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IMPORTANT BULLETIN
Real and Present Danger Issues
First Quarter 2024

PLEASE BE SURE THAT RCF STAFF READ THIS

The Ohio Health Care Association (OHCA) compiled data on Real and Present Danger (RPD) citations for all residential care facilities surveyed in the first quarter of 2024. Key findings include:

- **Total RPD Citations:** 14
- **Surveys with Associated Death:** 6

Monthly Breakdown of Citations:

- **January:** 4 citations
- **February:** 4 citations
- **March:** 6 citations

Citations by Regulation Code:

- **R390 (Change in Condition):** 1 citation
- **R562 (Choking):** 1 citation
- **R710 (Elopement/Water Damage):** 4 citations
- **R711 (Abuse/Elopement):** 3 citations
- **R712 (CPR/Neglect/Financial-Payment):** 4 citations
- **R717 (Sex Abuse):** 1 citation

This data highlights the areas of concern within residential care facilities, with particular emphasis on elopement/bed rail entrapment and abuse, which were cited multiple times. It underscores the need for improved oversight and preventative measures in these critical areas.

If an adverse occurrence happens in your facility, OHCA recommends immediately investigating and reviewing the incident thoroughly by the QA Committee. The facility should implement a QAPI plan even if there is no evidence of noncompliance and all policies and procedures have been followed. If a survey team disagrees with the facility's conclusion or identifies noncompliance, implementing an appropriate and thorough action plan can limit the time frame of noncompliance. A timely and comprehensive action plan can demonstrate that the alleged noncompliance has been fully corrected before the survey and serve as evidence of past noncompliance in a Real and Present Danger situation, which may be taken into consideration by ODH if a fine is imposed.

Summaries of these citations are listed below, along with comments and recommendations.

Facility A: R710 Rights of Residents – Elopement
01/04/2024 Complaint Investigation
The facility failed to provide adequate supervision and ensure the safety of a resident who left independently and did not return as expected. The resident's Health Care Power of Attorney (HCPOA) was not notified until approximately 18 hours later, and a missing person report was not filed until 24 hours after the resident's departure. This lack of timely response placed the resident at significant risk, as police found the resident after having spent the night in his car in cold conditions. The resident was subsequently admitted to the hospital due to missed medications and reported pain.

Key Findings:

- **Elopement Incident**: A resident, who was cognitively impaired and physically independent, signed out of the facility to go to the grocery store but did not return. Despite being signed out, the staff failed to notice his absence for over 18 hours, and his daughter/HCPOA was not informed until the next day.
- **Delayed Response**: The facility staff, including Licensed Practical Nurses (LPNs) and State Tested Nurse Aides (STNAs), failed to communicate and properly document the resident's whereabouts or status, assuming he had left with family. No immediate action was taken to locate the resident until the next day.
- **Inaccurate Documentation**: The two-hour check logs for two days incorrectly indicated that the resident was in his

room when he was absent from the facility.

- **Medical and Safety Risks**: A resident who required medication for multiple chronic conditions missed his medications for over 36 hours, leading to hospitalization for evaluation. The resident was also exposed to cold weather conditions overnight, putting him at risk of hypothermia or other medical complications.
- **Lack of Staff Communication**: Interviews with staff revealed that they did not prioritize documenting changes in the resident's behavior or report his absence appropriately. Some staff assumed he had left the facility but did not verify his return or communicate concerns to higher-level staff.

Corrective Actions Implemented:

- **Education for Staff**: The Executive Director or designee educated staff on missing persons procedures, resident two-hour checks, and accurate documentation. Staff were also educated on the resident sign-out process.
- **Review of Resident Handbook**: The resident was provided with an updated version, which included responsibilities for signing out. The resident's contact information was updated, and the sign-out process was reviewed with the resident.
- **Assessment of Residents Able to Leave**: The facility assessed four additional residents who could leave the center independently. Licensed nurses evaluated these residents to ensure their cognitive ability to leave safely.
- **Sign-Out Log and Tracking**: The sign-out log was revised to include the anticipated return time and a contact number. It was also moved to the nursing station for better staff oversight. Assisted living nursing staff were educated on this revised process.
- **Monitoring and Auditing**: The facility implemented a plan to conduct random audits twice a week for 30 days, focusing on two-hour checks, sign-out compliance, and alert charting for residents requiring extra supervision.
- **Drills for Missing Residents**: The facility initiated twice-weekly missing resident drills to ensure staff understood the proper procedures for responding to such incidents.
- **Safety Committee Involvement**: Findings from the audits and drills were to be reported to the facility's Safety Committee for review and further action.

While the Real and Present Danger was abated, the facility continued monitoring compliance with their corrective action plan to ensure staff followed proper protocols for resident safety, supervision, and elopement prevention.

Facility B: R711 Rights of Residents – Sexual Abuse (Resident to Resident)

01/08/2024 Complaint Investigation

The facility failed to protect residents from sexual abuse and did not provide adequate supervision or interventions to prevent nonconsensual sexual activities involving cognitively impaired residents. This led to Real and Present Danger, exposing residents to potential physical, emotional, and psychological harm.

