NCHCFA has compiled Immediate Jeopardy data for all facilities surveyed during the fourth quarter of 2022. There were 26 Immediate Jeopardies issued to facilities in this quarter. North Carolina Department of Health and Human Services, Division of Health Service Regulation cited 22 of these citations at a severity level J and four at a severity level K. Additionally, there were 13 citations in October, 12 citations in November, and one citation in December.

The Immediate Jeopardy citations were as follows:

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<tr>
<th>CITATION CODE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>F689</td>
<td>Accidents</td>
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<tr>
<td>F600</td>
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<td>F580</td>
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Most citations were from complaint surveys. The Division of Health Service Regulation has seen increased complaints, leading to more complaint surveys. If you have an adverse occurrence in your facility, NCHCFA recommends that the incident be immediately and thoroughly investigated and reviewed by the QA Committee. The facility should implement a QAPI plan even if the facility believes that there is no non-compliance evidence, and the facility has followed all facility policies and procedures. If a survey team identifies an instance of non-compliance, implementing the appropriate and thorough action plan may limit the time frame that the facility is determined to be out of compliance. A timely and comprehensive action plan may demonstrate that the alleged non-compliance is fully corrected and serve as evidence of past non-compliance in an immediate jeopardy situation.

This report is compiled from data available through January 25, 2023, in the Quality Certification and Oversight Reports and the NCDHHS Regulated Facilities and Statement of Deficiencies websites. Summaries of the citations for Fourth Quarter 2022 are below.

This report is confidential and to be used only for educational purposes by members of the North Carolina Health Care Facilities Association. Any unauthorized transmission or reproduction is expressly prohibited.
FACILITY A (EASTERN REGIONAL OFFICE)

F689 (Accidents)
Immediate jeopardy began when a cognitively impaired resident was observed out in the parking lot unsupervised in his wheelchair. The resident was observed outside the facility by staff who failed to provide interventions. The resident was later found away from the facility near a major highway. The facility was not aware the resident had left the premises until a passerby called the facility to inform them. A staff member who had just left the facility also found the resident and stayed with him until they were transported back to the facility.

Comment/Suggestions

Eloppement
- Facilities must respond immediately following their missing resident plan when an individual hears an alarm, or they identify a resident missing.
- Facilities must thoroughly investigate a door alarm to ensure residents have not exited the building unsupervised.
- Staff should be educated and trained to provide interventions to residents who have exited the building and training to identify residents who may have exited unsupervised.
- Residents who have known exit seeking behaviors, should have specific interventions for elopement risk.
- Facilities for at-risk individuals should have a comprehensive alarm or door security system, including all potential exit doors.

FACILITY B (WESTERN REGIONAL OFFICE)

F689 (Accidents)
Immediate jeopardy began when the Director of Nursing witnessed a resident attempting to go out to smoke with an oxygen tank on the back of his wheelchair and oxygen in use via nasal cannula and no interventions were put in place. Resident was then observed smoking while sitting outside in the designated area with oxygen tank attached to his wheelchair and nasal cannula in place. The resident was receiving supplemental oxygen via nasal cannula tubing. Upon observation, the resident placed cigarette in ash tray and came back into building with oxygen in place.

Comment/Suggestions

Smoking
- Facilities should ensure safe smokers are smoking safely to include a safe area and in a safe situation.
- Residents who smoke who also use oxygen must be educated on oxygen use while smoking and staff should monitor for safe smoking practices.
The facility should ensure all residents who are safe smokers are assessed and care planned for safe smoking.

Facilities should reassess residents for safe smoking when smoking policies are violated. Staff should report breaches of smoking policy immediately.

Staff should be educated in safe smoking practices.

FACILITY C (CENTRAL/EASTERN REGIONAL OFFICE)

F689 (Accidents)
Immediate Jeopardy began when a resident was being transferred with a total mechanical lift and one of the four loops from the resident's sling detached from the lift, resulting in the resident falling to the floor. The facility was found to not have secured the 4 loops of the sling during the transfer when the fall occurred. The fall resulted in multiple fractures and severe pain.

