TEXAS
Department of Aging and Disability Services

COMMISSIONER
Jon Weizenbaum

January 26, 2017

To: Nursing Facilities (NFs)

Subject: Provider Letter No. 17-01 — Quarterly Immediate Jeopardy Reports

The Texas Department of Aging and Disability Services (DADS) has begun to publish quarterly immediate jeopardy (IJ)[1] summary reports. These reports will be published as the data for each quarter in a calendar year becomes available.

The IJ reports will present quantitative and qualitative information regarding all tags cited at the IJ level for licensing and certification surveys and incident investigations performed in nursing facilities during the reporting period. DADS is sharing this information to assist providers in the identification of IJ trends and to prompt providers to review their internal operations and strengthen quality assurance measures.

The quarterly report for January – March 2016 is attached to this letter in order to give providers a perspective of the type of information contained in the IJ report.

Additional IJ reports are available on the HHS Reports and Presentations website. As new reports become available, they will be added to this URL and a GovDelivery Update will be sent to stakeholders that have signed up to receive nursing facility related updates.

If you have questions about this letter, please contact a NF program specialist with the Policy, Rules and Curriculum Development section at 512-438-3161.

Sincerely,

[signature on file]

Mary T. Henderson
Associate Commissioner
Regulatory Services

MTH:cg

Attachment

[1] See *Title 42 Part 488.301 of the Code of Federal Regulations (Definitions)*

Quarterly IJ Summary Report
January 2016 – March 2016

The following report presents quantitative and qualitative information regarding all tags cited at the Immediate Jeopardy (IJ) level during Licensing surveys and Complaint or Incident investigations performed in Nursing Facilities during the first quarter of 2016 (01/01/2016 – 03/31/2016).

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 of the surveys and investigations conducted, resulting in 130 citations of twenty-three unique 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):

Table 1

F-Tag	% Cited*	F-Tag	% Cited*
F155	1.5%	F224	15.4%
F157	7.7%	F226	14.6%
F221	0.8%	F490	13.1%
F223	1.5%	F309	10.8%
F224	15.4%	F323	8.5%
F225	6.2%	F157	7.7%
F226	14.6%	F225	6.2%
F279	0.8%	F281	3.8%
F281	3.8%	F314	3.8%
F282	0.8%	F333	3.1%
F309	10.8%	F155	1.5%
F314	3.8%	F223	1.5%
F319	0.8%	F425	1.5%
F322	0.8%	F441	1.5%
F323	8.5%	F221	0.8%
F329	0.8%	F279	0.8%
F332	0.8%	F282	0.8%
F333	3.1%	F319	0.8%
F353	0.8%	F322	0.8%
F425	1.5%	F329	0.8%
F441	1.5%	F332	0.8%
F490	13.1%	F353	0.8%
F520	0.8%	F520	0.8%

*Rounded to nearest tenth *Rounded to nearest tenth

Table 2

Region	# of IJs	# of NFs	% of IJs/NF
1	2	73	2.7%
2/9/10	9	134	6.7%
3	6	275	2.2%
4/5	1	184	0.5%
6	12	167	7.2%
7	4	147	2.7%
8/11	6	246	2.4%
Total	40	1226	3.3%

Table 3

# of IJs			
from Complaints	from Incidents	from Surveys	Total
28	0	12	40

Tag References

Resident Rights:

155 Right to refuse treatment
157 Notification of changes

Resident Behavior & Facility Practice:

221 Use of restraints
223 Abuse
224 Mistreatment, Neglect, Misappropriation
225 Investigate and report allegations and terminate staff involved in Mistreatment, Abuse/Neglect
226 Facility Policies & Procedures for Abuse/Neglect/Mistreatment

Resident Assessment:

279 Establish comprehensive Care Plans
281 Services provided meet professional standards of quality
282 Care provided by qualified persons in accordance with Plan of Care

Quality of Care:

309 Care provided attains/maintains highest practicable well-being
314 Pressure Ulcers
319 Assessment/treatment: Mental and psychological difficulties
322 Assessment/treatment: Feeding tubes
323 Free of and supervised for accident hazards
329 Unnecessary Medications
332 Medication error rate ≤ 5%
333 Free of significant medication errors

Nursing Services:

353 Sufficient Nursing Staff

Pharmacy Services:

425 Pharmacy Services

Infection Control:

441 Infection control program

Administration:

490 Administration
520 Quality assessment and assurance

Acronyms

CNA – Certified Nursing Assistant
CPR – Cardiopulmonary Resuscitation
EKG - Electrocardiogram
DADS – Department of Aging and Disability Services
DON – Director of Nurses
ICU – Intensive Care Unit
LAR – Legal Authorized Representative
LVN – Licensed Vocational Nurse
MA – Medication Aide
NFA – Nursing Facility Administrator
QAA – Quality Assessment and Assurance

Region 3
Exit Date: 1/1/16
Purpose of Visit: Complaint Investigation
Tags: F224/F226/N983; F323/N1130/N1131; F490/N1412
Issues: A resident was placed on a shower gurney with no head support, fell off and became non-responsive. The resident was transferred to the hospital, placed on a ventilator and remained there for two weeks before transferring to a different nursing facility. The DON failed to ensure proper supervision and operation of assistive devices.

Deficient Practice: The facility failed to provide adequate supervision and assistive devices to the resident and failed to implement policies and procedures to prohibit neglect. Facility administration failed to ensure effective use of resources.

Region 2/9/10
Exit Date: 1/06/16
Purpose of Visit: Complaint Investigation
Tags: F157/N837/N838; F224/F226/N983; F314/N1121; F490/N1412
Issues: For multiple residents receiving treatment for pressure ulcers, the facility failed to notify residents' physicians or families/LARs of deteriorating conditions and failed to provide physician ordered wound care. The resident was transferred to the hospital with necrotic wounds. The NFA failed to supervise the DON to ensure the facility was compliant with physician orders, missed treatment identification and proper documentation.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to ensure effective treatment of pressure ulcers, to notify and consult with a physician or family/LAR for needed changes to treatment plans. Facility administration failed to ensure effective use of resources.

Region 2/9/10
Exit Date: 1/06/2016
Purpose of Visit: Complaint Investigation
Tags: F333/N1140
Issues: A resident was admitted to ICU after an accidental overdose of rapid acting insulin.

Deficient Practice: The facility failed to ensure resident's insulin administration was free of significant errors.

Region 6
Exit Date: 01/07/2016
Purpose of Visit: Complaint Investigation
Tags: F157/N837; F224/F226/N983/N984; F279/F282/N1077/N1088; F309/N1114; F490/N1412
Issues: A resident had continuous episodes of loose stools, developed difficulty chewing, loss of appetite and weakness lasting off and on for thirty-one days. The facility did not consult with the physician on these issues, failed to provide follow-up specimen samples, and failed to develop a care plan to prevent further decline. The resident was admitted to the hospital with severe sepsis, clostridium difficile colitis, acute renal failure and dehydration. The resident died six days after admission. The NFA failed to ensure the facility's policies and procedures were followed to prohibit neglect.

Deficient Practice: The facility failed to implement policies to prevent neglect, failed to develop and follow a comprehensive care plan, failed to notify and consult with a physician or family/LAR for condition changes and failed to provide services to attain or maintain the residents' highest possible well-being. Facility administration failed to ensure effective use of resources.

Region 6
Exit Date: 1/08/2016
Purpose of Visit: Standard Survey
Tags: F157/N836; F224/N984; F309/N1114; 490/1412
Issues: A resident had a fall and then was allowed to self-transfer from their wheelchair to the bed immediately after. The resident was complaining of hip pain. The facility did not immediately inform the resident's physician of the fall or

hip pain. The resident did not receive an x-ray until the following day. The resident was sent to hospital for a fractured hip and surgical repair. The NFA failed to ensure the facility's policies and procedures were followed to prohibit neglect.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to notify and consult with a physician or family/LAR for condition changes and failed to provide services to attain or maintain the residents' highest possible well-being. Facility administration failed to ensure effective use of resources.

Region 2/9/10
Exit Date: 1/08/2016
Purpose of Visit: Complaint Investigation
Tags: F314/N1121/N1121; F490/N1412
Issues: A resident was admitted to the facility without pressure ulcers. Ten days after admission, the wound nurse identified pressure ulcers resulting in treatments with little change to the wound. The wound nurse went on vacation and wound care was sporadic, resulting in hospital admission where the wounds were described as necrotic and infected. The NFA and the DON failed to ensure interventions were implemented to prevent development and worsening of pressure ulcers.

