

Quarterly IJ Summary Report October 2019 – December 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 (10/01/2019 – 12/30/2019).

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

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*
550	2.2%	689	21.7%
580	8.7%	684	17.4%
600	10.9%	600	10.9%
607	4.3%	580	8.7%
610	2.2%	837	8.7%
656	2.2%	607	4.3%
660	2.2%	550	2.2%
678	2.2%	610	2.2%
684	17.4%	656	2.2%
686	2.2%	660	2.2%
689	21.7%	678	2.2%
693	2.2%	686	2.2%
697	2.2%	693	2.2%
755	2.2%	697	2.2%
760	2.2%	755	2.2%
837	8.7%	760	2.2%
842	2.2%	842	2.2%
849	2.2%	849	2.2%
925	2.2%	925	2.2%

*Rounded to the nearest tent



Table 2

Region	# of IJs	# of NFs	% of IJs/NF
1	0	92	0%
2	4	137	2.9%
3	9	230	3.9%
4	6	196	3.1%
5	5	189	2.6%
6	5	180	2.8%
7	1	231	0.4%
Total	30	1255	2.4%

Table 3
Number of IJs

from Complaints	from Incidents	from Surveys	Total
21	3	6	30

Tag References

483.10 - Resident Rights:

- 550 Residents Rights/Exercise 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

483.21 - Comprehensive Resident Centered Care Plans:

- 656 Develop/Implement Comprehensive Care Plan
- 660 Discharge Planning Process

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
- 697 Pain Management

483.45 - Pharmacy Services:

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

483.70 - Administration:



- 837 Governing Body
- 842 Resident Records – Identifiable Information
- 849 Hospice Services

48.390 – Physical Environment

- 925 Maintains Effective Pest Control Program
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Acronyms

CPR – Cardiopulmonary Resuscitation

LAR – Legally Authorized Representative

Region 3**Exit Date:** 10/01/2019**Purpose of Visit:** Complaint/Incident Investigation**Tags:** F600/N1284**Situations:** The facility failed to protect a resident from an alleged abuse perpetrator. A staff member allegedly hit the resident in the head with a bottle used for perineal care and sprayed the resident in the eyes with the contents of the bottle. The facility allowed the alleged perpetrator to work an additional twelve days at the facility.**Deficient Practice:** The facility failed to implement policies and procedures to prevent abuse.**Region 3****Exit Date:** 10/03/2019**Purpose of Visit:** Complaint/Incident Investigation**Tags:** F600/N1284; F925/N1717**Situations:** The facility failed to intervene when ants were observed in a resident's room. As a result, the resident was attacked and received ant bites requiring hospitalization.**Deficient Practice:** The facility failed to implement policies and procedures to prevent abuse and failed to maintain an effective pest control program so that the facility was free of pests.**Region 5****Exit Date:** 10/04/2019**Purpose of Visit:** Complaint Investigation**Tags:** N1526 (Licensure Tag Only)**Situations:** The facility failed to provide food in the appropriate form to a resident who was ordered a mechanically softened diet, resulting in the resident choking on the food and subsequently dying. The facility failed to follow the requirements for a mechanically softened diet for three other residents, putting them at harm.**Deficient Practice:** The facility failed to ensure that residents on a mechanically soft diet with a diagnosis of dysphagia (oropharyngeal) received the appropriate prescribed diet required for their safety.**Region 4****Exit Date:** 10/04/2019**Purpose of Visit:** Incident Investigation**Tags:** F689/N1433**Situations:** The facility failed to implement interventions for a resident after their spouse told the facility the resident had expressed that they did not want to be there. The resident was found after two in the morning outside the facility in the middle of the street, four hours after last being observed.

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

Region 4

Exit Date: 10/09/2019

Purpose of Visit: Incident Investigation

Tags: F678/N1234

Situations: The facility failed to immediately initiate CPR on a resident who was found unresponsive with no pulse or respirations and had a full code status, which allows full interventions to restart the heart. The resident was ultimately pronounced dead at the facility.

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

Region 4

Exit Date: 10/11/2019

Purpose of Visit: Complaint Investigation

Tags: F660/N1275

Situations: The facility did not develop and implement an effective discharge plan for a resident. The facility did not make referrals to appropriate agencies such as home health services and follow-up appointments with physicians, and did not provide special instructions required to care for the resident upon discharge. The resident was discharged from the facility with a pureed diet, pressure ulcers, and an indwelling urinary catheter. The resident did not receive any services to meet their special needs for fifteen days which led to the resident being "severely neglected" and admitted to the hospital. The resident was hospitalized for sepsis (potentially life-threatening condition caused by the body's response to an infection), aspiration (food or liquids entering an airway), ileus (obstruction of part of the intestine), infection of a severe pressure injury, and kidney injury. The resident required a ventilator machine to breathe, a colostomy, and a feeding tube while hospitalized.

