CONSORTIUM FOR QUALITY IMPROVEMENT, SURVEY & CERTIFICATION OPERATIONS (CQISCO)

DIVISION OF SURVEY & CERTIFICATION

Examples of Immediate Jeopardy Identified in 2018

Long Term Care Enforcement Branch
Compiled by: Stephanie M. Davis, MS., RD
Chief, LTC Enforcement Branch
Region IV-Atlanta

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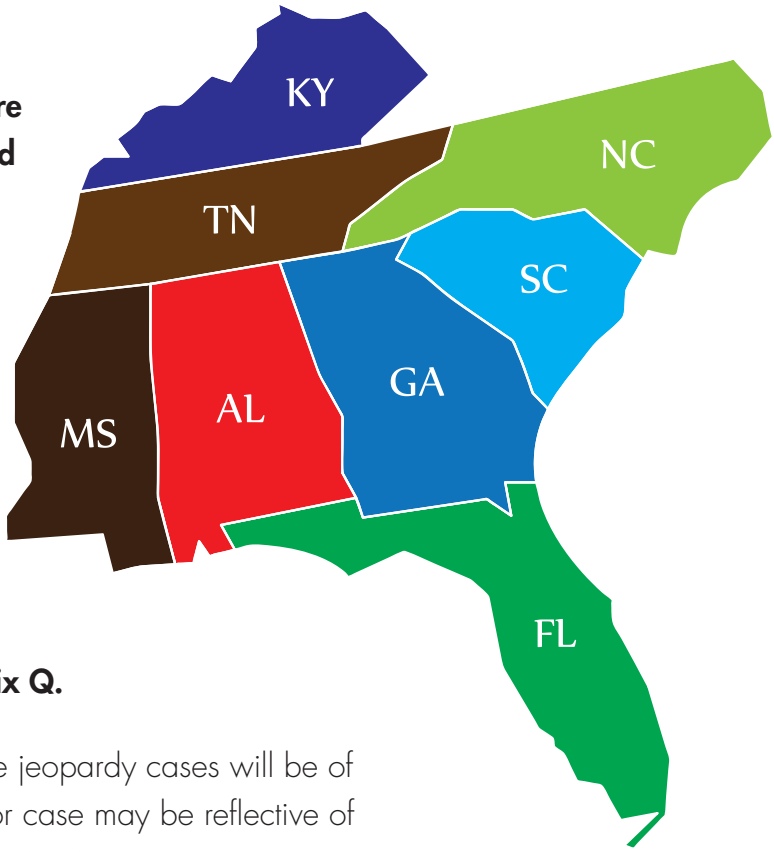
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

INTRODUCTORY MESSAGE

This handout includes a sample of various immediate jeopardy cases that have occurred in skilled nursing homes in Region IV during calendar year 2018. The list is not all inclusive. Region IV is comprised of eight states in the Southeastern United States, i.e. Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee.



A "deficiency" is defined as a facility's failure to meet a participation requirement specified in the Social Security Act or in Part 483, Subpart B. Immediate jeopardy is a situation in which immediate corrective action is necessary because the facility'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 receiving care in a facility. Additional information regarding immediate jeopardy is available in Appendix Q.

We hope that this brief summary of immediate jeopardy cases will be of help to you and your staff. A single situation or case may be reflective of noncompliance with one or more Federal participation requirements.

Stephanie M. Davis

Sincerely,

Stephanie M. Davis, MS., RD
CMS, Region IV

CATEGORY: ABUSE

42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

Case 1

An immediate jeopardy was identified on January 18, 2018. The facility failed to protect residents from sexual abuse. A resident with a known history of sexual abuse by the family members, exhibited sexually inappropriate behavior towards staff and peers, sexual gratification to self, and searched for sexual material on the internet while in the facility. The facility did not address the resident's sexual behavior or increase supervision and oversight of the resident. The resident sexually assaulted another resident, and the abuse was captured on video.

Case 2

An immediate jeopardy was identified on March 2, 2018. The facility failed to protect residents from abuse, neglect and injuries of unknown origin. A resident was transferred to the hospital for respiratory distress. Emergency room records documented that the resident had sustained blunt force chest trauma, fractured ribs, and hemothorax. The resident subsequently died from the injuries. A second resident was found with a fractured finger, and a third resident was found with a fractured elbow. All three residents were cognitively impaired, vulnerable and required extensive to total assistance with activities of daily living.

Case 3

An immediate jeopardy was identified on March 4, 2018. The facility failed to protect a resident from sexual abuse. A Certified Nursing Assistant walked into a resident's room while an employee was sexually assaulting a resident and masturbating. The perpetrator fled the nursing home, and was later arrested by the police, and charged with first degree sexual abuse. The facility failed to follow their policy for screening of staff prior to employment.