Comment/Suggestions

Transfer Accidents
- Staff should be trained on manufactures specifications and safe lift use.
- Staff should be monitored to validate and demonstrate safe transfer practices.
- Lift and slings should be inspected for wear and tear and function status.
- Review care plans for accuracy of needed assistance with transfers.

FACILITY D (EASTERN REGIONAL OFFICE)

F689 (Accidents)
Immediate Jeopardy began when a cognitively impaired resident was observed with a plastic sandwich bag in his mouth alone in his room during mealtime. The resident had a history of putting non-food items in his mouth. The resident was not supposed to be served nonedible items on their food tray and needed extensive assistance with meals.

Comment/Suggestions

Accidents (non-edible food items)
- Assess and care plan residents for behaviors such as putting in edible items in their mouth with goals and interventions.
- Staff should be trained on resident specific behaviors.
- Nonedible items that should not be delivered on meal trays to residents should be removed and monitored to ensure safe practices.
- Assist residents with meals as assessed to ensure safety.

FACILITY E (WESTERN/CENTRAL REGIONAL OFFICE)

F760 (Significant Medication Error)
Immediate Jeopardy began when the facility failed to administer the correct medications to a resident. The nurse administered medications to a resident that were prescribed for another resident. The resident received the wrong medications which included blood thinner, anticonvulsant, hypertensive, anti-anxiety, and antidepressants. The nurse administering the medication prepared her medications, stepped away from the cart and then returned and picked up the medications and administered them to the wrong resident. The resident was unconscious and unresponsive and was admitted to the hospital for an accidental overdose.

Comment/Suggestions

Significant Medication Errors

- Facilities should ensure that nurses administer all medications following the physician’s order.
- Facilities must ensure nurses are trained to verify the identity of residents before administering medications to ensure safety.
- Nurses must not “pre-pour” medications for administration.
- Ensure nurses report medication omission or errors to physicians.

FACILITY F (EASTERN REGIONAL OFFICE)

F580 (Notification) and F684 (Quality of Care)

Immediate Jeopardy began when the facility failed to communicate about a resident’s fall and failed to notify the physician of a fall which delayed in the assessment, care, and identification of multiple facial fractures. There was a lack of communication from the nurse aid related to the resident’s fall. The resident presented with facial bruising which led to an investigation from the facility in which it was determined the resident had fallen and it was not reported.

Comment/Suggestions

Notifications and Quality of Care

- The facility should ensure all residents are assessed and monitored following a fall.
- Staff should be trained to immediately report falls to nursing.
- Facilities should report falls to all required parties, including physicians.

FACILITY G (CENTRAL REGIONAL OFFICE)

F600 (Abuse) and F607 (Abuse Policy and Procedures)

Immediate Jeopardy began when the facility failed to protect a cognitively impaired resident from physical abuse when a nurse aide slapped the hand of a resident. The resident reached out to the nurse aide during care with feces covered hand, the aide slapped the resident’s hand. The incident was witnessed by staff who failed to report immediately. The resident did not have the cognition to express the outcome. DHSR determined that a reasonable person would have been traumatized by being slapped during care. The staff’s failure to report immediately allowed the nurse aide to continue to care for residents after an allegation of abuse.
Comment/Suggestion

Abuse and Abuse Policy and Procedures

- Abuse incidents/allegations should be reported immediately to required parties (Law Enforcement APS, DHSR).
- Alleged perpetrators should be removed from resident care immediately following an abuse allegation.
- Abuse policy and procedures should be followed to include protection, investigation and reporting of all incidents.
- Ensure all staff are up to date on abuse training and monitor staff interactions with residents.
- Ensure staff are up to date on what to report, when and whom to report abuse concerns to.

FACILITY H (WESTERN REGIONAL OFFICE)

F600 (Abuse)
Immediate Jeopardy began when the facility failed to protect a resident from an injury of unknown origin. Resident was identified to be guarding areas of their body and hollering out in pain. Resident was sent out to the hospital for evaluation and was determined to have multiple fractures (which included bilateral hips, femur was broken in three or more places and fracture of the superior pubic ramie extending into the pubic body) which required surgical interventions. The resident required extensive assistance with transfers and bed mobility. Injuries were determined to be from trauma of unknown origin.