Deficient Practice: The facility failed to ensure a resident admitted without pressure ulcers did not develop them (unless clinically unavoidable). Facility administration failed to ensure effective use of resources.

Region 3
Exit Date: 1/09/2016
Purpose of Visit: Complaint Investigation
Tags: F309/N1114; F333/N1140; F425/N1294; F490/N1412
Issues: For one resident who was crying, anxious, nauseous and unable to sleep due to pain, the facility did not provide pain relieving interventions for eleven hours after admission. During a medication pass, a fifteen percent medication error rate was observed, including not following proper pre-medication administration procedures and missed medications. Record reviews showed multiple days of missed medications. The NFA failed to ensure the highest practical well-being for residents.

Deficient Practice: The facility failed to provide services to attain or maintain the residents' highest possible well-being, to ensure residents were free of significant medication errors and to provide pharmaceutical services to meet resident needs. Facility administration failed to ensure effective use of resources.

Region 2/9/10
Exit Date: 1/11/2016
Purpose of Visit: Complaint Investigation
Tags: F225/N989; F226/N983; F323/N1131
Issues: A resident at risk for falls was left in a room unsupervised for three hours. The resident fell out of their wheelchair and was found in a pool of coagulated blood. The resident was transferred to a hospital and returned the following day with sutures in the head. Their condition declined and the resident passed away ten days after the incident. Another resident experienced multiple skin tears and bruises (eight in two months) caused during resident transfers. The facility failed to implement interventions to prevent injuries.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to thoroughly report and investigate an incident, and failed to supervise and prevent accidents.

Region 6
Exit Date: 1/13/2016
Purpose of Visit: Complaint Investigation
Tags: F223/N982; F224/N989; F309/N1114, F490/N1412
Issues: Multiple residents were handled roughly and were verbally abused. One resident had their call light taken away and a staff member refused to tell another resident their name. Two residents experienced falls and were not properly

assessed. One resident, who had lacerations to the head from the fall, became non-responsive two days after the fall and was not properly assessed. A non-emergency ambulance was called instead of 911. The NFA failed to implement policies to prevent neglect and to supervise the DON to ensure that the facility conducted accurate assessments of residents.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to thoroughly report and investigate an incident, and failed to provide services to attain or maintain the residents' highest possible well-being. Facility administration failed to ensure effective use of resources.

Region 7
Exit Date: 1/15/2016
Purpose of Visit: Complaint Investigation
Tags: F224/F226/N983; F333/N1140
Issues: A resident became unresponsive and was hospitalized due to an overdose of medicine given to him in error by a MA. The resident was placed on a ventilator at the hospital.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect and to ensure residents were free from significant medication errors.

Region 6
Exit Date: 1/15/2016
Purpose of Visit: Complaint Investigation
Tags: F157
Issues: Over the course of forty-four days, for physician ordered blood sugar tests, the facility failed to immediately inform the resident's physician when results exceeded three hundred (healthy levels should be below 180 post-meal, for a diabetic) after twenty-two of twenty-four tests (a ninety-two percent failure rate). Twice the results exceeded six hundred.

Deficient Practice: The facility failed to notify and consult with a physician or family/LAR on significant changes in condition and need for altered treatment.

Region 2/9/10
Exit Date: 1/15/2016
Purpose of Visit: Complaint Investigation
Tags: F314/N1120/N1121
Issues: Multiple residents were identified with pressure ulcers or at risk for pressure ulcers and were not properly assessed. Identified ulcers were not treated for as many as twenty days; several residents were not treated in compliance with physician orders.

Deficient Practice: The facility failed to ensure residents reviewed for pressure ulcers received necessary care/treatment to promote healing and prevent infection.

Region 6
Exit Date: 1/16/2016
Purpose of Visit: Standard Survey
Tags: F157/N837; F309/N1114; F490/N1412;
Issues: For four residents, the facility failed to document conditions and inform residents' physicians of symptoms. The facility delayed a physician ordered STAT EKG, did not follow-up with doctor regarding abnormal results and multiple cases of elevated blood pressure and heart rate. The NFA failed to oversee and implement strategies to follow policies and procedures for changes in condition.