Key issues include:

- **Failure to intervene**: Although inappropriate behaviors between cognitively impaired residents were documented, the staff did not intervene effectively.
- **Unreported abuse**: On multiple occasions, staff witnessed sexual intercourse between cognitively impaired residents but did not report these incidents to the administration.
- **Inadequate investigations**: The facility failed to investigate allegations of sexual abuse reported by an Ombudsman.
- **Lack of assessments**: The facility did not conduct comprehensive assessments to determine the residents' capacity to consent to sexual activity.
- **Failure to implement interventions**: Despite repeated incidents, no effective interventions or supervision were implemented to prevent further abuse. Staff failed to adequately supervise or separate the involved residents, and necessary protocols were not followed.

The Real and Present Danger was abated when the facility implemented corrective actions, including:

- Conducting skin audits for involved residents.
- Staff training on managing sexual behaviors, reporting abuse, and redirecting residents.
- One-to-one supervision for a resident and enhanced staffing.
- Communication with physicians to create individualized service plans for residents involved.
- Emergency discharge planning for the resident due to ongoing inappropriate behaviors.

The violation remains as the facility continues to monitor and implement corrective measures.

Facility C: R712 Rights of Residents – Neglect

01/22/2024 Complaint Investigation, Self-Reported Incident Investigation

The facility failed to prevent neglect of a resident, leading to serious harm. The resident, who was fully dependent on staff for care, was left without incontinence care or proper supervision throughout a 12-hour shift. Staff failed to reposition her in her Broda chair,

resulting in the resident falling and sustaining a brain injury and scalp laceration. The incident exposed two other residents, who also relied on Broda chairs, to similar risks of neglect.

Key findings include:

- **Failure of care**: An LPN and two caregivers did not provide incontinence care or reposition a resident during their 12-hour shift. As a result, she was found soaked in urine and lying face down in a pool of blood after falling from her Broda chair.
- **Injuries sustained**: The resident suffered a small brain bleed and a scalp laceration that required sutures. She was diagnosed with a mild/moderate traumatic brain injury and was admitted to the hospital.
- **Staff miscommunication**: Both caregivers claimed there was confusion about who was responsible for the resident's care, which led to her being neglected for the entire shift.
- **Incorrect positioning in the Broda chair**: The resident was left in her Broda chair unsupervised and improperly positioned, which contributed to her fall and injury.
- **Immediate staff terminations**: The LPN and both caregivers were terminated following the facility's investigation into the neglect.

Corrective actions to abate the Real and Present Danger included:

- Termination of the responsible staff members.
- All care associates must be trained on the correct use of Broda chairs and incontinence care, and non-compliant staff must be prohibited from working until trained.
- Audits of resident care plans and incontinence care practices.
- Monitoring of nursing documentation and regular audits of resident conditions.

Although the Real and Present Danger was abated, the violation continues as the facility is in the process of fully implementing corrective actions and ensuring compliance.

Facility D: R711 Rights of Residents – Verbal/Physical Abuse (Staff to Resident)

01/24/2024 Complaint Investigation

The facility failed to protect two residents, both cognitively impaired and residing in a secured memory care unit, from verbal and physical abuse by staff. Specifically, a Resident Care Partner (RCP) was found to have verbally and physically abused these residents during showers, and the facility failed to properly address the situation until the next day. The abuse included degrading comments, spraying water in a resident's face, and physically forcing a resident into a chair. These incidents were not handled appropriately, resulting in Real and Present Danger and causing potential psychological and physical harm to the residents.

Key issues include:

- **Verbal and physical abuse**: The RCP sprayed water in a resident's face when she became agitated and used racial slurs and obscene language towards another resident. The RCP also pushed one of the residents into a chair when he would not comply.
- **Failure to report and act**: Despite another RCP reporting the abuse to a Licensed Practical Nurse (LPN) and recording some of the incidents, the RCP was allowed to continue working the rest of the shift and the following day.
- **Delayed response**: The Executive Director (ED) was not notified until the next day, and the RCP was not suspended until later that day. The facility substantiated the verbal abuse but initially downplayed the physical abuse as a "he said/she said" situation without properly addressing the physical aspect of the allegations.
- **Non-compliance with policy**: The facility failed to follow its abuse policy, which mandates the immediate suspension of suspected perpetrators and timely reporting of incidents. The abuse was not reported to the police, and family members were not informed about the incidents until later.

Corrective actions to abate the Real and Present Danger included:

- Immediate suspension of the RCP and termination four days later.
- Skin assessments of the involved residents showed no signs of physical abuse.
- Facility-wide re-education on abuse prevention and reporting policies.
- Regular monthly training on abuse and neglect, extended for 90 days post-incident.
- Additional measures, such as the posting of emergency contact numbers and ongoing audits to ensure compliance.

The facility is in the process of fully implementing corrective actions, and the violation remains under observation as compliance is being monitored.

Facility E: R710 Rights of Residents – Elopement

01/30/2024 Complaint Investigation

The facility failed to protect a resident, who had Alzheimer's dementia and a significant mental health history, from eloping and dying from hypothermia. The resident left the facility without staff knowledge at 1:22 A.M., exiting through an egress door without alarms. He was found deceased outside, face down in the snow, approximately seven and a half hours later by a Licensed Practical Nurse (LPN). The outside temperature was between six- and 10 degrees Fahrenheit, with a wind chill of seven below zero. The resident's cause of death was hypothermia and blunt force injuries, with small hemorrhages and contusions on his scalp.

