Quarterly IJ Summary Report
January 2020 – March 2020

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 2020 (01/01/2020 – 03/31/2020).

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 fifty-one citations of seventeen 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***
578	2.0%	600	23.5%
580	7.8%	689	21.6%
600	23.5%	684	13.7%
607	2.0%	580	7.8%
610	3.9%	610	3.9%
658	2.0%	678	3.9%
678	3.9%	686	3.9%
684	13.7%	726	3.9%
686	3.9%	578	2.0%
689	21.6%	607	2.0%
697	2.0%	658	2.0%
726	3.9%	697	2.0%
740	2.0%	740	2.0%
760	2.0%	760	2.0%
773	2.0%	773	2.0%
835	2.0%	835	2.0%
837	2.0%	837	2.0%

*Rounded to the nearest tent

Table 2

Region	# of IJs	# of NFs	% of IJs/NF
1	0	89	0.0%
2	5	138	3.6%
3	7	233	3.0%
4	3	194	1.5%
5	3	188	1.6%
6	7	179	3.9%
7	3	231	1.3%
Total	28	1252	2.2%

Table 3
Number of IJs

from Complaints	from Incidents	from Surveys	Total
16	7	5	28

Tag References

483.10 - Resident Rights:
- 578 Request/Refuse/Discontinue Treatment; Formulate Advanced Directives
- 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:
- 658 Services Provided Meet Professional Standards

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
- 697 Pain Management

483.35 Nursing Services
- 726 Competent Nursing Staff

483.40 Behavioral Health Services
- 740 Behavioral Health Services

483.45 - Pharmacy Services:
- 760 Residents are Free of Significant Med Errors

483.50 – Laboratory, Radiology, and Other Diagnostic Services
- 773 Lab Svs Physician Order/Notify of Results

483.70 - Administration:

835 Administration
837 Governing Body

Acronyms

CPR – Cardiopulmonary Resuscitation
DNR – Do Not Resuscitate
ER – Emergency Room
LAR – Legally Authorized Representative

Region 2
Exit Date: 01/02/2020
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1285; F686/N1423
Situations: The facility failed to update a resident's care plan and review it for effective monitoring of the resident's orthopedic boot, resulting in a lapse of procedures to implement skin assessments and identify need for wound care. The facility failed to ensure effective skin assessments were being conducted. The resident was transferred to the hospital following the onset of an altered mental status and was diagnosed to cellulitis of the left leg. The resident had developed three pressure ulcers.

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 2
Exit Date: 01/09/2020
Purpose of Visit: Incident Investigation
Tags: F689/N1433
Situations: The facility failed to ensure a resident's assistive device attached to their wheelchair was in proper functioning order, resulting in the resident falling out of the wheelchair when the device failed. The facility did not make repairs following the incident until the state investigation began.

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

Region 2
Exit Date: 01/16/2020
Purpose of Visit: Standard Survey
Tags: F600/N1285; N1432
Situations: The facility failed to ensure staff were trained and could demonstrate proper procedures for securing a resident in a wheelchair in the facility van. The resident fell out of their wheelchair when the van stopped abruptly and sustained multiple fractures to their left leg. The facility failed to fully investigate the incident per policy.

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: 01/16/20
Purpose of Visit: Complaint Investigation
Tags: F580/N1129; F684/N1416
Situations: The facility failed to immediately consult with a resident's physician when the resident, who was on blood thinning medication, fell and hit their head. The resident

was transferred to the hospital two days later where they were diagnosed with a brain bleed. The resident died in 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 that residents received treatment and care in accordance with professional standards of practice.

Region 3
Exit Date: 01/17/2020
Purpose of Visit: Incident Investigation
Tags: F689/N1433
Situations: The facility failed to ensure a resident received adequate supervision resulting in the resident eloping from the facility. The facility remained unaware until a staff member on their way into work found the resident walking nearly half a mile from the facility.

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

Region 3
Exit Date: 01/19/2020
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1284/N1285; F610/N1292; F689/N1433
Situations: The facility failed to supervise a resident with a history of inappropriate sexual behavior and failed to protect others from them. Three other residents alleged inappropriate contact and the perpetrating resident was found unclothed on top of a fourth resident.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse, failed to have evidence that all alleged violations were thoroughly investigated, and protective measures were put in place to prevent further potential abuse, and failed to ensure adequate supervision to prevent accidents.

Region 4
Exit Date: 01/23/2020
Purpose of Visit: Incident Investigation
Tags: F689/N1433
Situations: The facility failed to effectively supervise a resident with a history of exit-seeking behaviors resulting in the resident eloping without facility knowledge. The resident was found in the middle of a highway.

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

Region 4
Exit Date: 01/24/2020
Purpose of Visit: Standard Survey
Tags: F689/N1433

Situations: The facility failed to effectively supervise a resident with a history of exit-seeking behaviors resulting in the resident eloping without facility knowledge. The resident was found by staff of a local business who informed the facility of the elopement.