Deficient Practice: The facility failed to notify and consult with a physician or family/LAR on significant changes in condition and need for altered treatment, and to provide services to attain or maintain the residents' highest possible well-being. Facility administration failed to ensure effective use of resources.

Region 3
Exit Date: 1/17/2016
Purpose of Visit: Complaint Investigation
Tags: F225/N986/N1552; F226/N983
Issues: The facility was employing an individual (housekeeper) who was not employable in a nursing facility due to a past finding of abuse and neglect (while working as a CNA). The facility was aware of the staff member's presence in the registry but did not think it affected employment as a housekeeper.

Deficient Practice: The facility employed an individual who had a finding in the state nurse aide registry concerning abuse, neglect or mistreatment of residents or misappropriation of property, and failed to implement policies and procedures to prevent neglect or abuse.

Region 6
Exit Date: 1/20/2016
Purpose of Visit: Complaint Investigation
Tags: F157/N836; F224/N983; F281/N1087; F309
Issues: The facility failed to notify necessary parties within the facility, and the resident's physician or family/LAR for four hours while the resident was actively bleeding. The resident was sent to the hospital and required a transfusion of blood.

Deficient Practice: The facility failed to immediately consult the physician or family/LAR on significant changes in condition, failed to implement policies and procedures to prevent neglect, to provide services that met professional standards and to provide services to attain or maintain the residents' highest possible well-being.

Region 2/9/10
Exit Date: 1/22/2016
Purpose of Visit: Complaint Investigation
Tags: F323/N1131
Issues: A resident who was unsupervised and in a wheelchair eloped from a dialysis clinic and was found later by police and returned to the facility. Prior to elopement, the facility had no specific plan regarding the resident's safety while at the dialysis clinic.

Deficient Practice: The facility failed to provide adequate supervision and monitoring of the resident.

Region 2/9/10
Exit Date: 1/29/2016
Purpose of Visit: Complaint Investigation
Tags: F225/N989/N991; F226/N984; F323/N1130; F490/N1412
Issues: The facility had multiple resident elopements from a secured unit. Two residents were found, off facility grounds, to have fallen and sustained injuries. The facility failed to appropriately investigate and to develop and implement plans of care. The NFA failed to implement the facility's abuse and neglect policy by failing to investigate and report the incidents of resident elopement.

Deficient Practice: The facility failed to implement policies and procedures to prevent neglect, failed to thoroughly investigate and report non-compliance with policies and failed to ensure residents reviewed for elopement risk received adequate supervision. Facility administration failed to ensure effective use of resources.

Region 1
Exit Date: 2/04/2016
Purpose of Visit: Standard Survey
Tags: F223/N982; F224/984; F225/N989; F226/N983; F490/N1412; F520/N1512

Issues: A staff member cursed, yelled at and threatened residents, took away the call light from one resident, and refused to assist another resident to the toilet. The facility allowed continued unsupervised direct care after the allegations. The facility failed to use QAA meetings to investigate and evaluate care of residents in contact with the staff member. The NFA did not investigate until the staff member had worked two full shifts after the allegations, and did not investigate thoroughly, missing other effected residents.

Deficient Practice: The facility failed to ensure residents were free from verbal or mental abuse, to implement policies and procedures that prohibited mistreatment, neglect or abuse, failed to fully report and investigate incidents, and to maintain a QAA committee that evaluated systems and developed and implemented plans of action to correct deficiencies.

Region 8/11
Exit Date: 2/7/2016
Purpose of Visit: Complaint Investigation
Tags: F221/N974; F224/F226/N983; F323/N1131
Issues: Nine residents were found to have bed rails in use without assessment or physician orders. One resident was found with their head caught between the side-rail and mattress and was pronounced dead within forty-seven minutes of discovery.

Deficient Practice: The facility failed to ensure the right to be free from any physical restraints imposed for purposes of discipline or convenience, to implement policies and procedures that prohibited neglect, to ensure the residents' environment remains free of accident hazards, and that each resident receives adequate supervision and assistance devices.

