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 second quarter of 2019 (04/01/2019 – 06/30/2019).

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-seven of the surveys and investigations conducted, resulting in fifty-three citations of eighteen 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

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<tr>
<th>F-Tag (Sorted by Tag Number)</th>
<th>% Cited*</th>
<th>F-Tag (Sorted by Frequency Cited)</th>
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*Rounded to the nearest tent
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### Table 3

<table>
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<th>from Incidents</th>
<th>from Surveys</th>
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</thead>
<tbody>
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<td>4</td>
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<td>27</td>
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</tbody>
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### Tag References

**483.10 - Resident Rights:**
- 580 Notify of Changes (Injury/Decline/Room, Etc.)

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

**483.21 - Comprehensive Resident Centered Care Plan:**
- 655 Baseline Care Plan

**483.24 - 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
- 693 Tube Feeding Management/Restore Eating Skills
- 694 Parenteral/IV Fluids

**483.35 - Nursing Services:**
- 725 Sufficient Nursing Staff

**483.45 - Pharmacy Services:**
- 755 Pharmacy Svcs/Procedures/Pharmacists/Records

**483.50 - Laboratory, Radiology, and other Diagnostic Services:**
- 773 Lab Svcs Physician Order/Notify of Results

**483.60 - Food and Nutrition Services:**
812  Food Procurement, Store/Prepare/Serve - Sanitary

483.70 - Administration:
  835  Administration

483.80 – Infection Control
  880  Infection Prevention & Control

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**Acronyms**

CPR – Cardiopulmonary Resuscitation
HHSC – Health and Human Services Commission
LAR – Legally Authorized Representative
### Region 3
**Exit Date:** 04/05/2019  
**Purpose of Visit:** Incident Investigation  
**Tags:** F684/N1416; F773/N1753  
**Situations:** The facility failed to effectively assess and notify a resident’s physician and family/LAR when the resident exhibited changes in condition, including a positive e. coli test, the results of which the facility failed to obtain in a timely manner. The resident began to refuse medications, became lethargic, apneic, had purple-tinged skin at the fingertips, and was unable to hold up their head to eat or drink. The resident was transferred to the hospital forty-eight hours after the symptoms began and was diagnosed with severe sepsis and kidney failure. The resident died five days later.

**Deficient Practice:** The facility failed to ensure sufficient nursing staff with the appropriate competencies to provide services to attain or maintain the residents’ highest practicable well-being and failed to promptly notify the physician of laboratory results in accordance with facility policy and procedures.

### Region 6
**Exit Date:** 04/09/2019  
**Purpose of Visit:** Complaint/Incident Investigation  
**Tags:** F580/N1129; F600/N1284; F655; F684/N1416; F835/N1721  
**Situations:** The facility failed to develop an effective care plan for a resident admitted following a craniectomy and partial removal of the skull and did not implement interventions to mitigate falls and other risks of damage to the area. The resident was subsequently discovered on the floor by their bed. The facility failed to transfer the resident in a manner that would prevent injury to the head and they were lifted back into their bed with a mechanical lift. The facility failed to immediately inform the physician following a change in condition after the fall. The resident died thirty minutes after being discovered on the floor.

**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 and implement a baseline care plans for residents, failed to ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. Facility administration failed to ensure effective use of resources.

### Region 7
**Exit Date:** 04/09/2019  
**Purpose of Visit:** Complaint/Incident Investigation  
**Tags:** F580/N1129; F686/N1422/N1423  
**Situations:** The facility failed to inform the physicians of two residents when they were discovered to have pressure ulcers. Both residents experienced deterioration of the wounds, and one required hospitalization during which another ulcer was found previously unidentified by the facility. The latter resident required surgical intervention.
**Deficient Practice:** The facility failed to notify and consult with a physician or family/LAR of changes in condition, and failed to ensure that residents having pressure ulcers received necessary treatment and services to promote healing.

**Region 4/5**  
**Exit Date:** 04/11/2019  
**Purpose of Visit:** Standard Survey  
**Tags:** N1285; N1438 (Federal tags lowered via IDR)  
**Situations:** The facility failed to implement a system to ensure that orders for lab tests for medications requiring them were completed. A resident was ordered a blood-thinning medication and did not receive a blood test for over forty days. A stat blood test was ordered following discovery of this failure and returned critical lab values.  
**Deficient Practice:** The facility failed to implement policies and procedures to prevent neglect and failed to ensure the drug regimen was adequately monitored to prevent unnecessary medications.

