

Quarterly IJ Summary Report January 2019 – March 2019

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 first quarter of 2019 (01/01/2019 – 03/31/2019).

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

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

Table 1

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
580	6.8%	684	18.9%
584	2.7%	600	9.5%
600	9.5%	689	8.1%
607	6.8%	580	6.8%
641	1.4%	607	6.8%
656	1.4%	835	6.8%
658	1.4%	726	4.1%
675	1.4%	837	4.1%
678	2.7%	921	4.1%
684	18.9%	584	2.7%
686	2.7%	678	2.7%
689	8.1%	686	2.7%
692	1.4%	755	2.7%
726	4.1%	812	2.7%
755	2.7%	880	2.7%
757	1.4%	641	1.4%
760	1.4%	656	1.4%
770	1.4%	658	1.4%
801	1.4%	675	1.4%
808	1.4%	692	1.4%

F-Tag (Sorted by Tag Number)	% Cited*	F-Tag (Sorted by Frequency Cited)	% Cited*
812	2.7%	757	1.4%
835	6.8%	760	1.4%
837	4.1%	770	1.4%
880	2.7%	801	1.4%
908	1.4%	808	1.4%
921	4.1%	908	1.4%

*Rounded to the nearest tent

Table 2

Region	# of IJs	# of NFs	% of IJs/NF
1	1	79	1.3%
2/9/10	3	137	2.2%
3	7	288	2.4%
4/5	3	170	1.8%
6	7	187	3.7%
7	3	152	2.0%
8/11	4	253	1.6%
Total	28	1266	2.2%

**Table 3
Number of IJs**

from Complaints	from Incidents	from Surveys	Total
13	2	13	28

Tag References

483.10 - Resident Rights:

- 580 Notify 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

483.20 – Resident Assessments:

- 641 Accuracy of Assessments

483.21 - Comprehensive Resident Centered Care Plan:

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

483.24 - Quality of Life:

- 675 Quality of Life
- 678 Cardio-Pulmonary Resuscitation (CPR)



483.25 - Quality of Care:

- 684 Quality of Care
- 686 Treatment/Svcs to Prevent/Heal Pressure Ulcers
- 689 Free of Accident Hazards/Supervision/Devices
- 692 Nutrition/Hydration Status Maintenance

483.35 - Nursing Services:

- 726 Competent Nursing Staff
- 740 Behavioral Health Services

483.45 - Pharmacy Services:

- 755 Pharmacy Svcs/Procedures/Pharmacists/Records
- 757 Drug Regimen is Free from Unnecessary Drugs
- 760 Residents are Free from Significant Med Errors

483.50 – Laboratory, Radiology, and other Diagnostic Services:

- 770 Laboratory Services

483.60 – Food and Nutrition Services:

- 801 Qualified Dietary Staff
- 808 Therapeutic Diet Prescribed by Physician
- 812 Food Procurement, Store/Prepare/Serve - Sanitary

483.70 - Administration:

- 835 Administration
- 837 Governing Body

483.80 – Infection Control

- 880 Infection Prevention & Control

483.90 – Physical Environment

- 908 Essential Equipment, Safe Operating Condition
- 921 Safe/Functional/Sanitary/Comfortable Environment

Acronyms

CPR – Cardiopulmonary Resuscitation

ER – Emergency Room

ICU – Intensive Care Unit

LAR – Legally Authorized Representative

MAR – Medication Administration Record



Region 4**Exit Date:** 01/03/2019**Purpose of Visit:** Incident Investigation**Tags:** F678/N1233

Situations: The facility failed to immediately initiate CPR for a resident with a full code status (which allows full interventions to restart the heart) when they were discovered to have no pulse or respirations. The resident was instead pronounced dead with no attempt at resuscitation. The facility failed to train staff to be aware of or review the code status of all residents when necessary.

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

Region 6**Exit Date:** 01/12/2019**Purpose of Visit:** Standard Survey**Tags:** F580/N1129; F675/N1307; F726/N1446

Situations: The facility failed to effectively assess, treat, and monitor a resident after they began to complain of chest pain, difficulty breathing, and experienced a nose bleed. The facility did not ensure the resident's physician, family/LAR, and oncoming staff were notified after the changes in condition occurred. The resident died shortly after the onset of the symptoms.