Region 3
Exit Date: 2/7/2016
Purpose of Visit: Standard Survey
Tags: F322/N1129; F490/N1412
Issues: Two residents with gastro tubes were positioned during drug administration in a way that caused gagging and choking. The NFA and the DON failed to ensure compliance with maintaining proper positioning for residents that received medications and/or feedings via gastrostomy tubes.

Deficient Practice: The facility failed to ensure residents with gastrostomy tubes received appropriate treatment and services to prevent aspiration or serious illness. Facility administration failed to ensure effective use of resources.

Region 2/9/10
Exit Date: 2/10/2016
Purpose of Visit: Complaint Investigation
Tags: F157/N827; F309/N1114; F329/N1136
Issues: A resident on long term blood thinning therapy began bleeding from a previous intravenous site, and experienced nasal bleeding and lower back and abdominal pain with ineffective treatment. The resident was admitted to the ICU, their condition deteriorated, and the resident died eleven days after ICU admission.

Deficient Practice: The facility failed to notify and consult with a physician or family/LAR when a significant change of condition occurred, to provide services to attain or maintain the residents' highest possible well-being, and to ensure medication therapy was free from unnecessary drugs.

Region 6
Exit Date: 2/16/2016
Purpose of Visit: Complaint Investigation
Tags: F224/N983; F309/N1114; F441/N1342/N1348
Issues: The NFA failed to implement appropriate protocols for infection control resulting in the spread of norovirus, effecting forty-five residents.

Deficient Practice: The facility failed to develop and implement their policy that prohibited neglect, to provide services to attain or maintain the residents' highest possible well-being, and to maintain an infection control program to provide a safe, sanitary environment to help prevent transmission of disease or infection. Facility administration failed to ensure effective use of resources.

Region 3
Exit Date: 2/19/2016
Purpose of Visit: Standard Survey
Tags: F323/N1131
Issues: A resident with exiting behaviors eloped from the facility and was found in the parking lot with extensive traumatic wounds to the face and scalp. The facility failed to have a care plan in place to address the resident's exit-seeking behaviors.

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

Region 7
Exit Date: 2/22/2016
Purpose of Visit: Standard Survey
Tags: F309/N1114; F490/N1412
Issues: For a resident with a history of weight loss, the facility failed to provide care and services to prevent the resident from developing the inability to swallow, resulting in decreased nutritional intake for five days. The facility failed to address a request to evaluate the resident and the resident passed away.

Deficient Practice: The facility failed to provide care and services to attain or maintain the residents' highest possible well-being. Facility administration failed to ensure effective use of resources.

Region 6
Exit Date: 2/23/2016
Purpose of Visit: Complaint Investigation
Tags: F155/N827; F224/N984; F281/N1087; F309/N1114; F490/N1412
Issues: The facility did not initiate CPR on a resident found unresponsive. The resident died in the facility. The NFA failed to ensure the facility followed protocol for performance of CPR and accurate monitoring, assessment, and physician notification of changes in condition.

Deficient Practice: The facility failed to ensure the right to formulate advance directives, to develop and implement their policy that prohibited neglect and to ensure that staff provided services that met professional standards of quality, and to provide services to attain or maintain the resident's highest possible well-being. Facility administration failed to ensure effective use of resources.

Region 8/11
Exit Date: 2/24/2016
Purpose of Visit: Complaint Investigation
Tags: F224/N983; F226/N984; F319/N1126; F323/N1131
Issues: Multiple residents with identified psychological difficulties and aggressive behaviors were not properly documented, assessed, treated and monitored. Incidents include one resident stabbing another in the face with a butter knife after repeated unaddressed confrontations, a suicide attempt, and medication non-compliance.

Deficient Practice: The facility failed to develop and implement their policy that prohibited neglect, to ensure residents who displayed mental or psychological difficulties were provided appropriate care and treatments for assessed problems, and to ensure residents were provided adequate supervision.

Region 6
Exit Date: 2/26/2016
Purpose of Visit: Complaint Investigation
Tags: F225/N983/N989; F226/N992
Issues: For two residents, the facility failed to report and investigate allegations of abuse.

Deficient Practice: The facility failed to ensure that alleged violations involving mistreatment, neglect or abuse were reported immediately to the NFA and to implement policies and procedures that prohibited neglect, mistreatment or abuse.

