9%	607	8.1%
607	8.1%	656	4.3%
609	0.5%	686	4.3%
610	1.9%	678	3.3%
624	0.5%	755	2.9%
655	0.5%	760	2.4%
656	4.3%	610	1.9%
658	0.5%	726	1.9%
678	3.3%	697	1.4%
684	9.5%	805	1.4%
686	4.3%	690	1.0%
689	24.3%	693	1.0%
690	1.0%	695	1.0%
693	1.0%	776	1.0%

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
694	0.5%	925	1.0%
695	1.0%	550	0.5%
697	1.4%	578	0.5%
698	0.5%	584	0.5%
725	0.5%	609	0.5%
726	1.9%	624	0.5%
755	2.9%	655	0.5%
760	2.4%	658	0.5%
773	0.5%	694	0.5%
776	1.0%	698	0.5%
777	0.5%	725	0.5%
805	1.4%	773	0.5%
842	0.5%	777	0.5%
908	0.5%	842	0.5%
919	0.5%	908	0.5%
925	1.0%	919	0.5%
926	0.5%	926	0.5%

*Rounded to the nearest tenth

Table 2

Region	# Of IJs	# Of NFs	% Of IJs/NF
1	6	82	7.32%
2	11	134	8.21%
3	59	224	26.34%
4	31	187	16.58%
5	41	186	22.04%
6	27	164	16.46%
8	28	141	19.86%
11	7	77	9.09%
Total	210	1195	17.57%

Table 3
Number of IJs

from Complaints	from Incidents	from Surveys	Total
95	14	22	131

Tag References

483.10 – Resident Rights:
- 550 Resident Rights/Exercise of Rights
- 578 Request/Refuse/Discontinue Treatment; Formulate Adv Dir
- 580 Notification of Changes (Injury/Decline/Room, Etc.)
- 584 Safe/Clean/Comfortable/Homelike Environment

483.12 - Freedom from Abuse, Neglect, and Exploitation:
- 600 Free from Abuse and Neglect
- 607 Develop/Implement Abuse/Neglect, etc. Policies
- 609 Reporting of Alleged Violations
- 610 Investigate/Prevent/Correct Alleged Violation

483.15 – Admission, Transfer, and Discharge:
- 624 Preparation for Safe/Orderly Transfer/Discharge

483.21 – Comprehensive Resident Centered Care Plans:
- 655 Baseline Care Plan
- 656 Develop/Implement Comprehensive Care Plan
- 658 Services Provided Meet Professional Standards

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
- 690 Bowel/Bladder incontinence, Catheter, UTI
- 693 Tube Feeding Management/Restore Eating Skills
- 694 Parenteral/IV Fluids
- 695 Respiratory/Tracheostomy Care and Suctioning
- 697 Pain Management
- 698 Dialysis

483.35 Nursing Services
- 725 Sufficient Nursing Staff
- 726 Competent Nursing Staff

483.45 Pharmacy Services
- 755 Pharmacy Svcs/Procedures/Pharmacist/Records
- 760 Residents are Free of Significant Med Errors

483.50 – Laboratory, Radiology, and Other Diagnostic Services:
- 773 Lab Svs Physician Order/Notify of Results
- 776 Radiology/Other Diagnostic Services

777 Radiology/Diag. Svcs Ordered/Notify Results

483.60 – Food and Nutrition Services:

805 Food in For to Meet Individual Needs

483.70 – Administration:

842 Resident Records – Identifiable Information

483.90 Physical Environment

908 Essential Equipment, Safe Operating Condition
919 Resident Call System
925 Maintains Effective Pest Control Program
926 Smoking Policies

Acronyms

CPR – Cardiopulmonary Resuscitation
UTI – Urinary Tract Infection

Region 3
Exit Date: 07/01/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to effectively assess, monitor, and inform a resident's physician after the resident had critically low blood glucose levels. The facility had the same failures related to a resident with x-ray results that indicated pulmonary edema and pneumonia. Both residents died within twenty-four hours of the changes in condition.

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

Region 4
Exit Date: 07/01/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F607/N3484; F686/N3949; F689/N4030
Situations: The facility failed to protect multiple residents from physical and sexual abuse by other residents and from verbal abuse by staff. The facility failed to effectively monitor and provide treatment to two residents who developed pressure ulcers, and failed to follow the physician's treatment orders, resulting in deterioration of the wounds. The facility failed to ensure a resident's low air loss mattress was inflated. The facility failed to ensure a resident was properly secured in their wheelchair during transport, resulting in the resident falling out of the wheelchair. The facility failed to ensure the floor straps on the van were functioning properly resulting in the same resident's wheelchair lifting from the vehicle floor during a later transport.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect; failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing; and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 3
Exit Date: 07/01/2024
Purpose of Visit: Complaint Investigation
Tags: F690/N3967
Situations: The facility failed to follow up with a physician for thirteen days after a resident's catheter was discovered leaking.

Deficient Practice: The facility failed to consult with the physician when the resident experienced a change in condition or a need to alter treatment significantly.

Region 8
Exit Date: 07/01/2024

Purpose of Visit: Incident Investigation
Tags: F656/N3784; F689/N4030
Situations: The facility failed to implement interventions to protect a resident with a history of falls from falling multiple times after being admitted to the facility. The resident had five falls after admission, the last resulting in a subdural hemorrhage (bleeding between the brain and its outermost covering) which required hospitalization.