Deficient Practice: The facility failed to ensure an effective discharge planning process was implemented to effectively transition to post discharge care to prevent a readmission

Region 4

Exit Date: 10/17/2019

Purpose of Visit: Complaint/Incident Investigation

Tags: F689/N1433

Situations: The facility failed to implement interventions for a resident who expressed the desire and intent to leave the facility. Two weeks after these declarations were made the resident was found by the police over a mile from the facility, lying in the grass.

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



Region 3**Exit Date:** 10/18/2019**Purpose of Visit:** Standard Survey**Tags:** F684/N1416

Situations: The facility failed to ensure three residents received appropriate treatment for their central venous catheters, including routinely monitoring and assessing the site for infections or complications, changing the dressing and access port routinely and as needed, and physician orders related to the devices. One resident did not received care for forty-five days, one for twenty days, and one for ten days.

Deficient Practice: The facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

Region 5**Exit Date:** 10/18/2019**Purpose of Visit:** Complaint Investigation**Tags:** F837/N1725

Situations: The facility did not have an effective system in place to fund payment for employees' paychecks and vendors. The facility could not make payroll on scheduled paydays and could not pay vendors timely. Banks in the local and surrounding towns would not cash facility staff payroll checks due to insufficient funds. The facility had been having payroll and vendor payment issues for approximately six months. Facility staff had resigned due to not being paid timely. The facility had over thirteen thousand dollars in unpaid utilities.

Deficient Practice: The facility failed to ensure the governing body established and implemented policies regarding the management and operation of the facility.

Region 3**Exit Date:** 10/25/2019**Purpose of Visit:** Standard Survey**Tags:** F607/N1285

Situations: The facility failed to implement their policies ensuring they did not hire staff with convictions that would bar employment. The facility did not run a background check and hired a staff member who had been convicted of assault causing bodily injury. The facility failed to do searches of the employee misconduct registry and nurse aid registry for four other staff members.

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

Region 2**Exit Date:** 10/28/2019**Purpose of Visit:** Complaint Investigation**Tags:** F689/N1432

Situations: The facility did not have an effective system in place to fund payment for employees' paychecks and vendors. The facility could not make payroll on scheduled payday and could not pay vendors timely. Banks in the local and surrounding towns would not cash facility staff payroll checks due to insufficient funds. Facility staff had resigned due to not being paid timely.

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: 10/29/2019

Purpose of Visit: Standard Survey

Tags: F686/N1423

Situations: The facility failed to provide appropriate equipment and treatment for a resident with pressure ulcers. The facility failed to effectively and regularly assess the pressure ulcers, resulting in deterioration of the wounds. The facility failed to perform wound care using proper technique. For another resident with a pressure ulcer and sepsis (potentially life-threatening condition caused by the body's response to an infection), the facility failed to follow physician orders for treatment and did not assess the wound.

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

Region 3

Exit Date: 10/31/2019

Purpose of Visit: Complaint Investigation

Tags: F580/N1130; F684/N1416

Situations: The facility failed to identify a change in condition and inform a resident's physician when the resident reported sudden blindness in the right eye. The facility made an assessment and decided the lack of pain and normal pupil response did not constitute a change in condition.

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 3

Exit Date: 10/31/2019

Purpose of Visit: Complaint/Incident Investigation

Tags: F656/N1389; F684/N1416

Situations: The facility failed to perform blood glucose tests on a resident and did not provide the resident with their medication, including their insulin and anti-coagulant, for five days. The resident was found nonverbal and unable to follow prompts and was sent to the hospital where they were diagnosed with an acute stroke and critically high blood glucose.



Deficient Practice: The facility failed to develop and implement a comprehensive person-centered care plan and failed to provide treatment and care in accordance with professional standards of practice and the comprehensive care plan.

Region 3

Exit Date: 11/03/2019

Purpose of Visit: Compliant/Incident Investigation

Tags: F689/N1432

Situations: The facility failed to effectively set up a resident's low air loss mattress resulting in the resident falling and sustaining a neck fracture, a laceration to the forehead, and a hematoma to the back of the head. The facility failed to ensure another resident's room remained free of accident hazards by placing a bed mattress next to their bed as a fall mat. The resident fell and sustained a facial fracture.

