Quarterly IJ Summary Report
January 2017 – March 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 first quarter of 2017 (01/01/2017 – 03/31/2017).

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 132 citations of twenty-seven 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*
155	0.76%	0226	18.94%
157	6.82%	223	17.42%
166	0.76%	309	9.09%
223	17.42%	490	7.58%
225	1.52%	157	6.82%
226	18.94%	323	5.30%
279	1.52%	425	3.79%
280	1.52%	281	3.03%
281	3.03%	333	3.03%
282	2.27%	282	2.27%
309	9.09%	314	2.27%
314	2.27%	353	2.27%
322	0.76%	505	2.27%
323	5.30%	520	2.27%
325	0.76%	225	1.52%
328	1.52%	279	1.52%
333	3.03%	280	1.52%
353	2.27%	328	1.52%
367	0.76%	441	1.52%
385	0.76%	155	0.76%
425	3.79%	166	0.76%
441	1.52%	322	0.76%
490	7.58%	325	0.76%
501	0.76%	367	0.76%
505	2.27%	385	0.76%
518	0.76%	501	0.76%
520	2.27%	518	0.76%

*Rounded to nearest tenth

Table 2

Region	# of IJs	# of NFs	% of IJs/NF
1	0	78	0.00%
2/9/10	5	137	3.65%
3	10	287	3.48%
4/5	8	176	4.55%
6	4	183	2.19%
7	3	154	1.95%
8/11	5	257	1.95%
Total	35	1272	2.75%

Table 3
Number of IJs

from Complaints	from Incidents	from Surveys	Total*
24	3	6	33

*Two surveys were conducted by CMS contract staff and are not represented in this table.

Tag References

Resident Rights:
155 Right to refuse treatment
157 Notification of changes
166 Resolve Grievances

Resident Behavior & Facility Practice:
223 Abuse
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
280 Participation in Care Planning
281 Services provided meet professional standards of quality
282 Services by Qualified Professionals

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

Nursing Services:
353 Sufficient Nursing Staff

Dietary Services:
367 Therapeutic Diets

Physician Services:
385 Physician Services & Supervision

Pharmacy Services:

425 Pharmacy Services

Infection Control:

441 Infection Control Program

Administration:

490 Administration
501 Medical Director
505 Promptly Notify Doctor of Lab Findings
518 Training for Emergency Preparedness
520 Quality Assessment & Assurance

Acronyms

AED – Automatic External Defibrillator
CDC – Centers for Disease Control
CPR – Cardiopulmonary Resuscitation
DADS – Department of Aging and Disability Services
DNR – Do Not Resuscitate
DON – Director of Nurses
ICU – Intensive Care Unit
LAR – Legally Authorized Representative
NFA – Nursing Facility Administrator
NP – Nurse Practitioner
QAA – Quality Assessment & Assurance
QAP – Quality Assurance Program

Purpose of Visit: Complaint Investigation
Tags: F155/N827; F223/F226/N983
Issues: For two residents found unresponsive, the facility failed to initiate CPR per physician orders and residents' preferences, resulting in the death of both residents. The facility did not have a sufficient system in place to identify the code status of each resident.

Deficient Practice: The facility failed to provide basic life support, including CPR, to residents requiring such emergency care prior to the arrival of emergency medical personnel, and failed to implement policies to prevent neglect.

Region 8/11
Exit Date: 01/05/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F223/N982; F226/N984; F323/N1130
Issues: The facility failed to ensure that certified staff were present during resident care. One resident was left in the unsupervised care of an unlicensed staff member who attempted to transfer the resident, though the resident required two people during transfers. The resident fell out of the bed during the attempted transfer and sustained a fracture to the femur.

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: 01/13/2017
Purpose of Visit: Complaint Investigation
Tags: F223/F226/N983; F309/N1005
Issues: The facility did not properly assess and provide treatment for a resident who complained of excruciating pain and was exhibiting signs and symptoms of a gastrointestinal bleed. After surveyor intervention, the resident was transferred to the hospital where they were diagnosed with a gastrointestinal bleed and a urinary tract infection. The resident required a blood transfusion and was placed in the ICU.

Deficient Practice: The facility 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 6
Exit Date: 01/14/2017
Purpose of Visit: Standard Survey
Tags: F226/N983; F282/N1088; F367/N1221; F490/N1412
Issues: The facility failed to provide pureed diets for four residents with dysphagia (difficulty swallowing) per physician orders. The NFA failed to monitor food and nutrition services and failed to ensure dietary staff prepared and served meals in accordance with physician directives.