Key issues include:

- **Inadequate supervision and assessment**: The resident, who had a high risk of cognitive impairment and mental health issues, was not checked on for over eight hours when he left the facility and was later found deceased. There was no alarm system on the egress door, and staff were unaware that the resident had exited the building.
- **Failure to assess safety risks**: Although the resident had a history of wandering and cognitive issues, the facility did not identify him as being at risk for elopement or implement necessary safety measures, such as alarms or regular checks.
- **Failure of door security systems**: The egress door the resident used to leave did not have an alarm or signage indicating that the door would lock after exiting. The resident did not have a key fob or call pendant to re-enter the facility.

Corrective actions to address Real and Present Danger included:

- **Staff education and safety measures**: Staff were educated on inclement weather and resident safety and initiated one-hour checks on all assisted living residents, including 15-minute door checks during overnight hours.
- **Door inspections and alarms**: Egress doors were inspected, sensors were installed, and signage was posted to alert residents and staff that the doors would lock after exiting. Staff pagers were also set to alert when doors were opened.
- **Resident risk assessments**: All residents were reassessed for safety risks, especially for elopement, and care plans were updated accordingly. Six additional residents were identified as being at risk for elopement, and safety checks were implemented.
- **Staff and resident training**: Staff were trained on door sensor functionality and safety checks, while residents were educated on proper door use and the need for key fobs to re-enter the facility.
- **Policy revisions**: The facility revised its safety check standard operating procedures (SOP), which now require documentation and frequent door checks. The Executive Director (ED) monitors compliance.

The violation continues as the facility is still in the process of monitoring compliance with the corrective action plan.

Facility F: R562 Dietary Services; Supervision of Special Diets – Choking

01/31/2024 Complaint Investigation

The facility failed to prevent an incident of choking that led to the death of a resident, who required supervision and assistance with meal intake and soft, bite-sized foods. The resident was served an incorrect diet and left unsupervised during dinner, leading to her choking on food. Staff could not effectively perform the Heimlich maneuver, and Emergency Medical Services (EMS) arrived but could not save her. The resident was pronounced dead after EMS cleared her airway but found her unresponsive with no pulse. This incident placed 15 other residents with swallowing difficulties at risk as well.

Key failures include:

- **Improper diet and lack of supervision**: The resident, who required a soft, bite-sized diet and assistance with meals, was served the wrong food and left unsupervised during her meal. This lack of proper oversight directly led to her choking and subsequent death.
- **Failure to follow care plans**: Although the resident had recommendations for a speech therapy assessment and adaptive eating utensils, these were not followed up on, and no action was taken to adjust her diet or provide the necessary eating assistance.
- **Inadequate communication between staff**: The staff did not ensure proper communication regarding the resident's dietary needs and assistance requirements, leading to the tragic incident.

Corrective actions taken to address Real and Present Danger included:

- **Resident assessments**: 35 residents with significant weight loss, swallowing issues, or other risk factors were identified. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) completed Eat-10 assessments, identifying 15 residents at risk of swallowing difficulties. Speech therapy referrals or diet downgrades were ordered for these residents.
- **Dietary changes and supervision**: Four residents received speech therapy referrals, and 11 under hospice care had their diets downgraded. Going forward, Eat-10 assessments will be performed for new admissions and residents with a change in condition to ensure appropriate dietary adjustments and supervision.
- **Staff education and compliance audits**: Staff were re-educated on change of condition guidelines and meal supervision. New communication tools were implemented to communicate dietary and condition changes promptly. Monthly audits are planned to ensure ongoing compliance with the corrective action plan.

- **Speech therapy involvement and follow-up**: Speech therapists will provide written recommendations for at-risk residents, which will be promptly communicated to primary care providers so that care plans can be adjusted accordingly.
- **Dietary oversight improvements**: The consulting dietician's role was reviewed to ensure they provide timely reports and recommendations, with the facility committing to quarterly audits of dietary compliance.

Although the Real and Present Danger was abated, the facility is still in the process of implementing its corrective action plan to ensure ongoing compliance and prevent future incidents like the one that led to the resident's death.

Facility G: R712 Rights of Residents – CPR

02/20/2024 Complaint Investigation

The facility failed to properly respond to a code emergency, resulting in a delay in initiating CPR and contacting Emergency Medical Services (EMS) for a resident who was identified as a Full Code (requiring resuscitation if necessary). This failure, along with non-functional call lights and untrained staff, placed the resident at significant risk and contributed to the resident's death.

Key issues identified:

- **Delay in CPR and EMS Contact**: When the resident was found unresponsive, the Director of Nursing (DON) failed to immediately initiate CPR or contact EMS. It took approximately 16 minutes before EMS was called, resulting in a severe delay in care. The DON had no phone and had to leave the resident to run downstairs to alert others, resulting in a critical time loss.
- **Non-functional Call Lights**: The resident's call light was not working properly, having been reported as faulty days before the incident. Despite a maintenance order, the issue was unresolved, and staff were instructed to check on the resident every hour. However, no documentation confirmed these checks were performed.
- **Inadequate Emergency Response Training**: The DON was unaware of the crash cart's location on the second floor and could not operate the Automated External Defibrillator (AED) due to a lack of training. The DON's unfamiliarity with the AED and the crash cart location delayed the emergency response.
- **Understaffing**: On the night of the incident, the facility was understaffed, with only one staff member covering the assisted living side and two staff members in the memory care unit. The memory care unit was left unattended while staff assisted the DON in responding to the resident's code, which posed additional risks.