Case 4

An immediate jeopardy was identified on March 23, 2018. The facility failed to protect a resident from physical abuse. On March 7, 2018, a Licensed Practical Nurse (LPN) slapped a resident and twisted and pinched the resident's upper arm. Two, Certified Nursing Assistants witnessed the abuse, but failed to report the incident for two days. The alleged perpetrator continued to work during this time interval.

Case 5

An immediate jeopardy was identified on April 19, 2018. The immediate jeopardy was due to the facility's failure to investigate or report inappropriate sexual behavior by a resident who was known to exhibit sexual behaviors such as exposing himself toward staff and residents, inappropriate gestures, and unwanted sexual advances to female residents.

Case 6

An immediate jeopardy was identified on June 6, 2018. The facility failed to protect four vulnerable residents from sexual abuse by another resident. A male resident with a history of inappropriate sexual behaviors was repeatedly found "peeping into female residents rooms" while they were nude or changing clothes. The male resident often entered the female resident rooms to kiss and fondle their breasts or private areas. The facility failed to monitor the male resident or adhere to the 30 minute checks ordered by the attending physician.

Case 7

An immediate jeopardy was identified on June 20, 2018. The facility failed to implement safety measures to protect residents after three staff persons were suspected of abuse. A resident was found with injuries of unknown origin with extensive, suspicious bruising to the torso. The facility also failed to conduct a thorough investigation and allowed one of the suspected staff person to continue providing care to the residents. .

Case 8

An immediate jeopardy was identified on July 12, 2018. The facility failed to timely report and investigate an alleged abuse of a resident by an Agency Certified Nursing Assistant (CNA). A resident reported that an agency CNA squeezed and pulled her arm as hard as she could, resulting in bruising to the area.

Case 9

An immediate jeopardy was identified on August 6, 2018. The facility failed to protect residents from verbal and physical abuse. Five residents on the Dementia Unit were slapped, kicked, punched, slammed into a doorway and/or pushed to the ground by the alleged perpetrator. One resident who was pushed to the ground by another resident was rendered unconscious and required medical treatment. The facility failed to recognize the abuse, conduct an investigation and adhere to abuse policies and procedures. .

Case 10

An immediate jeopardy was identified on October 25, 2018. The facility failed to protect residents from sexual abuse. A resident, with a known history of sexually inappropriate behaviors, with cognitively impaired peers, was observed by two facility staff sexually assaulting another resident. The perpetrator was hospitalized for evaluation and treatment. The hospital discharge summary stated the perpetrator only violated women with dementia, had a way of telling you what you want to hear and was dangerous to self and others. Upon readmission to the nursing home, the facility failed to implement any interventions to mitigate the opportunities for the perpetrator to sexually assault other residents, and did not increase the supervision of the resident.

Case 11

An immediate jeopardy was identified on November 7, 2018. The facility failed to protect residents from abuse. A cognitively impaired resident with known history of psychosis, dementia, Alzheimer's, adult failure to thrive and weakness, was observed eating food off another resident's tray in the dining room. A Certified Nursing Assistant (CNA) observed the resident taking the food and swiped the tray off the table. The CNA's action led to a physical altercation between the CNA and the resident.

Case 12

An immediate jeopardy was identified on January 30, 2018. A resident was abused and forcibly pulled out of bed into a shower chair against their will. The facility failed to adhere to abuse policies and procedures and protect the resident from additional abuse, as the alleged perpetrator continued providing direct patient care. Further the facility failed to report the allegation of abuse as required.

CATEGORY: SUPERVISION TO PREVENT ACCIDENTS

42 CFR 483.25 Accidents

The facility must ensure that the resident environment remains as free of accident hazards as possible and each resident receives adequate supervision and assistance devices to prevent accidents.

Case 13

An immediate jeopardy was identified on January 9, 2018. The facility failed to maintain essential heating and air conditioning equipment, in resident rooms in safe, operating condition. Knobs were observed missing from individual heating units, consequently, staff controlled the temperature of rooms by plugging in and removing the electrical cords from the outlet. The manipulation of the electrical cords triggered sparks and fire emissions from the electrical outlets, and resulted in burned and melted electrical plugs and wall outlets.

Case 14

An immediate jeopardy was identified on January 12, 2018. A resident eloped from the nursing home without staff knowledge. The resident was found walking down the driveway, unharmed by Maintenance staff. Prior to the elopement, the resident repeatedly asked to go home, was observed sitting by the exit doors, and had exhibited exit seeking behavior.