Deficient Practice: The facility failed to implement policies and procedures to prohibit neglect, failed to provide services in accordance with each resident's written plan of care, and failed to provide a diet as prescribed by residents' physicians. Facility administration failed to ensure effective use of resources.

Region 3
Exit Date: 01/17/2017
Purpose of Visit: Incident Investigation
Tags: F223/F226/N983 F281/N1087; F309/N1114
Issues: The facility failed to properly assess and provide care for a resident who fell and sustained a hematoma to the forehead. The resident was not transferred to the hospital for over two hours. The resident was diagnosed at the hospital with a subdural hematoma (hemorrhage) and was admitted to the ICU where the resident later died.

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

Region 2/9/10
Exit Date: 01/20/2017
Purpose of Visit: Standard Survey
Tags: F223/N226/N983
Issues: The facility failed to ensure a resident was free from neglect when a staff member with a history of seizures was allowed to provide sensitive care to the resident. The staff member had a seizure while providing catheter care to a resident and pulled the catheter out with the bulb inflated as the staff member fell. The resident experienced extreme pain and bleeding and was transferred to the hospital. The resident now requires a urologist to remove and replace the catheter monthly and experiences anxiety when staff performs catheter care. The facility failed to report the incident to DADS and failed to investigate, resulting in the staff members continued care of residents.

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

Region 6
Exit Date: 01/20/2017
Purpose of Visit: Complaint Investigation
Tags: F157/N837; F223/N982; F490/N1412; F505/N1444
Issues: The facility failed to consult with a resident's physician when the resident had critical lab values on two separate occasions. They also failed to notify the physician when the resident refused to allow urine collection for a urinalysis, and did not follow-up with additional attempts to collect. The resident was transferred to the hospital with a fever and was diagnosed with severe dehydration, urinary tract infection, and hypernatremia (a high concentration of sodium ions in the blood).

Deficient Practice: The facility failed to notify and consult with a physician or family/LAR of changes in condition, failed to implement policies to prevent neglect, and failed to promptly notify the ordering physician or nurse practitioner of laboratory results that fell outside of the clinical reference ranges. Facility administration failed to ensure effective use of resources.

Region 8/11
Exit Date: 01/21/2017
Purpose of Visit: Complaint Investigation
Tags: F223/N983; F226/N984; F309/N1114
Issues: The facility failed to assess and consult with a physician when a resident complained of feeling unwell and difficulty breathing for approximately two hours. The resident subsequently lost consciousness and the facility failed to initiate CPR. The resident was transferred to the hospital via EMS where they were pronounced dead.

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

Region 7
Exit Date: 01/25/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F223/N226/N983
Issues: The facility left a resident with dysphagia (difficulty swallowing) unsupervised during a meal. The resident overfilled their mouth and was found unresponsive. The facility initiated CPR and transferred the resident to the hospital.

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

Region 2/9/10
Exit Date: 01/27/2017
Purpose of Visit: Complaint Investigation
Tags: F223/F226/N983; F323/N1130
Issues: A resident was given a full cup of hot coffee and the resident spilled the coffee, sustaining second degree burns to the abdomen and left thigh, and was hospitalized for treatment. The resident remained in the hospital for eleven days. After the incident, the facility failed to train staff to monitor coffee temperatures and allowed residents to self-serve coffee in the dining room.

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

Region 3
Exit Date: 02/01/2017
Purpose of Visit: Complaint Investigation
Tags: F223/N983; F226/N990; F441/N1343/N1350; F490/N1412
Issues: The facility failed to initialize assessments of residents exposed to mumps by multiple staff members. The facility did not have an effective, comprehensive infection control policy in place to prevent, identify, report, investigate, and control infectious illnesses. The NFA and DON failed to ensure that policies and procedures were followed to protect residents and prevent the exposure to and spread of infection.

Deficient Practice: The facility failed to implement policies to prevent neglect, 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. Facility administration failed to ensure effective use of resources.