**Region 4/5**  
**Exit Date:** 04/15/2019  
**Purpose of Visit:** Complaint Investigation  
**Tags:** F580/N1130; F684/N1416  
**Situations:** The facility failed to immediately notify a physician when a resident exhibited stroke-like symptoms. The resident continued to exhibit the symptoms into the next day and was transferred to the hospital nearly twenty-four hours after the onset of symptoms. The resident was diagnosed with a stroke and was discharged to a different facility in terminal condition where they died three days later.  
**Deficient Practice:** The facility failed to notify and consult with a physician or family/LAR of changes in condition and failed to ensure that residents received treatment and care in accordance with professional standards of practice.

**Region 8/11**  
**Exit Date:** 04/17/2019  
**Purpose of Visit:** Complaint/Incident Investigation  
**Tags:** F600/N1285; F678/N1307  
**Situations:** The facility failed to immediately initiate CPR on a resident with a full code status (which allows full interventions to restart the heart).  
**Deficient Practice:** The facility failed to implement policies and procedures to prevent neglect and failed to ensure that a resident received CPR in accordance with professional standards of practice.

**Region 4/5**  
**Exit Date:** 04/17/2019  
**Purpose of Visit:** Standard Survey  
**Tags:** F689/N1433
**Situations:** The facility failed to implement interventions for a resident who began exhibiting exit-seeking behaviors. The resident eloped from the facility and the facility was unaware for approximately six hours. The resident was found nearly twenty hours after they were determined to be missing in a nearby city twelve miles from the facility.

**Deficient Practice:** The facility failed to ensure adequate supervision was provided to prevent an elopement.

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**Region 3**  
**Exit Date:** 04/18/2019  
**Purpose of Visit:** Standard Survey  
**Tags:** F580/N1129; F693/N1431  
**Situations:** The facility failed to effectively assess and notify a physician when a resident had a significant change in condition following a g-tube replacement. The resident began vomiting, bleeding, and experiencing abdominal pain. The facility failed to elevate the resident’s bed to the angle required per facility policy and the resident aspirated when they began to vomit. The resident was transferred to the hospital and diagnosed with sepsis and aspiration pneumonia.

**Deficient Practice:** The facility failed to notify and consult with a physician or family/LAR of changes in condition and failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding.

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**Region 4/5**  
**Exit Date:** 04/19/2019  
**Purpose of Visit:** Complaint/Incident Investigation  
**Tags:** F600/N1284; F607/N1285  
**Situations:** The facility failed to develop a plan and implement interventions to prevent a resident from verbally and physically abusing other residents. The resident touched another in a sexually inappropriate way and received treatment from a behavioral hospital. Following the resident’s return to the facility, they continued to engage in sexually inappropriate verbal and physical abuse of four other residents.

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

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**Region 1**  
**Exit Date:** 04/23/2019  
**Purpose of Visit:** Incident Investigation  
**Tags:** F689/N1433  
**Situations:** The facility failed to transfer a resident with the assistance of a lift, as required by their care plan. The resident fell to the floor onto their knees resulting in a fractured femur and dislocation and displacement of the right knee’s arthroplasty (knee replacement) rod.

**Deficient Practice:** The facility failed to provide adequate supervision and assistive devices to prevent accidents.
Region 4/5
Exit Date: 04/25/2019
Purpose of Visit: Standard Survey
Tags: F600/N1284/N1285; F607/N1292
Situations: The facility failed to investigate and report when a resident with a history of sexually inappropriate behaviors sexually abused another resident by touching their thighs and genitals.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and failed to thoroughly investigate and prevent further potential abuse.

Region 4/5
Exit Date: 05/09/2019
Purpose of Visit: Standard Survey
Tags: F600/N1285; F686/N1422/N1423; F725/N1468
Situations: The facility failed to effectively monitor and treat five residents with pressure ulcers, resulting in deterioration of existing and development of new ulcers. The facility failed to monitor a resident’s blood glucose levels as ordered.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to ensure that residents having pressure ulcers received necessary treatment and services to promote healing, and failed to provide nursing care with a sufficient number of nursing personnel with appropriate competencies and skills on a 24-hour basis to provide nursing care for all residents in accordance with resident care plans.

