Quarterly IJ Summary Report
July 2019 – September 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 third quarter of 2019 (07/01/2019 – 09/30/2019).

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 forty-one of the surveys and investigations conducted, resulting in eighty-seven citations of twenty-five 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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*Rounded to the nearest tenth

Table 2

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<th># of IJs</th>
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Table 3

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<th>from Incidents</th>
<th>from Surveys</th>
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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
- 610 Investigate/Prevent/Correct Alleged Violation

**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
- 692 Nutrition/Hydration Status Maintenance
695 Respiratory/Tracheostomy Care and Suctioning
700 Bedrails

483.30 Physician Services
710 Resident’s Care Supervised by a Physician
712 Physician Visits – Frequency/Timeliness/Alternate NPP’s

483.40 – Behavioral Health Services:
740 Behavioral Health Services

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

483.60 – Food and Nutrition Services:
804 Nutritive Value/Appear, Palatable/Prefer Temp

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

483.70 - Administration:
835 Administration
837 Governing Body

483.75 – Quality Assurance and Performance Improvement
867 QAPI/QAA Improvement Actions

483.80 – Infection Control
880 Infection Prevention & Control

48.390 – Physical Environment
908 Essential Equipment, Safe Operating Condition
909 Resident Bed
925 Maintains Effective Pest Control Program

Acronyms

ADL – Activities of Daily Living
CPR – Cardiopulmonary Resuscitation
DON – Director of Nurses
HHSC – Health and Human Services Commission
LAR – Legally Authorized Representative
QA – Quality Assurance
### Region 4

**Exit Date:** 07/01/2019  
**Purpose of Visit:** Complaint Investigation  
**Tags:** F580/N1130; F684/N1416  

**Situations:** The facility failed to immediately inform a resident’s physician and effectively respond when the resident began to exhibit left side weakness, declines in communication and swallowing, a decreased level of consciousness, and other stroke-like symptoms. Approximately three hours later the resident also began to exhibit rapid respirations, elevated blood pressure and pulse, inability to move their left side, and their right side was rigid. The resident was transferred to the hospital and returned to the facility in terminal condition on hospice services.

**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 receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan.

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### Region 3

**Exit Date:** 07/02/2019  
**Purpose of Visit:** Complaint/Incident Investigation  
**Tags:** F580/N1129; F600/N1284; F607/N1285; F684/N1416/N1432  

**Situations:** The facility failed to notify a resident’s physician after the resident fell during an inappropriate transfer and failed to effectively assess the resident and document the incident. For two days the facility failed to document and assess after the resident and a family member reported significant pain in the resident’s leg. The resident received an x-ray that revealed two bilateral leg fractures and was transferred and subsequently admitted to the hospital over two days after the incident.

**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 ensure that residents received treatment and care in accordance with professional standards of practice.

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### Region 4

**Exit Date:** 07/03/2019  
**Purpose of Visit:** Incident Investigation  
**Tags:** F689/N1433  

**Situations:** The facility failed to implement effective interventions for a resident who was identified as at-risk for elopement. The facility failed to act when the resident proclaimed their desire to leave the facility and began to pack their belongings. The facility did not have a WanderGuard system in place and the alarms to alert when a door was opened were turned off on several halls. The resident eloped and was found on the ground outside of the facility by a visitor.

**Deficient Practice:** The facility failed to ensure adequate supervision was provided to prevent accidents.
Region 6
Exit Date: 7/13/2019
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1284; F686/N1422/N1423; F835/N1721
Situations: The facility failed to assess and treat pressure ulcers for two residents. One resident developed a severe pressure ulcer while at the facility, which was not identified until it was stage IV (depth of pressure ulcer may extend into muscles/tendons/bone, width may extend beyond the opening). The facility failed to prevent deterioration of a previously identified pressure ulcer in another resident. The facility did not effectively assess other wound care needs for residents. One resident was not assessed upon readmission with 14 staples, which were not removed for twenty-seven days. For another resident, the facility failed to follow treatment orders and assess their skin accurately. The facility failed to train relevant staff to monitor, assess, and treat pressure ulcers.

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 ensure it was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable.

Region 4
Exit Date: 07/16/2019
Purpose of Visit: Complaint Investigation
Tags: F684/N1416; F755/N1599; F835/N1721
Situations: The facility failed to ensure residents received treatment and care in accordance with professional standards when a staff member’s child was permitted to crush and mix medications, respond to residents’ requests for assistance, pass ice water, be present during a medical procedure, and deliver pain medication to a resident. The facility failed to investigate and report the incident.