Region 2/9/10
Exit Date: 02/02/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F157/N838; F223/N226/N983; F322/N1129; F325/N1132
Issues: The facility failed to administer enteral nutrition (food received through a tube) to a resident, who received up to fifty percent of their caloric requirements in this manner, for twelve days. Records indicated that when the resident was given enteral nutrition the amount was incorrect or the feeding pump was not functioning properly. For another resident who had experienced a weight loss of twenty-two percent in thirty days, the facility failed to follow the dietician's recommendations to address the weight loss. The facility failed to evaluate and address a fifteen percent weight loss in thirty days for another resident. The facility failed to notify a resident's physician when the resident did not complete an antibiotic therapy for a UTI due to refusal of the medications, refused meals, and displayed verbal and physical aggression with increased frequency.

Deficient Practice: The facility failed to notify and consult with a physician or family/LAR of changes in condition, failed to implement policies to prevent neglect, failed to ensure appropriate treatment and services were provided to prevent complications of enteral feedings, and failed to maintain acceptable parameters of nutritional status.

Region 7
Exit Date: 02/03/2017
Purpose of Visit: Complaint Investigation
Tags: F223/F226/N983; F333/N1140; F425/N1294
Issues: The facility failed to ensure that multiple residents received their required medications. Many of the medications were found to be unavailable in the facility for long periods of time. One resident did not receive medications for a prostate condition that restricts urine flow for thirty-one days and was hospitalized with severe sepsis (the body's aggressive response to infection that includes, among other symptoms, organ failure) and urinary retention. One

resident did not receive antibiotics to treat pneumonia and antibiotic eye drops for an eye infection, resulting in the resident's degrading condition and hospitalization. Four residents did not receive their blood-pressure regulating medications, one of whom also missed their medications for cardiac disease and depression. One resident with a diagnosis of congestive heart failure did not receive their diuretic for fourteen days. Records indicate that the DON was made aware of the unavailability of many of these medications and failed to take appropriate action.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to ensure that residents were free from significant medication errors, and failed to provide pharmaceutical services to meet the needs of each resident.

Region 6
Exit Date: 02/03/2017
Purpose of Visit: Complaint Investigation
Tags: F157/N837; F223/F226/N983; F282/N1088; F309/N1114; F353/N1145; F490/N1412; F505/N1444; F518/N1500
Issues: The facility failed to order a resident's STAT basic metabolic panel (blood test used to measure glucose levels, electrolyte and fluid balance, and kidney function) for over ten hours after it was ordered by the nurse practitioner (NP). The facility did not transfer the resident to the hospital for fourteen hours after the NP ordered that the resident should be transferred. The test results returned a critical potassium level. The resident was found unresponsive over five hours after the facility received the laboratory results and was transferred to the hospital where they were pronounced dead. The facility also failed to have sufficient staff during an overnight shift to provide incontinent care to a resident and to evacuate the same resident, who was forgotten during a tornado alert.

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, failed to provide services in accordance with each resident's written plan of care, failed to provide services to attain or maintain the residents' highest possible well-being, failed to ensure sufficient staffing to provide nursing related services, failed to promptly notify the ordering physician or nurse practitioner of laboratory results that fell outside of the clinical reference ranges, and failed to effectively train all employees on emergency and evacuation procedures in the event of an emergency that required evacuation. Facility administration failed to ensure effective use of resources.

Region 8/11
Exit Date: 02/07/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F223/N983; F226/N984; F281/N1178; F309/N1114; N1600
Issues: The facility failed to properly assess a resident who choked on food and did not check the airway for obstructions and perform the Heimlich maneuver to dislodge the food. Due to this failure, the resident could not receive air into the lungs with the oxygen bag. The facility did not initiate CPR on the resident until they had moved into the resident's room and did not initiate use of the AED (automatic external defibrillator) to detect sinus rhythm and to defibrillate the heart because the wrong electrode pads were in use on the AED, rendering it unusable. Records indicated that the AED had not been inspected and tested in over five months. The resident subsequently died as a result of these failures.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to provide services that met professional standards, failed to provide services to attain or maintain the residents' highest possible well-being, and failed to maintain and test the AED according to the manufacture's guidelines and keep records of the maintenance and testing.

Region 2/9/10
Exit Date: 02/10/2017
Purpose of Visit: Complaint Investigation
Tags: F224/F226/N983; F314/N1120/N1121

Issues: The facility failed to properly assess and treat pressure ulcers for three residents, each of whom experienced severe deterioration in the wounds and development of more ulcers after discovery of the initial wounds. The facility failed to notify the physicians for all three residents effected.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, and failed to ensure that residents having pressure ulcers received necessary treatment and services to promote healing.