Case 15

An immediate jeopardy was identified on January 17, 2018. A cognitively impaired resident, wearing a wanderguard bracelet and residing in the secure unit, eloped from the facility, without staff knowledge. The resident crossed a three-lane road to a car dealership, and attempted to purchase a car. The police were notified and returned the resident to the nursing home.

Case 16

An immediate jeopardy was identified on February 22, 2018. An unsecured and half full oxygen tank was observed in one of the facility's resident transport vans (Transport van #1). Interviews with two alert and oriented residents revealed they had recently observed an unsecure oxygen tank while being transported in the transport van. The facility failed to identify unsecured oxygen tanks as a safety hazard and risk for possible explosion or other emergent event. Staff failed to follow the facility's policies and procedures for safe oxygen storage, by not ensuring oxygen tanks were secured in a holder during resident transport. In addition, staff were not conducting pre-transport checks of the facility's transport vans to ensure they did not contain hazards and were safe for resident transports.

Case 17

An immediate jeopardy was identified on March 12, 2018. The facility failed to supervise residents who require constant supervision while smoking. These residents were observed with smoking materials such as cigarettes and lighters on their person and smoking on facility grounds unsupervised.

Case 18

An immediate jeopardy was identified on March 14, 2018. The facility failed to protect a resident from an altercation from another resident. The resident who struck the other resident had previously been on 1:1 observations with 15 minute checks due to physically altercations with other residents. In between a 15 minute check, the resident struck another resident in the face. An X-ray and CT scan did not reveal any injuries. Law enforcement was also notified.

Case 19

An immediate jeopardy was identified on March 14, 2018. The facility failed to protect a resident who required a 2-person assist for turning, repositioning and incontinent care. During incontinent care, the nursing assistant (NA) turned the resident without assistance, which resulted in the resident rolling off the bed on to the floor. The NA then utilized a mechanical lift without assistance to place the resident back into bed. The resident sustained a spiral fracture of the femur.

Case 20

An immediate jeopardy was identified on March 12, 2018. The facility failed to notify the Department of Social Services (DSS) Guardian immediately when the resident stated that he planned to leave the facility and take a bus to visit friends. The resident left the facility and did not return. Approximately 12 hours later, the DSS guardian and police were notified and a missing person report was filed. The resident was located at an Emergency Room.

Case 21

An immediate jeopardy was identified on March 15, 2018. The facility failed to protect a resident when being transferred from bed to wheelchair utilizing a hoyer lift with two CNAs present. During the transfer, the handle that keeps the lift legs locked in place became disengaged from the locked position. This caused the lift legs to retract causing the lift bar to swing and hit the resident in the head. The facility failed to protect residents from neglect by failing to remove the malfunctioning lift from service.

Case 22

An immediate jeopardy was identified on March 26, 2018. The facility failed to check the functionality of a wandering device prior to placing it on a resident who was assessed as high risk for wandering. The resident exited the building without staff knowledge and without the wander guard system activating. The resident walked approximately a half a mile, with snow on the ground, and got into the vehicle of a person leaving a shopping center. The resident was returned to the facility and assessed without injury.

Case 23

An immediate jeopardy was identified on April 10, 2018. The facility failed to supervise residents to prevent accidents. At 5:00 AM on March 26, 2018, a cognitively impaired resident fell and staff failed to report the fall. At 7:15 AM, the physical therapist attempted to assist the resident to a standing position, however, the resident cried out in pain. X-rays confirmed the resident had sustained a fractured right femur. The resident was admitted to the hospital for surgery..

Case 24

An immediate jeopardy was identified on April 20, 2018. Staff failed to prevent residents from leaving the facility unsupervised. On March 25, 2018 at 5:10 AM, an alarm sounded at the facility and was deactivated by staff without accounting for all residents. At 6:35 AM, the facility received a telephone call from the local hospital notifying the nursing home that a cognitively impaired resident had eloped from the nursing home and was admitted for observation. The resident was assessed by the hospital. The nursing home had no knowledge of the elopement.

Case 25

An immediate jeopardy was identified on May 4, 2018. The facility failed to supervise a resident assessed to be unsafe for smoking. On May 2, 2018, ashes from the cigarette were observed burning the foam between portions of the resident's neck brace. The resident was not wearing a protective apron.

Case 26

An immediate jeopardy was identified on May 4, 2018. The facility failed to properly supervise residents to prevent accidents. A resident was disembarking from the facility bus with her walker when the vehicle's lift ramp went up instead of down. This reverse action caused the resident to fall, hit her head and sustain bruises to her arm.

Case 27

An immediate jeopardy was identified on May 11, 2018. The Immediate jeopardy was identified when the facility discontinued the use of a wander guard for a resident with a history of exiting seeking behavior. The resident exited the facility, fell from the wheelchair, broke her nose and bruised her face.