Deficient Practice: The facility failed to develop and implement a comprehensive person-centered care plan for each resident and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 6
Exit Date: 07/02/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F690/N3937
Situations: The facility failed to inform a physician of a resident's two missed urologist appointments, their changing skin conditions, and complaints of pain, resulting in delayed treatment and severe deterioration of the wound.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to consult with the physician when the resident experienced a change in condition or a need to alter treatment significantly.

Region 3
Exit Date: 07/03/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F658/N3826; F684/N3937
Situations: The facility failed to identify and document a resident's tube drain, placed to drain an abscess on their torso, during admission. The facility failed to identify the drain for nine days after admission, by which time the area was infected and the resident required hospitalization.

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 3
Exit Date: 07/04/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3878; F607/N3484; F610/N3505
Situations: The facility failed to report and to put interventions in place after a resident allegedly sexually assaulted another resident, the latter of whom was unable to consent to sexual activity. The alleged perpetrator was later found naked in bed with the latter.

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 8
Exit Date: 07/07/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N3949; F925/N4984
Situations: The facility failed to obtain a physician's order for treatment and wound care for a resident's right heel blister resulting in the wound deteriorating to a severe pressure ulcer that was later found to have maggots.

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 maintain an effective pest control program so that the facility is free of pests.

Region 4
Exit Date: 07/10/2024
Purpose of Visit: Incident Investigation
Tags: F600/N3481; F607/N3484
Situations: The facility failed to protect two residents from physical and verbal abuse when a staff member yelled and threw objects at them.

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

Region 6
Exit Date: 07/10/2024
Purpose of Visit: Standard Survey
Tags: F686/N3946
Situations: The facility failed to effectively treat a resident's moisture associated skin damage, resulting in the wound deteriorating into a severe pressure ulcer, requiring hospitalization due to sepsis and bacterial infection.

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 2
Exit Date: 07/10/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to provide effective supervision when a resident left the facility and was locked out all night.

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 a resident who had verbalized a desire or attempted to leave multiple times. The resident was found nearly half a mile from the facility.

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

Region 3
Exit Date: 07/11/2024
Purpose of Visit: Standard Survey
Tags: F600/N3481
Situations: The facility failed to protect a resident from physical abuse during incontinence care when a staff member smacked them on the side and buttock and told them to be quiet when they protested.

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

Region 4
Exit Date: 07/17/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N6478; F607/N3484
Situations: The facility failed to protect a resident from physical and verbal abuse by a staff member when they were shoved and called derogatory names.

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

Region 5
Exit Date: 07/17/2024
Purpose of Visit: Standard Survey
Tags: F656/N3784; F689/N4030
Situations: The facility failed to update a resident's care plan to indicate that they required assistance with eating and were at risk of choking. The resident was unmonitored during meals resulting in them choking and their subsequent death.

Deficient Practice: The facility failed to develop and implement a comprehensive person-centered care plan for each resident and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 5
Exit Date: 07/18/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F726/N4120

Situations: The facility failed to ensure staff were trained to report changes in condition when a staff member failed to report a resident's symptoms of dizziness while taking them to the shower room. The resident fell while the staff member was assisting with the shower, resulting in fractures to the skull and an acute traumatic subarachnoid hemorrhage (bleeding between the brain and its outermost covering).

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to ensure staff were competent and trained in their job responsibilities.

Region 2
Exit Date: 07/19/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4027
Situations: The facility failed to ensure o residents were properly secured during transport, resulting in both falling out of their wheelchairs and sustaining injuries.

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

Region 3
Exit Date: 07/19/2024
Purpose of Visit: Incident Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to assess a resident and inform their physician when they began to exhibit changes in condition and complain when their leg was touched. Diagnostics were not ordered until the following day when an x-ray revealed a fractured hip.

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: 07/19/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F686/N3946
Situations: The facility failed to assess and treat a resident's pressure ulcers resulting in deterioration of the wounds. The failure continued until the resident's family intervened and the resident was sent to the hospital.

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

Region 5
Exit Date: 07/19/2024
Purpose of Visit: Complaint/Incident Investigation

Tags: F580/N3010; F755/N4561; F760/N4600
Situations: The facility failed to ensure a resident received their prescribed antibiotics and failed to inform the resident's physician that the prescription was not available, resulting in the resident requiring hospitalization due to infection.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition; 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 5
Exit Date: 07/21/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F697/N4009; F755/N4561
Situations: The facility failed to ensure that two residents received their prescribed pain medication for multiple days, resulting in the residents experiencing excruciating pain.

Deficient Practice: The facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences; 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: 07/22/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F697/N4009; F776/N5068
Situations: The facility failed to provide a resident with pain medication after they had an unwitnessed fall and exhibited signs of pain. The facility failed to obtain x-rays of the wound for over seventeen hours before the resident was transferred to the hospital and diagnosed with a hip fracture.

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; and failed to provide radiology or other diagnostic services to meet the needs of its residents in a timely manner.

Region 4
Exit Date: 07/23/2024
Purpose of Visit: Incident Investigation
Tags: F693/N3997
Situations: The facility failed to ensure a resident's tube feeding was stopped by the ordered time. The resident received tube feeding and water flushes via the pump for an additional six hours, resulting in an excess volume delivery causing the resident to vomit, become cyanotic (when the skin, lips or nails turn a bluish color) and develop critically low oxygen saturation levels. The resident was transferred to the hospital

where they were diagnosed with aspiration pneumonia (food or liquid is breathed into the airways or lungs), acute respiratory failure, and required intubation.

