Quarterly IJ Summary Report
July 2017 – September 2017

The following report presents quantitative and qualitative information regarding all tags cited at the Immediate Jeopardy (IJ) level during licensing surveys and complaint or incident investigations performed in nursing facilities during the third quarter of 2017 (07/01/2017 – 09/30/2017).

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

During this period, an IJ level tag was cited for thirty-five of the surveys and investigations conducted, resulting in 117 citations of nineteen 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):

Table 1

F-Tag	% Cited*	F-Tag	% Cited*
151	0.85%	224	20.51%
155	1.71%	226	19.66%
157	3.42%	323	12.82%
223	6.84%	309	11.97%
224	20.51%	223	6.84%
225	0.85%	490	5.98%
226	19.66%	281	5.13%
279	1.71%	157	3.42%
281	5.13%	333	2.56%
282	0.85%	155	1.71%
309	11.97%	279	1.71%
314	1.71%	314	1.71%
323	12.82%	151	0.85%
328	0.85%	225	0.85%
333	2.56%	282	0.85%
360	0.85%	328	0.85%
441	0.85%	360	0.85%
490	5.98%	441	0.85%
501	0.85%	501	0.85%

*Rounded to nearest tenth

Table 2

Region	# of IJs	# of NFs	% of IJs/NF
1	1	77	1.30%
2/9/10	9	140	6.43%
3	13	290	4.48%
4/5	5	175	2.86%
6	2	186	1.08%
7	1	155	0.65%
8/11	4	255	1.57%
Total	35	1278	2.74%

Table 3
Number of IJs

from Complaints	from Incidents	from Surveys	Total
19	10	6	35

Tag References

Resident Rights:
151 Exercise of rights
155 Right to refuse treatment
157 Notification of changes

Resident Behavior & Facility Practice:
223 Abuse
224 Mistreatment, Neglect, Misappropriation
225 Investigate and report allegations and terminate staff involved in Mistreatment, Abuse or Neglect
226 Facility Policies & Procedures for Abuse/Neglect/Mistreatment

Resident Assessment:
279 Comprehensive Care Plans
281 Services meet professional Standards
282 Services by Qualified Professionals

Quality of Care:
309 Care provided attains/maintains highest practicable well-being
314 Pressure Ulcers
323 Free of and supervised for accident hazards
328 Special Needs / Specialized Services
333 Free of significant medication errors

Dietary Services:
360 Dietary Services

Infection Control:

441   Infection Control Program

Administration:

490   Administration

501   Medical Director

Acronyms

AED – Automatic External Defibrillator

CPR – Cardiopulmonary Resuscitation

ICU – Intensive Care Unit

LAR – Legally Authorized Representative

TEXAS
Health and Human
Services

Region 4/5
Exit Date: 07/03/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F224/N983; F323/N1131
Issues: The facility failed to implement interventions for a resident who had a history of falls. Due to this failure, the resident continued to experience falls, several of which resulted in injuries to the head.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, and failed to provide adequate supervision to prevent accidents.

Region 3
Exit Date: 07/07/2017
Purpose of Visit: Incident Investigation
Tags: F224/N983; F226/N984; F323/N1131
Issues: The facility failed to prevent a resident from eloping after the resident had identified the desire to leave the facility. The resident eloped and was found a mile away from the facility. The facility failed to effectively train employees to notify staff of and monitor residents at risk for elopement.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, and failed to provide adequate supervision to prevent accidents.

Region 3
Exit Date: 07/12/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F323/N1131
Issues: The facility failed to ensure a resident identified with exit seeking behaviors received effective supervision to prevent elopement from the facility, and that the WanderGuard system in the facility was properly functioning. The resident eloped from the facility and was found near a busy highway by the police.

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

Region 7
Exit Date: 07/13/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F224/N983; F323
Issues: The facility failed to ensure a resident with a history of elopement received effective supervision to prevent further incidents. The resident eloped and spent more than eight hours overnight outside the facility.

Deficient Practice: The facility failed to implement policies and procedures to prohibit neglect, and failed to provide adequate supervision to prevent accidents.

Region 2/9/10
Exit Date: 07/14/2017
Purpose of Visit: Incident Investigation
Tags: F309/N1114
Issues: The facility did not effectively assess and respond when a resident was reported to be in their room, limp, with one eye open and one closed. The resident was left with no further assessment for over two hours before receiving CPR for twenty minutes prior to a pronunciation of death.

Deficient Practice: The facility failed to attain or maintain the residents' highest possible well-being.