Case 28

An immediate jeopardy was identified on May 4, 2018. A resident eloped from the nursing home without staff knowledge. A Certified Nursing Assistant disarmed the alarm, then returned to her work area without accounting for all residents in the building. The resident was found several hours later by the Activities Director.

Case 29

An immediate jeopardy was identified on June 8, 2018. A resident was transferred by one Certified Nursing Assistant instead of two Aides as specified by the physician, the MDS and the care plan. The resident fell off the sliding board onto the floor, hitting their new below the knee amputation (BKA) and wound. The resident's surgeon was consulted after the fall. Due to the severe injury, the surgeon hospitalized the resident to convert the below knee amputation to an above the knee amputation.

Case 30

An immediate jeopardy was identified on July 9, 2018. The facility failed to provide a resident with the required two-person assist, while providing care. One staff person rolled the resident to one side of the bed and the resident rolled out of the bed to the floor, landing on her knees. The resident experienced increased pain and swelling to the knees that was not reported to the physician until five days later. X -rays for the knees showed an impacted right knee fracture. The resident died while in the hospital.

Case 31

An immediate jeopardy was identified on August 6, 2018. The facility failed to supervise residents to prevent accidents for residents that required two staff transfers. A Certified Nursing Assistant utilized a sit to stand lift to transfer a resident from the chair to the bathroom. As a result the resident fell, sustaining facial injuries. Staff did not report the incident and the attending physician was not notified of the fall with injuries.

Case 32

An immediate jeopardy was identified on August 13, 2018. The facility failed to supervise a resident with exit seeking and elopement behaviors. On July 22, 2018, a resident eloped from the facility twice without staff knowledge. The first time, the resident was only gone for a few minutes before being discovered. The second time the resident was gone for more than an hour.

Case 33

An immediate jeopardy was identified on October 16, 2018. A resident with known exit seeking behaviors wandered away from the facility without staff knowledge. The resident left the building through a door that was not equipped with an alarm. In addition, the resident was to be observed and monitored every 15 minutes by staff. When staff failed to locate the resident during one of the 15-minute checks, no action was initiated. An off-duty employee noticed the resident in a parking lot and assisted the resident back to the facility.

Case 34

An immediate jeopardy was identified on October 16, 2018. A dependent resident experienced an 'unwitnessed' resident fall from their bed, hitting their head on the floor. Nursing personnel notified the attending physician, who ordered an X-ray of the resident's shoulder, but failed to report that the resident was receiving Coumadin, daily. The facility failed to consistently monitor the resident and conduct neurological checks as required. The resident died.

Case 35

An immediate jeopardy was identified on October 11, 2018. The facility failed to supervise and monitor a cognitively impaired, dependent resident that utilized a wheelchair for mobility. Staff wheeled a resident outside and left them on the front porch for an unspecified period of time. The next day the resident was noted to have a sun burn and blisters on their arms, which necessitated treatment. Six days later, the resident was again left unattended outside. The resident fell from their wheelchair to the ground, where they remained for more than an hour, with ants crawling over their body. A student nurse found the resident in the parking lot and notified facility personnel. The resident was returned to the facility confused, disoriented and complaining of being thirsty.

Case 36

An immediate jeopardy was identified on October 19, 2018. A resident receiving oxygen via nasal cannula used a cigarette lighter to "fix the hem on his pants." The resident caught fire, sustaining first degree burns on his hands and facial hair. The resident was transported to the hospital for treatment.

Case 37

An immediate jeopardy was identified on November 1, 2018. The facility failed to supervise a resident with known wandering behaviors. The resident eloped from the facility without staff knowledge. The resident traveled one half mile from the nursing home and crossed a two-lane road before being located by staff on a side street.

Case 38

An immediate jeopardy was identified on October 29, 2018. The facility failed to supervise residents to prevent accidents and investigate an injury of unknown origin. A resident sustained a fall, which X-rays confirmed resulted in an acute fractured right hip. Staff indicated the fall was unwitnessed and continued to perform routine activities of daily living care which caused the non-displaced fracture to worsen, become displaced and subsequently caused significant pain to the resident. The resident remains in the nursing home and is currently bedridden.

42 CFR 483.24 Quality of Life

Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.

Case 39

An immediate jeopardy was identified on March 13, 2018. The facility failed to initiate CPR on a Full Code resident who was found unresponsive. The RN entered the room and found the resident without a pulse or respiration. The RN left the room to call the ambulance. No one, including the RN, returned to the resident's room to initiate CPR.