Corrective Actions Taken:

- **Crash Cart Audits**: The facility audited and restocked crash carts, ensuring they were available and functional on the second floor and in the memory care unit. The DON was educated on how to audit crash carts weekly, and audits will be performed for compliance.
- **Staff Education and Emergency Drills**: Staff were in-serviced on the Code Blue Response Protocol, including how to locate crash carts, respond to emergencies, and the importance of not leaving the memory care unit unattended. Code Blue drills will be conducted twice weekly for four weeks to ensure compliance.
- **Overhead Paging and Call Light Repairs**: The facility's overhead paging system was repaired, and all call lights were audited. While the resident's call light could not be fixed due to the system's age, the facility implemented alternative checks for residents with faulty call lights.
- **CPR and AED Training**: The DON completed online CPR training, and staff were educated on using facility phones for emergency paging and operating the AED machine.
- **Improved Staffing and Monitoring**: The facility identified 26 full-code residents and implemented processes to monitor call lights and staff knowledge of emergency procedures. The staffing situation was addressed to prevent future understaffing during emergencies.

Although the immediate danger was abated, the facility is still implementing and monitoring its corrective action plan to ensure ongoing compliance with emergency response protocols.

Facility H: R390 Changes in Resident Health Status; Incidents; Infection Control – Change in Condition

02/26/2024 Complaint Investigation

The facility failed to timely identify and address an acute change in condition for a resident, resulting in delayed medical care and eventual death. The resident exhibited stroke-like symptoms, including slurred speech and an unsteady gait. However, despite staff observations and concerns, proper medical attention was not sought until hours later. The resident was eventually transported to the hospital, where he was diagnosed with a cerebrovascular accident (stroke) and a terminal brain bleed. He was admitted to hospice six days later and passed away two days after that.

Key Findings:

- **Delayed Response to Stroke Symptoms**:
    - A Resident Assistant (RA) identified that the resident had slurred speech and an unsteady gait. Despite expressing concerns about a potential stroke, no immediate action was taken to send the resident to the hospital.

    - An RN documented the resident's condition in late entries, noting slurred speech and unsteadiness around two hours later, yet did not call for emergency medical assistance. It wasn't until after a fall an additional 45 minutes later that the nurse contacted the resident's physician and received an order to send him to the hospital.
- **Inaccurate Documentation**:
    - The RN failed to document the resident's condition and care accurately in real time. Key details were entered late, including documentation of the resident's condition, the fall, and the subsequent transfer to the hospital hours after the resident began showing signs of a stroke.
    - The late entries do not reflect timely or appropriate medical care for the resident's rapidly declining condition.
- **Lack of Timely Medical Intervention**:
    - EMS was not called until nearly seven hours after the initial symptoms were observed. The delay in seeking medical care likely contributed to the severity of the resident's condition, including the diagnosis of a subdural hematoma.
    - By the time EMS arrived, the resident was confused, unresponsive to some commands, and had sustained significant brain damage.
- **Failure to Follow Facility Policy**:
    - The facility's Change in Condition Policy, which requires immediate notification of the physician and prompt medical attention for acute changes in condition, was not followed. Both the RA and RN failed to act promptly despite identifying clear signs of a stroke.
    - The facility's lack of adherence to this policy resulted in a critical delay in care.
- **Root Cause Analysis and Corrective Actions**:
    - The facility implemented corrective actions, including a root cause analysis, staff education on the Change in Condition Policy, and audits of resident progress notes. All staff were re-educated on prompt physician notification and accurate documentation of changes in condition.
    - The facility also implemented a plan for ongoing monitoring, including audits of resident progress notes and random audits of adherence to the Change in Condition Policy.

Corrective Actions Implemented:

- **Identification of Like Residents**: The facility identified five residents with similar risks and assessed them to ensure any changes in condition were promptly reported.
- **Staff Education**: Both nursing and resident assistant staff received re-education on the Change in Condition Policy and proper documentation procedures.
- **Audits and Monitoring**: The facility developed a plan for daily audits of resident progress notes and documentation to ensure changes in condition are reported and acted upon promptly. These audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee for further review.

The facility failed to provide timely care for the resident, whose stroke symptoms were not adequately addressed for nearly seven hours, resulting in hospitalization, hospice admission, and eventual death. The delay in seeking medical attention violated the resident's rights and contributed to the harm. The corrective actions taken by the facility aim to prevent similar incidents in the future, ensuring that staff are properly trained and that changes in resident conditions are promptly addressed.

Facility I: R717 Rights of Residents – Sexual Abuse (Resident to Resident)

02/28/2024 Complaint Investigation

The facility failed to protect a resident from sexual abuse and failed to report the allegation of abuse promptly. The incident involved a resident waking up to find her pants removed and suspecting she had been raped. The failure to act immediately and the delayed reporting resulted in Real and Present Danger and the potential for further harm. Corrective actions were implemented nineteen days later, but the violation persists as the facility continues monitoring and implementing measures to ensure compliance.