Region 3
Exit Date: 02/10/2017
Purpose of Visit: Complaint Investigation
Tags: F223/F226/N983; F309/N1114
Issues: The facility failed to recognize a resident's signs and expressions of suicidal intent and to monitor the resident throughout the night to ensure the resident did not have the means or opportunity to follow through with the intent. The resident was found the following morning with oxygen tubing wrapped around the neck and was sent to the emergency room.

Deficient Practice: The facility 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 3
Exit Date: 02/11/2017
Purpose of Visit: Standard Survey
Tags: F166/N983; F225/N994; F226/N989/N990
Issues: The facility failed to report and investigate allegations from one resident and another resident's family regarding physically rough and disrespectful treatment. The NFA was not made aware of the concerns for over three weeks from the time of one complaint and one week from the time of the second. The facility failed to immediately notify DADS of the alleged incidents and subsequent investigation.

Deficient Practice: The facility failed to make prompt efforts to resolve grievances, failed to ensure immediate action was taken to prevent further potential violations of residents' right to be free from abuse, failed to ensure grievances related to abuse were immediately reported to DADS, and failed to implement policies and procedures to prevent abuse.

Region 3
Exit Date: 02/15/2017
Purpose of Visit: Dementia Focus Survey (conducted by CMS contract staff)
Tags: F282; F309; F323; F328; F490; F520
Issues: The facility failed to ensure safe smoking practices were implemented, to ensure care plans were followed for residents who smoked, and to ensure the Quality Assurance Program (QAP) addressed unsafe smoking. The facility failed to ensure a resident's right to formulate an advanced directive was honored when the resident wished to implement the Do Not Resuscitate (DNR) order, and the physician would not sign the order. The facility failed to ensure a tracheostomy kit and cannula (plastic tube used to administer oxygen) were at the bedside of a resident with a tracheostomy.

Deficient Practice: The facility failed to provide services in accordance with each resident's written plan of care; failed to provide services to attain or maintain the residents' highest possible well-being; failed to ensure each resident received adequate supervision to prevent accidents; failed to provide tracheostomy (an airway surgically created for breathing) care, consistent with professional standards of practice and the comprehensive care plan; and failed to maintain a QAA committee that evaluated systems and developed and implemented plans of action to correct deficiencies. Facility administration failed to ensure effective use of resources.

Region 7

Exit Date: 02/18/2017
Purpose of Visit: Incident Investigation
Tags: F157/N837; F223/N983; F226/N984; F333/N1140; F425/N1294
Issues: The facility routinely failed to administer a resident's blood thinning medication during days when the resident went to dialysis. The facility failed to make the resident's physician aware of the error. The resident was sent to the hospital and diagnosed with pulmonary embolism (blood clot in the lungs). The facility failed to provide another resident's blood thinner for six days and did not inform the resident's physician or the NFA and DON.

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, failed to ensure that residents were free from significant medication errors, and failed to provide pharmaceutical services to meet the needs of each resident

Region 3
Exit Date: 03/02/2017
Purpose of Visit: Complaint Investigation
Tags: F223/F226/N983; F441/N1342
Issues: The facility failed to effectively isolate residents treated for the influenza virus according to CDC guidelines and recommendations. Five residents developed influenza after the resident initially treated for the virus was removed from isolation earlier than recommended. One of the resident's affected required transfer to the hospital where the resident died from complications related to the virus.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, 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 6
Exit Date: 03/02/2017
Purpose of Visit: Complaint Investigation
Tags: F157/N837; F223/N983; F226/N1077; F279/N1120; F314/N1121; F490/N1412
Issues: The facility failed to implement effective interventions for a resident, who spent long periods in a wheelchair, to ensure they did not develop pressure ulcers. The resident developed a pressure ulcer which deteriorated and the resident was admitted into the hospital with diagnoses of osteomyelitis (bone infection) and unstageable sacral (bottom of spine) pressure ulcer infected with e-coli and pseudomonas bacteria. The facility failed to monitor and implement interventions to prevent development of pressure ulcers for another resident identified as at risk for them. The resident developed a pressure ulcer to the right heel fourteen days after admission into the facility. For both residents, the facility failed to inform their physicians of the status of the wounds and the recommendations for wound care.

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; failed to develop a comprehensive care plan, based on a comprehensive assessment, upon admission and after a change of condition; and failed to ensure that residents having pressure ulcers received necessary treatment and services to promote healing and prevent infection. Facility administration failed to ensure effective use of resources.