Deficient Practice: The facility failed to ensure that residents receiving enteral feeding received appropriate care and services to prevent complications.

Region 6
Exit Date: 07/23/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F600/N3484
Situations: The facility failed to assess, monitor, and inform a physician when a resident with late-stage cancer had a change in condition. The resident was ultimately transferred to the hospital where they died.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to implement policies and procedures to prevent abuse and neglect.

Region 4
Exit Date: 07/25/2024
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to implement safety measures after a resident received second-degree burns from spilling hot coffee on themselves.

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

Region 3
Exit Date: 07/25/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937
Situations: The facility failed to order an x-ray for a resident for two weeks after they complained of pain in their wrist and hand. The pain worsened and the resident's wrist started to show signs of injury. After fourteen days an x-ray was ordered and revealed a displacement fracture of one of the resident's wrist bones.

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

Region 3
Exit Date: 07/25/2024
Purpose of Visit: Standard Survey
Tags: F580/N3010; F689/N4027
Situations: The facility failed to use a resident's wheelchair footrest while pushing their wheelchair, resulting in the resident fracturing their leg. The facility failed to ensure the injury was reported to a physician, resulting in a delay of four days before x-rays diagnosed the fracture.

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 11
Exit Date: 07/26/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent a resident with a history of exit-seeking behaviors from eloping. The resident left the facility and was found at a nearby apartment complex.

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

Region 8
Exit Date: 07/26/2024
Purpose of Visit: Standard Survey
Tags: F805/N4330
Situations: The facility failed to ensure a resident with orders for modified food was given the appropriate meal, resulting in the resident choking.

Deficient Practice: The facility failed to ensure provided food was prepared in the proper form to meet residents' needs.

Region 8
Exit Date: 07/26/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F755/N4561
Situations: The facility failed to follow physician orders for a resident's fentanyl patch resulting in them becoming unresponsive and suffering respiratory failure.

Deficient Practice: The facility failed to provide pharmaceutical services, including procedures that assured accurate administering of all drugs to meet the needs of the residents.

Region 3
Exit Date: 07/26/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement effective interventions to prevent a resident from eloping twice within six months, the second time after they were placed on the secured unit.

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

Region 4

Exit Date: 07/26/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030; F926/N4987
Situations: The facility failed to ensure residents were monitored while smoking. Three residents, one of whom was on oxygen, were smoking in non-smoking areas and were permitted to keep their smoking materials in the rooms. The resident on oxygen sustained burns to the face when their oxygen caught fire.

Deficient Practice: The facility failed to provide adequate supervision and assistive devices were provided to prevent accidents and failed to follow federal, state, and local laws and regulations regarding smoking, smoking areas, and smoking safety.

Region 2
Exit Date: 07/26/2024
Purpose of Visit: Standard Survey
Tags: F580/N3013; F684/N39367
Situations: The facility failed to assess and monitor a resident, and inform their physician, after they had a change in condition exhibited by low oxygen saturation levels, need for supplemental oxygen, vomiting, and complaints of pain. No additional assessments were conducted, and the resident was ultimately transferred to the hospital where they died.

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

Region 8
Exit Date: 07/27/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F678/N3580
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 with no pulse or respirations.

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

Region 5
Exit Date: 07/27/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4030; F726/N3628; F908/N4063
Situations: The facility failed to ensure their mechanical lift was safe and functioning properly and to train staff not to use it when it was determined unsafe. The lift was used despite showing signs of significant wear of the slings, three of which broke while transferring a resident.

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

trained in their job responsibilities, and failed to maintain all mechanical, electrical, and patient care equipment in a safe operating condition.

Region 2
Exit Date: 07/27/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4027/N4030
Situations: The facility failed to lower a resident's bed and place a fall mat beneath it while the resident was in it resulting in the resident falling from the bed and getting their arm stuck between the grab bars.

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

Region 8
Exit Date: 07/28/2024
Purpose of Visit: Standard Survey
Tags: F580/N3013; F678/N3580; F693/N3937
Situations: The facility failed to continuously perform CPR on a resident with a full code status (code status that allows all interventions to restart the heart) when they were found unresponsive with no pulse or respirations. The facility failed to inform a physician, assess, and monitor after a resident had a significant change in condition that included pain, decreased oxygenation, vomiting, and fecal incontinence. The resident subsequently died. The facility failed to ensure they had all the supplies required for a resident's tube feeding needs when they were admitted.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition, failed to follow physician orders and the resident's advance directives, and failed to ensure that residents receiving enteral feeding received appropriate care and services to prevent complications.

Region 6
Exit Date: 07/29/2024
Purpose of Visit: Complaint Investigation
Tags: F684/N3937
Situations: The facility failed to transport a resident to the hospital in a timely manner after they had a fall that resulted in a subdural hematoma (bleeding between the brain and its outermost covering), allowing nearly three hours to pass before the resident was transported.