Deficient Practice: The facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, failed to provide pharmaceutical services, including the dispensing and administering of drugs and biologicals to meet residents’ needs, and failed to ensure it was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable.

Region 6
Exit Date: 07/17/2019
Purpose of Visit: Standard Survey
Tags: F600/N1284/N1286; F684/N1416; F692/N1434; F695/N1437
Situations: The facility failed to effectively train and supervise a resident who chose to perform their own tracheostomy care and did not provide the supplies and equipment necessary to do so. The resident developed a respiratory infection that required antibiotic therapy. The facility failed to follow physician and dietician recommendations.
for two residents who received nutrition through enteral feeding. One resident experienced a significant decrease in weight over the course of a month. The facility did not assess and consult with a physician when a resident experienced extremely low blood glucose levels and continued in the failure after the resident was found unresponsive throughout the day. Twelve hours following the onset of their hypoglycemic state the resident was transported to the hospital where they were intubated and placed on a ventilator. The facility failed to consult with a resident’s physician after they complained of hip pain following a mechanical lift transfer.

**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, failed to ensure residents fed by enteral means maintained acceptable parameters of nutritional status, and failed to ensure a resident who needed respiratory care including tracheostomy care and tracheal suctioning was provided such care consistent with professional standards of practice.

### Region 1
**Exit Date:** 07/23/2019  
**Purpose of Visit:** Complaint/Incident Survey  
**Tags:** F689/N1433  
**Situations:** The facility failed to supervise a resident after they were assisted outside of the facility. The resident was left alone outside in temperatures greater than ninety-five degrees for over two hours.  
**Deficient Practice:** The facility failed to ensure adequate supervision was provided to prevent accidents.

### Region 4
**Exit Date:** 08/02/2019  
**Purpose of Visit:** Standard Survey  
**Tags:** F580/N1130; F600/N1284; F607/N1285; F684/N1416; F686/N1423; F710/N1548; F712/N1561; F867/N1822  
**Situations:** The facility failed to ensure that a resident’s care was supervised by a physician. The resident had not been seen by the attending physician for over sixty days. The facility failed to immediately consult with a physician when this resident’s blood glucose levels were dangerously low. The resident remained at critical blood glucose levels for over two hours before being transferred to the hospital when the resident was non-responsive. For the same resident, the facility failed to notify a physician when they developed two pressure ulcers and did not effectively treat the wounds. The pressure ulcers deteriorated and eventually developed sepsis (potentially life-threatening condition caused by the body's response to an infection). The resident was transferred to the hospital where they died. The QA committee failed to identify these lapses in care for the resident and did not implement measures to correct the issues.  
**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 abuse, failed to ensure that residents received treatment and care in accordance with professional standards of practice, failed to ensure that residents having pressure ulcers received necessary treatment and services to promote healing, failed to ensure that a physician supervised the medical care of residents, failed to ensure physician visits were provided at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter, and failed to ensure that the quality assessment and assurance committee (QAA) developed and implemented appropriate plans of actions to correct and identify potential deficiencies of care.

**Region 1**
*Exit Date:* 08/02/2019  
*Purpose of Visit:* Incident Investigation  
*Tags:* F600/N1284; F689/N1433; F908/N1689  
*Situations:* The facility did not ensure the sling used with the mechanical lift was in good condition before attempting to transfer a resident. The sling broke away from the lift, dropping the resident and resulting in severe head injuries, including lacerations that required sutures and possible brain bleed, as well as multiple skin tears to the upper and lower extremities.  
**Deficient Practice:** The facility failed to implement policies and procedures to prevent neglect, failed to provide adequate supervision and assistive devices to prevent accidents, and failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition.

**Region 3**
*Exit Date:* 08/05/2019  
*Purpose of Visit:* Complaint/Incident Investigation  
*Tags:* F600/N1284; F607/N1285; F610/N1292  
*Situations:* The facility failed to protect two residents from abuse. Two staff members were alleged to have each hit a resident. One staff member admitted to the allegation and was suspended initially during the facility’s investigation but was allowed to return. The second was not suspended during the investigation and the facility failed to conduct it thoroughly and with personnel familiar with the process.  
**Deficient Practice:** The facility failed to implement policies and procedures to prevent abuse and failed to have evidence that all allegations of abuse and neglect were thoroughly investigated.

