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IMPORTANT BULLETIN
Immediate Jeopardy Issues
Fourth Quarter 2024

PLEASE BE SURE THAT FACILITY STAFF READ THIS

OHCA has compiled Immediate Jeopardy data for all Ohio facilities surveyed during the fourth quarter of 2024. Surveyors found twenty-seven (27) Immediate Jeopardy citations in twenty-four (24) facilities. Surveyors cited two (2) facilities with multiple IJ citations. The Ohio Department of Health cited twenty-three (23) citations at a severity level of J and four (4) at a K level. There were four surveys with an associated death. They cited F600 (Free from Abuse and Neglect) six times, F689 (Free of Accidents) eight times, F684 (Quality of Care) six times. Others cited once this quarter were F760 (Medication Error), F725 (Sufficient Nursing Staff), F744 (Treatment for Dementia), F690 (Bowel/Bladder), F695 (Respiratory/Trach Care), F583 (Personnel Records), and F607 (Development of Abuse/Neglect Policies).

If you have an adverse occurrence in your facility, OHCA recommends that the incident be immediately thoroughly investigated and reviewed by the QA Committee. The facility should implement a QAPI plan even if the facility believes that there is no evidence of noncompliance, and the facility staff has followed all facility policies and procedures. If a survey team disagrees with the facility's conclusion or identifies an instance of noncompliance, implementing the appropriate and thorough action plan may limit the facility's time frame. A timely and comprehensive action plan may demonstrate that the alleged noncompliance is fully corrected and serve as evidence of past noncompliance in an immediate jeopardy situation.

Summaries of these citations are listed below:

Facility A: F600 Freedom from Abuse, Neglect, and Exploitation (K) – Neglect
F689 Free of Accident Hazards/Supervision/Devices (K) – Burns/Smoking
10/29/2024 Complaint Investigation, Partial Extended Survey
F600: The facility failed to ensure a resident was free from neglect when staff did not implement fire procedures timely when a mattress/bedding fire occurred in the residents' room. This resulted in Immediate Jeopardy when a fire occurred in the residents' room which ignited their mattress/bedding on fire, activating the fire alarm and sprinkler system and facility staff did not attempt to immediately implement fire protocols to rescue, contain, and/or extinguish the fire (did not immediately take a fire extinguisher into the room and did not immediately help other residents evacuate the hall or close all resident room doors in the area of the fire). The resident sustained burns to her legs, torso, and arm, was transferred to the hospital and admitted to the SICU. She was also treated for acute respiratory failure with hypoxia and intubated with a moderate inhalation injury. This was cited at a K level as an additional nine residents residing in the same smoke compartment were at potential risk for the likelihood of serious injury, impairment, negative health outcomes, and/or death due to potential for the fire and smoke to spread throughout the hall.
F689: The facility failed to ensure the residents' environment remained as free from accident hazards as is possible when one resident who utilized oxygen therapy and who smoked cigarettes possessed

smoking materials, including cigarettes and a cigarette lighter, in her room. This resulted in Immediate Jeopardy when a fire occurred in a residents' room and was cited at a K level as these placed additional residents residing in the same smoke compartment at potential risk.

Facility B: F600 Freedom from Abuse, Neglect, and Exploitation (J) – Abuse (Staff to Resident)
10/23/2024 Complaint Investigation, Partial Extended Survey
The facility failed to prevent an incident of staff to resident abuse. This resulted in Immediate Jeopardy and actual physical and psychosocial harm when a CNA physically abused a resident by spraying the resident in the face with pepper spray. As a result, the resident complained of his eyes burning and facility staff observed his eyes were red. In addition, a PTSD Assessment was completed for the resident which indicated the resident considered the event traumatic, had nightmares or thought about the event when he did not want to, had been frequently on guard or watchful or easily startled, and felt guilty or unable to stop blaming himself or others for the event.