Key Findings:

- **Delayed Reporting of Abuse**:
    - The resident woke up, discovered her pants were off, and suspected she had been raped. She reported this to the Resident Caregiver (RCG), who failed to notify anyone immediately, as required by facility policy. Instead, the RCG allowed the resident to return to bed without contacting the appropriate personnel or authorities.
    - The abuse was not reported for over six hours when the resident informed a different RCG of the suspected assault. Only then was the House Manager and the local police contacted.
- **Physical Evidence and Examination**:
    - The resident was transported to the local emergency room (ER) by EMS after reporting the assault. A Sexual Abuse Nurse Examiner (SANE) performed an examination, finding lacerations, abrasions, and evidence consistent with sexual assault, including the presence of semen on the resident's underwear and clothing.
    - The resident was diagnosed with sexual assault, treated with antibiotics, and discharged back to the facility.
- **Lack of Proper Response and Investigation**:

    - The RCG failed to follow the facility's abuse reporting protocol, which requires immediate notification of a supervisor when a resident reports suspected abuse.
    - The facility's initial response was inadequate, as it took over six hours for the report to be made. The resident's roommate reported that another resident had been moving around in bed during the night but had not called for help.
    - A review of security footage showed no direct view of the resident's room, but another resident was observed acting suspiciously. That resident was placed under close supervision and discharged to his mother's care later that day.
- **Resident Safety Concerns**:
    - Interviews with other residents revealed concerns about new admissions, with some feeling uncomfortable or unsafe. Two residents specifically expressed discomfort related to interactions with newer residents.
    - The facility later moved all female residents to rooms close to the caregivers' stations and under camera surveillance to increase safety.
- **Corrective Actions**:
    - Immediate steps were taken to educate staff on proper reporting of abuse and neglect, including the requirement to notify supervisors of any allegations of abuse immediately.
    - The facility implemented hourly rounds and close monitoring of residents to ensure safety, with audits and interviews conducted regularly to assess residents' feelings of safety.
    - Staff were re-educated on abuse policies, with ongoing education planned for six weeks. New admissions will be reviewed to ensure they are appropriate for the facility.

Corrective Actions Taken:

- **Staff Education**: All staff were re-educated on the facility's abuse policy, including the proper reporting of abuse allegations.
- **Resident Safety Audits**: Hourly checks and increased monitoring of all residents were instituted. Female residents were moved to rooms near caregivers and under surveillance.
- **Monitoring and Audits**: The facility began regular audits and interviews with residents to ensure they felt safe and that any issues were addressed promptly.
- **Enhanced Supervision**: New admissions are being closely reviewed for appropriateness, and staff are ensuring that residents are safe from abuse and harm.

The facility's failure to immediately report and respond to the resident's allegation of sexual abuse placed her and other residents at risk. While corrective actions have been implemented, including staff education, resident monitoring, and safety audits, the facility is still ensuring ongoing compliance and adherence to abuse prevention and reporting policies. The incident underscores the need for timely reporting and immediate action when abuse is suspected.

Facility J: R711 Rights of Residents – Elopement

02/29/2024 Complaint Investigation

The facility failed to maintain a resident's safety and adequately monitor his whereabouts after he went outside to smoke a cigarette in the early morning hours. The resident was last seen around 4 A.M. and was not found until approximately four hours later when the Health and Wellness Director (HWD) discovered him lying unresponsive, partially submerged in the facility pond. Emergency services later confirmed he had passed away. The incident placed the resident and an additional 72 residents who could exit the facility unsupervised at risk of serious harm or death.

Key Findings:

- **Failure to Monitor a Resident After He Exited the Facility**:
    - The resident, who was cognitively intact based on his Brief Interview for Mental Status (BIMS) assessment, went outside to smoke at approximately. The staff did not check to ensure he returned inside.
    - Staff were aware of residents propping open the smoking area door with objects such as rocks, allowing them to bypass ringing the doorbell to re-enter, yet they did not address or monitor this practice.
- **Incident Discovery and Response**:
    - The resident was found unresponsive by the HWD, lying on his back with his legs partially submerged in the facility pond.
    - Emergency services were called, and the resident was pronounced dead on-site.
    - Initial observations by the County Coroner revealed no signs of blunt force trauma or immediate visible injuries. The cause of death was not immediately determined, and an autopsy was scheduled.
- **Staff Awareness and Witness Statements**:
    - Statements from a State Tested Nursing Assistant (STNA) and a Personal Care Assistant (PCA) confirmed that they saw the resident go outside to smoke but did not verify his return.
    - Neither staff member checked on the resident after he was last seen around 4 A.M., and no one ensured the resident had returned to the facility.

    - Residents confirmed they often used rocks or other objects to prop open the door, enabling them to bypass notifying staff to re-enter the building.
- **Facility Oversight and Lack of Safety Procedures**:
    - The facility failed to follow appropriate procedures to ensure a resident's safety after he exited the building. There was no immediate monitoring, and staff were unaware of his location for over three hours.
    - Staff also admitted that residents regularly bypassed safety protocols by propping the smoking area door open, a known practice but not addressed.
- **Corrective Actions Taken**:
    - **Installation of a STOP Alarm**: The facility installed an alarm on the smoking area door that would sound between 7:00 P.M. and 7:00 A.M., requiring staff to respond and ensure residents' safety when the door is opened.
    - **Supervised Smoking**: Staff fully supervised all smoking breaks between 7:00 P.M. and 7:00 A.M. After smoking, staff must ensure all residents return inside and account for their smoking materials.
    - **Resident and Staff Education**: Residents and staff were educated on the new process, including the requirement that residents notify staff when they go outside and check in upon return. Staff were also educated to walk the facility grounds if a resident does not return within the specified time.
- **Ongoing Audits and Monitoring**:
    - The facility initiated regular audits of smoking breaks and exit procedures to ensure compliance. Staff were instructed to perform rounds and ensure the smoking door alarm was functioning correctly.
    - Weekly interviews and audits with residents and staff were planned to ensure the new safety protocols were understood and adhered to.