**Region 7**
*Exit Date:* 08/05/2019  
*Purpose of Visit:* Standard Survey  
*Tags:* F689/N1432/N1433  
*Situations:* The facility did not implement interventions to prevent falls for three residents. One resident fell nine times within two months, three of which resulted in head injuries. One of the falls required staples. Another resident fell five times within a week and a third fell once, sustaining a head injury.
Deficient Practice: The facility failed to ensure each resident received adequate supervision to prevent accidents.

Region 3
Exit Date: 08/05/2019
Purpose of Visit: Complaint Investigation
Tags: F835/N1721; F837/N1725; N1880
Situations: The facility failed to ensure employees, vendors, and utilities (including electricity, gas, water, and generator) were paid timely and failed to provide an effective plan of correction timely.

Deficient Practice: The facility failed to implement policies regarding the management and operation of the facility and the corporate management company failed to be actively engaged and involved in the management of the facility, which resulted in the facility being unable to pay utility bills, vendors, and employees.

Region 4
Exit Date: 08/08/2019
Purpose of Visit: Complaint/Incident Investigation
Tags: F689/N1433
Situations: The facility did not follow a resident’s care plan and utilize two people and a mechanical lift during a transfer. The resident fell and sustained a comminuted fracture (splinter of the bone into more than two fragments) to both their tibia and fibula. The resident developed compartment syndrome, where pressure in their muscle increased risking limits to blood flow, and required a fasciotomy (muscle compartment is cut to allow the tissue to swell and decrease pressure) and ultimately amputation of the leg above the knee.

Deficient Practice: The facility failed to ensure each resident received adequate supervision to prevent accidents.

Region 1
Exit Date: 08/10/2019
Purpose of Visit: Incident Investigation
Tags: F689/N1432
Situations: The facility failed to develop a care plan and implement interventions for a resident with a history of ingesting foreign objects and rummaging. The facility did not secure cleaning chemicals and other objects capable of harming residents if ingested. The resident ingested cleaning chemicals, began coughing and vomiting, and had to transfer to a hospital for treatment.

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 3
Exit Date: 08/12/2019  
**Purpose of Visit:** Complaint Investigation  
**Tags:** F580/N1129; F607/N1285; F684/N1416; F925/N925  
**Situations:** The facility failed to assess a resident and notify their physician after discovering ants in their room and all over their body. The resident sustained multiple bites from the ants and their condition deteriorated over the following two days. The facility continued in the failure until the resident’s hospice provider intervened three days after the incident.  
**Deficient Practice:** The facility failed to notify and consult with a physician or family/LAR of changes in condition, failed to develop and implement policies and procedures to prevent neglect, failed to ensure residents received treatment and care for wounds in accordance with professional standards of practice, and failed to maintain an effective pest control program to ensure the facility was free of pests.

### Region 5
Exit Date: 08/13/2019  
**Purpose of Visit:** Complaint Investigation  
**Tags:** F610/N1292; F689/N1433  
**Situations:** The facility failed to supervise a resident who went outside for a supervised smoke break but subsequently left the resident unattended for over three hours. The resident was eventually found outside, lethargic, with a temperature of 101 degrees, and blistered skin. The resident was transferred to the hospital and treated for heat exhaustion. The facility failed to effectively investigate this incident as well as an altercation between to residents that resulted in bruising to the eye of one of the residents.  
**Deficient Practice:** The facility failed to thoroughly investigate and prevent further potential abuse and failed to ensure adequate supervision to prevent accidents.

### Region 6
Exit Date: 08/13/2019  
**Purpose of Visit:** Complaint Investigation  
**Tags:** F580/N1130; F684/N1416  
**Situations:** The facility failed to notify the physician that the ordered IV fluids were unavailable and that there would be a significant delay in receiving them. The facility did not inform the physician of the resident’s abnormal lab conditions which a medication that had been ordered would further exacerbate. The facility did not notify the physician of increased symptoms of dehydration and confusion, resulting in a delay in the transfer to a hospital for treatment. The resident was ultimately transferred to the hospital with dehydration, pneumonia, sepsis (potentially life-threatening condition caused by the body’s response to an infection), and nineteen percent kidney function and subsequently died at the hospital.  
**Deficient Practice:** The facility failed to notify and consult with a physician or family/LAR of changes in condition and failed to provide treatment and care based on the comprehensive assessment, in accordance with professional standards.
Region 4
Exit Date: 08/13/2019
Purpose of Visit: Compliant/Incident Investigation
Tags: F689/N1433
Situations: The facility failed to implement interventions to ensure three residents identified as at-risk for elopement did not elope. The three residents were discovered walking down the middle of a road toward a major intersection.
Deficient Practice: The facility failed to ensure adequate supervision to prevent accidents.