Case 40

An immediate jeopardy was identified on March 23, 2018. The facility failed to honor a resident's advanced directives and provide Cardiopulmonary Resuscitation (CPR). On March 12, 2018, the resident was found unresponsive, with absence of respirations and heartbeat. Staff initially contacted 911, then canceled the request. After a thorough review of the medical record, staff determined the resident was a Full Code, however, 12 to 20 minutes had elapsed. Emergency Medical Services (EMS) arrived, initiated CPR, however, the resident was deceased.

Case 41

An immediate jeopardy was identified on October 19, 2018. The facility failed to provide Cardiopulmonary Resuscitation (CPR) to a full code resident that was found unresponsive. Nursing personnel delayed CPR for 30 minutes. The resident expired.

Case 42

An immediate jeopardy was identified on October 23, 2018. The facility failed to provide Cardiopulmonary Resuscitation (CPR) to a full code resident that was found unresponsive. Nursing personnel did not initiate CPR or call 911. The resident expired. .

Case 43

An immediate jeopardy was identified on October 25, 2018. The facility failed to provide Cardiopulmonary Resuscitation (CPR) to a full code resident that was found unresponsive. Nursing personnel did not initiate CPR. The resident expired.

RESIDENT RIGHTS

42 CFR 483.10

The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

Case 44

An immediate jeopardy was identified on October 25, 2018. The facility failed to honor a resident's advanced directives, which specified, Do Not Resuscitate. When the resident experienced a significant change in clinical condition and became unresponsive, staff initiated Cardiopulmonary Resuscitation (CPR), called 911, and transferred the resident to the hospital where other resuscitative efforts were performed, including intubation and defibrillation (electric shock). A family member arrived during the provision of CPR by Emergency Medical Services (EMS) in the nursing home. The family reiterated that the resident was DNR. An investigation revealed that the DNR documents had been kept by the Social Worker and had not been incorporated into the electronic health record.

Case 45

An immediate jeopardy was identified on November 1, 2018. The facility failed to honor a resident's advanced directives, which specified, Do Not Resuscitate. When the resident experienced a significant change in clinical condition and became unresponsive, staff initiated Cardiopulmonary Resuscitation (CPR), called 911, and transferred the resident to the hospital where other resuscitative efforts were performed, including intubation and defibrillation (electric shock). The resident's daughter repeatedly informed staff that her Mother had requested a DNR; however, the medical record was not up-to-date. An investigation revealed that the DNR documents were in a chart that had been purged.

Case 46

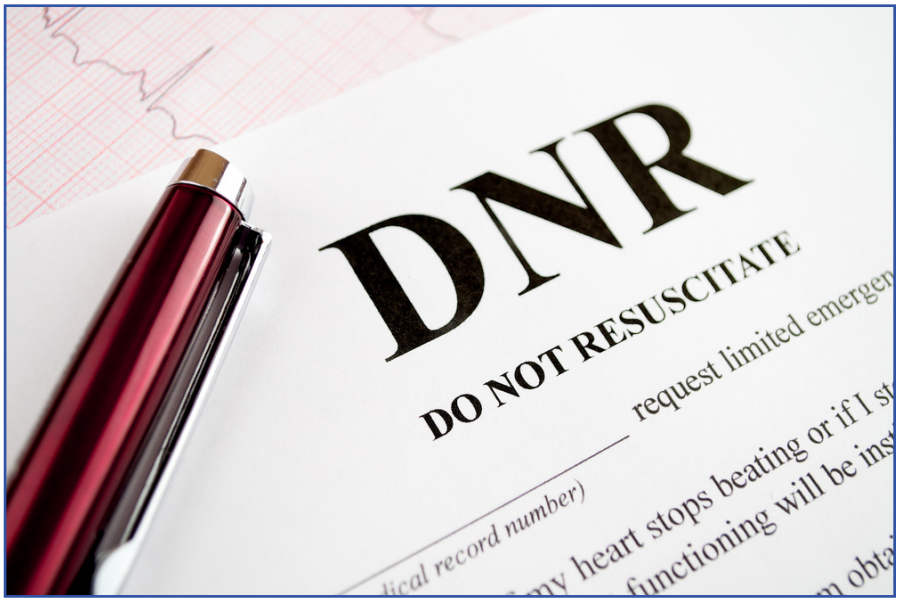
An immediate jeopardy was identified on March 12, 2018. The facility failed to honor a resident's advance directive, which specified Do Not Resuscitate (DNR). A resident pressed the call light for assistance in the bathroom, and was found unresponsive by staff with agonal breathing. The facility initiated Cardiopulmonary resuscitation (CPR) against the resident's wishes and was transferred to the hospital for critical care.