Comment/Suggestion

Abuse

- Ensure staff are trained to immediately report falls, bruises, and changes in resident condition to nursing staff.
- Abuse incidents/allegations should be reported immediately to required parties (Law Enforcement APS, DHSR).
- Abuse policy and procedures should be followed to include protection, investigation and reporting of all incidents.
- Ensure all staff are up to date on abuse training and monitor staff interactions with residents.
- Ensure staff are up to date on what to report, when and whom to report abuse concerns to.

FACILITY I (WESTERN REGIONAL OFFICE)

F678 (CPR)
Immediate Jeopardy began when the facility failed to provide cardiopulmonary resuscitation (CPR) and suctioning to a resident who was a full code. The facility only performed chest compressions until emergency medical services (EMS) arrived. It was determined that the needed equipment to provide suctioning and airway support for the resident was in the facilities
crash cart and the nurse did not have keys to unlock the cart. EMS transported the resident to the hospital and given the extended cardiac arrest time of 32 minutes and the lack of neurologic responsiveness, the resident was intubated and admitted to the intensive care unit (ICU). Resident was transitioned to comfort care and passed away.

Comment/Suggestion

CPR
- Accurately determine residents code status.
- If emergency supplies are in a locked area, facilities must ensure staff have access (to include Agency Nurses).
- Evaluate the location of your emergency supplies/equipment to ensure they are easily accessible in case of an emergency.

FACILITY J (WESTERN REGIONAL OFFICE)

F600 (Abuse) and F610 (Investigate Alleged Violations)
The immediate jeopardy began when a nurse aide witnessed another nurse aide grab a resident’s right arm in a rough jerking motion to transfer her to the bedside commode, which resulted in a skin tear to the right arm and the resident being fearful. The incident was witnessed by staff who failed to report immediately. The staff’s failure to report immediately allowed the nurse aide to continue to care for residents after an allegation of abuse. This had the high likelihood to put other residents at high risk for abuse and harm.

Comment/Suggestion

Abuse and Abuse Policy and Procedures
- Abuse incidents/allegations should be reported immediately to required parties (Law Enforcement APS, DHSR).
- Alleged perpetrators should be removed from resident care immediately following an abuse allegation.
- Abuse policy and procedures should be followed to include protection, investigation and reporting of all incidents.
- Ensure all staff are up to date on abuse training and monitor staff interactions with residents.
- Ensure staff are up to date on what to report, when and whom to report abuse concerns to.

FACILITY K (WESTERN REGIONAL OFFICE)

F689 (Accidents)
Immediate Jeopardy began when failed to prevent a resident, who had been deemed incompetent and had a history of wandering and exit seeking behaviors, from exiting the facility unsupervised and without staff knowledge. The resident was located by the police department at a two-lane highway intersection approximately eight miles from the facility.
Immediate Jeopardy Issues: Fourth Quarter 2022

The facility also failed to ensure wheelchair securement was according to manufacturer recommendations for providing a safe facility van transport when a resident slid partially out of the wheelchair, underneath the lap belt, causing her knees to hit the floor of the van resulting in minor bruising to her hand and knees.

Comment/Suggestions

Elopement
- Facilities must respond immediately following their missing resident plan when an individual hears an alarm, or they identify a resident missing.
- Facilities must thoroughly investigate a door alarm to ensure residents have not exited the building unsupervised.
- Residents who have known exit seeking behaviors, should have specific interventions for elopement risk.
- Wanderguards should be checked.
- Facilities for at-risk individuals should have a comprehensive alarm or door security system, including all potential exit doors.

Comment/Suggestions

Wheelchair Securement
- Staff should be trained in specific wheelchair securement systems for transportation.
- Staff should be monitored to use wheelchair securement systems correctly and safely. Staff should be able to demonstrate the correct securement procedures.
- Ensure the manufacture specifications/recommendations are followed for all wheelchair securement systems.
- If a wheelchair securement system malfunctions or is inoperable, identify with staff alternate means to transport residents.

