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IMPORTANT BULLETIN
Immediate Jeopardy Issues
Third Quarter 2024

PLEASE BE SURE THAT FACILITY STAFF READ THIS

OHCA has compiled Immediate Jeopardy data for all Ohio facilities surveyed during the third quarter of 2024. Surveyors found twenty-two (22) Immediate Jeopardy citations in seventeen (17) facilities. Surveyors cited four (4) facilities with multiple IJ citations. The Ohio Department of Health cited twenty citations at a severity level of J, one at a K level, and one at an L level. There were six surveys with an associated death. They cited F600 (Free from Abuse and Neglect) five times, F689 (Free of Accidents) four times, F684 (Quality of Care) three times, F686 (Pressure Ulcers) twice, and F678 (CPR) twice. Others cited once this quarter were F880 (Infection Prevention & Control), F760 (Medication Error), F725 (Sufficient Nursing Staff), F692 (Nutrition/Hydration), F610 (Investigate Abuse), and F609 (Reporting of Alleged Violations).

Summaries of these citations are listed below:

Facility A: F600 Freedom from Abuse, Neglect, and Exploitation (J) - Neglect
7/22/24 Complaint Investigation, Partial Extended Survey
Immediate Jeopardy, including actual harm and subsequent death began when an incident of neglect occurred when the facility failed to prevent a fall with injury (rib fracture), to ensure timely and appropriate treatment was provided immediately post fall, to timely identify an acute change in condition and obtain immediate medical care. As a CNA was attempting to place a fitted sheet on a bed while the resident was in the bed, the resident fell from the bed. The CNA exited the room without speaking to the resident. The resident was heard crying and yelling out and subsequently transferred to the hospice where she was diagnosed with a closed rib fracture. After her return to the facility, the facility failed to complete neurological (neuro) checks and timely identify an acute change in condition and obtain immediate medical care resulting in an emergent transfer to the hospital. The resident was transported to the hospital where she subsequently expired.

Facility B: F689 Free of Accident Hazards/Supervision/Devices (J)
7/3/2024 Complaint Investigation, Partial Extended Survey
Immediate Jeopardy, including actual harm began when a resident was unattended/unsupervised outside and fell into a pond. The resident had a diagnosis of dementia with intermittent confusion and resided on the facility's secure memory care unit. Upon assessment, the resident's hair and clothing were wet and she was observed to be coughing. The resident was subsequently transferred to the hospital for evaluation and treatment of aspiration (of pond water). She returned to the hospital with an order for an

antibiotic. The lack of supervision, at the time of the incident, placed the resident at risk for additional injury/death from possible drowning. In addition, a concern that did not rise to Immediate Jeopardy occurred when the facility failed to ensure comprehensive, accurate, and individualized elopement assessments and care plans were in place for five other residents to prevent actual and/or potential elopement.

Facility C: F880 Infection Prevention & Control (J)
7/1/2024 Complaint Investigation, Extended Survey
The facility failed to implement immediate action to protect residents for Legionella when a water sample test detected Legionella on the 300 Hall. At that time, the facility stopped using the water on the 300 Hall but implemented no additional interventions for other areas of the facility. This resulted in Immediate Jeopardy and serious life-threatening harm and the potential for additional negative health outcomes and/or death when a resident, who resided on the 100 Hall, developed respiratory symptoms and experienced a change in condition. The resident was sent to the hospital for further evaluation and subsequently was admitted to the ICU with diagnoses including sepsis with acute renal failure and septic shock due to an unspecified organism and later tested positive for Legionella pneumonia. Following the notification to the facility that the resident had tested positive for Legionella pneumonia, the facility did not notify the local health department or implement any immediate actions to protect the remaining residents of the facility, placing them at potential risk for Legionella bacteria exposure.

Facility D: F692 Nutrition/Hydration Status Maintenance (J)
7/8/2024 Annual Survey, Extended Survey
The facility failed to ensure that a resident, who was identified at nutritional risk, was provided with a comprehensive and individualized nutritional plan to include monitoring of nutritional status, physician notification of diet changes and discharge from hospice services, and implementation of nutritional interventions to prevent weight loss and honor the resident's right for food preferences. This resulted in Immediate Jeopardy and serious life-threatening harm related to malnutrition/weight loss when the resident experienced significant weight loss and a severely low body-mass index due to the facility's failure to address the resident's refusal to consume pureed foods, obtain hospice services/offer in-house palliative care or order comfort foods, negatively impacting the resident's psychosocial well-being due to not being able to participate in food related activities and evidence of continued weight loss. The resident was observed during the survey to request money to obtain food from the facility vending machine and obtain food of regular consistency on her own to consume, indicating she was hungry.