Region 3
Exit Date: 03/07/2017
Purpose of Visit: Complaint Investigation
Tags: F223/F226/N986; F281/N1082; F333/N1136; F425/N1293
Issues: The facility administered to a resident five medications that were not meant for the resident. The resident's heart rate and blood pressure dropped and they were sent to the hospital and admitted into the ICU.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to provide services that met professional standards, failed to ensure that residents were free from significant medication errors, and failed to provide pharmaceutical services to meet the needs of each resident

Region 8/11
Exit Date: 03/07/2017
Purpose of Visit: Complaint Investigation
Tags: F157/N837; F223/N982; F226/N983; F281/N1087; F309/N1114; F385/N1246
Issues: The facility failed to accurately assess a resident who began to experience congestion and labored breathing, and tested low oxygen saturation levels. The facility did not consult the resident's physician or notify the family/LAR, and did not communicate the severity of the resident's condition to oncoming personnel. The resident was sent to the hospital, over two hours after initial signs of medical distress, where the resident subsequently died.

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, failed to provide services that met professional standards, failed to provide services to attain or maintain the residents' highest possible well-being, and failed to ensure that the medical care of each resident was supervised by a physician.

Region 3
Exit Date: 03/08/2017
Purpose of Visit: Incident Investigation
Tags: F223/N983; F226/N1130; F323/N1131; F490/N1412
Issues: The facility failed to supervise a resident after escorting them off the secure unit to an activity. The resident eloped and the facility remained unaware until a community member brought the resident back to the facility almost two hours after the activity had ended. The resident had wandered approximately one thousand yards away from the facility.

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. Facility administration failed to ensure effective use of resources.

Region 4/5
Exit Date: 03/10/2017
Purpose of Visit: Complaint Investigation
Tags: F225/N983; F226/N989; F309/N1114
Issues: The facility failed to properly assess and monitor a resident who was found unresponsive on the floor, and failed to ensure that relevant facility staff were aware of the incident. The resident was returned, at the time, to a feces soiled bed with no further assessment. The resident, who was diabetic and taking multiple blood thinning medications, complained of headaches and was demonstrably lethargic for the following two days. Three days following the initial fall, the resident was found unresponsive and transferred to the hospital where they were diagnosed with intracranial bleeding. The resident died in the hospital.

Deficient Practice: The facility failed to ensure allegations of abuse or neglect were thoroughly investigated and reported, 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: 03/15/2017
Purpose of Visit: Complaint Investigation
Tags: F425/N1293

Issues: The facility failed to provide medications as ordered for twelve residents. Medications missed included, among others, those to treat blood pressure, inflammation, convulsions, diabetes, respiratory issues, prostate issues, and blood clotting. The majority of residents missed one to three doses of medication, with one resident missing forty-six doses.

Deficient Practice: The facility failed to administer, order and have available medications in accordance with the physician's orders.

Region 4/5
Exit Date: 03/16/2017
Purpose of Visit: Dementia Focus Survey (conducted by CMS contract staff)
Tags: F280; F309; F323; F490; F501; F520
Issues: The facility failed to implement interventions for a resident who demonstrated aggressive behavior toward other residents. The resident was found to have slammed a door on another resident, resulting in a fractured clavicle for the latter, who expressed continued fear of the aggressor. Over the course of the following month, the resident exhibited additional aggressive behavior, on nine separate occasions, toward seven additional residents. The Quality Assessment and Assurance (QAA) Committee failed to ensure that residents in the facility's secure unit were protected from aggressive actions; to update the facilities QAA policy; to identify deficient hand-washing practices; to ensure staff developed and revised person-centered approaches to effectively manage resident behaviors; to ensure adherence to guidance to develop a care plan for a resident on antipsychotic medication, and a nutritional care plan for another resident; to ensure that the consultant pharmacist identified two irregularities in medication administration for two residents; to ensure that one resident was provided with physician ordered nutritional supplements; and to ensure blood draws and a urinalysis were completed in a timely manner, per physician orders, for one resident.

Deficient Practice: The facility failed to assure the staff developed and implemented a person-centered, comprehensive plan of care to address the aggressive behaviors; failed to provide services to attain or maintain the residents' highest possible well-being; and failed to provide adequate supervision to prevent accidents; failed to maintain a QAA committee that evaluated systems and developed and implemented plans of action to correct deficiencies. Facility administration failed to ensure effective use of resources.