Facility C: F684 Quality of Care (J) – Delayed Treatment
10/01/2024 Complaint Investigation, Partial Extended Survey
The facility failed to provide adequate, timely and necessary care and services, including timely re-scheduling of vascular surgeon appointments for a resident who had vascular wounds to meet the residents' total care needs. This resulted in Immediate Jeopardy when a vascular surgery follow-up appointment was canceled with no evidence of attempts by facility staff to re-schedule or schedule a new vascular surgery consult until a month later, when an appointment was made for the following week with a new vascular surgeon. However, prior to the new appointment, the resident suffered a significant change in condition which caused a lengthy hospitalization and ultimately discussion of possible emergent amputations. The resident and his family considered the options and ultimately decided against amputations and opted for end-of-life care with hospice at another skilled nursing facility. Additionally, the facility failed to transcribe and schedule appointments for two other residents whose hospital after visit summaries listed the need for follow up appointments with outside specialists.

Facility D: F684 Quality of Care (J) – Change in Condition
10/15/2024 Complaint Investigation, Partial Extended Survey
The facility failed to provide adequate and necessary care to meet the total care needs of a resident by failing to consistently monitor blood glucose levels as ordered, failed to administer insulin as ordered and failed to monitor the resident after an acute/significant change in condition. This resulted in Immediate Jeopardy and actual harm when the resident was noted to have an acute change in condition with lack of evidence of timely and necessary monitoring and intervention/treatment. The resident was eventually emergently transferred to the hospital and was diagnosed with diabetic ketoacidosis, severe hypernatremia, and septic shock. She was intubated and Life Flighted to a larger hospital where she was admitted to the ICU.

Facility E: F684 Quality of Care (J) – Change in Condition
10/31/2024 Complaint Investigation, Partial Extended Survey
The facility failed to ensure that a resident received timely and adequate treatment and care and medical intervention to treat a change in condition. For 2 weeks, the resident exhibited increased nausea/vomiting, diarrhea, and abdominal pain. In addition, the resident had orders for levothyroxine with concerns the mediation was not ordered/provided at an appropriate dose to meet the resident's needs. During his time, the facility failed to take appropriate action by updating the physician on a

change of condition which also included abnormal laboratory values. The physician was finally notified that the residents' TSH level was elevated at 44.9. Upon notification of the abnormal TSH level, the physician, who was unaware the resident was already receiving levothyroxine, ordered levothyroxine at a lower dose. This resulted in Immediate Jeopardy when the resident's abnormal laboratory values (sodium, potassium, and creatinine) six days later were obtained and there was no evidence the physician was notified. The resident continued with nausea, vomiting, abdominal pain, decreased appetite, weight loss, and weakness for an additional 3 weeks. The resident then presented with coffee ground emesis, exhibited abdominal pain rated a 10 out of 10 and hypotension and was transferred to the ER. The resident was subsequently admitted to the hospital with severe dehydration, severe malnutrition, and an abnormal TSH which was noted to possibly be a contributing factor of the resident's GI issues. The resident required IV fluids and IV levothyroxine.

Facility F: F689 Free of Accident Hazards/Supervision/Devices (J) - Elopement
10/23/2024 Complaint Investigation, Partial Extended Survey
The facility failed to provide adequate supervision and monitor Wander Guard functioning for a resident with a history of exit seeking behavior to prevent elopement. This resulted in Immediate Jeopardy when the resident eloped from the facility without staff knowledge, through a smoking patio exit door and traveled from Ohio to Wisconsin, under unknown circumstances. The resident was not seen by facility staff for nearly three hours before he was discovered missing. The resident was missing from the facility for over two days when he was found by a university police department on a college campus in Wisconsin, approximately 425 miles away from the facility. During the time the resident was missing, he missed hemodialysis treatment and several prescription medications.

Facility G: F689 Free of Accident Hazards/Supervision/Devices (J) - Elopement
10/17/2024 Complaint Investigation, Extended Survey, Annual Survey
The facility failed to provide adequate supervision to ensure a resident at risk for elopement and residing on a secure unit did not elope from the facility. This resulted in Immediate Jeopardy when the resident left the facility without staff knowledge, was missing for over five hours before staff identified him as missing and was subsequently found 11 hours later at a residence 20 miles from the facility in a different county. The local police had picked up the resident who was walking on an interstate near the facility and transported him to his prior residence.