Region 2
Exit Date: 08/15/2019
Purpose of Visit: Standard Survey
Tags: F684/N1416; F760/N1442
Situations: The facility failed to properly transcribe the resident’s medication orders following readmission from the hospital. The resident was administered more insulin than was prescribed and given a medication that had been discontinued. The facility did not monitor the resident’s blood glucose levels and the resident developed severe hypoglycemia and seizure-like activity requiring hospitalization.
Deficient Practice: The facility failed to provide treatment and care based on the comprehensive assessment, in accordance with professional standards; and failed to ensure each resident's drug regimen was free of significant medication errors.

Region 5
Exit Date: 08/15/2019
Purpose of Visit: Complaint Investigation
Tags: F600/N1285; N1291; F610/N1292; F689/N1432; F804/N1525
Situations: The facility failed to ensure coffee made accessible to residents was a safe temperature for consumption without injury. A resident sustained significant burns to their mouth and throat, requiring hospitalization in a burn unit and the inability to take food or drink by mouth. The facility failed to investigate the subsequent written grievance of abuse and did not implement interventions to ensure a similar incident did not happen again.
Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and neglect, failed to ensure in response to an allegation of abuse or neglect there was a thorough investigation, ensure further potential abuse was prevented during the investigation and ensure the investigative results were reported to HHSC, the facility failed to provide adequate supervision to prevent accidents, and failed to ensure each resident received drinks provided at a safe and appetizing temperature.
**Region 4**

**Exit Date:** 08/15/2019  
**Purpose of Visit:** Standard Survey  
**Tags:** F689/N1433  

**Situations:** The facility did not supervise a resident, who was identified as at-risk for elopement, to prevent the resident from leaving the facility without staff knowledge, and to ensure the alarms on the exit doors were not functioning properly. The resident left the facility and made it to the business next door close to a major highway.

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

**Region 4**

**Exit Date:** 08/16/2019  
**Purpose of Visit:** Incident Investigation  
**Tags:** F689/N1433  

**Situations:** The facility failed to implement interventions for two residents identified as at-risk for elopement. One resident attempted to escape on two occasions. Another eloped from the facility and received a ride from a stranger to their former apartment over a mile away from the facility.

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

**Region 6**

**Exit Date:** 08/19/2019  
**Purpose of Visit:** Complaint/Incident Investigation  
**Tags:** F692/N1434  

**Situations:** The facility failed to consult with a physician for two residents who experienced continued weight loss and did not implement the dietician’s recommendations to prevent the weight loss. One resident experienced a weight loss of over seventeen percent in six months and the other almost six percent within a month. The former was ultimately admitted to the hospital with diagnoses of dehydration, malnutrition, and sepsis (potentially life-threatening condition caused by the body's response to an infection) and was placed on hospice.

**Deficient Practice:** The facility failed to ensure residents maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise.

**Region 6**

**Exit Date:** 08/21/2019  
**Purpose of Visit:** Complaint Investigation  
**Tags:** F600/N1285; F684/N1416; F835/N1721
**Situations:** The facility failed to ensure staff were effectively trained on resident transfers and those that received training were trained by qualified staff members. One resident dependent on staff for all ADL’s received a hip fracture of unknown origin, and another was observed being transferred incorrectly. The facility failed to properly assess and notify a physician for two residents who experienced a change in condition, one of whom was identified with facial angioedema (rapid swelling beneath the skin) and was found unresponsive eleven hours later.

**Deficient Practice:** The facility failed to implement policies and procedures to prevent neglect, failed to ensure treatment and care was provided in accordance with professional standards of practice, and failed to ensure it was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable.

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**Region 1**
**Exit Date:** 08/21/2019
**Purpose of Visit:** Complaint/Incident Investigation
**Tags:** F689/N1432; F700/F909/N1690

**Situations:** The facility failed to ensure the assistance bars on a resident’s bed were secured safely. The bars were not secured tightly and there was a gap between the bed and bars. The resident was found with their neck and jaw wedged between the mattress and one of the bars, unresponsive, and without pulse and was pronounced dead.