Facility E: F684 Quality of Care (J)
7/29/2024 Complaint Investigation, Partial Extended Survey
The facility failed to provide comprehensive, resident centered care to adequately manage and prevent worsening of cardiac conditions. This resulted in Immediate Jeopardy and serious life-threatening harm/death when the resident with a history of multiple cardiac diagnoses did not receive the correct physician ordered dose of diuretics or antiarrhythmic medications for his

cardiac conditions upon admission to the facility. The resident also did not receive comprehensive, individualized care for his extensive cardiac history including monitoring for fluid volume overload (input and output), monitoring of weights, and use of anti-embolism stockings. Despite the residents' known history of hypokalemia, no potassium supplement was ordered on admission to the facility. Potassium supplements were ordered once the facility identified the resident had a critical (low) potassium level. However, the resident experienced vomiting after meals and the physician was not notified of the resident's declining condition. The resident was then found unresponsive, CPR was initiated, however unsuccessful, and the resident passed away.

Facility F: 686 Treatment/Services to Prevent/Heal Pressure Ulcer (J)
7/23/2024 Complaint Investigation, Partial Extended Survey
The failure to develop and implement a comprehensive and individualized pressure ulcer program to ensure necessary care and services to prevent the development of, worsening of, and promote the healing of a facility acquired pressure ulcer resulted in Immediate Jeopardy and actual harm. One resident was seen by a wound care team for MASD on the sacrum that had progressed from MASD to a Stage III pressure ulcer. The ulcer then deteriorated with an increase in size and the resident was documented to have a change in condition with increased lethargy, no food intake at lunch, minimal fluid intake, abnormal vital signs including an elevated temperature, elevated heart rate, decreased blood pressure, and an elevated white blood cell count. Wound cultures were ordered but were not obtained until four days later. Ther resident was transferred to the hospital five days after their change in condition and admitted for treatment of sepsis secondary to decubitus/pressure ulcer. In addition, another concern that did not rise to Immediate Jeopardy but did result in actual harm occurred to two other residents when the facility failed to provide the necessary care and services for the prevention and development of and then worsening of Stage III pressure ulcers.

Facility G: F600 Free from Abuse and Neglect (J) - Staff to Resident Sexual Abuse
8/22/2024 Complaint Investigation, Partial Extended Survey
The facility failed to prevent staff-to-resident sexual abuse. This resulted in Immediate Jeopardy and the potential for actual physical and psychological harm when a staff member witnessed an incident of potential sexual abuse between another staff member and a resident. The resident had a court appointed legal guardian due to mental incapacity with a known history of hypersexual tendencies. The incident was reported to nursing staff and the Administrator. The accused staff member was suspended pending an investigation of alleged sexual abuse, the local police department was notified, and a Self-Reported Incident (SRI) was completed. The accused staff member confessed to police to having sexual interactions with the resident for the last nine to twelve months. The staff member was arrested and charged with sexual assault of the resident.

Facility H: F600 Free from Abuse and Neglect (J) – Staff to Resident Abuse
F689 Free of Accident Hazards/Supervision/Devices (J)
8/7/2024 Complaint Investigation, Partial Extended Survey

Abuse: Immediate Jeopardy, the potential for actual physical hard and actual psychosocial harm occurred when a staff member physically abused a resident by jumping on and punching the resident after the resident hit the staff member with his cane. Other staff in the area told the staff member to back away from the resident but she did not and had to be restrained by another staff member as she continued to kick and further assault the resident. The resident revealed that he did not feel safe at the facility due to the incident. The staff member was immediately removed from the building and police and emergency medical services were called. The resident was found to have no physical injuries. The staff member was terminated from the facility and police filed assault charges. The facility Administrator revealed to surveyors that the facility determined the root cause of the (abuse) incident was due to the staff member lacking behavior health training.
Free of Accidents: Immediate Jeopardy and the potential for actual harm occurred when a resident (who had a legal guardian and was care-planned as an elopement risk) exited the facility without staff knowledge after a staff member propped the back (locked) door of a secured unit open with a wet floor sign. The night shift staff and following day shift staff did not conduct complete rounding and were unaware the resident had exited the facility. The resident was subsequently located at her father's house in a city approximately 16 miles away from the facility after the father had to call the facility to inform them where the resident was.