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

Region 4

Exit Date: 11/07/2019

Purpose of Visit: Standard Survey

Tags: F689/N1433

Situations: The facility failed to implement interventions for a resident who began exhibiting increased wandering behaviors and had tried to leave the facility. The resident eloped from the facility in the middle of the night and was found in the parking lot of the store next to the facility with a fractured neck and nose.

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

Region 7

Exit Date: 11/09/2019

Purpose of Visit: Standard Survey

Tags: F600 F607/N1285; F689/N1433

Situations: The facility failed to ensure that the mechanical lifts were functioning properly, and that staff were trained to use them. The facility failed to ensure staff were performing transfers as instructed in the residents' care plans. One resident fell when the sling of a mechanical lift became detached, resulting in a hip contusion. Another resident was transferred incorrectly, with one staff member instead of two, resulting in the resident falling and sustaining a lower leg fracture.

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



Region 6**Exit Date:** 11/12/2019**Purpose of Visit:** Complaint/Incident Investigation**Tags:** F580/N1130/N1131; F684/N1416

Situations: The facility failed to effectively assess and consult with a physician when a resident was observed with large bruising on their upper chest and continued to administer the resident's anticoagulant medication for seven days after the initial observation. The facility failed to implement the resident's care plan related to their risk of bleeding and bruising due to their anticoagulant medication regimen.

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 5**Exit Date:** 11/15/2019**Purpose of Visit:** Complaint/Incident Investigation**Tags:** F550/N1130; F837/N1725/N1880

Situations: The facility failed to protect a resident's rights when pictures and videos of the resident were taken and posted to social media. The facility failed to ensure funds were available to meet all financial obligations, including paying employees and vendors. The facility had over sixteen thousand dollars in unpaid bills to vendors.

Deficient Practice: The facility failed to treat each resident with respect, dignity and care in a manner and in an environment that promoted enhancement of their quality of life, while protecting the rights of the resident, and failed to ensure the governing body established and implemented policies regarding the management and operation of the facility.

Region 5**Exit Date:** 11/20/2019**Purpose of Visit:** Complaint/Incident Investigation**Tags:** F600/N1285; F610/N1292; F689/N1432

Situations: The facility failed to follow a resident's care plan during a transfer resulting in the resident falling and sustaining a fracture to their femur. Within the week following this incident, the resident also sustained a fracture to their other femur, the origin of which was unknown. Another resident had two unwitnessed falls. The resident complained of pain and shortness of breath following the second fall and an x-ray revealed two fractured ribs and an air pocket on the outside of one lung. The facility failed to investigate the injury of unknown origin for the first resident and failed to investigate an incident where another resident was found on the floor of their room with a head injury. The latter resident was sent to the hospital and returned to the facility on hospice with a diagnosis of traumatic subdural hematoma and died.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to have evidence that all alleged violations were thoroughly investigated,



and protective measures were put in place to prevent further potential neglect, and failed to ensure that residents environment remained as free of accident hazards as possible.

Region 3

Exit Date: 11/25/2019

Purpose of Visit: Incident Investigation

Tags: F689/N1432

Situations: The facility failed to implement effective interventions for a resident known to be at-risk for elopement. The resident eloped from the facility and the facility remained unaware until a family member of the resident called to inform the facility that the resident had been found in a nearby store parking lot by law enforcement.

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

Region 5

Exit Date: 11/26/2019

Purpose of Visit: Complaint/Incident Investigation

Tags: F755/N1442; F760/N1599

Situations: The facility failed to administer the correct doses of a resident's anti-nausea medication. Two times, the resident was given five times their prescribed dose of medication. The resident died eleven hours after the second time the incorrect dose was given.

Deficient Practice: The facility failed to provide pharmaceutical services to meet the needs of each resident and failed to ensure residents were free of significant medication errors.

Region 6

Exit Date: 11/27/2019

Purpose of Visit: Complaint/Incident Investigation

Tags: F684/N1416; F697; F849/N1887/N1888

Situations: The facility failed to accurately assess and inform a resident's physician and hospice service when the resident complained of excruciating and uncontrolled pain after their return from the hospital. The facility did not administer the resident's pain medication as indicated by their discharge orders. The resident continued to experience pain until their death two days after returning to the facility. The facility failed to assess a resident after two falls in one day. The facility did not consult with the resident's physician when they complained of pain three days after the fall. The facility waited an additional two days to identify a neck fracture. The facility failed to report an observation of a resident who had blood on their pillow and complained of pain when their head was touched. The resident's injuries were later identified by their hospice provider and they were diagnosed at the hospital with a scalp contusion and bruises to



the neck and face. The facility failed to have policies in place that ensured care was properly coordinated between them and hospice agencies.