**Deficient Practice:** The facility failed to implement policies and procedures to prevent neglect and failed to ensure adequate supervision to prevent accidents; failed to ensure the correct installation, use, and maintenance of bed rails; and failed to conduct regular inspection of all bed frames, mattresses, and bed rails, as part of a regular maintenance program to identify areas of possible entrapment.

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**Region 6**
**Exit Date:** 08/26/2019
**Purpose of Visit:** Complaint Investigation
**Tags:** F684/N1416; F740/N1428

**Situations:** The facility failed to develop and implement an effective care plan for a resident with behavioral concerns that affected themselves and others. The facility did not implement the prescribed psychiatric consultation for the resident for six months and did not consult with a physician when the resident expressed their desire to die, refused care, yelled and cursed at staff members, and attempted to pull out their tracheostomy tube. The facility did not effectively attempt to treat the resident when they were found unresponsive with their tracheostomy tube dislodged. The resident was transferred to the hospital where they died.

**Deficient Practice:** The facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan, failed to ensure residents received the necessary behavioral health care and services to attain or maintain their highest practicable well-being.
<table>
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<td>The facility failed to supervise a resident identified as at-risk for elopement. The resident was brought to the nurse’s station for supervision but was left unattended. The resident exited the facility and fell out of their wheelchair, sustaining a broken nose and bruises to the head. The facility failed to have the alarms on exit doors operational.</td>
<td>The facility failed to ensure adequate supervision to prevent accidents.</td>
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<td>Incident Investigation</td>
<td>F580/N1130; F684/N1416</td>
<td>The facility failed to notify a physician and assess a resident when they had trouble breathing. The facility continued in this failure after a family member requested physician notification. The resident continued to show distress the following day and did not eat. The resident was found unresponsive in their room and was transferred to a hospital where they died.</td>
<td>The facility failed to notify and consult with a physician or family/LAR of changes in condition and failed to ensure that residents receive treatment and care in accordance with professional standards of practice.</td>
</tr>
<tr>
<td>4</td>
<td>08/29/2019</td>
<td>Incident Investigation</td>
<td>F689/N1433</td>
<td>The facility failed to supervise a resident identified as at-risk for elopement. The resident eloped from the facility and was found at a neighboring facility, close to a major highway.</td>
<td>The facility failed to provide adequate supervision to prevent accidents.</td>
</tr>
<tr>
<td>4</td>
<td>08/30/2019</td>
<td>Complaint Investigation</td>
<td>F580/N1130; F684/N1416</td>
<td>The facility failed to effectively assess and adequately inform a resident’s physician when they had stroke-like symptoms resulting in a lapse in care for the</td>
<td></td>
</tr>
</tbody>
</table>
symptoms. The resident was transferred to the hospital over twenty hours after the symptoms were identified and was diagnosed with an acute stroke.

**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 receive treatment and care in accordance with professional standards of practice.

| Region 5  | Exit Date: 08/31/2019  
Purpose of Visit: Complaint Investigation  
Tags: F686/N1422/N1423; F835/N1721  
Situations: The facility failed to ensure that four residents with pressure ulcers were treated effectively to heal the ulcers and prevent deterioration. Two residents were admitted without pressure ulcers and were fully ambulatory and developed them at the facility. All four were ineffectively treated and their pressure ulcers worsened.  
**Deficient Practice:** The facility failed to ensure that residents having pressure ulcers received necessary treatment and services to promote healing and failed to ensure it was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable. |

| Region 4  | Exit Date: 09/10/2019  
Purpose of Visit: Complaint Investigation  
Tags: F837/N1725  
Situations: The facility failed to ensure funds were available to meet all financial obligations, including paying employees and vendors. Banks in the area refused to honor payroll checks as the facility often had insufficient funds. The facility had over seventy thousand dollars in unpaid bills to vendors.  
**Deficient Practice:** The facility failed to ensure the governing body established and implemented policies regarding the management and operation of the facility. |

| Region 6  | Exit Date: 09/14/2019  
Purpose of Visit: Complaint/Incident Investigation  
Tags: F600/N1284; F684/N1416  
Situations: The facility failed to ensure staff were trained on how to properly transfer residents and where to find information on what method to transfer residents with. One resident was improperly transferred and fell resulting in a fracture to both lower right leg bones.  
**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:** 09/14/2019  
**Purpose of Visit:** Standard Survey  
**Tags:** F689/N1433  
**Situations:** The facility failed to supervise and implement interventions for a resident identified as at-risk for elopement. The resident eloped from the facility and fell. Bystanders who witnessed the fall called an ambulance and the resident was taken to the hospital with fractures to the skull and facial bones. The resident eloped from the facility again nearly two months later and was found on the ground in the street by a visitor.  
**Deficient Practice:** The facility failed to provide adequate supervision to prevent accidents.