Region 3
Exit Date: 07/14/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F333/N1140
Issues: The facility failed to administer a prescribed anticoagulant to a resident after the resident was admitted to the facility from the hospital. The failure continued for ten days and the resident was sent to the hospital and diagnosed with blood clots to the lower extremities.

Deficient Practice: The facility failed to ensure that residents were free from significant medication errors.

Region 4/5
Exit Date: 07/16/2017
Purpose of Visit: Complaint Investigation
Tags: F224/N983; F323/N1130
Issues: The facility did not remove hazardous chemicals from a resident's room which the resident was seen rubbing it into their eyes. The facility failed to alert the oncoming shift of the incident resulting in a delay of physician notification and care. The resultant injury rendered the resident with the ability to see only colors and shapes, without detail.

Deficient Practice: The facility failed to implement policies and procedures to prohibit neglect, and failed to provide adequate supervision to prevent accidents.

Region 3
Exit Date: 07/20/2017
Purpose of Visit: Complaint Investigation
Tags: F224/N983; F226/N984; F328/N1135; F490/N1412
Issues: The facility did not ensure that two residents were provided with resuscitation devices and emergency tracheotomy supplies, and failed to accurately document the accessibility of such devices.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, and failed to ensure that respiratory care services provided by the facility met

professional standards of practice. Facility administration failed to ensure effective use of resources.

Region 3
Exit Date: 07/21/2017
Purpose of Visit: Standard Survey
Tags: F223/F226/N983; F323/N1131
Issues: The facility did not ensure that a resident received proper supervision and failed to implement precautionary procedures to prevent the resident from eloping from the facility. The resident eloped three times within three months.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, and failed to provide adequate supervision to prevent accidents.

Region 3
Exit Date: 07/27/2017
Purpose of Visit: Complaint Investigation
Tags: F224/F226/N983; F309/N1114
Issues: The facility failed to accurately assess and treat the diabetic wounds of two residents. Both residents developed wounds to their toes. One resident developed gangrene and osteomyelitis (bone infection), resulting in amputation of one of the resident's toes. The second resident developed a toe infection, osteomyelitis, and the tip of the resident's third toe fell off.

Deficient Practice: The facility failed to implement policies to prevent neglect, and failed to provide services to attain or maintain the residents' highest possible well-being.

Region 4/5
Exit Date: 07/28/2017
Purpose of Visit: Standard Survey
Tags: F224/N983; F323/N1131
Issues: The facility did not secure a resident in a wheelchair during transportation. The van made a sudden stop causing the resident to fall out of the wheelchair and sustain a broken leg.

Deficient Practice: The facility failed to implement policies to prevent neglect, and failed to provide adequate supervision to prevent accidents.

Region 3
Exit Date: 07/31/2017
Purpose of Visit: Incident Investigation
Tags: F224/F226/N983; F281/N1087; F309/N1114
Issues: The facility failed to assess a resident who was reported to be lethargic and unable to get up to eat during lunch. The resident was later found unresponsive, without a pulse, and the facility did not initiate CPR for ten minutes. The resident was transported to the hospital where they died.

Deficient Practice: The facility failed to implement policies to prevent neglect, failed to provide services which met professional standards of quality, and failed to provide services to attain or maintain the residents' highest possible well-being.

Region 2/9/10
Exit Date: 07/31/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F157/N837/N838; F224/N984; F226/N983; F309/N1105
Issues: For one resident, the facility received orders for a stat lab and urinary analysis after informing a physician that the resident seemed unwell and out of character, but the facility failed to notify the physician that the tests could not be done for over five hours. The lab results were not received by the facility until late morning of the following day, prompting the facility to transfer the resident to the hospital where the resident died. Another resident reported that they had fallen four days prior and did not want to get out of bed due to pain to the right leg during movement, and cramping to the right thigh. A physician ordered a venous ultrasound, but the facility failed to inform the physician that the test could not be done on weekends. The following day, the facility failed to inform the physician that the resident had increased swelling and pain, and that they continued to have difficulty scheduling the ordered test. Another physician ordered that an x-ray be taken of the leg and it was determined that the resident had sustained a fracture to the femur and the resident was transferred to the hospital.

Deficient Practice: The facility failed to notify and consult with a physician or family/LAR of changes in condition, failed to implement policies and procedures to prevent neglect, and failed to provide services to attain or maintain the residents' highest possible well-being.

Region 1
Exit Date: 08/07/2017
Purpose of Visit: Standard Survey
Tags: F224/N983; F226/N984; F323/N1131
Issues: The facility failed to put interventions into place and to provide adequate supervision on the memory unit to prevent residents from falling. Two residents in the unit experienced falls. One resident sustained a dislocated shoulder, fractured rib, head lacerations and bruises. The other resident sustained bruises and lacerations. The facility failed to update the residents' care plans to address the incidents and prevent future accidents.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, and failed to provide adequate supervision to prevent accidents.