Case 47

An immediate jeopardy was identified on March 30, 2018. The facility failed to honor a resident's advanced directives, which specified Do Not Resuscitate. On February 19, 2018, the resident was found unresponsive, with absence of respirations and heartbeat. Staff initiated cardiopulmonary resuscitation (CPR) for seven minutes, then Emergency Medical Services (EMS) arrived to assist. The resident did not recover and was pronounced dead by EMS. The family that arrived on the scene questioned staff about the provision of CPR, and the resident's choice for a DNR. .

Case 48

An immediate jeopardy was identified on April 5, 2018. The facility failed to honor a resident's advanced directives, which specified Do Not Resuscitate. On February 22, 2018, the resident was found unresponsive, with absence of respirations and heartbeat. Staff called a Code Blue, initiated chest compressions and called 911. Paramedics arrived to provide assistance, however, the Director of Nursing Services (DON) reviewed the medical record, determined the resident had a DNR, and advised staff to discontinue CPR.



CATEGORY: QUALITY OF CARE

42 CFR 483.25 Quality of Care

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices.

Case 49

An immediate jeopardy was identified on January 16, 2018. The facility failed to administer Glucagon to a resident that became unresponsive with a glucose of 24mg/dl. The nurses could not access and administer the Glucagon per protocol because the medication was locked in the supervisor's office. The resident was transported to the hospital by Emergency Medical Services for care.

Case 50

An immediate jeopardy was identified on January 19, 2018. A resident in respiratory distress with wet breath sounds and decreased responsiveness was not monitored by the night shift nurse. The oncoming day shift nurse found the resident with an oxygen saturation of 62 percent with labored breathing and tube feeding infusing. The resident was transported to the hospital, admitted for treatment and expired the same day.

Case 51

An immediate jeopardy was identified on February 15, 2018. The facility failed to transcribe wound care orders, and administer treatments as ordered by the attending physician, for a resident with pressure ulcers from January 9, 2018 through February 13, 2018. The resident's wounds deteriorated.

Case 52

An immediate jeopardy was identified on January 30, 2018. The facility failed to provide sufficient staffing to meet the individualized needs of each resident. The attending physician wrote multiple orders for a dermatology and surgical consult for a resident with a lesion on his head. The facility failed to follow-up on the consult. Further, the facility failed to provide wound care, treatments and tube feedings for nine residents as ordered by the attending physician.

Case 53

An immediate jeopardy was identified on February 28, 2018. A resident fell from the bed to the floor sustaining a large head hematoma. The agency nurse did not assess the resident, monitor the resident's neurological status, or report the injury to the physician. The agency nurse reported that she did not monitor the resident because she did not receive any orientation and training from the facility.

Case 54

An immediate jeopardy was identified on February 5, 2018. The facility failed to provide sufficient staff for the care of residents. On February 5, 2018, one Licensed Practical Nurse (LPN) was scheduled for 61 residents, consequently, sliding scale insulin scheduled for administration at 4:00 PM and 5:00 PM was not administered until 7:00 PM and 8:00 PM respectively, along with insulin ordered for 9:00 PM. One resident's blood glucose reading was recorded as 235mg/dl and did not receive the sliding scale as ordered. Other residents' blood glucose ranged from 65mg/dl to 516mg/dl without notifying the attending physician as ordered.

Case 55

An immediate jeopardy was identified on March 3, 2018. The facility failed to assure that medications were available in the correct dosage for five residents, resulting in significant medication errors. One resident was ordered to receive Cymbalta 60mg for anxiety/depression; however, only received 20mg for over sixty days. Another resident received the incorrect dosage of Oxycodone 5mg of for pain management; however, 20mg was ordered. The facility also failed to follow-up and notify the physician when residents presented with blood glucose levels greater than 401mg/dl.

Case 56

An immediate jeopardy was identified on March 9, 2018. The facility failed to apply a resident's oxygen via his tracheostomy collar and his Astral ventilation system immediately after assisting the resident into bed. The resident was found unresponsive in his bed and had passed away. In addition, it was determined the facility had admitted other residents, who had tracheostomies that required ventilation assistance.

Case 57

An immediate jeopardy was identified on April 12, 2018. The facility failed to follow speech therapy recommendation to supervise a resident who was at risk of aspiration pneumonia and impulsive behaviors such as placing large amounts of food in the mouth. In addition, it was recommended to also provide a mechanical soft diet and honey thick liquid consistency. The resident was found unresponsive after eating dinner and C.P.R. was initiated. The hospital records shows that the resident had a large bolus of food impacted in the proximal esophagus. The Computed Tomography (CT) scan of the head showed the resident had diffuse cerebral edema and diffuse infarct from diffuse anoxic injury. The resident died.