Deficient Practice: The facility failed to notify and consult with a physician or family/LAR of changes in condition, failed to provide the necessary care and services to attain or maintain the highest practicable well-being, and failed to ensure sufficient nursing staff with the appropriate competencies to provide services to attain or maintain the residents' highest practicable well-being.

Region 3**Exit Date:** 01/14/2019**Purpose of Visit:** Standard Survey**Tags:** F678; F684

Situations: The facility failed to ensure staff were trained to immediately initiate CPR on a resident found unresponsive, resulting in a staff member delaying in order to find assistance. The facility failed to follow a physician's treatment orders for a resident who had received staples in their head and to ensure the resident wore a BiPAP (a ventilator used to deliver pressurized air through a mask to the patient's airways) while sleeping.

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

Region 6**Exit Date:** 01/17/2019**Purpose of Visit:** Complaint Investigation

Tags: F600/N1284; F684/N1416; F755/N1598; F835/N1721

Situations: The facility failed to ensure its ability to meet a resident's needs prior to the resident being admitted. The facility failed to order a newly admitted resident's critical antibiotic medication, resulting in a four-day period during which the resident did not receive it. The resident was admitted to the hospital with sepsis and was placed on a ventilator.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to ensure that residents received treatment and care in accordance with professional standards of practice, and failed to provide pharmaceutical services to meet the needs of each resident. Facility administration failed to ensure effective use of resources.

Region 8/11

Exit Date: 01/21/2019

Purpose of Visit: Complaint Investigation

Tags: F600/N1284; F607/N1258; F656/N1380; F658/N1389; F684/N1416; F689/N1432; F726

Situations: The facility failed to ensure a resident with a history of choking was properly monitored. The resident had incidents of choking on two separate occasions, the second of which resulted in their death. The facility failed to investigate the first incident and implement interventions. The facility failed to ensure staff were aware of, or to review, residents code statuses and performed CPR on the resident, who had a DNR. The facility failed to adhere to a resident's prescribed diet.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to develop and implement a comprehensive person-centered care plan, failed to ensure the services provided by the facility met professional standards of quality, failed to provide adequate supervision to prevent accidents, and failed to ensure sufficient nursing staff with the appropriate competencies to provide services to attain or maintain the residents' highest practicable well-being.

Region 3

Exit Date: 01/25/2019

Purpose of Visit: Standard Survey

Tags: F600/F607/N1285; F684/N1416; F770/N1747

Situations: The facility failed to ensure that laboratory results for three residents were reviewed and that treatment, as a result, was initiated timely. One resident's antibiotics were delayed for three days, during which time their health continued to deteriorate, resulting in hospitalization for septic shock and acute renal failure. The resident died at the hospital. Two other residents were delayed their medication and treatment due to the failure.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to ensure that residents received treatment and care in accordance with professional standards of practice, and failed to provide or obtain timely laboratory services.



Region 3**Exit Date:** 01/28/2019**Purpose of Visit:** Standard Survey**Tags:** F584/N1328; F835/N1721; F837/N1725; F908/N1689; F921/N1683; N1880**Situations:** The facility failed to ensure that the ceilings in multiple halls were free of water damage and harmful mold. The facility failed to ensure that a washing machine, two dryers, and the HVAC in the laundry room, and the refrigerator and walk-in freezer in the kitchen, were maintained and in safe operating condition. The facility failed to meet financial obligations to staff, utility providers, and vendors.**Deficient Practice:** The facility failed to ensure residents had a right to a safe, clean, comfortable and homelike environment; failed to maintain all mechanical and electrical equipment in safe operating condition; and failed to satisfy obligations at the time they come due. The governing body failed to implement policies regarding the management and operation of the facility and facility administration failed to ensure effective use of resources.**Region 4/5****Exit Date:** 02/01/2019**Purpose of Visit:** Complaint Investigation**Tags:** F812/N1536; F835/N1721; F837/N1725; F921/N1683**Situations:** The facility failed to maintain the septic system, allowing a foul-smelling black substance to come up through the drains, including a drain in the kitchen floor. The facility did not prevent rainwater from leaking onto a functional light fixture and into the food preparation area of the kitchen. The facility continued to serve food to the residents prepared in the kitchen. The facility failed to maintain the grease trap in the courtyard, allowing it to back up and cause a strong odor. The facility failed to provide the correct sanitizing chemicals for the dishwasher and kitchen sink. The facility failed to ensure the fire alarm system was functioning correctly and alerted the fire and police departments if activated.**Deficient Practice:** The facility failed to ensure food was prepared in a sanitary and safe environment, failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The governing body failed to implement policies regarding the management and operation of the facility and facility administration failed to ensure effective use of resources.**Region 3****Exit Date:** 02/01/2019**Purpose of Visit:** Complaint/Incident Investigation**Tags:** F600/F607/N1285; F684/N1416; F835/N1721; F880/N1647**Situations:** The facility failed to effectively implement infection control protocols following the presentation of suspected norovirus. The facility did not follow quarantine, hygiene, or decontamination procedures, and the facility experienced an outbreak of the symptoms which affected up to forty-two residents and thirty-one staff.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to ensure that residents received treatment and care in accordance with professional standards of practice, and failed to maintain an infection control program designed to help prevent the transmission of disease and infection. Facility administration failed to ensure effective use of resources.