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

Region 5
Exit Date: 07/29/2024
Purpose of Visit: Complaint Investigation
Tags: F600/N3484; F755/N4561

Situations: The facility failed to ensure a resident received their thyroid medication, resulting in critically increased thyroid stimulating hormone levels that caused changes in condition exhibited by fatigue, dizziness, and depression.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to provide pharmaceutical services, including procedures that assured accurate administering of all drugs to meet the needs of the residents.

Region 5
Exit Date: 07/30/2024
Purpose of Visit: Complaint Investigation
Tags: F686/N3949
Situations: The facility failed to assess, monitor, and treat a residents wound, which was present upon admission, resulting in the wound deteriorating into a severe pressure ulcer.

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: 07/30/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to follow-up with a resident's physician for two days after lab results indicated the resident had a UTI and failed to ensure effective treatment. The facility failed to recognize and monitor the resident's changes in condition as exhibited by their head leaning heavily to one side, severe incontinence, confusion, and weakness.

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 11
Exit Date: 07/31/2024
Purpose of Visit: Complaint Investigation
Tags: F689/N4030
Situations: The facility failed to implement adequate supervision to prevent a resident from eloping. A resident left the facility and walked to a nearby store where they were found in a state of confusion.

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

Region 4
Exit Date: 08/01/2024
Purpose of Visit: Complaint Investigation
Tags: F689/N4030

Situations: The facility failed to implement interventions to prevent a resident, who was identified as at-risk for elopement, from eloping. The resident left that facility by unknown means and was found ambulating in their wheelchair along a busy road with no sidewalk or shoulder.

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

Region 4
Exit Date: 08/01/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3967
Situations: The facility failed to assess a resident after they fell. The resident was immediately transferred to their bed and was not assessed by a nurse.

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

Region 8
Exit Date: 08/02/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent a resident from eloping. The resident eloped from the facility and was found near an intersection.

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

Region 3
Exit Date: 08/02/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent a resident from eloping. The resident eloped from the facility without their awareness until a family member reported they had been found eight miles from the facility.

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

Region 5
Exit Date: 08/02/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F607/N6487; F609/N3511; F610/N3532
Situations: The facility failed to protect a resident from abuse when a staff member dragged them to the shower and sprayed them while they were clothed. The facility failed to properly report and investigate the allegations and permitted the alleged perpetrator to continue working with residents.

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 8
Exit Date: 08/06/2024
Purpose of Visit: Complaint Investigation
Tags: F755/N4561; F760/N4600
Situations: The facility failed to ensure staff followed medication administration practices resulting in a resident receiving an overdose of methadone, for which they had no order.

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: 08/06/2024
Purpose of Visit: Incident Investigation
Tags: F600/N6478; F607/N3484
Situations: The facility failed to protect a resident from verbal abuse by a staff member.

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

Region 4
Exit Date: 08/07/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent a resident from eloping. The resident eloped from the facility and crossed a four-lane highway.

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

Region 8
Exit Date: 08/08/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent a resident from eloping. The resident eloped from the facility and was found next door inside a vehicle.

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

Region 5
Exit Date: 08/08/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937; F689/N4030
Situations: The facility failed to ensure a resident was assessed by a nurse after they were found on the ground in the dining room. The resident was on the ground for over an hour and a half until family members arrived and assisted them to bed. There was no nursing documentation or incident report. The facility failed to ensure a resident did not elope from an emergency exit door after a staff member used a pin code to bypass the door. The resident was found by a staff member at a local gas station, but the staff member did not stay with the resident. The resident was later taken to the hospital and tested positive for cocaine.

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 5
Exit Date: 08/09/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F607/N3487
Situations: The facility failed to protect a resident from sexual assault by a staff member which was captured on camera by a confidential informant.

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

Region 4
Exit Date: 05/02/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement effective interventions to prevent two residents from eloping from their secured unit.

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

Region 11
Exit Date: 08/10/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F607/N3484
Situations: The facility failed to protect a resident from verbal abuse by a staff member and failed to report the allegation.

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

Region 3
Exit Date: 08/10/2024
Purpose of Visit: Complaint Investigation
Tags: F684/N3937
Situations: The facility failed to treat a resident's wound on their left great toe resulting in the resident developing osteomyelitis (bone infection).

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

Region 2
Exit Date: 08/10/2024
Purpose of Visit: Complaint Investigation
Tags: F760/N4600
Situations: The facility failed to administer physician ordered medications to a resident that included handheld nebulizer breathing treatments, inhalers, nasal sprays, and tablets for diagnosed respiratory illnesses resulting in the resident being admitted to hospital with diagnoses of acute exacerbation of chronic obstructive pulmonary disease (lung disease causing breathing problems) and shortness of breath.

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

Region 3
Exit Date: 08/12/2024
Purpose of Visit: Complaint Investigation
Tags: F584/N3628; F925/N4984
Situations: The facility and administration failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior and did not ensure resident rooms were clean, sanitary, and free of food debris and drink spills to prevent ants, gnats, and flies which were found in residents' rooms. One resident received 102 ant bites to the torso and arms.

Deficient Practice: The facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment and failed to maintain an effective pest control program so that the facility is free of pests.

Region 3
Exit Date: 08/12/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3010; F600/N3478; F607/N3484; F684/N3937
Situations: The facility failed to assess, report, and inform a physician after a resident fell out of bed during incontinence care. The facility failed to ensure staff followed the

resident's care plan to always have two staff assisting with incontinence care. The resident was sent to the hospital six days after the fall and was diagnosed with two leg fractures.