Facility H: F690 Bowel/Bladder Incontinence, Catheter, UTI (J) – Change in Condition
10/29/2024 Complaint Investigation, Partial Extended Survey, Focused Infection Control Survey
The facility failed to ensure comprehensive monitoring and timely identification of a change in resident condition related to the use of an indwelling urinary catheter. This resulted in Immediate Jeopardy when the resident had decreased urine output with only a total of 200 ml over three nursing shifts. However, the nursing staff did not follow up to comprehensively assess the resident during this time period or follow up with CNA staff to inquire about the resident's urine output during their shifts. The nursing staff did not notify the physician that the resident had 0-100 ml of urine output each nursing shift. The resident's family requested the resident be transferred to the ER. Upon arrival at the hospital, the resident was assessed to have a firm abdomen, abdominal distention, and pain in the lower stomach region. The resident's indwelling catheter was replaced and began draining dark, thick, purulent urine. The resident had 2000 ml of urine output after the indwelling catheter was replaced. The resident was diagnosed with altered mental status, a UTI, and septic shock. The resident was subsequently discharged

to an inpatient hospice center and expired five days later. The resident's death certificate noted cause of death was bacteremia due to septic shock and heart disease.

Facility I: F725 Sufficient Nursing Staff (K) – Resident's Unattended
10/12/2024 Annual Survey
The facility failed to ensure designated and consistent staffing was provided on one of five total halls in the facility to ensure sufficient staff to provide needed care and services to the residents that resided on that hall. This resulted in Immediate Jeopardy when observations during the survey revealed times where the residents were left unattended on the hall with no staff members in the area. Staff reported there was no process in place to coordinate supervision, monitoring, or assistance for the residents on this hall. In addition, the call system on this hall only illuminated on the annunciator panel located on that hall; therefore, in the event of an emergent need, when no staff were present on the hall, the residents were not able to alert staff in other areas of the facility. Residents reported that if they needed assistance, they had to utilize the elevator to go down to other floors of the facility to locate staff. Additionally, residents reported that due to no staff presence on this hall at mealtimes, residents had to retrieve their own meals trays from the food carts because no staff were available to assist.

Facility J: F744 Treatment/Service for Dementia (K) – Physical/Psychosocial Harm (Resident to Resident)
10/11/2024 Annual Survey, Extended Survey
The facility failed to develop and implement comprehensive and individualized treatment and services to ensure residents, who displayed behaviors and/or were diagnosed with dementia received the appropriate treatment and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being. This resulted in Immediate Jeopardy and included an incident of actual physical and psychosocial harm to a resident when staff failed to provide adequate supervision/intervention to prevent the resident from being assaulted by another resident. The lack of specialized training for providing care to residents with diagnosis of dementia, the failure to provide identified services including medical treatment, specialized care services and social activities to all residents, and the failure to ensure adequate staffing levels were maintained to provide necessary resident supervision put all residents on the secured memory care unit at risk for additional harm.

Facility K: F600 Freedom from Abuse, Neglect, and Exploitation (J) –Abuse (Staff to Resident)
11/14/2024 Complaint Investigation, Partial Extended Survey
The facility failed to ensure that a resident with cognitive impairment was free from staff to resident abuse with a CNA physically abused the resident while providing care. This resulted in Immediate Jeopardy when the facility failed to protect the resident's right to be free from physical and emotional/mental abuse. Video surveillance captured the incidents of abuse that occurred while the CNA was providing personal care services to the resident and video surveillance also captured the resident's emotional distress as a result of the incident.

Facility L: F684 Quality of Care (J) – Continuity of Care
11/19/2024 Complaint Investigation, Partial Extended Survey
The facility failed to ensure a resident's continuity of care from the hospital to the facility was thoroughly reviewed and implemented. This resulted in Immediate Jeopardy when the resident received Coumadin despite hospital orders and recommendations to stop anticoagulation therapy until seen by the neurosurgeon. Consequently, this resulted in the resident being sent to the hospital and admitted to

the neuro critical care until due to an increased subdural hemorrhage and a craniotomy for subdural evacuation.