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

Region 6
Exit Date: 01/24/2020
Purpose of Visit: Complaint Investigation
Tags: F580/N1129; F600/N1284; F686/N1422/N1423
Situations: The facility failed to effectively assess and document a resident's pressure ulcers and applied treatment that had not been ordered by a physician.

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 having pressure ulcers received necessary treatment and services to promote healing.

Region 2
Exit Date: 01/27/2020
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1285; F689/N1432
Situations: The facility failed to ensure that the facility van's wheelchair securement straps were in good working order and that staff were trained to use them effectively and recognize issues. These failures resulted in a resident falling twice on separate days, the second one resulting in a hematoma to the back of the head.

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

Region 5
Exit Date: 02/03/2020
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1285; F689/N1416
Situations: The facility failed to protect residents from a resident with aggressive behaviors. The aggressor struck one resident, attempted to get in bed with and strike three others, and entered a fifth resident's room and undressed in front of the room's occupant. All affected residents expressed fear for their safety.

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

Region 6
Exit Date: 02/03/2020
Purpose of Visit: Standard Survey
Tags: F684/N1416
Situations: The facility failed to follow physician orders and check a resident's blood pressure at regular scheduled times. The facility failed to effectively document and follow-up when the resident's condition changed, and their blood pressure dropped. The resident was later found unresponsive and transferred to the hospital in cardiac arrest and died an hour after arrival.

Deficient Practice: The facility failed to provide treatment and care based on the comprehensive assessment, in accordance with professional standards.

Region 3
Exit Date: 02/05/2020
Purpose of Visit: Standard Survey
Tags: F684/N1416; F697
Situations: The facility failed to effectively assess and treat a resident when they were found to have a bruise on their right leg and displayed obvious signs of discomfort. Their condition continued for over twenty-four hours before an x-ray was ordered and it was determined they had a fracture to the leg.

Deficient Practice: The facility failed to provide treatment and care based on the comprehensive assessment, in accordance with professional standards and failed to ensure that residents reviewed for pain management received the necessary care and services to attain or maintain the highest practicable well-being.

Region 3
Exit Date: 02/08/2020
Purpose of Visit: Complaint Investigation
Tags: F580/N1130; F684/N1416; F773/N1747
Situations: The facility failed to notify a resident's physician and LAR when the resident was assessed to have undergone a significant change in condition. The resident was unable to eat and could not support their own body without assistance. The facility failed to obtain the resident's laboratory results timely, resulting in a delay in treatment. The resident was diagnosed with sepsis (potentially life-threatening condition caused by the body's response to an infection), urinary tract infection, kidney failure, pneumonia, severe hyperkalemia (high potassium levels), severe hypernatremia (high concentration of sodium in the blood), and lactic acidosis (overproduction or underutilization of lactic acid). The resident died at the hospital three days after they began to exhibit the changes in condition.

Deficient Practice: The facility failed to notify and consult with a physician or family/LAR of changes in condition, failed to ensure treatment and care was provided in accordance with professional standards of practice, and failed to promptly notify the physician of laboratory results in accordance with facility policy.

Region 5
Exit Date: 02/11/2020
Purpose of Visit: Compliant/Incident Investigation
Tags: F600/N1284; F610/N1292; F684/N1416
Situations: The facility failed to ensure a resident on continuous oxygen was transferred from an oxygen tank to an oxygen concentrator, which can provide unlimited oxygen if it is powered. The oxygen tank became depleted and the resident went into respiratory distress. The facility failed to respond and assess the resident after the resident's family indicated their condition. The facility failed to investigate a resident's injury of unknown origin and their allegation of abuse.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect and abuse, failed to have evidence that all alleged violations were thoroughly investigated, and protective measures were put in place to prevent further potential neglect or abuse, and failed to ensure treatment and care was provided in accordance with professional standards of practice.

Region 4
Exit Date: 02/14/2020
Purpose of Visit: Complaint/Incident Investigation
Tags: F658/N1442; F760/N1480; F837/N1725
Situations: The facility administered a medication to a resident without reviewing physician orders and did not document the administration of the medication. The resident did not have an order for the medication and was allergic to it. The resident died fifteen hours after receiving the medication. The facility failed to investigate and report allegations that a staff member was working while in an impaired state for twenty-three days after being made aware.

Deficient Practice: The facility failed to ensure services provided in accordance with the written plan of care met professional standards of quality, failed to ensure residents were free of significant medication errors, and failed to ensure the governing body established and implemented policies regarding the management and operation of the facility.

Region 6
Exit Date: 02/14/2020
Purpose of Visit: Incident Investigation
Tags: F689/N1433; F835/N1721
Situations: The facility failed to ensure three residents were transferred by at least two staff members as required by their care plan. They were subject to a single-person transfer resulting in one falling and lacerating their head, one experiencing knee pain after transfer, and one who received a cut on their knee while being transferred. Two residents were transferred into their wheelchairs without the wheelchairs being properly positioned and secured. Administration failed to ensure staff were trained in proper transfer techniques.