Case 58

An immediate jeopardy was identified on April 20, 2018. The facility failed to administer medication as ordered by the attending physician. A resident was to receive ABH gel (Ativan, Benadryl and Haldol Gel), one milliliter (ml), topically, twice daily. The nurse administered an entire 10 milliliter, pre-filled syringe orally. The resident became lethargic and unresponsive, and was transported by EMS to the hospital for admission. The resident subsequently died.

Case 59

An immediate jeopardy was identified on April 10, 2018. A resident was observed to have wounds and blisters on the lower abdomen, buttocks, left leg and right ankle, which were consistent with second degree burns. The resident was admitted to the hospital. On April 13, 2018, the survey team identified water temperatures in five bathrooms that were greater than 120 degrees Fahrenheit.

Case 60

An immediate jeopardy was identified on April 27, 2018. During direct observations, nursing staff on two different units failed to disinfect blood glucose monitoring machines between each resident use.

Case 61

An immediate jeopardy was identified on April 27, 2018. Staff failed to notify the attending physician of a significant change in a resident's condition. On March 19, 2018, the resident was found unresponsive and transferred to the hospital, where the blood sugar was documented as 1028 mg/dl. The resident was admitted with Hyperglycemia (high blood sugar) and Diabetic Coma. The resident expired on April 3, 2018. A second resident was experiencing respiratory difficulty with decreased dietary intake and the facility failed to notify the doctor. The family intervened and the resident was admitted to the hospital with sepsis and pneumonia. The resident subsequently died.

Case 62

An immediate jeopardy was identified on May 15, 2018. The facility failed to have competent, qualified staff on the evening shift to provide deep suctioning emergency tracheostomy care for residents. This failure resulted in a 15-minute delay in clearing the airway for two residents while awaiting arrival of EMS and transport to a hospital.

Case 63

An immediate jeopardy was identified on May 16, 2018. The facility failed to appropriately assess the complaint of an alert, oriented resident who reported to staff a feeling of being impacted/constipated with pain and discomfort for seven consecutive days. After the family intervened, the resident was admitted to the hospital severely constipated with a perforated bowel. The resident subsequently died.

Case 64

An immediate jeopardy was identified on May 22, 2018. During direct observations, nursing staff failed to disinfect blood glucose monitoring machines between each resident use, to minimize the transmission of blood borne pathogens.

Case 65

An immediate jeopardy was identified on May 23, 2018. During direct observations, nursing staff on two different nursing units failed to disinfect blood glucose monitoring machines between each resident use to minimize the transmission of blood borne pathogens. Staff also failed to wash their hands between each resident to minimize cross contamination and spread of infection.

Case 66

An immediate jeopardy was identified on May 8, 2018. The facility failed to transcribe and administer the correct medications to a resident. Consequently, the resident received multiple sedating medications in a short period of time, and multiple other medications at the incorrect dosage or were intended for other residents. The resident became unresponsive, was transported by EMS to the hospital and placed on a ventilator.

Case 67

An immediate jeopardy was identified on May 11, 2018. The facility failed to report and provide appropriate care for a resident who experienced a significant change in condition. The resident was observed by staff over a two-day period with slurred speech, drooling, right facial drooping and slouched posture. The family intervened and the resident was transported to the hospital. The hospital diagnoses included CVA with indeterminate lacunar infarcts in the right basil ganglia and right thalamus. The resident was subsequently placed on hospice.

Case 68

An immediate jeopardy was identified on July 9, 2018. The facility failed to supervise a resident who required a pureed diet, after receiving a whole Nutrigrain bar. The resident had a history of aspiration pneumonia and oropharyngeal dysphasia. After being found in distress, the resident was transferred to the hospital and admitted with acute respiratory failure and aspiration pneumonia. The resident died after returning to the nursing home for comfort measures.

Case 69

An immediate jeopardy was identified on July 2, 2018. The facility failed to notify and timely report a critical lab value to the medical staff. A resident's Dilantin level was documented at 52 mcg/ml. The normal range is 10-20 mcg/ml. The resident was found to be lethargic with a heart rate of 42 beats per minute. The resident was sent to the hospital and was found to have Dilantin toxicity with bradycardia.

Case 70

An immediate jeopardy was identified on August 6, 2018. The facility failed to provide a resident with a pureed diet and thickened liquids. The resident choked and aspirated on the regular food items and subsequently died.