The facility's failure to adequately monitor the resident after he exited the building resulted in his death and placed other residents at risk. While corrective actions, such as alarms, supervised smoking breaks, and ongoing monitoring, have been implemented, the violation remains under scrutiny as the facility continues to ensure compliance with these measures. The failure to prevent the unsafe propping open of doors and lack of timely checks on residents who exit the facility highlight significant lapses in resident safety protocols.

Facility K: R712 Rights of Residents – CPR

03/13/2024 Complaint Investigation

The facility failed to initiate life-sustaining measures, specifically Cardiopulmonary Resuscitation (CPR), for a resident who had a Full Code advance directive, resulting in their death. The incident occurred when a resident was found unresponsive by a Licensed Practical Nurse (LPN) and a Resident Assistant (RA). Despite the resident being unresponsive, not breathing, and showing signs of a faint pulse, the LPN failed to begin CPR or any rescue measures while waiting for emergency medical personnel. EMS was contacted immediately, and CPR was initiated by them upon their arrival seven minutes after the resident was found. However, the resident passed away while being transported to the hospital.

Key Findings:

- **Failure to Initiate CPR**:
    - The resident had a Full Code advance directive, which means that in the event of cardiac or respiratory arrest, life-saving interventions such as CPR should be initiated immediately.
    - The LPN found the resident unresponsive but did not start CPR or perform any rescue breathing. EMS was called, but life-saving measures were delayed until their arrival, seven minutes after the resident was found.
    - The delay in starting CPR meant that critical minutes for potential resuscitation were lost.
- **Emergency Services Response**:
    - EMS was contacted, and they arrived and began CPR.
    - Unfortunately, by the time EMS arrived and initiated CPR, the resident had already been in asystole (absence of heartbeat) and did not survive the transport to the hospital.
- **Violation of Facility Policy and Standards**:
    - The facility policy required that staff initiate CPR immediately for residents with a Full Code advance directive.
    - The LPN's failure to perform CPR violated the facility's policy, the Ohio Board of Nursing laws and rules, and the American Heart Association's CPR guidelines, emphasizing the critical need for immediate CPR in emergencies involving unresponsive individuals.
- **Impact on Other Residents**:
    - The facility had 21 additional residents with a Full Code advance directive who were also at risk, as the staff failed to provide adequate life-saving measures when needed.
    - This incident exposed significant lapses in ensuring that residents with Full Code status received appropriate care during emergencies.
- **Corrective Actions**:
    - **CPR Certification Audit**: The Business Office Manager (BOM) audited the CPR certification status of licensed staff. The audit revealed that only 6 out of 12 licensed staff members were CPR-certified.

    - **Training and Certification Requirement**: The facility implemented a corrective plan, requiring all non-CPR-certified staff to obtain certification. Staff who failed to complete certification would be removed from the work schedule until they became certified.
    - **Incident Report Audit**: The Vice President of Clinical Operations completed an audit of incident reports related to cardiac arrests involving Full Code residents. The audit reviewed incidents to identify any further issues regarding the facility's response to emergencies involving Full Code residents.
- **Ongoing Compliance**:
    - The facility is in the process of monitoring and implementing corrective actions, such as ensuring all staff members are properly trained in CPR and promptly addressing any gaps in emergency response procedures.

The facility's failure to provide immediate CPR to a resident despite his Full Code status resulted in the resident's death and exposed other residents with Full Code directives to potential harm. Delays in initiating life-saving measures such as CPR are critical, and the facility is now implementing corrective measures to ensure such a failure does not occur again.

Facility L: R710 Rights of Residents – Elopement

03/12/2024 and 04/30/2024 Complaint Investigations

Based on observation, record review, and facility policy evaluation, the facility failed to ensure a resident was provided a safe environment and adequate supervision, resulting in the resident's elopement. This incident occurred when a resident, who was deaf, independently mobile, and had moderately impaired cognitive skills, exited the building without staff knowledge through a side door that sounded an alarm. However, staff failed to visually check the exterior or follow the facility's missing person procedures. As a result, the resident walked 0.4 miles in cold temperatures across a four-lane road to a nearby store, where an employee contacted the resident's Power of Attorney (POA). The facility was unaware of the resident's absence for approximately two hours.