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 3
Exit Date: 08/12/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478; F607/N3481; F610/N3487; F684/N3937
Situations: The facility failed to protect a resident from verbal abuse by a staff member and failed to thoroughly investigate the incident. The facility failed to implement interventions to protect a resident, who was unable to consent to sexual activity and had an incident of sexual abuse at the facility previously, from sexual assault by a resident three months later.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect; failed to provide evidence that all alleged violations of neglect, abuse, or misappropriation of property were thoroughly investigated to prevent further 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 5
Exit Date: 08/13/2024
Purpose of Visit: Standard Survey
Tags: F607/N3484; F610/ N3511
Situations: The facility failed to follow their policies regarding abuse when a resident alleged they were being raped by staff at night. The facility failed to report the allegations and to thoroughly investigate them.

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 8
Exit Date: 08/0613/2024
Purpose of Visit: Complaint Investigation
Tags: F600/N3481; F656/N3784
Situations: The facility failed to protect two residents from physical abuse when they were attacked by another resident. The facility failed to implement interventions after the first incident, resulting in the second occurring about three weeks later.

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 3
Exit Date: 08/14/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937; F689/N4030; F919/N4951/N4954
Situations: The facility failed to provide care to a resident during the night shift and failed to assist the resident back into a safe and comfortable position after their leg fell down the side of the bed, resulting in swelling and pain in the leg and causing the resident to cry. The facility failed to ensure all resident's call lights were functioning. The facility failed to ensure two residents, with histories of exit-seeking behavior, were effectively supervised to prevent their elopement.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice, failed to ensure adequate supervision and assistive devices were provided to prevent accidents, and fail to have a functional communication system for residents to call staff for assistance.

Region 8
Exit Date: 08/14/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F656/N3784; F689/N4030
Situations: The facility failed to ensure two residents received assistance while eating, resulting on one of the residents to choke to death.

Deficient Practice: The facility failed to develop and implement a comprehensive person-centered care plan for each resident and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 2
Exit Date: 08/15/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3448; F607/N3484; F624/N3487
Situations: The facility failed to ensure that residents and family were provided enough notice prior to an emergency closure to make arrangements for care and ensure all residents needs were met. The facility failed to ensure a resident was supervised in the facility van when they were left unsupervised for over an hour, with outside temperatures reaching 107 degrees, requiring emergency services to be called to evaluate the resident. The facility failed to ensure the van was in working order resulting in the vehicle breaking down in transit with three residents onboard. The van was broken down on the side of the road for approximately six hours and two residents required hospitalization due to heat-related illness.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to ensure residents were provided sufficient preparation and orientation to ensure safe and orderly transfer or discharge.

Region 4
Exit Date: 08/16/2024
Purpose of Visit: Complaint Investigation
Tags: F678/N3580
Situations: The facility failed to initiate CPR on a resident with a full code status (code status that allows all interventions to restart the heart) when they were found in the dining hall unresponsive. CPR was not initiated until emergency services arrived, twelve minutes after the resident was found. The resident was transported to the hospital where food was found in their airway and they were pronounced dead.

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

Region 1
Exit Date: 08/16/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481
Situations: The facility failed to protect a resident from abuse by a staff member when they were slapped on the arm.

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

Region 3
Exit Date: 08/16/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N013; F684/N3937
Situations: The facility failed to assess, treat, and monitor a resident after they were found with multiple ant bites and did not inform a physician or the resident’s LAR about the incident and the subsequent room change.

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: 08/17/2024
Purpose of Visit: Incident Investigation
Tags: F600/N3478; F607/N3484; F655/N3778
Situations: The facility failed to develop a care plan to address a resident who was admitted with suicidal ideations. Less than a month after being admitted, the resident reported having consumed hand sanitizer and wanting to die.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care.

Region 8
Exit Date: 08/19/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4027
Situations: The facility failed to ensure residents did not have access to smoking paraphernalia when a resident obtained a lighter and set a piece of paper on fire in their room while their oxygen concentrator was on.

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

Region 4
Exit Date: 08/20/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to properly secure a resident while they were transported in the facility van, resulting in the resident falling forward out of their wheelchair and sustaining a head injury that required hospitalization.

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

Region 5
Exit Date: 08/20/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F760/N4600
Situations: The facility failed to ensure a resident's blood glucose levels were monitored and that insulin was administered regularly for over two weeks, resulting in the resident developing critically high blood glucose levels and going into diabetic ketoacidosis (a life-threatening complication of diabetes).

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

Region 6
Exit Date: 08/20/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to continue to monitor and obtain treatment orders from a physician for a resident who was admitted while in active respiratory distress. The resident was left unattended and unmonitored after an initial oxygen treatment and was ultimately found unresponsive and subsequently pronounced dead.

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

Region 4
Exit Date: 08/21/2024
Purpose of Visit: Complaint Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent residents from eloping. One resident eloped from a window in a secure unit and broke the fence, the other wandered outside and was assumed to be in the bathroom until a staff member found them out near the dumpsters.

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

Region 5
Exit Date: 08/22/2024
Purpose of Visit: Standard Survey
Tags: F600/N3481
Situations: The facility failed to protect a resident from abuse by a staff member when they were caught on surveillance cameras slapping the resident on three occasions during one shift while providing care.