Deficient Practice: The facility failed to ensure that residents environment remained as free of accident hazards as possible 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 well-being.

Region 2
Exit Date: 02/15/2020
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1284; F689/N1432
Situations: The facility failed to protect a resident from another following an altercation between the two that left the former with suspicious bruising and a laceration to the head. The residents had another altercation resulting in the previously injured resident being sent to the hospital with several lacerations requiring staples.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and failed to ensure that residents environment remained as free of accident hazards as possible.

Region 6
Exit Date: 02/19/2020
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1284; F740/N1428
Situations: The facility failed to protect five residents from a resident with a history of aggressive behaviors towards others. The resident was physically abusive towards all five others on separate occasions, one of which resulted in bodily injury. The facility failed to ensure the aggressor received appropriate behavioral health services to mitigate their aggression.

Deficient Practice: The facility failed to implement policies and procedures to prevent abuse and failed to ensure each resident received and the facility provided the necessary behavioral health care and services to attain or maintain the highest practical well-being.

Region 7
Exit Date: 02/20/2020
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1285; F726/N1739
Situations: The facility failed to ensure trained staff performed a resident transfer, resulting in the resident falling and fracturing their arm.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect and failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable well-being.

Region 3
Exit Date: 02/21/2020
Purpose of Visit: Incident Investigation
Tags: F678
Situations: The facility failed to immediately begin and continuously provide CPR when a resident was determined to have no pulse or respirations as there was confusion about the resident's code status. CPR was not initiated until at least fifty minutes after the resident was found unresponsive. The resident was declared dead at the facility.

Deficient Practice: The facility failed to provide basic life support, including CPR, to a resident requiring emergency care.

Region 3
Exit Date: 02/24/2020
Purpose of Visit: Complaint/Incident Investigation
Tags: F678
Situations: The facility failed to provide CPR and basic life support for a resident when their tracheostomy tube became dislodged. The resident was transferred to the hospital and required life support and died after they were removed from the ventilator.

Deficient Practice: The facility failed to provide basic life support, including CPR, to a resident requiring emergency care.

Region 7
Exit Date: 03/09/2020
Purpose of Visit: Incident Investigation
Tags: F600/N1284; F607/N1585; F689/N1433
Situations: The facility failed to ensure a resident who had a history of grabbing food and choking was effectively supervised. The resident choked on three occasions, the final of which resulted in the resident's death. The facility failed to ensure that residents did not have access to food in a form they could not safely consume.

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

Region 3
Exit Date: 03/10/2020
Purpose of Visit: Complaint/Incident Investigation
Tags: F600/N1285
Situations: The facility failed to ensure that a resident who required two people to help with ADL's received care as identified by their care plan. The resident fell out of their bed while being provided incontinence care by one person, was disconnected from their ventilator, and was transferred to the hospital where they were diagnosed with a broken hip and rib.

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

Region 6
Exit Date: 03/12/2020
Purpose of Visit: Complaint/Incident Investigation
Tags: F684/N1416; F726/N1446
Situations: The facility failed to monitor a resident and inform their physician when they had a change in condition, developing fever, vomiting, and an elevated heart rate. The facility failed to ensure a quick transfer to the hospital. The resident was finally admitted into the ER and diagnosed with severe septic shock (localized or system-wide infection), necrotizing fasciitis (infection that results in the death of parts of the body's soft tissue), and cellulitis (bacterial skin infection) of the lower left extremity. The resident died in the hospital.

Deficient Practice: The facility failed to ensure treatment and care was provided in accordance with professional standards of practice and failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable well-being.

Region 7
Exit Date: 03/13/2020
Purpose of Visit: Standard Survey
Tags: F689/N1432
Situations: The facility failed to ensure the hot water on a hall with residents with significant cognitive impairments was regulated at a safe temperature. The water, which should not exceed 110 degrees was measured at temperatures that ranged from 130 to 153 degrees.

Deficient Practice: The facility failed to ensure the resident environment remained as free from accident and hazards as possible.

Region 5
Exit Date: 03/24/2020
Purpose of Visit: Incident Investigation
Tags: F578/N1234
Situations: The facility performed CPR on a resident with a DNR order.

Deficient Practice: The facility failed to implement facility Resident Rights policy related to respecting resident's choice to receive or not receive cardiopulmonary resuscitation determined by advanced directives

Region 6
Exit Date: 03/30/2020
Purpose of Visit: Complaint Investigation
Tags: F580/N1130; F684/N1416
Situations: The facility failed to assess a resident and notify their physician when they had a change in condition. The facility failed to inform the resident's physician about abnormal laboratory results. The resident was found unresponsive and unreadable oxygen levels and was pronounced dead an hour later.

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 failed to ensure treatment and care was provided in accordance with professional standards of practice.