Region 7
Exit Date: 05/09/2019
Purpose of Visit: Standard Survey
Tags: F684/N1416
Situations: The facility failed to review and transcribe a resident’s allergy list upon readmission to the facility on two occasions. The failure resulted in the resident receiving a medication to which they were allergic and going into anaphylactic shock requiring hospitalization.

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

Region 6
Exit Date: 05/10/2019
Purpose of Visit: Complaint Investigation
Tags: F600/N1284; F689/N1433
Situations: The facility failed to implement interventions for a resident who was physically and verbally abusive to several other residents. The resident had multiple incidents of abuse, including punching one resident and forcefully taking another
Resident’s walker, causing them to fall. The facility continued to allow subsequent altercations and threatening behavior towards residents.

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

**Region 4/5**  
**Exit Date:** 05/13/2019  
**Purpose of Visit:** Complaint/Incident Investigation  
**Tags:** F600/N1284; F607/N1285  
**Situations:** The facility failed to effectively intervene when a resident was verbally abusive toward another resident. The facility ineffectively attempted to redirect the former resident following a verbal altercation in the dining room. The resident later went to the other’s room and continued the altercation, resulting in the latter resident attempting to choke the former.

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

**Region 3**  
**Exit Date:** 05/13/2019  
**Purpose of Visit:** Complaint/Incident Investigation  
**Tags:** F609/N1291; F610/N1992  
**Situations:** The facility failed to investigate and report to HHSC when three residents were identified having bruises of unknown origin.

**Deficient Practice:** The facility failed to ensure all alleged violations involving abuse and neglect, including injuries of unknown origin, were reported timely to the HHSC, and failed to have evidence that all allegations of abuse and neglect were thoroughly investigated.

**Region 4/5**  
**Exit Date:** 05/15/2019  
**Purpose of Visit:** Incident Investigation  
**Tags:** F689/N1433  
**Situations:** The facility failed to effectively supervise a resident with a history of smoking while their oxygen mask was placed on the back of their wheelchair with the oxygen turned on. The resident lit a cigarette under those conditions, igniting the tubing and causing burns to their face, ears, neck, chest, and abdomen.

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

**Region 4/5**  
**Exit Date:** 05/16/2019  
**Purpose of Visit:** Standard Survey  
**Tags:** F600/N1284; F607/N1285; F610/N1292
**Situations:** The facility failed to implement interventions when a resident engaged in acts of sexual abuse. The resident touched the genital area of another resident and the facility determined that it was not intentional and did not update their care plan to prevent future similar actions. The resident subsequently touched another resident inappropriately, which the facility did not document, and continued to exhibit inappropriate sexual behaviors toward staff.

**Deficient Practice:** The facility failed to implement policies and procedures to prevent abuse and failed to thoroughly investigate and prevent further potential abuse.

**Region 8/11**  
**Exit Date:** 05/17/2019  
**Purpose of Visit:** Standard Survey  
**Tags:** F880/N1647

**Situations:** The facility failed to obtain physician orders for droplet and isolation precautions for a resident admitted from the hospital with such precautions identified due to MRSA (highly resistant bacterial infection) in their sputum (saliva and mucus mixture coughed up from the respiratory tract). This failure continued for eight days following the resident’s admission and resulted in the facility failing to enact appropriate infection control procedures. Appropriate protective equipment was not worn, the resident was not made to wear a mask outside of their room, cleaning staff were not made aware of orders for contact isolation, and communal showers used by the resident were not effectively disinfected.

**Deficient Practice:** The facility failed to maintain an infection control program designed to provide a sanitary environment to help prevent the development and transmission of infections.

**Region 7**  
**Exit Date:** 05/24/2019  
**Purpose of Visit:** Complaint/Incident Investigation  
**Tags:** F600/N1286; F684/N1416; F880/N1647

**Situations:** The facility failed to follow proper procedures during wound care for two residents. A clean field was not maintained during care, and wounds were not appropriately draped when caretakers left the treatment area. The facility failed to effectively assess the wound for one resident, allowing maggots to form in the wound requiring hospitalization.