Key Findings:

- **Resident Elopement Incident**:
    - The resident exited the facility between 4:45 A.M. and 5:05 A.M. through a side door near his room, which triggered an alarm. Staff members responded but failed to properly check the outside perimeter or initiate the missing person procedure.
    - The resident, who was deaf and had moderate cognitive impairment, walked to a store 0.4 miles away in 36.1°F temperatures, crossing a four-lane road. He was discovered at the store, and the employee contacted the POA, who notified the facility. The resident returned to the facility without injuries around 7:15 A.M.
- **Failure in Alarm Response**:
    - The staff responding to the exit alarm did not visually check the exterior environment or search the perimeter to ensure no residents had exited the building. This delayed the recognition of the resident's absence, allowing him to be away from the facility for about two hours.
- **Corrective Actions Taken**:
    - **Resident Assessment and Return**: Upon his return, a nurse assessed the resident, and no injuries were found. The resident's POA was notified, and the resident was listed as at risk for elopement.
    - **Communication Support**: The facility contacted an interpreter to help communicate with the resident due to his hearing impairment. Through the interpreter, it was discovered that the resident left the facility frustrated over a malfunctioning television.
    - **Staff Re-education and Counseling**: Staff involved in the incident were counseled on the proper procedures for responding to exit door alarms and missing resident protocols. Employees received written warnings and were retrained on responding appropriately to alarms and conducting searches of the facility perimeter.
    - **Elopement Risk Binder**: The resident's profile was added to the facility's Elopement Risk Binder with his photo, and elopement drills were initiated for staff training.
    - **Revised Sign-Out Process**: The facility updated its sign-out procedures, requiring any responsible party's anticipated return time and contact information. This new process was communicated to all staff, and a plan was established to train new employees.
    - **Increased Monitoring**: Twice-weekly missing resident drills and charting audits were introduced to validate staff understanding of the missing resident and alarm procedures.
    - **Resident Assessments**: Eight residents were reassessed for their cognitive ability to leave the facility independently. The facility identified residents who needed closer supervision for elopement risk and documented these assessments.
- **Ongoing Compliance and Monitoring**:
    - Random audits of the sign-out process and alert charting documentation are scheduled twice weekly for 30 days to ensure compliance.
    - Staff members will continue receiving education on alarm response, missing resident protocols, and the revised sign-out process. New employees will be trained on these procedures as part of their orientation.

The facility's failure to ensure proper supervision and response to the alarm allowed the resident to elope from the facility, placing him at serious risk of harm. Immediate corrective actions, including staff retraining, procedural revisions, and enhanced monitoring, have been implemented to prevent future incidents and ensure resident safety.

Facility M: R710 Rights of Residents – Water Line Break

03/14/2024 Complaint Investigations

Based on observations, reviews, and interviews, the facility failed to provide a safe environment after a water line broke, causing significant damage in the hallway where several resident rooms were located. This resulted in exposed hazards such as bare wood studs with protruding nails, uncovered electrical junction boxes with live wires, and damaged smoke detectors, posing a real and present danger to residents. The facility also failed to initiate a fire watch for the missing smoke detectors, putting residents at risk of fire-related injuries or death.

Key Findings:

- **Water Line Break and Subsequent Damage**:
  - A hot water line broke, causing severe water damage in the hallway where ten residents' rooms were located.
  - Damaged drywall was removed, exposing insulation, bare wood studs with nails or screws, and electrical junction boxes with live wires. Two smoke detectors were also damaged, leaving live wires exposed.
- **Hazardous Environment**:
  - Observations revealed multiple hazards in the hallway, including exposed electrical wires, hanging insulation, discolored ceilings, and large holes in the drywall.
  - Exposed electrical junction boxes and damaged smoke detectors increased the risk of electrocution and delayed fire detection, creating a serious safety threat to residents.
- **Failure to Initiate Fire Watch**:
  - After removing the damaged smoke detectors, the facility failed to start a fire watch, increasing the potential for undetected fires and endangering residents.
- **Delayed Repairs**:
  - Despite the damage occurring, repairs were delayed. The facility did not obtain estimates for repair for a month and a half, and no repairs were initiated for an additional three days.
  - Interviews with staff, including the former Maintenance Director, confirmed that repairs were delayed due to the facility's failure to address the faulty water circulation pump, which contributed to the water line freezing.
- **Resident Impact**:
  - Residents in the affected area expressed dissatisfaction with the prolonged state of disrepair. Three residents were temporarily relocated, but others remained in the hazardous environment.
  - Two residents were assessed with cognitive impairments, and their exposure to the hazards posed additional risks.
- **Corrective Actions**:
  - **Water Line Repair**: The water line was repaired, and ServPro provided water mitigation services to clean up the water and provide dehumidification and heat.
  - **Smoke Detector and Electrical Repairs**: Repairs began, including insulation installation, drywall repairs, and the replacement of damaged ceiling lights and smoke detectors.
  - **Fire Watch**: A fire watch was initiated until the smoke detectors were fully operational. A&M Fire inspected and tested the smoke detectors.
  - **Staff Training and Audits**: Staff were re-educated on environmental safety standards and the importance of maintaining a safe environment. The Executive Director began conducting facility audits to ensure safety and proper maintenance practices.
- **Ongoing Compliance**:
  - The facility continues to monitor the environment, conduct safety audits, and train staff to ensure ongoing compliance with state regulations and safety standards. A new Maintenance Director is being trained to oversee repairs and safety measures.

The facility's failure to ensure timely repairs and adequately address the exposed hazards posed a significant risk to residents, potentially leading to life-threatening injuries, electrocution, or fire-related harm. Immediate corrective actions, including staff training, repairs, and safety audits, have been implemented to rectify the situation, but ongoing compliance is required to ensure a safe environment for all residents.

Facility N: R712 Rights of Residents – Payroll/Finance

03/11/2024 Complaint Investigations

Based on observations, reviews, and interviews, the facility failed to meet its financial obligations for the delivery of care, maintenance, and ensuring timely payroll for staff, resulting in real and present danger. The facility could not pay staff on time, and vendor services such as dietitian, therapy, pest control, and recycling were interrupted due to delinquent payments. This placed residents at risk for harm or displacement due to potential interruptions in care and services.