Facility M: F684 Quality of Care (J) – Change in Condition
11/25/2024 Complaint Investigation, Partial Extended Survey
The facility failed to ensure a resident received appropriate treatment and care and medical intervention to timely treat a change in condition. This resulted in Immediate Jeopardy and ultimately resulted in death when a resident, who was dependent on staff for oral intake, was being fed breakfast by a CNA, stared coughing, became congested and eventually had white secretions from his nose and mouth impairing his airway. Subsequently, the resident coded and expired in the facility after failed attempts of resuscitation. The resident experienced the change in condition at 7:40 a.m. but was not properly assessed/treated and subsequently coded at 9:37 a.m.

Facility N: F689 Free of Accident Hazards/Supervision/Devices (J) - Elopement
11/26/2024 Compliant Survey, Focused Infection Control Survey, Partial Extended Survey
The facility failed to provide adequate supervision for a resident who was assessed to be high risk for elopement, had a history of exit seeking behavior, resided on the secured memory care unit, and had a wander guard to prevent elopement. This resulted in Immediate Jeopardy when the resident followed dietary staff through the secured memory care door, traveled through the facility and eloped through the front door without staff knowledge. Furthermore, the resident's wander guard alarmed at the front door when he exited; however, staff failed to timely respond and further failed to adequately investigate the source of the alarm upon response. Facility staff were unaware the resident was missing until notified by the local police department he had been found, approximately two hours after he was last seen in the facility by staff.

Facility O: F689 Free of Accident Hazards/Supervision/Devices (J) - Smoking
11/19/2024 Complaint Investigation, Partial Extended Survey
The facility failed to ensure a safe environment free from a potential accident hazard when smoking materials were not secured to prevent unsafe smoking in resident rooms. This resulted in Immediate Jeopardy when a resident who was assessed to require staff supervision and the use of a smoking apron was observed alone in his room with a strong cigarette odor and visible cigarette smoke in the air. A CNA also verified that the resident's roommate had been seen previously smoking in the room. Additionally, the resident's bathroom had cigarette ashes on the floor, burn marks on the toilet seat and toilet paper holder, and two cigarette butts were found in the plastic trash located next to the bed. This resident's room was located across the hall from a resident who was identified to utilize oxygen.

Facility P: F760 Residents are Free of Significant Med Error (J) – Medication Errors
11/08/2024 Complaint Investigation, Partial Extended Survey
The facility failed to ensure that a resident was free from a significant medication error and failed to ensure the error was reported immediately so that timely and appropriate medical intervention could be provided. The resulted in Immediate Jeopardy and actual harm/death of a resident who was erroneously administered medications that included Methadone 40 mg and likely hydromorphone 8 mg. These medications were ordered for another resident. The LPN did not report the medication error and therefore no medical intervention was initiated. 12 hours after receiving the wrong medication, the resident was found unresponsive in a common area and resuscitative measures were initiated but ultimately unsuccessful.

Facility Q: F583 Personal Privacy/Confidentiality of Records (J) - Privacy
F600 Free from Abuse, Neglect, and Exploitation (J) – Abuse/Exploitation (Staff to Resident)
F607 Develop/Implement Abuse/Neglect Policies (J) – Reporting to State Agency
12/11/2024 Complaint Investigation, Partial Extended Survey
F583/F600/F607: The facility failed to protect the privacy of a resident during personal care. This resulted in F583 Immediate Jeopardy when a CNA made a cell phone recording of a resident (with an Alzheimer's diagnosis) who was observed in the video slouched in a shower chair with her paints around her ankles and her shirt pulled up above her breasts exposing her bare body from her breasts down to just above her ankles. After taking the video, the CNA posted the video to social media which had the potential to be viewed by an unlimited number of people without the resident's knowledge and/or consent. This resulted in F600 Immediate Jeopardy as the video was taken in a manner that would demean and humiliate the resident constituting a situation of abuse. This resulted in F607 Immediate Jeopardy as while the facility did report the incident to the State agency, the facility concluded the incident of abuse was unsubstantiated based on the resident being "unaware" of the incident.

Facility R: F600 Free from Abuse, Neglect, and Exploitation (J) – Sexual Abuse (Resident to Resident)
12/17/2024 Complaint Investigation, SRI Investigation, Partial Extended Survey
The facility failed to ensure a resident, who had dementia, was deemed incompetent, and unable to provide consent, was free from resident-to-resident sexual abuse. This resulted in Immediate Jeopardy when a resident who had a history of engaging in physical activity (i.e. hand holding and touching behaviors) with the resident without care planned interventions, was observed by a CNA engaged in an activity indicative of oral sex on the incompetent resident.