**Deficient Practice:** The facility failed to implement policies and procedures to prevent abuse, failed to ensure residents received treatment and care for wounds in accordance with professional standards of practice, and failed to maintain an infection control program designed to provide a sanitary environment to help prevent the development and transmission of infections.

**Region 2/9/10**
Exit Date: 05/24/2019
Purpose of Visit: Standard Survey
Tags: F812/N1536
Situations: The facility served undercooked, unpasteurized eggs to four residents with diagnoses of diseases that contributed to weakened immune systems.
Deficient Practice: The facility failed to prepare and serve food in accordance with professional standards for food service safety.

Region 3
Exit Date: 05/24/2019
Purpose of Visit: Standard Survey
Tags: F686/N1423
Situations: The facility failed to provide appropriate care and treatment for two residents with pressure ulcers. For one of those residents, the facility missed three wound care treatments resulting in deterioration of the wound.
Deficient Practice: The facility failed to provide adequate supervision and assistive devices to prevent accidents.

Region 4/5
Exit Date: 05/30/2019
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1284; F607/N1286
Situations: The facility failed to protect a resident from sexual abuse. The resident alleged that they were raped following discovery of injury to the genitals consistent with sexual assault. The resident was fearful, and the injury required surgical repair. The facility failed to report the allegations to law enforcement.
Deficient Practice: The facility failed to implement policies and procedures to prevent abuse.

Region 4/5
Exit Date: 06/12/2019
Purpose of Visit: Incident Investigation
Tags: F689/N1433
Situations: The facility failed to effectively supervise a cognitively impaired resident who was able to elope and was found by local law enforcement less than a mile from the facility.
Deficient Practice: The facility failed to ensure adequate supervision to prevent accidents.

Region 3
Exit Date: 06/16/2019
Purpose of Visit: Complaint/Incident Investigation  
Tags: F600/N1286; F689/N1433  
Situations: The facility failed to develop and implement systems to supervise residents with exit-seeking behaviors. Two residents were able to elope from the facility, one of whom was found in a sewage culvert with facial and scalp contusions and was later found to have sustained a fractured facial bone.  
Deficient Practice: The facility failed to implement policies and procedures to prevent neglect and failed to ensure adequate supervision to prevent accidents.

Region 3  
Exit Date: 06/20/2019  
Purpose of Visit: Complaint/Incident Investigation  
Tags: F580/N1130; F684/N1416; F689/N1433; F694; F773/N1753  
Situations: The facility failed to effectively assess a resident when they began to complain of chest pain, nausea, shortness of breath, and experienced restlessness, anxiety, falls, and changes in heart rate. The facility did not notify the resident’s physician. The resident was found face down on the floor the following day with no respirations or pulse and was pronounced dead. The facility failed to monitor a newly admitted resident who eloped from the facility without their knowledge for five hours. The resident was found by local law enforcement at a store over a mile from the facility. The facility failed to care for a resident’s PICC line site and change the dressing as required. The resident was admitted to the hospital with diagnoses of leukocytosis (abnormally high levels of white blood cells), deep vein thrombosis (blood clot in a deep vein), shock, and cardiac arrest. The resident died at the facility. For the same resident, the facility failed to notify a physician of critical laboratory values.  
Deficient Practice: The facility failed to notify and consult with a physician or family/LAR of changes in condition, facility failed to ensure treatment and care was provided in accordance with professional standards of practice, failed to ensure adequate supervision to prevent accidents, failed to ensure the PICC line site was maintained consistent with professional standards of practice and in accordance with physician orders, and failed to promptly notify the physician of critical laboratory results.

Region 6  
Exit Date: 06/27/2019  
Purpose of Visit: Complaint Investigation  
Tags: F580/N1130; F755/N1599  
Situations: The facility failed to administer cardiac medications as order to a resident with a pacemaker and did not inform the resident’s physician of the lapse. The resident exhibited respiratory distress and high blood pressure and was sent to the hospital where they were diagnosed with pulmonary edema, accelerated hypertension, and required intubation.  
Deficient Practice: The facility failed to notify and consult with a physician or family/LAR of changes in condition, and failed to provide pharmaceutical services,
including the dispensing and administering of drugs and biologicals to meet residents’ needs.