Region 8/11
Exit Date: 08/07/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F224/N983; F226/N993; F309/N1114; F441/N1343

Issues: The facility did not administer scabies treatment medication to seven patients as ordered, resulting in deep tissue injuries for one patient due to scratching. The facility failed to follow procedures to prevent the spread of infection, and did not report the scabies outbreak, effecting sixteen residents over five months, to Health and Human Services.
Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to provide services to attain or maintain the residents' highest possible well-being, and failed to establish and maintain an infection control program that provided a safe environment to prevent the development and transmission of disease and infection.

Region 3 **Exit Date:** 08/08/2017 **Purpose of Visit:** Complaint Investigation **Tags**: F155/N827; F224/N226/N983; F281/N1087; F309/N1114 **Issues**: When a resident was found unresponsive and without a pulse, the facility failed to suction the resident's tracheotomy tube to ensure there was no occlusion, failed to affix the resuscitation bag to the tracheotomy collar rather than the mouth, and failed to immediately utilize the AED. The resident died at the facility.
Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to provide services which met professional standards of quality, and failed to provide services to attain or maintain the residents' highest possible well-being.

Region 3 **Exit Date**: 08/12/2017 **Purpose of Visit**: Incident Investigation **Tags**: F309/N1114; F360/N1192 **Issues**: The facility failed to ensure dietary accommodations were met when a resident was served shellfish, which was a documented food allergy. The resident developed an allergic reaction requiring hospitalization.
Deficient Practice: The facility failed to provide services to attain or maintain the residents' highest possible well-being, and failed to provide each resident with a diet that met his or her daily nutritional and special dietary needs.

Region 2/9/10 **Exit Date**: 08/14/2017 **Purpose of Visit**: Incident Investigation **Tags**: F224/F226/N983; F323/N1131 **Issues**: The facility failed to assess the WanderGuard system's functionality to ensure residents at risk for elopement could not elope. One resident in a wheelchair eloped from the facility and was found on the ground about a half-mile from the facility by a passerby. The facility was unaware of the elopement until the police department called to ask if they were missing a resident. During the investigation, two other residents with

WanderGuard bracelets were reviewed to determine the systems functionality. One of the residents did not have their bracelet on and the other did not activate the system.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, and failed to ensure each resident received adequate supervision and assistive devices to prevent accidents.

Region 6
Exit Date: 07/16/2017
Purpose of Visit: Standard Survey
Tags: F151/N893; F223/N982; F224/N983; F226/N984; F309/N1114; F490/N1412
Issues: The facility failed to ensure that three residents received effective treatment for pain, one of whom had a fractured femur. One of the residents was threatened by two members of staff who claimed that the resident would be discharged if any more requests for pain medication were made. For the resident with the fractured femur, the facility failed to thoroughly investigate and report the cause of the incident and document findings of alleged neglect.

Deficient Practice: The facility failed to ensure residents could exercise their rights without interference, coercion, discrimination or reprisal; failed to implement policies and procedures to prevent neglect; and failed to provide services to attain or maintain the residents' highest possible well-being. Facility administration failed to ensure effective use of resources.

Region 4/5
Exit Date: 08/17/2017
Purpose of Visit: Incident Investigation
Tags: F157/N838; F224/N984; F309/N1114
Issues: A resident with diabetes had blood glucose levels measured at greater than 450 (normal levels should be below 180, post-meal, for diabetics) multiple times over the course of a month. The facility failed to clarify physician orders for treatment, failed to obtain orders for sliding scale insulin administration to respond to elevated blood glucose levels, and failed to keep the physician informed of continued elevated levels. The resident was found to have a blood glucose level of 600 in the middle of the night, and was pale and lethargic. The resident died an hour after these assessments.

Deficient Practice: The facility failed to consult with the physician when a change of condition occurred, failed to implement policies and procedures to prevent abuse and neglect, and failed to provide services to attain or maintain the residents' highest possible well-being.

Region 8/11
Exit Date: 08/17/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F223/N982; F224/N983; F226/N984; F279/N1077; F281/N1087; F490/N1412; F501/N1437

Issues: The facility failed to ensure that a resident, who was a known sex-offender, received adequate supervision to prevent the perpetration of any sexual offenses. The facility failed to properly assess the dangers when the resident was found in another resident's room, twice, and failed to put interventions in place to protect the latter resident, who was raped by the offender two nights after the facility was made aware of the offender's visits to the room. The victim reacted by withdrawing into the fetal position while clutching tightly to the bedsheets. The facility failed to have care plans that addressed four other residents who were registered sex offenders, putting other facility residents in danger.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect, failed to develop and implement a comprehensive person-centered care plan to meet the residents' needs, and failed to provide services which met professional standards of quality. Facility administration failed to ensure effective use of resources and to implement resident care policies and coordinate medical care in the facility.