Case 71

An immediate jeopardy was identified on October 16, 2018. Registered Nurses were not available on the 3:00 p.m. – 11:00 p.m. and 11:00 p.m. -7:00 a.m. shifts to provide care, treatment, and services to residents with a tracheostomy. When a resident's tracheostomy was dislodged, staff on duty transferred the resident to the hospital emergency room for treatment. Moreover, staff failed to maintain emergency tracheostomy equipment at bedside in accordance with the plan of care and professional standards of care. Further, direct observation revealed that staff did not utilize sterile procedures to minimize cross contamination during the provision of tracheostomy care.

Case 72

An immediate jeopardy was identified on October 23, 2018. The facility failed to provide a resident with elevated blood sugar levels sliding scale insulin as ordered by the attending physician because the medication was not available. Nursing personnel did not inform the attending physician. The resident started vomiting and was transferred to the hospital with a blood sugar of 485, and assessed for diabetic ketoacidosis. The resident remained in the hospital for two days. In addition, staff to resident abuse was witnessed by a Certified Nursing Assistant, who reported the incident to supervisory nursing personnel. The nurses did not take any action to protect the resident from abuse; the perpetrator continued working and the DON and administrator were not notified.

Case 73

An immediate jeopardy was identified on October 26, 2018. The facility failed to supervise and monitor a resident during meal service to minimize complications. A Certified Nursing Assistant fed a dependent resident pureed breakfast entrees. The resident started choking. The Certified Nursing Assistant continued to place food in the resident's mouth, and failed to notice the resident was unable to swallow, as they were distracted an using their personal cell phone. The resident began having difficulty breathing and was transported to the hospital, where they subsequently died. The autopsy report stated the cause of death was hypoxia due to food asphyxiation.

Case 74

An immediate jeopardy was identified on October 30, 2018. Physician orders specified for staff to provide specific quantities of Novolin R insulin four times daily, 24 units of Levemir at bedtime and to notify the physician if the blood sugar was below 70. The facility failed to notify the physician of low blood sugars for eleven days in September. The resident became unresponsive, was transported by EMS to the hospital with a blood sugar of 35 mg/ml and symptoms that included right arm tingling, slurred speech, increased confusion and weakness. Following treatment at the hospital, the resident returned to the facility.

INFECTION CONTROL

42 CFR 483.80 Infection Control

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection.

Case 75

An immediate jeopardy was identified on February 27, 2018. The facility failed to clean and disinfect a glucometer between the uses of two residents. The manufacturer's instructions for cleaning and disinfecting the device was not followed.

Case 76

An immediate jeopardy was identified on October 18, 2018. A nurse utilized the same Novolog flex pen to administer insulin to two, different residents. There are eleven residents in the nursing home that utilize insulin flex pens. The shared usage of flex pens placed residents at risk for the transmission of blood borne pathogens.

Case 77

An immediate jeopardy was identified on October 26, 2018. A nurse was observed using the same glucometer to check the blood sugar levels of two (2) residents without cleaning the unit before or after testing each resident. The glucometer was also observed in the medication cart with a dark red substance, resembling blood, on the device.

42 CFR 483.15 Transfer and Discharge

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

- *The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.*
- *The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.*
- *The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.*
- *The health of individuals in the facility would otherwise be endangered.*
- *The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.*
- *For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.*
- *The facility ceases to operate. The facility may not transfer or discharge the resident while the appeal is pending.*

Case 78

An immediate jeopardy was identified on March 5, 2018. The facility failed to provide discharge planning services to a resident. The resident was discharged to a motel without medications, and no arrangements were made for meals. The resident did not have a working telephone to seek help from community resources.

Case 79

An immediate jeopardy was identified on June 19, 2018. The facility failed to develop and implement post-discharge planning prior to discharging a resident with a recent below the amputation to the community. The facility failed to arrange for a home assessment, identify the resident's needs, or make referrals to local agencies for support services prior to discharge. An attempt to transfer the resident to a hotel failed due to a lack of funds. The resident was then transferred to a home which the van driver reported was not habitable and had no electricity or running water.

Special Thanks to Region IV State Agency Directors and surveyors for all of your hard work and efforts to protect the public health and safety.

Dr. Renard Murray,
Retired Consortium
Administrator

Jean Moody-Williams,
Acting Consortium Administrator (CA)

Sandra M. Pace,
Associate Consortium
Administrator (ACA)

Linda Smith, Associate Regional
Administrator (ARA)

Dr. Richard Wild, CMS Chief
Medical Officer for Atlanta and
Boston Regional Offices

Stephanie M. Davis, MS., RD, Chief,
Long Term Care Enforcement Branch

Other members of the Long Term Care Enforcement team include, but are not limited to:
Bessie Barnes, Frederick Hamilton, Tina Holloway, Phyllis King, Sondra Rothwell & Bridget Dunner-Wallo.

Making Care Safer for all Americans