Region 2/9/10

Exit Date: 02/05/2019

Purpose of Visit: Incident Investigation

Tags: F689/N1432/N1433

Situations: The facility failed to effectively monitor and apply interventions for two residents with a history of dysphagia (difficulty swallowing), requiring thickened liquids. One resident obtained a cup of coffee and staff intervened prior to the resident attempting to drink it. The other resident obtained a beverage and drank it, showing signs of aspiration. The resident was transferred to the hospital where they died the following day.

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

Region 3

Exit Date: 02/06/2019

Purpose of Visit: Complaint/Incident Investigation

Tags: F580/N1129; F684/N1416; F689/N1433; F692/N1434

Situations: The facility failed to assess and monitor a resident who exhibited poor respiratory conditions and continuous coughing and did not inform the resident's physician or family/LAR of the changes in condition. The resident was ultimately sent to the hospital and diagnosed with sepsis, fever, and pneumonia. The resident died at the hospital. For the same resident, the facility failed to intervene following a weight loss of greater than ten percent.

Deficient Practice: The facility failed to notify and consult with a physician or family/LAR of changes in condition, failed to ensure each resident received treatment and care in accordance with professional standards of practice, failed to provide adequate supervision to prevent accidents, and failed to ensure residents maintained acceptable parameters of nutritional status.

Region 7

Exit Date: 02/08/2019

Purpose of Visit: Complaint/Incident Investigation

Tags: F684/N1416

Situations: The facility failed to effectively communicate and implement a physician order for regular skin assessments on a resident wearing a temporary splint. The resident developed an ulcer to the right foot, ultimately requiring amputation of the lower leg.



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

Region 3

Exit Date: 11/03/2018

Purpose of Visit: Standard Survey

Tags: F641/N1353; F684/N1416

Situations: The facility inaccurately transcribed a physician order and discontinued a resident's critical antibiotic and steroid, following a corneal transplant. The resident missed thirty-two doses of their antibiotic and nineteen doses of their steroid. The resident was subsequently admitted to the hospital with an ulcer in their eye.

Deficient Practice: Failed to accurately make a comprehensive assessment, and failed to ensure each resident received treatment and care in accordance with professional standards of practice.

Region 6

Exit Date: 02/13/2019

Purpose of Visit: Complaint Investigation

Tags: F580/N1129; F684/N1416; F726/N1446

Situations: The facility failed to assess and monitor a resident after a series of low blood pressure values were identified. The facility did not have a baseline care plan developed regarding low or high blood pressure and had no procedures in place to hold blood pressure medication in the event of low blood pressure. The resident's condition continued to deteriorate for over eight hours until emergency services were contacted. Emergency service personnel initiated resuscitation procedures but were unsuccessful and the resident was pronounced dead upon arrival at the hospital.

Deficient Practice: The facility failed to notify and consult with a physician or family/LAR of changes in condition, failed to ensure each resident received treatment and care in accordance with professional standards of practice, failed to ensure sufficient nursing staff with the appropriate competencies to provide services to attain or maintain the residents' highest practicable well-being.

Region 4/5

Exit Date: 02/14/2019

Purpose of Visit: Complaint/Incident Investigation

Tags: F580/N1130; F584/N1416

Situations: The facility failed to assess a resident for eight days after they complained of leg pain and exhibited a deformity, the leg turning inward. The facility failed to inform the resident's physician of the change in condition. The resident was ultimately transferred to the hospital and diagnosed with a fractured hip, requiring surgery.