FACILITY L (CENTRAL REGIONAL OFFICE)

F689 (Accidents)
Immediate jeopardy began when the facility failed to secure a resident in a sit to stand lift per manufacturer's instructions and failed to provide a safe transfer which resulted in a fall with major injury. The resident was found to have slipped out of the sling during a transfer. The resident sustained a shoulder fracture.

Comment/Suggestions

Transfer Accidents
- Staff should be trained on manufactures specifications and safe lift use.
- Staff should be monitored to validate and demonstrate safe transfer practices.
- Lift and slings should be inspected for wear and tear and function status.
Immediate Jeopardy Issues: Fourth Quarter 2022

- Review care plans for accuracy of needed assistance with transfers.

FACILITY M (WESTERN REGIONAL OFFICE)

F689 (Accidents)
Immediate Jeopardy began when residents were provided with an unsafe area to smoke. Residents had to navigate uneven pavement, with holes and cracks, to get to the side of the two-lane road which had a posted speed limit of 35 miles per hour and heavy local traffic for smoking. The facility failed to ensure residents had a means to call for help. It was determined that some residents smoked day and night and staff were not always aware of when the residents were at the location smoking. It was determined there was no protection from the elements or interventions in place to warn drivers of the residents by the side of the road. There was no receptacle provided for the residents to extinguish their cigarettes or to leave their cigarette butts. It was further determined that sometimes when residents returned from smoking the facility doors were locked and they could not gain entry.

Comment/Suggestions

Smoking
- Facilities should ensure safe smokers are smoking safely to include a safe area and in a safe situation.
- Residents who smoke who also use oxygen must be educated on oxygen use while smoking and staff should monitor for safe smoking practices.
- The facility should ensure all residents who are safe smokers are assessed and care planned for safe smoking.
- Facilities should reassess residents for safe smoking when smoking policies are violated. Staff should report breaches of smoking policy immediately.
- Staff should be educated in safe smoking practices.

FACILITY N (CENTRAL REGIONAL OFFICE)

F689 (Accidents)
Immediate Jeopardy began when a resident with severe cognitive impairment and wandering behaviors exited the facility unattended. The resident was observed on the facility video footage exiting the facility and walking out of the facility parking lot onto a two-lane road with a speed limit of 35 MPH. The resident was found 1.9 miles away from the facility and was returned to the facility. The door alarm sounded when the resident exited, the staff who responded to the alarm failed to go outside to observe any residents.

Comment/Suggestions

Elopement
- Facilities must respond immediately following their missing resident plan when an individual hears an alarm, or they identify a resident missing.
Facilities must thoroughly investigate a door alarm to ensure residents have not exited the building unsupervised.

Residents who have known exit seeking behaviors should have specific interventions for elopement risk.

Wanderguards should be checked.

Facilities for at-risk individuals should have a comprehensive alarm or door security system, including all potential exit doors.

**FACILITY O (CENTRAL/EASTERN REGIONAL OFFICE)**

F600 (Abuse) and F610 (Investigate Alleged Violations)

Immediate Jeopardy began when nurse aides provided care to a resident who was resistant, and the resident sustained a right femur fracture. Staff provided care of a cognitively impaired resident who was resisting and flailing her arms and legs. The resident's arm was held down while care was provided. The resident sustained a femur fracture and required surgery. The facility failed to protect residents when nurse aides were not removed from resident care assignments after an allegation of abuse. This had the high likelihood to put other residents at high risk for abuse and harm. The facility also failed to conduct a thorough investigation.

**Comment/Suggestion**

**Abuse and Abuse Policy and Procedures**

- Abuse incidents/allegations should be reported immediately to required parties (Law Enforcement APS, DHSR).
- Alleged perpetrators should be removed from resident care immediately following an abuse allegation.
- Abuse policy and procedures should be followed to include protection, investigation and reporting of all incidents.
- Ensure all staff are up to date on abuse training and monitor staff interactions with residents.
- Ensure staff are up to date on what to report, when and whom to report abuse concerns to.