Region 8/11
Exit Date: 2/26/2016
Purpose of Visit: Standard Survey
Tags: F224/F226/N983; F281/N1087; F314/N1120; F490/N1412
Issues: For two residents admitted without pressure ulcers, the facility failed to accurately identify, stage, and document developing pressure ulcers. Residents' documentation contained omitted information and inconsistent, contradicting staging and description of their wounds. The DON failed to effectively supervise to ensure that accurate identification, assessment, and documentation of pressure ulcers were implemented. The facility did not reassess or update residents' Braden Scale Risk Assessments for predicting pressure ulcers.

Deficient Practice: The facility failed to develop and implement their policy that prohibited neglect, to provide services that met professional standards of quality, and to ensure a resident who enters the facility without pressure ulcers does not develop them.

Region 3
Exit Date: 2/29/2016
Purpose of Visit: Standard Survey
Tags: F332/N1139; F333/N1140; F425/N1294
Issues: For multiple residents, an MA failed to administer physician ordered medications, to follow physician instructions for medication orders, and to notify the charge nurse of medication errors.

Deficient Practice: The facility failed to ensure residents were free from a medication error rate of five percent or more, that residents were free from significant medication errors, and to provide pharmaceutical services to meet the needs of each resident.

Region 6
Exit Date: 3/1/2016
Purpose of Visit: Complaint Investigation
Tags: F224/N983; F309/N1114
Issues: A resident was not assessed after a CNA informed the LVN that the resident was having difficulty breathing and was gasping for air. The resident developed fever and their oxygen saturation fell to the forties (normal oxygen saturation is between seventy five and one hundred). The DON left the resident unattended while in critical condition to assist the LVN in calling 911. The resident was transferred to hospital and died four days later.

Deficient Practice: The facility failed to develop and implement their policy that prohibited neglect and to provide services to attain or maintain the resident's highest possible well-being.

Region 4/5
Exit Date: 3/4/2016
Purpose of Visit: Standard Survey
Tags: F224/F226/N983/N984; F225/N989/N990; F323/N1131

Issues: One resident received second degree burns from coffee. The resident had not been assessed for their ability to handle coffee and the facility was not monitoring the temperature of the coffee prior to the incident. Another resident was found with a cup of cleaning agent from a bottle that had been left open by the resident's table.

Deficient Practice: The facility failed to develop and implement their policy that prohibited neglect, to ensure allegations of abuse or neglect were thoroughly investigated and reported, and to ensure adequate supervision was provided to prevent accidents.

Region 2/9/10
Exit Date: 3/4/2016
Purpose of Visit: Complaint Investigation
Tags: F323/N1131
Issues: A resident at risk for elopement and with a Wander Guard eloped from facility without facility knowledge. The resident was found by the police over a mile from facility with lacerations to their forehead that required stiches.

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

Region 8/11
Exit Date: 3/11/2016
Purpose of Visit: Complaint Investigation
Tags: F224/F226/N983/N984; F323/N1131; F353/N1144
Issues: Low staffing resulted in two resident-on-resident altercations in one unit, one leading to a resident being sent to the hospital and receiving staples in their head. During meal time, one resident did not have their wheelchair correctly positioned or locked and they fell out. The facility did not provide incontinent care for thirty minutes after another resident urinated, soaking their pants to the knees. The facility did not cut a resident's nails for nine days, resulting in over an inch-and-a-half long nails with brown buildup beneath.

Deficient Practice: The facility failed to develop and implement their policy that prohibited neglect, to ensure each resident received adequate supervision and assistance devices to prevent accidents, and to provide sufficient nursing staff to ensure nursing related services that attain or maintain the highest practicable well-being of each resident.

Region 6
Exit Date: 3/15/2016
Purpose of Visit: Complaint Investigation
Tags: F225/N989/N990/N991/N992/N993/N994; F226/N983
Issues: The facility failed to immediately report and investigate two allegations regarding a resident being verbally abused. The facility did not report to DADS for two weeks for one allegation and five days for the other. The facility's corporate office did not begin investigation of concerns sent through their compliance line until two days after it was received.

Deficient Practice: The facility failed to develop and implement their policy that prohibited abuse and to thoroughly investigate and report allegations of abuse.