Deficient Practice: The facility failed to notify and consult with a physician or family/LAR of changes in condition, and failed to ensure each resident received treatment and care in accordance with professional standards of practice.



Region 6**Exit Date:** 02/20/2019**Purpose of Visit:** Standard Survey**Tags:** F684/N1416; F689/N1432

Situations: The facility failed to implement interventions for a resident identified as at-risk for falls. The resident sustained four falls, resulting in head injuries. The resident was identified to require one-on-one supervision, which was not implemented. Following one fall, the resident exhibited a change in condition that was not properly assessed for treatment. A CT scan for the resident was ordered, which they did not receive. The resident was found unresponsive and was transferred to the hospital where they were diagnosed with a traumatic subarachnoid hemorrhage (bleeding in the brain) and admitted to the ICU.

Deficient Practice: The facility failed to ensure treatment and care was provided in accordance with professional standards of practice, and failed to provide adequate supervision to prevent accidents.

Region 8/11**Exit Date:** 02/22/2019**Purpose of Visit:** Complaint/Incident Investigation**Tags:** F600/N1284; F607/N1285

Situations: The facility failed to implement interventions for a resident with a history of aggressive behaviors. The failures lead to an incident during which the resident caused serious injury to another resident, additionally causing the victim and five other residents to express fear and a feeling of insecurity related to the exhibited aggression.

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

Region 8/11**Exit Date:** 02/23/2019**Purpose of Visit:** Standard Survey**Tags:** F600/N1284; F607/N1294; F684/N1389

Situations: The facility failed to obtain physician orders for treatment and follow-up for a resident returning to the facility following a leg fracture. For over a month, the facility failed to follow-up with orthopedic assessments and to obtain orders for the care of the resident's soft cast. The facility did not monitor the injury or area where that cast was applied and the resident failed to recover their ability to walk. For the same resident, the facility failed to investigate the fall that resulted in the injury, failed to investigate a resident's allegation of inappropriate sexual behaviors directed toward them in their room, and failed to investigate a resident's allegation that the facility neglected to assist with a urostomy bag (a bag that collects urine externally) leak.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, and failed to ensure treatment and care was provided in accordance with professional standards of practice.



Region 3**Exit Date:** 02/23/2019**Purpose of Visit:** Standard Survey**Tags:** F580/N1129; F755; F760/N1442; F880; N1294

Situations: The facility failed to ensure that a resident's blood thinner was available and to contact the resident's physician when the facility ran out of the medication. The resident was transported to the hospital following a change in condition and was determined to be in atrial fibrillation and to have had a stroke. The facility failed to follow infection control protocols following the onset of nausea, vomiting, and diarrhea in a resident. The failure led to an outbreak of the same symptoms affecting twenty-six residents and eight staff members.

Deficient Practice: The facility failed to notify and consult with a physician or family/LAR of changes in condition, failed to provide pharmaceutical services to meet the needs of each resident, failed ensure residents were free of any significant medication errors, failed to maintain an infection control program designed to help prevent the transmission of disease and infection, and failed to provide treatment and care in accordance with professional standards of practice.

Region 8/11**Exit Date:** 02/26/2019**Purpose of Visit:** Standard Survey**Tags:** F801/N1501; F812/N1536

Situations: The facility failed to maintain the temperature of the walk-in refrigerator and continued to store food inside during a four-hour time period where the temperature was greater than ten degrees higher than the required forty-one degrees Fahrenheit or less. The facility failed to safely store and label unopened food, failed to monitor the temperature of milk served to residents and failed to implement their policy of monthly inspections of the walk-in refrigerator.

Deficient Practice: The facility failed to employ competent staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service; and failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety.

Region 1**Exit Date:** 02/27/2019**Purpose of Visit:** Standard Survey**Tags:** F686/N1422/N1423

Situations: The facility failed to effectively assess, treat, and monitor pressure ulcers for three residents, resulting in deterioration of the ulcers. The facility failed to contact the residents' physicians and, for two residents who refused treatment, failed to update their plan of care to address the issues. For one of the affected residents, the facility failed to properly transcribe the physician's treatment orders regarding the frequency of wound care.