Key Findings:

- **Failure to Meet Payroll Obligations**:
  - The facility failed to provide sufficient funds to meet staff payroll on multiple occasions.
  - Numerous employees had their payroll checks returned for insufficient funds, including 41 out of 62 staff members on one occasion and 45 out of 62 on another.
  - Employees expressed concerns about the facility's financial stability, with some considering terminating employment due to inconsistent payroll.
- **Outstanding Balances with Vendors**:
  - **Dietitian Services**: The facility failed to pre-pay the dietitian service as required, resulting in the termination of nutrition services for four days. Although payment was made to resume services, the dietitian required additional payments within a week to continue services.
  - **Recycling Services**: The facility owed $1,531.10 to the recycling company, with outstanding service balances. It was 60 days behind on payments.
  - **Pest Control**: The facility owed $723.95 for five months of pest control services. No payments had been made since before that time.
  - **Medical Director Services**: The facility owed $15,000.00 for services provided by the Medical Director, with payments overdue six months. Payment arrangements had been made but were not adhered to.
  - **Therapy Services**: The facility owed $103,531.89 for therapy services provided by Broad River Therapy, with unpaid invoices dating back to four months.
- **Interviews with Staff**:
  - Several staff members, including the Administrator, Director of Nursing (DON), and Business Office Manager (BOM), confirmed the payroll issues, with multiple checks being returned for insufficient funds. The facility's corporate office would wire the funds directly to employees' bank accounts after payroll checks bounced, but this process caused payment delays.
  - Employees expressed frustration and concern about the uncertainty of receiving their pay, which impacted staff morale and retention.
  - The Ombudsman reported that residents were aware of the facility's financial instability and feared it might close, forcing them to relocate.
- **Vendor Payment Delays**:
  - **Dietitian Services**: The facility's failure to pre-pay the required fees resulted in the temporary suspension of nutrition services, which posed a risk to residents requiring dietary management.
  - **Therapy Services**: The facility's significant debt to Broad River Therapy jeopardized the continuity of therapy services for residents.
- **Delayed Financial Recovery Efforts**:
  - The facility's corporate management failed to implement effective financial controls to prevent payroll and vendor payment issues from recurring. Payment delays and insufficient funds were ongoing, with no long-term solution provided by corporate leadership.
  - The facility was also delinquent in property tax payments, with $101,283.27 owed, further highlighting financial mismanagement.

Corrective Actions and Ongoing Compliance Issues:
Despite some corrective actions, such as wiring funds to cover bounced payroll checks and resuming vendor services, the facility has not yet fully resolved the underlying financial issues. Staff continue to express concerns about receiving their pay, and the facility remains at risk for interruptions in essential services. The real and present danger remains, as the facility has not yet implemented effective financial controls or established long-term solutions to ensure timely payments for staff and vendors.

The facility's inability to meet its financial obligations, including timely payroll for staff and payments to critical vendors, has created an ongoing real and present danger for residents and staff. Immediate and comprehensive corrective actions are required to restore financial solvency, ensure uninterrupted care and services for residents, and maintain a stable workforce. Without prompt resolution, the facility risks further deterioration in care quality, staff retention, and the well-being of its residents.

OHCA Recommendations for Handling Real and Present Danger Citations

When a facility becomes aware that surveyors are considering or recommending a Real and Present Danger citation, it is crucial to take immediate and strategic action to mitigate the situation. Here are the recommended steps and resources to effectively handle this critical scenario:

Immediate Actions and Resources

1. **Call for Assistance**:
    - **Long-term Care Specialty Law Firm**: Engage legal professionals with expertise in long-term care regulations to navigate the complexities of the citation process.
    - **Long-term Care Regulatory Consultants**: Consult with experts who specialize in regulatory compliance and can provide guidance on best practices and immediate actions.
    - **Association's Regulatory Contact**: Contact OHCA's regulatory contact for support and advice tailored to your specific circumstances.

Staff Training and Interview Management

- **Training on Handling Surveyor Interviews**:
    - **Management-Level Staff**: Ensure they are well-prepared to handle interviews with surveyors. Training should cover how to respond accurately and professionally without providing unintended verifications.
    - **Direct Care Staff**: Equip them with the knowledge and confidence to interact with surveyors appropriately, focusing on honesty and clarity.
- **Presence of a Witness and Documentation**:
    - **Witness During Interviews**: Always try to have another staff member present as a witness during surveyor interviews with management-level staff. This additional person can help ensure that the conversation is accurately recorded.
    - **Detailed Notetaking**: Take comprehensive notes during these interviews to document the discussion precisely. This practice helps verify what was communicated and prevents misinterpretations or unintended confirmations.

Strategic Goals

- **Forestalling the Citation**: Aim to prevent the Real and Present Danger citations from being issued by demonstrating compliance and addressing any immediate concerns the surveyors raise.
- **Minimizing Time Frame**: If the citation is inevitable, work to keep the time frame as short as possible by promptly addressing the issues and demonstrating corrective actions.

Summary

Facilities can better manage the risk of receiving a Real and Present Danger citation by calling for expert assistance, thoroughly training staff, and ensuring accurate documentation during surveyor interviews. These proactive measures are essential to maintaining compliance and ensuring the facility's continued operation without severe regulatory repercussions.