Facility S: F600 Free from Abuse, Neglect, and Exploitation (J) - Elopement
12/4/2024 Complaint Investigation
The facility failed to provide adequate supervision and comprehensive individualized interventions to prevent an unauthorized leave of absence for a resident who was under adult protection services with a guardian and guardian directive which prohibited the resident's husband from taking the resident off facility premises or into his vehicle. This resulted in Immediate Jeopardy and actual harm/death when the resident's husband took the resident outside the facility and then left the facility grounds with the resident in his vehicle without staff knowledge. The resident was found deceased by local police approximately 1.5 miles from the facility with a gunshot wound to the head.

Facility T: F684 Quality of Care (J) – Change in Condition
12/13/2024 Complaint Investigation, Partial Extended Survey
The facility failed to ensure that a resident received medications to prevent seizure activity and notify the physician of resident not receiving medications and having seizure activity. This resulted in Immediate Jeopardy and serious life-threatening harm when, as a result of not having his prescribed medications, the resident subsequently experienced continual tonic-clonic seizures requiring emergency Intramuscular and Intravenous administration of Versed, was transferred to the ER with critical laboratory values and subsequently transferred to a tertiary care facility where he was admitted to the neurological ICU.

Facility U: F689 Free of Accident Hazards/Supervision/Devices (J) - Elopement
12/20/2024 Self-Reported incident Investigation, Partial Extended Survey

The facility failed to provide adequate supervision and intervention to prevent a resident who had a history of wandering, from leaving the facility without staff knowledge. This resulted in Immediate Jeopardy when the resident exited the facility through the front door. At the time of the incident, a staff member reported hearing the door alarm sound but turned it off without investigation as the staff member assumed the alarm was activated by a person who had just delivered a food order. The resident was missing from the facility for approximately one hour and 45 minutes without staff knowledge. The resident was found five hours later by his nephew approximately five miles from the facility in the garage of the home in the community where he had previously resided. A sever winter weather warning was in effect at this time with temperatures between 21 degrees and 37 degrees recorded. Upon being found by his nephew, the resident was taken to the hospital for an examination, admitted to the hospital, and did not return to the facility.

Facility V: F689 Free of Accident Hazards/Supervision/Devices (J) - Elopement
12/4/2024 Complaint Investigation, Partial Extended Survey
The facility failed to provide adequate supervision and implement timely interventions for exit-seeking behaviors for a resident who was cognitively impaired, had a history of wandering and exit seeking behavior and who resided in a secured unit, to prevent his elopement from the facility without staff knowledge. This resulted in Immediate Jeopardy when the resident left the secured unit, got in a car in the parking lot which had the keys inside and drove approximately 8.2 miles away from the facility. The resident was missing from the facility for approximately two hours before staff were notified the resident had been located by the police and would be returned to the facility.

Facility W: F689 Free of Accident Hazards/Supervision/Devices (J) - Elopement
12/10/2024 Complaint Investigation, Partial Extended Survey
The facility failed to provide adequate supervision to prevent a resident who had a diagnosis of dementia, PTSD, and severe cognitive impairment, from leaving the facility without staff knowledge. This resulted in Immediate Jeopardy when the resident was seen (by camera footage) standing inside the facility in front of the main door when a visiting family member entered from outside, punched in the door code, and let the resident out of the building without notifying staff. A staff member reported hearing the door alarm sound, but did not respond as the staff member assumed the alarm was activated by a staff member retrieving food. The residents' whereabouts remained unknown for approximately one hour and 45 minutes without the knowledge of staff. A concerned citizen called the local police department after finding a confused male sitting on the curb of a five-lane, heavily traveled street approximately 0.6 miles from the facility. The police arrived and transported the male to the ER for further evaluation and called the facility to notify them that the male was a resident of their facility.