Facility I: F678 Cardio-Pulmonary Resuscitation (J)
F684 Quality of Care (J)

8/6/2024 Complaint Investigation, Partial Extended Survey
CPR: The facility failed to ensure all staff provided effective CPR. Additionally, the facility failed to ensure crash carts in emergency resuscitation efforts were readily available and accessible during a cardiac emergency. This resulted in Immediate Jeopardy and actual harm/subsequent death when staff failed to initiate effective CPR for a resident who experienced a cardiac emergency. A staff member was unable to immediately locate the crash cart which in turn caused the nurse to provide CPR to the resident for approximately four minutes on the resident's mattress (which decreased the effectiveness of CPR) and failed to provide any type of mechanical ventilation (via ambu bag) during this time. EMS arrived and assumed care for the resident, but the resident expired at the hospital.
Quality of Care: The facility failed to timely identify and provide adequate and necessary care for a resident who experienced an acute change in condition. This resulted in Immediate Jeopardy and actual harm/serious health outcomes and potential for death when the facility failed to recognize and adequately and timely respond to a decline in a resident's condition. The resident was observed to have difficulty swallowing and his diet was downgraded to pureed, has poor oral intakes for the following two days with no nursing assessments or monitoring completed and no evidence of the physician being notified. Additionally, the resident became unresponsive to any stimuli and nursing staff failed to assess or notify the physician and took no action to address the resident's decline. Although unresponsive, a nurse proceeded to place crushed medications mixed with chocolate pudding into the resident's mouth. Approximately 12 hours later, a different nurse assessed the resident and found his vital signs to be unstable and the resident had a large amount of chocolate pudding and crushed

medications in his mouth. EMS were called and the resident was sent to the hospital. Subsequently, the resident was admitted to the hospital and later admitted to hospice. The resident did not return to the facility.

Facility J: F600 Free from Abuse and Neglect (J) Staff to Resident Mental Abuse
9/16/2024 Complaint Investigation, Partial Extended Survey
Immediate Jeopardy and the potential for serious mental, emotional, and/or psychosocial harm occurred when facility staff willfully harassed, mocked, and ridiculed three residents by laughing at them during care, making fun of their physical disabilities during care, teasing them to elicit an angry response, and encouraging them to curse and show a middle finger. As a result, one resident began to have agitated behaviors which included throwing an item at staff and one resident stated the interaction with the staff made them feel horrible. This incident was videotaped on one of the staff members' personal cell phones. Upon conclusion of the facility's investigation, the staff members involved were terminated.

Facility K: F600 Free from Abuse and Neglect (J) Staff to Resident Abuse
F609 Reporting of Alleged Violations (J)
F610 Investigate/Prevent/Correct Alleged Violation (J)
9/23/2024 Complaint Investigation, Partial Extended Survey
Abuse: Immediate Jeopardy and the potential for serious life-threatening harm/injuries and psychosocial harm occurred when a staff member witnessed another staff member grab and force a resident to sit in her specialty tilt-in-space wheelchair while yelling at the resident to sit down. The staff member then positioned the tilt-in-space wheelchair with resident's feet in the air and her head pointing toward the ground. The resident was observed to be tearful and crying out that she feared the staff member. The resident remained in this position for approximately 15 minutes. The staff member received education following the incident regarding the use of restraints but was not removed from the facility or schedule despite the allegation of abuse reported. Another Immediate Jeopardy incident and actual physical harm occurred when another staff member was assisting a resident into the shower room. The resident became agitated, but the staff member continued the shower despite the resident's reaction. Following the incident, the resident reported to another staff member that she was forcefully grabbed, undressed, and "threw" into shower. This staff member failed to report the allegation of physical abuse to leadership staff. A few days later, the resident was found to have bruises on her right forearm, right chest, and a bruise to her right inferior upper arm the size of a thumb print. The resident was transported to the emergency room where e-rays of the resident's right arm were completed, and three fractures of the resident's right wrist were identified.
Reporting: The facility failed to ensure all allegations of physical and/or emotional abuse were reported immediately to the Administrator and State Survey Agency as required. The above allegations were not immediately reported as required.
Investigate/Prevent/Correct: The facility failed to implement the facility abuse policy related to allegations of physical and emotional abuse by allowing alleged perpetrators continued access to the specified victims and/or other vulnerable residents and failed to timely initiate an

investigation regarding the allegations of abuse. Both incidents above were not immediately investigated and both staff members continued to work at the facility.

Facility L: F689 Free of Accident Hazards/Supervision/Devices (J)
9/17/2024 Incidental Findings Discovered During the Course of a Complaint Investigation
The facility failed to provide adequate supervision to prevent a resident, who had moderately impaired cognition, a diagnosis of vascular dementia, and a previous incident of attempting to exit the facility, from leaving the facility unsupervised. This resulted in Immediate Jeopardy when the resident was able to presumably enter a locked elevator on the second floor with a group of community members and exit the locked front entrance with the group without staff knowledge and exit the facility unsupervised. The potential for serious life-threatening harm and/or injury occurred when the resident was missing for up to two hours and 45 minutes, ultimately being found by law enforcement at a local high school approximately three miles from the facility and near heavily traveled roads with speeds up to 50 miles per hour.