Deficient Practice: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan, failed to ensure pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences, and failed to ensure there was a communication process, including how the communication will be documented between the facility and the hospice provider, to ensure that the needs of the resident are addressed and met twenty-four hours per day.

Region 5

Exit Date: 12/02/2019

Purpose of Visit: Complaint/Incident Investigation

Tags: F837/N1725/N1880

Situations: The facility failed to ensure funds were available to meet all financial obligations, including paying employees, vendors, including those who provided food and equipment maintenance, and utility providers. The failures to pay vendors resulted in discontinuation of services and ongoing disrepair of equipment.

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.

Region 6

Exit Date: 12/03/2019

Purpose of Visit: Complaint Investigation

Tags: F684/N1416

Situations: The facility failed to assess and monitor a resident who had recently been diagnosed with pneumonia. The resident was found dead with their nasal cannula underneath them and signs of rigor mortis. An autopsy revealed cyanosis (blue discoloration due to inadequate oxygenation) to the upper extremities.

Deficient Practice: The facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

Region 2

Exit Date: 12/11/2019

Purpose of Visit: Complaint/Incident Investigation

Tags: F689/N1433

Situations: The facility failed to supervise a resident and locked them outside of the facility for over four hours. When the resident was discovered the facility sent them to the hospital where they were diagnosed with hypothermia.



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

Region 6

Exit Date: 12/12/2019

Purpose of Visit: Complaint/Incident Investigation

Tags: F693/N1431

Situations: The facility failed to ensure staff were trained to reinsert a resident's gastronomy tube, failed to ensure diagnostic study results confirmed placement of the tube, failed to ensure x-ray results of the placement were accurately reported to the resident's physician, and failed to assess the resident after a change in condition. The resident was transferred to the hospital where they were diagnosed with peritonitis (inflammation of the peritoneum, typically caused by bacterial infection either via the blood or after rupture of an abdominal organ) and sepsis (potentially life-threatening condition caused by the body's response to an infection) due to the misplaced tube. The resident later developed respiratory failure, required intubation, and subsequently died.

Deficient Practice: The facility failed to ensure that residents who were fed by enteral means received the appropriate treatment and services to prevent complications of an enteral feeding.

Region 2

Exit Date: 12/16/2019

Purpose of Visit: Complaint/Incident Investigation

Tags: F689/N1433

Situations: The facility failed to implement interventions for a resident known to be at-risk for elopement. The resident eloped from the facility without the facility being aware. A visitor, who did not know the resident, convinced the resident to get in their vehicle and informed the facility of the elopement. The facility failed to check the function of the WanderGuards for two other residents at-risk for elopement.

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

Region 4

Exit Date: 12/16/2019

Purpose of Visit: Complaint/Incident Investigation

Tags: F580/N1130; F684/N1416; F842/N1783

Situations: The facility failed to effectively assess and inform a resident's physician when they began to vomit and did not document in the resident's clinical record their complaints of vomiting, or any assessment or interventions. The resident was ultimately transferred to the emergency room where they were diagnosed with aspiration pneumonia and sepsis (potentially life-threatening condition caused by the body's response to an infection). The resident 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 ensure treatment, failed to ensure treatment and care was provided in accordance with professional standards of practice, and failed to ensure medical records were maintained in accordance with accepted professional standards and practices, were complete and accurately documented.

Region 3

Exit Date: 12/19/2019

Purpose of Visit: Complaint Investigation

Tags: F580/N1130; F600/N1284; F684/N1416

Situations: The facility failed to notify a resident's physician when the condition of the wound on the resident's foot deteriorated. Five days after the initial observation of the change, the resident was transferred to the hospital due to sepsis (potentially life-threatening condition caused by the body's response to an infection), gangrene, and osteomyelitis (inflammation of the spinal cord) related to the wound. The resident's left leg required amputation below the knee and they subsequently died from complications.

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 treatment and care was provided in accordance with professional standards of practice

Region 2

Exit Date: 12/19/2019

Purpose of Visit: Standard Survey

Tags: F689/N1432

Situations: The facility failed to effectively monitor a resident at-risk for elopement and were unaware when the resident left their locked unit to smoke outside. The resident was outside the facility, unsupervised, for over two hours before the facility became aware.

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