Facility X: F695 Respiratory/Tracheostomy Care and Suctioning (J) – Respiratory Care
12/4/2024 Complaint Survey, Partial Extended Survey
The facility failed to administer appropriate respiratory care, administration of a ventilator at night as ordered for a resident who had a compromised respiratory status. This resulted in Immediate Jeopardy when the resident was not placed on a ventilator as ordered by physician from the hospital to apply a vent at hour of sleep and to wean as tolerated. The resident was found unresponsive and required CPR and hospitalization.

Comments/Recommendations:

F600 – Free from Abuse and Neglect

• A facility's failure to meet financial obligations necessary to maintain appropriate care and services for residents, including, but not limited to, vendor contracts, payroll, taxes, and any other bills for resident equipment or services, will constitute a potential for neglect.
• Staff should be educated on diffusing and de-escalating situations with residents' behaviors. Staff should never forcefully touch a resident.
• Surveyors may cite any delay in assessment or treatment after an accident, injury, or change in condition as neglect. In situations of this nature, the immediacy of follow-up assessment, reporting, and action is vital. Neglect is also possible when the facility delays or fails to administer CPR.
• Neglect is the "failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish or emotional distress. Any deficiency can be cited as neglect, especially when surveyors cite the deficiency at the immediate jeopardy level. However, the Guidance states, “Neglect should not automatically be cited in addition to the Resident Rights/Quality of Care/Life tags. While the latter citations identify potential or actual negative outcomes in the areas of resident rights, quality of care, and quality of life, neglect identifies the facility’s failure to provide the required structures and processes to meet the needs of one or more residents This may include but is not limited to, the facility’s failure to provide necessary staff, supplies, services, policies, training, or staff supervision and oversight to meet the resident’s needs.” The Guidance states that noncompliance under such tags as F689 (falls/accidents) or F686 (pressure ulcers) do not automatically indicate noncompliance at F600 for neglect.
• The staff must supervise residents per their care plans and standards of practice.
• No matter the circumstance, abuse from staff to residents will always be cited as noncompliance.
• If the facility cannot meet a resident's needs, they must not admit or retain that resident.

F600 – Free from Abuse (Sexual/Physical)

• Staff should be educated on diffusing and de-escalating situations with residents' behaviors. Staff should never forcefully touch a resident.
• The facility must implement interventions to protect residents as soon as any abusive behaviors are identified in a resident or escalate. This may include hospitalization or discharge.
• The staff must supervise residents per their care plans and standards of practice.
• No matter the circumstance, abuse from staff to residents will always be cited as noncompliance.
• If the facility cannot meet a resident's needs, they must not admit or retain that resident.

F600 – Free from Neglect (Clinical)

• Anytime a resident is identified with a change of condition, the physician and emergency contact should be notified.
• A nurse should assess the resident and follow the ABCs of standard care for airway, breathing, and circulation. The nurse should then immediately notify emergency services, obtain vital signs, remain with the resident, and determine code status.
• Implementing clear protocols and conducting drills for immediate response to emergencies can assist staff with recognizing early signs of distress and implementing interventions or CPR in a timely manner.
• Emphasize the importance of accurate and timely documentation of assessments, care provided, and communications with medical providers. Regular audits of documentation practices can help ensure compliance.

• After any incident, conduct a thorough root cause analysis to identify systemic issues and develop corrective action plans to prevent recurrence.
• Surveyors may cite any delay in assessment or treatment after an accident, injury, or change in condition as neglect. In situations of this nature, the immediacy of follow-up assessment, reporting, and action is vital. Neglect is also possible when the facility delays or fails to administer CPR. 8
• Neglect is the "failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish or emotional distress. Any deficiency can be cited as neglect, especially when surveyors cite the deficiency at the immediate jeopardy level. However, the Guidance states, “Neglect should not automatically be cited in addition to the Resident Rights/Quality of Care/Life tags. While the latter citations identify potential or actual negative outcomes in the areas of resident rights, quality of care, and quality of life, neglect identifies the facility’s failure to provide the required structures and processes to meet the needs of one or more residents This may include but is not limited to, the facility’s failure to provide necessary staff, supplies, services, policies, training, or staff supervision and oversight to meet the resident’s needs.” The Guidance states that noncompliance under such tags as F689 (falls/accidents) or F686 (pressure ulcers) do not automatically indicate noncompliance at F600 for neglect.