**FACILITY P (WESTERN REGIONAL OFFICE)**

F600 (Abuse), F607 (Abuse Policy and Procedures) and F684 (Quality of Care)

Immediate Jeopardy began when a resident who had severe cognitive impairment was physically abused by a nurse aide. The facility failed to protect a cognitively impaired resident from physical abuse from an employee when a nurse aide put her hands on the resident's shoulders to get her to a seated position and slapped the resident on the side of her shoulder. The incident was witnessed by another staff member who failed to report the incident immediately. The facility failed to complete a thorough investigation of an allegation of abuse, and failed to report the allegation of abuse to the State Agency, local law enforcement, and adult protective services within the required timeframe.
Immediate jeopardy also began when a resident experienced signs and symptoms of a cardiac event and necessary emergent medical interventions were not provided. The resident had complaints of chest pressure, pain and vomiting. EMS was not called until the resident was found without a heartbeat. The resident experienced cardiac arrest and subsequently passed away.

**Comment/Suggestion**

**Abuse and Abuse Policy and Procedures**
- Abuse incidents/allegations should be reported immediately to required parties (Law Enforcement APS, DHSR).
- Alleged perpetrators should be removed from resident care immediately following an abuse allegation.
- Abuse policy and procedures should be followed to include protection, investigation and reporting of all incidents.
- Ensure all staff are up to date on abuse training and monitor staff interactions with residents.
- Ensure staff are up to date on what to report, when and whom to report abuse concerns to.

**Comment/Suggestion**

**Quality of Care**
- Accurately determine residents code status.
- The facility should activate 911 when a resident experiences symptom of a cardiac event.
- When communicating with the physician, the nurse must ensure to relay all symptoms to the physician (e.g., lethargy, pain, nausea, vomiting, history of cardiac issues).

**FACILITY Q (CENTRAL/EASTERN REGIONAL OFFICE)**

**F580 (Notification) and F760 (Significant Medication Error)**
Immediate Jeopardy began when, the facility failed to administer and anti-seizure medication and failed to notify the physician or the nurse practitioner that an anti-seizure medication that was not available for administration to a resident (multiple times). The resident missed multiple doses of the medication. The resident was hospitalized with cardiac issues and seizure activity. It was determined that missing the antiseizure medication was a significant error that could have resulted in brain injury related to uncontrolled seizure activity.

**Comments/Suggestions**

**Notification and Significant Medication Error**
- Facilities should ensure that a resident does not miss any doses of medication and if there is any delay in the process of obtaining medications, the facility should notify the physician immediately.
Immediate Jeopardy Issues: Fourth Quarter 2022

- Staff should be trained in the process of ensuring medications are available for administration and who to notify when medications are not available.

**FACILITY R (CENTRAL REGIONAL OFFICE)**

**F580 (Notification) and F684 (Quality of Care)**

Immediate Jeopardy began when the facility failed to identify a wound to residents posterior right leg, and necessary care and services were not provided and failed to notify the physician of the open wound found on a residents leg. A Nurse identified a wound on residents’ leg and there were no orders for wound care. Nurses failed to complete the weekly body observations that included wound observations and measurements. Later a nurse noted an open wound to the resident’s leg with foul smelling odor with some bleeding. The Nurse failed to address/communicate/report/document the condition/status/size/appearance of the wound. The residents’ condition changed, and the resident was hospitalized. The resident required treatment for septicemia and osteomyelitis related to the right leg wound.

**Comments/Suggestions**

**Notification and Quality of Care**

- The facility should ensure all residents wounds (new) or change in wounds are reported to the physician.
- Staff should be trained to report new wounds or changes in wounds to the physician.
- Facilities should ensure monitoring is in place for residents with wounds to include checks of the skin, changes in size and appearance or change in condition of the wound.
- Facilities should ensure treatments are in place and completed for resident wound care.