Region 1
Exit Date: 3/24/2016
Purpose of Visit: Complaint Investigation
Tags: F157/N837; F224/F226/N983.; F314/N1121
Issues: A resident had a small hole in their heel, but the facility did not inform the physician or family/LAR. Over the course of thirteen days, the facility did not change dressings on the area, failed to report changes, and did not inform the family/LAR or the physician of the condition. The resident was sent to the hospital at the family's request resulting in

the need for either amputation or placement in hospice. Another resident had not had the dressings on their lower leg changed in eight days.

Deficient Practice: The facility failed to notify the resident's physician and family/LAR of changes in condition, failed to implement written policies and procedures that prohibit neglect, and failed to ensure that residents having pressure ulcers received necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing.

Region 6
Exit Date: 3/31/2016
Purpose of Visit: Complaint Investigation
Tags: F157/N837; F224/N983; F225/N989; F309/N1114; F490/N1412
Issues: A resident complained of hip pain and had a bulging right hip. For six days the resident was not properly assessed and the facility did not inform the NFA. The resident was found to have a distal right femur fracture. The facility also failed to follow physician orders and care plan following the diagnosis by not using the Hoyer lift, instead using a two person transfer during which the resident experienced pain.

Deficient Practice: The facility failed to notify and consult with a physician or family/LAR concerning changes in condition, failed to implement policies to prevent neglect, failed to ensure alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, were immediately reported to the NFA of the facility and other officials, and failed to provide services to attain or maintain the resident's highest possible well-being. Facility administration failed to ensure effective use of resources.

Region 7
Exit Date: 3/24/2016
Purpose of Visit: Standard Survey
Tags: F323/N; F490/N1114
Issues: The facility failed to maintain hot water temperatures in resident room sinks within a safe temperature range. During the survey, hot water temperatures ranged from 112 to 143 degrees Fahrenheit with the potential of third degree burns within two seconds at 140 degrees Fahrenheit.

Deficient Practice: The facility failed to ensure the environment was free of accident and hazards. Facility administration failed to ensure effective use of resources to ensure highest possible well-being.

Region 7
Exit Date: 3/23/2016
Purpose of Visit: Complaint Investigation
Tags: F155/N827; F157/N837; F224/F226/N983; F281/N1087; F309/N1114
Issues: The facility failed to monitor a resident at full code for continued changes in condition, and failed to recheck, monitor, and notify the physician of the resident's abnormal vital signs and abnormal STAT lab work. The facility failed to provide an accurate description of the resident's change in condition, including the resident's altered mental status, abnormal vital signs and abnormal STAT lab work when EMS was called requesting a hospital transfer. The facility failed to initiate CPR when the resident was found to have no pulse and no respirations. The resident died at the facility. The facility did not provide a wedge cushion for a resident's wheelchair to prevent falling. The resident fell and the physician was not notified nor did the resident receive treatment until the following day. The resident was sent to the hospital and was diagnosed with an inoperable hip fracture, was placed on hospice and died the following month.

Deficient Practice: The facility failed to implement policies for advance directives, failed to implement policies and procedures to prohibit neglect, failed to ensure staff provided services that met professional standards of quality, to provide services to attain or maintain the resident's highest possible well-being, and to provide care and services in accordance with the comprehensive assessment to ensure residents were reviewed for changes in condition

Region 8
Exit Date: 3/23/2016
Purpose of Visit: Standard Survey
Tags: F281/N1088; F309/N1114
Issues: For multiple residents with implanted devices (one deep brain stimulator, one defibrillator and three pacemakers), there was no monitoring or care being provided. There were no comprehensive assessments or physician's orders to indicate the residents had these implants when they were first admitted and no subsequent checkups.

Deficient Practice: The facility failed to ensure that services provided by the facility met professional standards of quality and to provide services to attain or maintain the resident's highest possible well-being.

Region 8
Exit Date: 3/18/2016
Purpose of Visit: Standard Survey
Tags: F441/N
Issues: For four days, the facility failed to properly sanitize the glucometer before and after performing finger-sticks for blood sugar measurement on multiple residents.

Deficient Practice: The facility failed to maintain an infection control program designed to help prevent the development and transmission of disease and infection