Region 2/9/10
Exit Date: 08/18/2017
Purpose of Visit: Incident Investigation
Tags: F223/F226/N983; F323/N1131
Issues: The facility did not put interventions into place to mitigate violence between two residents with a history of altercations. The facility did not provide supervision in the dining room when the residents were together, allowing them to engage in a physical altercation, resulting in a fractured hip for one of the residents.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, and failed to ensure each resident received adequate supervision to prevent accidents.

Region 2/9/10
Exit Date: 08/21/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F224/N983; F225/N989/N990; F226/N984
Issues: The facility failed to protect a resident from abuse when the resident was forced to take medicine by having their nose held closed, was forced into the shower while upset, agitated, and combative, and had a washcloth held over their nose. The facility failed to effectively investigate the incident and did not suspend the offending staff member, allowing them to continue working in direct contact with residents.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, and failed to ensure incidents of abuse and neglect were thoroughly investigated and reported.

Region 2/9/10
Exit Date: 08/22/2017
Purpose of Visit: Complaint/Incident Investigation

Tags: F223/F226/N983; F323/N1131
Issues: The facility failed to ensure effective supervision to prevent elopement. A resident exited out of the unsecured front door, which was equipped with a WanderGuard, and traveled almost two miles from the facility, along a busy road, crossing multiple intersections. The resident was found by the police department confused and sweating heavily. The facility remained unaware of the resident's elopement for almost three hours.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, and failed to ensure each resident received adequate supervision and assistive devices to prevent accidents.

Region 6
Exit Date: 08/22/2017
Purpose of Visit: Complaint Investigation
Tags: F157/N836; F224/N983; F281/N1087; F309/N1114; F490/N1415
Issues: The facility did not assess and consult with a physician when a resident with a catheter complained of pain to the genitals. The resident was later sent to the hospital for respiratory issues where it was discovered the resident had a severe cut and open wound on the genitals. Another resident experienced low oxygen saturation levels, was not effectively assessed, and the physician was not consulted on the change in condition. The facility continued in this failure for over four hours when emergency services were contacted and the resident was sent to the hospital where they died.

Deficient Practice: The facility failed to consult with the physician when a change of condition occurred, failed to implement policies and procedures to prohibit neglect, failed to provide services which met professional standards of quality, and failed to provide services to attain or maintain the residents' highest possible well-being. Facility administration failed to ensure effective use of resources.

Region 2/9/10
Exit Date: 08/23/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F323/N1131
Issues: The facility failed to ensure effective supervision to prevent elopement for a resident assessed as at-risk for wandering. The resident went out the unattended front entrance and crossed over a bridge and a heavily trafficked, five-lane intersection. The facility remained unaware of the elopement until they were notified by staff at a local school.

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

Region 3
Exit Date: 08/23/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F223/F226/N983; F309/N1114

Issues: The facility failed to immediately transfer a resident to the hospital when the resident showed symptoms of a stroke. The resident was sent to the hospital where they were diagnosed with a stroke, but the hospital was unable to administer medication due to the severity of the symptoms.

Deficient Practice: The facility failed to implement policies and procedures to prohibit neglect, and failed to provide services to attain or maintain the residents' highest possible well-being.

Region 2/9/10
Exit Date: 09/06/2017
Purpose of Visit: Incident Investigation
Tags: F309/N1114; F333/N1140
Issues: The facility did not hold a resident's insulin medication, per physician orders, when the resident presented a blood glucose level of sixty-two (healthy, fasted blood glucose levels should be between seventy and one hundred). The facility also failed to monitor the resident's blood glucose levels every half-hour, per physician orders. The resident was found unresponsive and CPR was initiated, but the resident died in the facility. The facility failed to contact the physician for four other residents to obtain orders regarding blood glucose checks, parameters, and treatment options in the event of a change in condition.

Deficient Practice: The facility failed to provide services to attain or maintain the residents' highest possible well-being, and failed to ensure that residents were free from significant medication errors.

Region 3
Exit Date: 09/15/2017
Purpose of Visit: Intake Investigation
Tags: F224/F226/N983; F323/N1131
Issues: The facility failed to implement effective interventions to address a resident's wandering and entering other resident's rooms. The resident entered two others' rooms, resulting in the others physically assaulting the former, entered a room and drank the saliva and mucous sample of a resident being monitored for communicable diseases, and entered the conference room and drank an old cup of tea with a napkin floating inside.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, and failed to provide adequate supervision to prevent accidents.