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

Region 3
Exit Date: 08/22/2024
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to ensure staff were trained to use the mechanical lift properly and with assistance when required by a resident's care plan, resulting in a resident falling from the sling of the lift while being transferred from their wheelchair and sustaining a fractured clavicle, hip, and lower leg bone and a brain hemorrhage.

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

Region 4
Exit Date: 08/22/2024
Purpose of Visit: Standard Survey
Tags: F689/N4027/N4030
Situations: The facility failed to ensure a resident's fingernails were kept clean when the resident had a sticky black substance under them.

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

Region 5
Exit Date: 08/22/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4027/N4030
Situations: The facility failed to implement interventions to prevent two residents from eloping from the facility within two weeks of each other.

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

Region 5
Exit Date: 08/24/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent a resident from eloping. The resident left the facility and was gone for over two hours before being found a mile away at a gas station with a swollen and scratched face from a fall.

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

Region 2
Exit Date: 08/25/2024
Purpose of Visit: Standard Survey
Tags: F656/N3784; F689/N4027
Situations: The facility failed to ensure staff followed a resident's care plan to have at least two people assisting with transfers. During a single-person transfer, the resident produced a loud popping sound and was unable to stand, having to be lowered to the ground. The resident was found to have sustained a fractured femur that required surgery.

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

Region 1
Exit Date: 08/26/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F686/N3949
Situations: The facility failed to train staff to properly perform skin checks on a resident resulting in the development of a tendon-deep pressure ulcer that had not been noted on any of the previous month's skin checks.

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 3
Exit Date: 08/27/2024
Purpose of Visit: Complaint Investigation
Tags: F578/N3340
Situations: The facility failed to honor a resident's OOH-DNR order (advanced directive that does not permit resuscitation measures outside of a hospital setting) when CPR was initiated for forty-eight minutes after the resident was found unresponsive.

Deficient Practice: The facility failed to protect the residents right to request, refuse, and/or discontinue treatment.

Region 6
Exit Date: 08/28/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F684/N3937
Situations: The facility failed to assess a resident and contact a physician when the resident had ongoing episodes of vomiting over the course of two days, ultimately requiring emergency transport to the hospital.

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

Region 6
Exit Date: 08/29/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to keep a resident from eloping. The resident left the facility and remained missing until the following day when they were admitted into the emergency department with complaints of heat exhaustion and weakness.

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

Region 3
Exit Date: 08/29/2024
Purpose of Visit: Standard Survey
Tags: F656/N3784; F689/N4030
Situations: The facility failed to develop a care plan and implement interventions to prevent a resident with documented exit-seeking behaviors from eloping. The facility failed to update the resident's care plan after documented aggression required the transfer of the resident's roommate to another room.

Deficient Practice: The facility failed to develop and implement a comprehensive person-centered care plan for each reside and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 8
Exit Date: 08/29/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent a resident from eloping. The resident eloped from the facility, which remained unaware of the elopement until the local police department informed them the resident had been found nearly a half mile from the facility.

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

Region 5
Exit Date: 08/29/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N3937
Situations: The facility failed to ensure that two staff members assisted a resident with care, as required by their care plan, resulting in the resident falling out of their bed. The facility subsequently failed to document the fall and perform an assessment of the resident, who had abrasions and bruising to their face and back, and for two other residents who had falls that resulted in broken bones.

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

Region 5
Exit Date: 08/29/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F805/N4330
Situations: The facility failed to follow a resident's dietary orders when they were given a whole sandwich, instead of the resident's mechanically altered meal, resulting in the resident choking and dying.

Deficient Practice: The facility failed to ensure food was prepared in a form designed to meet individual needs.

Region 4
Exit Date: 08/29/2024
Purpose of Visit: Complaint 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. The facility failed to ensure staff were trained in proper emergency precautions following such an incident when the staff

member picked the resident up and returned them to their wheelchair prior to any assessment.

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

Region 8
Exit Date: 08/30/2024
Purpose of Visit: Standard Survey
Tags: F684/N3937
Situations: The facility failed to ensure a resident had a timely follow up appointment to have an esophageal stint removed, resulting in the device moving into their stomach. The facility failed to ensure a resident had a timely follow up cardiologist appointment as ordered, resulting in the resident not seeing a cardiologist until they were transferred to a hospital with exacerbated heart health issues.

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

Region 6
Exit Date: 08/30/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F678/N35880; F695/N4003; F755/N4561
Situations: The facility failed to ensure a residents tracheostomy device was properly attached, resulting in the unit becoming dislodged and causing the resident agonal breathing and sending them into cardiac arrest. The facility failed to immediately initiate CPR on the resident, who had a full code status (code status that allows all interventions to restart the heart), when they were found unresponsive. The facility failed to ensure a resident had an order for sliding-scale insulin, resulting in the resident receiving an overdose of the medication, causing critically low blood glucose levels.

Deficient Practice: The facility failed to follow physician orders and the resident's advance directives; failed to ensure a resident who needed respiratory care was provided such care, consistent 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 5
Exit Date: 08/31/2024
Purpose of Visit: Complaint Investigation
Tags: F686/N3949
Situations: The facility failed to reinstate a resident’s pressure ulcer treatment orders when they were readmitted from the hospital, resulting in deterioration of the wounds.

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: 08/31/2024
Purpose of Visit: Standard Survey
Tags: F600/N3481; F607/N3484; F656/N3784
Situations: The facility failed to implement interventions to address a resident's aggressive behaviors, resulting in the resident having physical altercations with two others.