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

Region 2/9/10

Exit Date: 03/02/019

Purpose of Visit: Standard Survey

Tags: F689/N1433

Situations: The facility failed to follow procedures for a resident who required two-person transfers with a mechanical lift and a one-person transfer without a mechanical lift was attempted. The transfer was unable to be completed and the resident was lowered to the ground. Subsequently, the resident complained of pain to the left arm and an x-ray was ordered, the results of which revealed a fractured upper arm.

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

Region 2/9/10

Exit Date: 03/15/2019

Purpose of Visit: Standard Survey

Tags: F757/N1438

Situations: For a resident with a history of severe seizures, the facility failed to obtain and review laboratory levels meant to monitor the effectiveness of three anti-seizure medications being taken. The resident had multiple seizures in one day, requiring intubation and hospitalization. Laboratory results from the hospital showed subtherapeutic levels for two of the three anti-seizure medications.

Deficient Practice: The facility failed to ensure each resident's drug regimen was free from unnecessary drugs.

Region 6

Exit Date: 03/15/2019

Purpose of Visit: Complaint/Incident Investigation

Tags: F584/N1328; F600/N1285; F835/N1721; F837/N1729; F921/N1713

Situations: The facility failed to provide residents with a sanitary environment, allowing residents to stay in areas with raw sewage backflowing onto the floors, upon which residents in wheelchairs were still allowed to propel. The facility did not address non-functioning toilets, roof leaks, and mold. The facility failed to ensure that the heating system for multiple residents was functioning during times when outside temperatures measured as low as thirty-seven degrees Fahrenheit. The facility failed to provide assessments and treatment of weight loss for four residents, all of whom lost significant weight over the course of six months without effective intervention. The facility failed to ensure that vendors were paid and that the facility had all the necessary items to meet residents' needs. The facility failed to ensure that it could meet payroll obligations to employees.



Deficient Practice: The facility failed to ensure residents had a right to a safe, clean, comfortable and homelike environment, and failed to implement policies to prevent neglect. The governing body failed to implement policies regarding the management and operation of the facility and facility administration failed to ensure effective use of resources.

Region 7

Exit Date: 03/16/2019

Purpose of Visit: Complaint Investigation

Tags: F684/N1416

Situations: The facility failed to provide a CPAP machine (a device used, typically at night, to deliver continuous pressurized air to the resident through a mask) to two residents with orders for the use of the devices. As a result of this failure, both residents required emergency transfer to the hospital with diagnosis of hypercarbia (increased carbon dioxide levels in the blood), one of whom was also diagnosed with obesity hypoventilation syndrome (failure to breathe rapidly or deep enough, resulting in low blood oxygen and high carbon dioxide levels), obstructive sleep apnea with aspiration pneumonia and acute metabolic encephalopathy (an organic disorder of the brain chemistry) secondary to hypercapnic respiratory acidosis (resulting from increased carbon dioxide in the blood lowering its pH).

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

Region 3

Exit Date: 03/18/2019

Purpose of Visit: Standard Survey

Tags: F686/N1423

Situations: The facility failed to effectively treat pressure ulcers that a resident developed at the facility. The ulcers deteriorated and became infected, requiring hospitalization. The facility failed to effectively treat another resident with existing pressure ulcers, resulting in deterioration of those that existed and failed to implement preventive measures resulting in the development of new pressure ulcers.

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

Region 6

Exit Date: 03/28/2019

Purpose of Visit: Complaint/Incident Investigation

Tags: F689/N1433; F808/N1435

Situations: The facility failed to ensure a resident identified at high-risk for choking and with an order for a pureed diet was given appropriate food and monitored. The resident



was provided with a sandwich and left unsupervised in their room while they ate. Due to this failure, the resident died of asphyxiation.

Deficient Practice: The facility failed to provide adequate supervision to prevent accidents, and failed to assure that residents received and consumed foods in the appropriate form as prescribed by a physician.

Region 6

Exit Date: 03/30/2019

Purpose of Visit: Complaint Investigation

Tags: F684/N1416

Situations: For a resident diagnosed with diabetes and end-stage renal disease, the facility failed to monitor their blood glucose levels and administer medication. The resident was found unresponsive in their room after missing an ordered test of blood glucose levels and their prescribed dose of insulin. The resident was found with obvious signs of rigor mortis and was pronounced dead at the facility by emergency service personnel.

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