Facility M: F689 Free of Accident Hazards/Supervision/Devices (J)
9/24/2024 Complaint Investigation, Partial Extended Survey
The facility failed to ensure a resident who had a known history of smoking with oxygen on, was assessed as an independent smoker, exhibited safe smoking practices, and did not smoke while wearing oxygen. This resulted in Immediate Jeopardy and serious life-threatening harm, injuries and/or death when the unsupervised resident lit a cigarette while wearing oxygen therapy via nasal cannula, in the designated smoking area. The resident's oxygen ignited and set the resident on fire, resulting in singed facial hair, and charred skin around his mouth, nose, and bilateral cheeks. While being treated by EMS, the resident began to experience a deteriorating airway and adventitious lung sounds. The resident was life flighted to a burn hospital and subsequently passed away approximately eight hours later from smoke inhalation and thermal burns.

Facility N: F686 Treatment/Services to Prevent/Heal Pressure Ulcer (K)
F725 Sufficient Nursing Staff (L)
9/18/2024 Complaint Investigation, Annual Survey, Extended Survey
Pressure Ulcers: The facility failed to provide adequate care and services to prevent and timely identify pressure ulcers and injuries for three residents. This resulted in Immediate Jeopardy and serious life-threatening harm, injuries, and/or negative outcomes when one resident developed six facility acquired deep tissue pressure injuries and was hospitalized for osteomyelitis. Another resident developed facility acquired unstageable pressure ulcers to the coccyx, left heal, and left lateral ankle, and was hospitalized for osteomyelitis. Furthermore, a third resident developed facility acquired MASD, which healed, and was then found to have an unstageable pressure ulcer to the coccyx.
Sufficient Staff: The facility failed to maintain sufficient levels of certified nursing assistant staff and licensed nursing staff to meet the total care needs of all facility residents. This resulted in Immediate Jeopardy when there were three LPN's and two CNA's on duty to provide for the

routine care, monitoring, medication administration, assessments, response to urgent resident needs and/or for treatments for all 105 residents residing in the facility.

Facility O: F678 Cardio-Pulmonary Resuscitation (J)
9/18/2024 Complaint Investigation, Partial Extended Survey
The facility failed to provide basic life support, including CPR, to a resident as per the resident's advanced directives, when the resident was found unresponsive and without a pulse/heartbeat. This resulted in Immediate Jeopardy and serious life-threatening harm, negative health outcomes, and subsequent death when the resident did not receive CPR, due to the facility staff inaccurately identifying the resident's code status as being a Do Not Resuscitate Comfort Care Arrest (DNRCC-A) from a report sheet, instead of a full code that was identified in her medical record and what she elected, as part of her advanced directives upon admission to the facility. CPR was not initiated, and EMS were not called until approximately an hour and fifteen minutes after the resident was found unresponsive and without a pulse. The resident was subsequently transported to the hospital and was pronounced deceased upon arrival.

Facility P: F684 Quality of Care (J)
9/17/2024 Complaint Investigation, Partial Extended Survey
The facility failed to ensure staff identified a change in condition for a resident when the resident experienced hypotension and diaphoresis and failed to notify the physician of this change in condition resulting in a delay in care and treatment. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm when the resident experienced this change in condition which was not reported to the physician and no treatment was provided. The resident's family member arrived at the facility four hours after the resident first exhibited a decline in condition and requested the resident be sent to the hospital. The resident was admitted to the hospital with diagnoses of septic shock and encephalopathy and expired at the hospital on the next day.

Facility Q: F760 Residents are Free of Significant Med Errors (J)
9/24/2024 Complaint Investigation, Partial Extended Survey
Immediate Jeopardy and serious life-threatening harm occurred when a resident, who had a known history of hypothyroidism and myxedema coma in 2021 and 2022, was not ordered or administered, Synthroid, used to treat hypothyroidism from admission on 9/7/2023 through 4/20/24 (at the time of admission, the resident's admission order for Synthroid was not transcribed accurately by the nursing staff) when the resident was transferred to the hospital due to a deterioration in the resident's condition. The resident was admitted to the ICU for treatment of acute toxic metabolic encephalopathy likely myxedema coma and elevated TSH. The hospital noted a concern for medication non-compliance at the nursing home due to no recent fill history and the medication/Synthroid not being listed on the resident's nursing home paperwork. Investigation revealed following the incident, the resident never walked again, developed a pulmonary embolism, and subsequently passed away three months later.