**Region 6**  
**Exit Date:** 09/17/2019  
**Purpose of Visit:** Complaint Investigation  
**Tags:** F686/N1422/N1423  
**Situations:** The facility failed to effectively monitor a resident’s pressure ulcer to ensure it was not worsening and failed to obtain wound cultures as ordered by the resident’s physician. The wound culture had to be order twice and antibiotic treatment was delayed. The wound continued to deteriorate and required debridement and the resident developed osteomyelitis (infection to the bone).  
**Deficient Practice:** The facility failed to ensure that residents having pressure ulcers received necessary treatment and services to promote healing.

**Region 6**  
**Exit Date:** 09/18/2019  
**Purpose of Visit:** Standard Survey  
**Tags:** F684/N1416; F686/N1422/N1423; F880/N1648/N1649/N1651  
**Situations:** The facility failed to assess and monitor a resident when they had a change in condition where fluid built up in their upper extremities and abdomen and did not communicate the change between shifts. The facility did not immediately act when the resident was found unresponsive and delayed in calling emergency services, first calling the DON, and the resident’s family and doctor. The resident died in the hospital the following day. The facility did not ensure that a resident admitted to the facility with a low risk for developing pressure ulcers received care to prevent them. The resident developed a pressure ulcer which became infected with staphylococcus and e. coli after the wound was treated with gloves used to handle biohazard bags. The resident was subsequently allowed to ambulate around the facility and interact with staff and other residents while they had an ongoing infection and a draining wound.  
**Deficient Practice:** The facility failed to ensure treatment and care was provided in accordance with professional standards of practice, failed to ensure that residents having pressure ulcers received necessary treatment and services to promote healing, failed to
maintain an effective infection control program designed to help prevent the development and transmission of disease and infection.

| Region 1 | Exit Date: 09/19/2019 |
| Purpose of Visit: Standard Survey |
| Tags: F600/N1285; F686/N1423 |
| **Situations:** The facility failed to consult with physicians and effectively treat three residents with pressure ulcers. The ulcers on all three residents deteriorated over the course of months. One of the residents missed several wound care treatments and another developed sepsis (potentially life-threatening condition caused by the body's response to an infection). |
| **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 1 | Exit Date: 09/20/2019 |
| Purpose of Visit: Incident Investigation |
| Tags: 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. The resident was taken to the hospital by EMS and pronounced dead. |
| **Deficient Practice:** The facility failed to provide basic life support, including CPR, prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. |

| Region 6 | Exit Date: 09/20/2019 |
| Purpose of Visit: Complaint/Incident Investigation |
| Tags: F580/N1129; F684/N1416 |
| **Situations:** The facility failed to notify a resident’s physician when the resident had a change in condition. The resident’s blood pressure and blood glucose levels became elevated and the resident was moaning and crying into the following day after the onset of the conditions. The physician was not notified until the resident was being transferred to the hospital via emergency services. The facility failed to effectively care for a resident’s rectal tube, requiring hospitalization twice for care of the device. |
| **Deficient Practice:** The facility failed to notify and consult with a physician or family/LAR of changes in condition and failed to ensure treatment and care was provided in accordance with professional standards of practice. |
### Region 4
**Exit Date:** 09/20/2019  
**Purpose of Visit:** Incident Investigation  
**Tags:** F689/N1433; N047  
**Situations:** The facility failed to implement effective interventions for a resident who was identified as at-risk for elopement. The facility did not respond immediately when the alarms on the exit doors sounded, waiting several minutes before looking for the resident. The resident was found by passersby propelling in their wheelchair on the shoulder of a major highway.  
**Deficient Practice:** The facility failed to provide adequate supervision to prevent accidents.

### Region 2
**Exit Date:** 09/30/2019  
**Purpose of Visit:** Complaint/Incident Investigation  
**Tags:** F600/N1285; F684/N1416  
**Situations:** The facility failed to ensure a resident’s correct wound care orders were received and did not provide the resident with the specialized wound dressing they needed. The failure continued for nearly a month and resulted in the resident being hospitalized with cellulitis to the lower extremity and sepsis (potentially life-threatening condition caused by the body's response to an infection).  
**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.