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

Region 5
Exit Date: 09/01/2024
Purpose of Visit: Complaint Investigation
Tags: F600/N3481; F607/N3484
Situations: The facility failed to implement interventions to prevent a resident from being abused by a family member. The facility failed to follow the resident's care plan during visits resulting in allegations of verbal and physical abuse.

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

Region 3
Exit Date: 09/03/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F695/N4003
Situations: The facility failed to assess and treat a resident after they had a change in condition and began to experience shortness of breath. The facility failed to inform a physician and obtain treatment orders. The resident was ultimately transferred to the hospital where they were intubated and subsequently 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 4
Exit Date: 09/04/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F607/N3484
Situations: The facility failed to protect residents from abuse after a staff member allegedly handled a resident roughly during care by allowing the alleged perpetrator to continue providing direct care to residents for seven days before being suspended while the investigation was ongoing.

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

Region 3
Exit Date: 09/04/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3013; F684/N3937; F773/N5059
Situations: The facility failed to assess a resident monitor and evaluate a resident's bowel sounds after they had a related change in condition. The facility failed to assess the resident after changes were noted and failed to provide the resident's medication. The facility failed to inform the resident's physician of ordered lab results, resulting in the resident being transferred to the hospital and diagnosed with sepsis and fecal impaction.

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 promptly notify the physician of laboratory results in accordance with facility policy.

Region 6
Exit Date: 09/05/2024
Purpose of Visit: Incident Investigation
Tags: F760/N4600
Situations: The facility failed to provide a resident their insulin for five days, resulting in the resident developing critically high blood glucose levels requiring hospitalization for diabetic ketoacidosis (a life-threatening complication of diabetes).

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

Region 1
Exit Date: 09/05/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F550/N2908; F600/N3478
Situations: The facility failed to obtain a resident's fully informed consent before performing a catheter procedure at 3:30 in the morning. The facility failed to protect a resident from verbal abuse by a staff member.

Deficient Practice: The facility failed to ensure each resident was treated with respect, dignity, and care in a manner and in an environment that promotes the maintenance or enhancement of their quality of life, recognizing each resident's individuality; and failed to implement policies and procedures to prevent abuse and neglect.

Region 3
Exit Date: 09/06/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4027
Situations: The facility failed to implement effective supervision to prevent a resident from eloping while the alarm on the door into the courtyard was removed. The resident

exited into the courtyard without staff being aware and was found over two hours after they were initially reported missing.

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

Region 8
Exit Date: 09/08/2024
Purpose of Visit: Complaint Investigation
Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent a resident with a history of exit-seeking behaviors from eloping. The resident was gone for over twelve hours before being found at a local hospital.

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

Region 8
Exit Date: 09/09/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F678/N3580
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.

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

Region 4
Exit Date: 09/09/2024
Purpose of Visit: Complaint Investigation
Tags: F684/N3937
Situations: The facility failed to provide wound care to a resident’s lower leg injury, resulting in the wound deteriorating and the resident being hospitalized with a bacterial skin infection.

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

Region 3
Exit Date: 09/10/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement effective supervision to prevent a resident from eloping while construction staff were using a side door. The resident left through the door and was found across a busy highway.

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

Region 4
Exit Date: 09/11/2024
Purpose of Visit: Incident Investigation
Tags: F689/N4030
Situations: The facility failed to properly secure a resident in the mechanical lift during a transfer resulting in the resident falling and sustaining head injuries and a separated shoulder.

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

Region 8
Exit Date: 09/11/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4027
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 sustaining hand and elbow fractures.

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

Region 4
Exit Date: 09/12/2024
Purpose of Visit: Complaint Investigation
Tags: F689/N4030
Situations: The facility failed to implement effective to prevent a resident, who was assessed at high risk for elopement, from eloping. The resident was allowed to sit out in front of the facility unsupervised. The facility was unaware of the elopement until the business next door called to inform them the resident was there.

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

Region 3
Exit Date: 09/12/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement effective interventions to prevent a resident from eloping from the secure unit while the doors were not functioning properly.

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

Region 3
Exit Date: 09/13/2024
Purpose of Visit: Standard Survey

Tags: F600/N3478/N3484
Situations: The facility failed to provide timely transportation to a resident from their offsite appointment, failing to pick up the resident for over four hours after the end of their appointment. The facility failed to ensure another resident made it to their appointment on time on two occasions.

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

Region 3
Exit Date: 09/14/2024
Purpose of Visit: Complaint Investigation
Tags: F698/N4012
Situations: The facility failed to follow a resident's follow up orders to take a resident to the hospital for further treatment following a dialysis appointment and failed to regularly assess the resident's vital signs.

Deficient Practice: The facility failed to ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Region 3
Exit Date: 09/17/2024
Purpose of Visit: Complaint Investigation
Tags: F697/N4009; F726/N4063
Situations: The facility failed to provide a resident with their pain medication, which included a device for self-administration, and failed to perform pain assessments on the resident as required by their care plan.

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; and failed to ensure staff were competent and trained in their job responsibilities.

Region 3
Exit Date: 09/18/2024
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 femur.

