IMMEDIATE JEOPARDY (IJ) TAG SCENARIOS

ADMINISTRATOR – TIM BROOKS

LAWYER – LIZ LAFOE

DHSS – TRACY NIEKAMP

SCENARIOS WRITTEN BY: NICKY MARTIN, LIBBY YOUSE AND PENNY KAMPETER

THE UNSEEN DANGER AT SUNRISE NURSING HOME IJ-F880

- November 2023 - Seeing an increase in COVID-19 cases among its residents on November 29th - 6 Residents and others tested positive for COVID-19
- Protocols not followed-
  - Residents who had tested positive were not separated from those who had tested negative.
  - The same lack of separation was observed in several rooms.
  - A few of the residents testing negative made a choice not to move or to leave their own room
- IJ tag was issued on November 29th, for failure to implement proper infection control measures that had put residents at immediate risk
- Residents who had initially tested negative, later tested positive after prolonged exposure to infected roommates.
- The CDC guidelines were clear: infected residents needed to be isolated in single rooms or, if necessary, in dedicated units with appropriate PPE, and no cross-contamination should occur.

INADEQUATE RESPONSE TO RESIDENT-TO-RESIDENT ABUSE IN A SPECIAL CARE UNIT
IJ-F600

- In a rural nursing home with a census of sixty-six (66), a significant failure in protecting residents from verbal and sexual abuse was identified in a special care unit.
- Resident #86, who had a history of verbal and physical sexually inappropriate behavior, ambulates independently, and has a BIMS score of 10. Despite being documented and reported by other residents and staff multiple times, Resident #86's inappropriate conduct, including unwanted touching and sexual comments, continued.
- This led to distress and demands for relocation off the special care unit from Resident #105, who experienced severe psychosocial effects and felt unsafe in the unit.
- An immediate jeopardy occurred during a recertification survey that began in July 2024.
- Facility progress notes reviewed revealed there were thirteen (13) instances of verbal or sexual abuse encounters towards other residents or facility staff members between December 17, 2023, and January 27, 2024. Physician's order dated January 28, 2024, stating that Resident #86 was not to be alone with residents or staff of the opposite sex and a documented event in May 2024 where: *"Resident #86 was found in Resident #63's room "participating in inappropriate sexual behaviors"*.
- Found that the failure to address Resident #86's behavior in a timely manner had already caused considerable harm.
- Resident #105, among others, suffered emotional and psychological distress due to the facility's negligence.

MEDICATION ERROR
IJ-F757

- Resident #1, a 60-year-old individual diagnosed with HIV, (Human Immunodeficiency Virus) and PML (progressive multifocal leukoencephalopathy), was admitted to the ABC facility on 6/1/2023
- Survey found:
  - The resident was not given their Biktarvy (contains three antiviral medications).
  - Resident #1's medical admission records clearly indicated the need for Biktarvy as part of their treatment plan for HIV. The medication order was documented in the resident's admission paperwork.
  - A review of Resident #1's medication administration records revealed that Biktarvy was not administered during the resident's stay. The failure to provide this medication was not documented as an intentional omission but rather an oversight in the medication administration process.
  - The facility failed to monitor the effectiveness of Resident #1's treatment and did not follow up on the missing medication. There were no documented attempts to address or rectify the omission once it was discovered.
  - This oversight had a direct impact on the resident's health, contributing to their deterioration and eventual death.
- ABC facility is cited an IJ under F757 for failing to provide appropriate medication management for Resident #1

PRESSURE ULCER PREVENTION AND MANAGEMENT IJ-F686

- Resident A, a 78-year-old individual with a history of diabetes and mobility issues, was admitted to KYM Nursing facility on 9/1/2023. Upon admission, Resident A presented with multiple wounds, including stage 2 pressure ulcers on the toes, left leg, right buttock, and a diabetic ulcer on the left great toe, as well as a wound on the right hip.
- Three weeks later, an inspection revealed the diabetic ulcer on the left great toe and wounds on the right hip and buttock had progressed significantly, leading to severe pain and increased risk of systemic infection
- The investigation revealed that KYM Nursing Home did not consistently implement or update the wound care plan as required. Specifically:
  - There were multiple instances where prescribed wound care treatments were either delayed or not administered as directed.
  - Dressing changes were not performed according to the recommended schedule, resulting in prolonged exposure of wounds to potential contaminants.
  - Resident A's repositioning, crucial for pressure ulcer prevention, was infrequent, leading to further deterioration of the existing wounds.
  - Documentation showed that infection control practices were not adhered to during wound care procedures. The lack of proper hand hygiene and sterile techniques contributed to the infections observed in Resident A's wounds.
- KYM Nursing Facility was cited F686 for failing to provide adequate care and treatment to prevent the worsening of Resident A's wounds. This widespread issue, affecting multiple wounds and causing actual harm to the resident, warrants a severity level of K.