Region 8/11
Exit Date: 03/20/2017
Purpose of Visit: Standard Survey
Tags: F223/N982; F226/N983; F279/N1077; F280/N1080; F323/N1130; F490/N1412; F520/N1512
Issues: The facility failed to implement interventions to address the needs of three residents who experience multiple falls. During the period reviewed, one resident fell six times, one fell seven times, and one fell twenty-one times and ultimately was transferred to the hospital with a fractured hip requiring surgical intervention. Insufficient documentation was found regarding the falls. The facility failed to ensure a resident's care plan included a nutritional supplement to address weight loss and medication to promote wound healing.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect; failed to develop a comprehensive care plan, based on a comprehensive assessment, upon admission and after a change of condition; failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment; failed to provide adequate supervision to prevent accidents; and failed to maintain a QAA committee that evaluated systems and developed and implemented plans of action to correct deficiencies. Facility administration failed to ensure effective use of resources.

Region 4/5
Exit Date: 03/22/2017
Purpose of Visit: Complaint/Incident Investigation
Tags: F328/N1135; F353/N1144

Issues: The facility failed to have staff, who knew how to set-up and operate an oxygen machine, available for a resident with a tracheostomy in the event that the resident's oxygen saturation levels fell below established safe parameters.

Deficient Practice: The facility failed to provide tracheostomy care, consistent with professional standards of practice and the comprehensive care plan, and failed to ensure sufficient staffing to provide nursing related services.

Region 2/9/10
Exit Date: 03/22/2017
Purpose of Visit: Standard Survey
Tags: F157/N837; F309/N1114; F314/N1120/N1121
Issues: The facility failed to immediately inform multiple residents' physicians and/or LARs for changes in condition. For approximately two hours, a resident was having seizures every three to four minutes, lasting between thirty seconds to a minute. A resident, admitted to the facility for rehabilitation services, complained of shoulder pain and did not see a physician for almost three months. A resident woke up with confusion, increased paleness, and complaining of pain and nausea. The resident did not receive treatment for almost three hours. A resident with a pressure ulcer and a surgical incision experience deterioration of both wounds. These failures resulted in lapses in care for each of the residents effected.

Deficient Practice: The facility failed to consult with the physician when a change of condition occurred, failed to provide services to attain or maintain the residents' highest possible well-being, and failed to ensure that residents having pressure ulcers received necessary treatment and services to promote healing and prevent infection.

Region 4/5
Exit Date: 03/22/2017
Purpose of Visit: Standard Survey
Tags: F157/N837; F223/N982; F226/N983; F309/N1114; F505/N1444
Issues: The facility failed to inform a resident's physician when the resident experienced low food and fluid intake, developed a urinary tract infection, had their blood pressure medication held, and returned critical laboratory values. The resident was transferred to the hospital and diagnosed with low blood pressure, hypothermia (abnormally low body temperature), altered mental state, and organ failure consistent with sepsis (the body's aggressive response to infection). The resident died two days after arriving at the hospital.

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 to attain or maintain the residents' highest possible well-being, and failed to promptly notify the physician on critical laboratory values.

Region 4/5
Exit Date: 03/24/2017
Purpose of Visit: Complaint Investigation
Tags: F157/N837; F309/N1114
Issues: The facility failed to effectively assess, monitor, and inform a physician when a resident experienced difficulty breathing and low oxygen saturation levels. The resident experienced these conditions for over four hours before being sent to the hospital. The resident's physician was not notified until after the resident arrived in the emergency room.

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

Region 4/5
Exit Date: 03/24/2017
Purpose of Visit: Complaint Investigation

Tags: F323/N1131
Issues: The facility failed to properly assess a resident as at risk for elopement. Consequently, the resident eloped from the facility and was found after dark, on the shoulder of a busy highway, nearly a half mile from the facility.

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

Region 3
Exit Date: 03/26/2017
Purpose of Visit: Complaint Investigation
Tags: F223/F226/N984; F281; F333/N1140; F353/N1144; F425/N1293; F490
Issues: The facility failed to administer medications to forty-five residents over the course of multiple days and times. Among other factors leading to these failures, the facility did not have sufficient staff available to effectively provide medication administration.

Deficient Practice: The facility failed to implement policies and procedures to prohibit neglect; failed to provide services that met professional standards; failed to ensure that residents were free from significant medication errors; failed to ensure sufficient staffing to provide nursing related services; and failed to administer, order, and have available medications in accordance with the physician's orders. Facility administration failed to ensure effective use of resources.