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

Region 5
Exit Date: 09/19/2024
Purpose of Visit: Complaint Investigation

Tags: F689/N4030
Situations: The facility failed to implement interventions to prevent two residents from falling when they had multiple falls in a short span of time. The facility failed to provide better supervision and, for one resident, failed to follow an order for a helmet.

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

Region 5
Exit Date: 09/19/2024
Purpose of Visit: Complaint Investigation
Tags: F678/N3580; F842/N5125
Situations: The facility failed to update a resident's medical record to indicate their change from a do-not-resuscitate (DNR) status to a full code status full code status (code status that allows all interventions to restart the heart), resulting in the resident not receiving CPR when they were found unresponsive.

Deficient Practice: The facility failed to follow physician orders and the resident's advance directives and failed to ensure that medical records were accurately documented.

Region 3
Exit Date: 09/19/2024
Purpose of Visit: Complaint Investigation
Tags: F686/N3946
Situations: The facility failed to effectively treat a resident's pressure ulcer resulting in it deteriorating and 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.

Region 1
Exit Date: 09/20/2024
Purpose of Visit: Complaint Investigations
Tags: F684/N3937
Situations: The facility failed to assess and treat two residents' surgical wounds, resulting in the residents' bandages not being changed until their follow-up thirteen and eighteen days later.

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

Region 8
Exit Date: 09/20/2024
Purpose of Visit: Complaint Investigation
Tags: F580/N3016; F686/N3946

Situations: The facility failed to prevent a resident from developing pressure ulcers and, following their development, failed to obtain orders for and provide treatment, resulting in the wounds deteriorating.

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 11
Exit Date: 09/20/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to implement effective interventions to prevent a resident from eloping. The resident remained missing until the local police department found them two miles from the facility.

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

Region 11
Exit Date: 09/20/2024
Purpose of Visit: Standard Survey
Tags: F580/N3013; F777/N5080
Situations: The facility failed to inform a resident's physician of their radiology report that indicated neck fractures for over four days after the resident had the fall expected to have resulted in the injuries.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition and failed to promptly notify the ordering physician of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner.

Region 4
Exit Date: 09/20/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3481; F607/N3484
Situations: The facility failed to protect a resident from abuse when a staff member caused an abrasion on their chest during a shower by scrubbing too hard. The facility allowed the staff member to continue providing care to the resident after the incident.

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

Region 6
Exit Date: 09/23/2024
Purpose of Visit: Complaint Investigation
Tags: F656/N3808; F689/N4030

Situations: The facility failed to update a resident's care plan and implement interventions, including lowering their bed to its lowest position, after the resident had multiple falls.

Deficient Practice: The facility failed to develop and implement a comprehensive person-centered care plan for each resident and failed to ensure adequate supervision and assistive devices were provided to prevent accidents.

Region 6
Exit Date: 09/24/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F580/N3013; F689/N4030; F776/N5068
Situations: The facility failed to ensure a resident was provided with adequate assistance while being assisted with a transfer, resulting in the resident falling and sustaining a broken arm and knee. The facility failed to inform the resident's physician of the fall and obtain x-rays in a timely manner.

Deficient Practice: The facility failed to consult with the physician regarding a change in condition, failed to ensure adequate supervision and assistance devices were provided to prevent accidents, and failed to provide radiology or other diagnostic services to meet the needs of its residents in a timely manner.

Region 4
Exit Date: 09/25/2024
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.

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

Region 5
Exit Date: 09/25/2024
Purpose of Visit: Standard Survey
Tags: F600/N3481
Situations: The facility failed to protect a resident from abuse by a family member with a suspected history of abuse. The resident was shouted at and forcefully fed despite their protests.

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

Region 6
Exit Date: 09/25/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478

Situations: The facility failed to protect a resident from abuse by a staff member when the staff member forcefully pushed the resident's wheelchair away and berated them after they unintentionally bumped into the staff member.

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

Region 4
Exit Date: 09/26/2024
Purpose of Visit: Standard Survey
Tags: F689/N4030
Situations: The facility failed to implement effective interventions to prevent a resident from eloping. The resident left through a side door where no staff were near enough to hear the alarm in a timely manner.

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

Region 6
Exit Date: 06/17/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030
Situations: The facility failed to ensure a resident was not left unattended in the facility courtyard. The resident scaled the fence and eloped from the facility.

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

Region 5
Exit Date: 09/27/2024
Purpose of Visit: Standard Survey
Tags: F678/N5548
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 with no pulse or respirations.

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

Region 6
Exit Date: 09/27/2024
Purpose of Visit: Standard Survey
Tags: F694/N400; F726/N4063
Situations: The facility failed to ensure all staff were properly trained in medication administration. A staff member was observed providing intravenous medications without removing air from tubing and syringes.

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 and failed to ensure staff were competent and trained in their job responsibilities.

Region 8
Exit Date: 09/28/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N4030; F805/N4330
Situations: The facility failed to ensure a resident received their food in the prescribed form, providing a regular textured meal instead of pureed. The facility failed to implement effective intervention to prevent a resident from eloping.

Deficient Practice: The facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents and failed to ensure provided food was prepared in the proper form to meet residents' needs.

Region 6
Exit Date: 09/30/2024
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N3478/N3481; F725/N4069
Situations: The facility failed to implement effective interventions to prevent resident-on-resident abuse, resulting in altercations that lead to a head injury and facial lacerations. The facility failed to ensure enough staff to supervise residents.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect and failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.