Region 4/5
Exit Date: 09/21/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F224/N983; F323/N1131
Issues: The facility did not protect others from three residents with a history of aggression. One of the residents attacked another, resulting in a subdural hematoma in the victim, requiring hospitalization in the ICU. Another offending resident attacked

three residents, choking one, resulting in bruising around the neck and face. A third offending resident attacked others by grabbing their arms, pulling their hair, trying to pull them off the commode, and punching them in the face.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect and abuse, and failed to provide adequate supervision to prevent accidents.

Region 2/9/10
Exit Date: 09/22/2017
Purpose of Visit: Standard Survey
Tags: F314/N1121
Issues: The facility failed to effectively treat a resident's pressure ulcer. The facility did not initiate a care plan for the ulcer, failed to inform the physician that an organism within the ulcer appeared to be resistant to the prescribed antibiotics, failed to inform the wound care nurse that the dressing around the ulcer came off and needed to be replaced, and failed to use pressure relieving devices for the resident.

Deficient Practice: The facility failed to ensure that residents having pressure ulcers received necessary treatment and services to promote healing.

Region 8/11
Exit Date: 09/26/2017
Purpose of Visit: Incident Investigation
Tags: F223/N983; F226/N982; F279/N1077/N1080; F323/N1130; F490/N1412
Issues: The facility failed to implement interventions to prevent chronic issues with residents falling. One resident fell fourteen times over a nine month period, ultimately resulting in a laceration to the head and hospitalization. Another resident fell nineteen times over a four month period, eventually resulting in a hip fracture. Another resident fell and was not properly assessed. Four days later the resident was diagnosed with a fracture. The facility failed to implement interventions for a resident with a pressure ulcer, failed to provide a resident who was unable to drink independently with an assistive drinking device, and failed to implement the care plan of a resident who smoked by not collecting their cigarettes and lighter, endangering the occupants of the facility.

Deficient Practice: The facility failed to implement policies and procedures to prohibit neglect, failed to develop and implement a comprehensive person-centered care plan to meet the residents' needs, and failed to provide adequate supervision to prevent accidents. Facility administration failed to ensure effective use of resources.

Region 8/11
Exit Date: 09/28/2017
Purpose of Visit: Complaint Investigation
Tags: F157/N837; F224/N983; F226/N984; F282/N1088; F314/N1120/N1121; F490/N1415

Issues: The facility failed to ensure that residents' pressure ulcers were effectively treated. One resident entered the facility with two pressure ulcers and developed an additional thirty-seven separate ulcers. On one occasion, the facility left ulcers uncovered and untreated for over three hours. Another resident was admitted into the facility with pressure ulcers and the facility did not obtain orders for treatment resulting in deterioration of the wounds, a foul odor, and necrosis (death of tissue). The facility had conflicting documentation of the condition of both residents' ulcers.
Deficient Practice: The facility failed to notify and consult with a physician or family/LAR of changes in condition, failed to implement policies and procedures to prohibit neglect, failed to follow and provide services in accordance with the care plan, failed to ensure that residents having pressure ulcers received necessary treatment and services to promote healing. Facility administration failed to ensure effective use of resources.

Region 3 **Exit Date**: 09/29/2017 **Purpose of Visit**: Complaint/Incident Investigation **Tags**: F155/N827; F224/F226/N983; F281/N1087; F309/N1114 **Issues**: The facility failed to immediately initiate CPR and utilize the AED when a resident was found to have no pulse or respirations. The resident was left alone in the room as assistance was sought and CPR was not initiated until the paramedics arrived. The resident died at the facility.
Deficient Practice: The facility failed to provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency care medical personnel; failed to implement policies and procedures to prohibit neglect; failed to provide services which met professional standards of quality; and failed to attain or maintain the residents' highest possible well-being.

Region 3 **Exit Date**: 09/30/2017 **Purpose of Visit**: Standard Survey **Tags**: F224/N226/N983; F309/N1114; F333/N1140 **Issues**: The facility incorrectly administered a resident's blood glucose medication, resulting in the resident's blood glucose levels dropping below normal parameters. The facility failed to properly transcribe the physician's orders to treat the resident and failed to notify the physician when they were unable to stabilize the resident, requiring a transfer to the hospital.
Deficient Practice: The facility failed to implement policies and procedures to prohibit neglect, failed to provide services to attain or maintain the residents' highest possible well-being, and failed to ensure that residents were free from significant medication errors.