F684 – Quality of Care/Delayed Treatment
• Facilities must ensure that they can provide the needed care for residents or discharge them to a place where they can receive it.
• Proactive training to staff may be beneficial to help recognize and report signs of aspiration, respiratory distress (e.g., coughing, congestion, abnormal secretions), or other changes in condition—especially during meals for residents dependent on feeding assistance.
• If a resident's condition changes, the facility must assess the resident, contact the physician, and determine whether the resident can manage their current care status.
• The resident must receive the required follow-up care. If necessary, the facility should coordinate this care with the appropriate clinicians.

F689 – Elopement
• The staff must monitor and follow care plan interventions to prevent elopement.
• The staff should only silence door alarms in facilities that provide care to persons who may wander when closed if there is a reset process.
• Facilities must respond immediately following their missing resident plan when an individual hears an alarm or identifies a resident missing. The response should include immediate headcounts, a sweep of indoor and outdoor spaces, etc.
• Facilities for at-risk individuals should have a comprehensive alarm or door security system, including all potential exit doors. Facilities must have procedures for checking these elopement prevention systems and devices - which the manufacturers generally provide for the successful operation of these items. When facilities utilize alarm systems such as Wanderguard, ensure that staff completes all manufacturer's recommendations for alarm placement, functional checks, and system tests.
• The facility must assess residents for elopement risk on admission and implement an acute care plan if the staff identifies the resident as at risk.
• Risk assessments for elopement should be completed on admission, quarterly, annually, and with a change in condition.

• Changes in behaviors, especially those that may increase the risk for elopement, such as increased wandering, voicing wanting to leave, etc., should be reported immediately, and the staff should reassess the resident's risk.
• Staff must not leave residents who are at risk for elopement unsupervised at external visits/appointments.
• Educate staff members on recognizing signs of wandering behavior and responding promptly.
• Conduct regular drills and exercises to practice emergency response protocols.

F689 – Burns/Smoking
• Smoking with oxygen is dangerous and can cause severe burns and death.
• Residents on oxygen who smoke must have care plans to ensure they are not using oxygen while smoking.
• For the safety of everyone in the facility, residents should not have smoking materials, including lighters/matches, on their person or in their room.
• If a facility allows smoking, a clinical assessment should be completed to assess residents' ability to smoke safely. Consider physical limitations such as residual effects from a stroke.
• Staff training is important to ensure they understand how to respond to smoking-related emergencies quickly.
• Ensure equipment such as signs, ashtrays, fire blankets, and fire extinguishers is readily available in the designated area and complete routine visual observations of equipment.

F725 - Sufficient Nursing Staff
• The facility must have sufficient nursing staff to ensure all residents receive their ordered medications and needed assessments.
• The facility must have enough direct care staff to ensure timely incontinence care and to meet other residents' needs.

F760 – Medication Errors
• Establishing a process for medication reconciliation upon admission and during transitions of care is critical. This may include a review in daily clinical meetings to review new medication orders and double check high-risk medications are transcribed correctly in the medication record.
• The resident initiated their emergency care, highlighting the need for staff to listen to, assess, and act accordingly.
• Following any serious medication error, conduct a thorough RCA to identify breakdowns in communication, system gaps, or human error, and implement corrective actions immediately.

F744 - Treatment/Service for Dementia

• Conduct thorough assessments upon admission and regularly thereafter, addressing physical, cognitive, behavioral, and psychosocial needs.
• Create individualized care plans that include behavioral interventions, medication management, social engagement strategies, and therapeutic activities specific to each resident's dementia progression and personal history.
• Training should include communication techniques, de-escalation strategies, behavior tracking, and trauma-informed care.

The IJ Task Force recommends that whenever a facility becomes aware that surveyors are considering or recommending an Immediate Jeopardy, it is best to call for assistance. We suggest resources include a long-term care specialty law firm, other long-term care regulatory consultants, and the association's regulatory contact. It is essential to forestall this development or, at a minimum, keep the time frame minimal. OHCA provides periodic training on immediate Jeopardy and how to prevent or mitigate these citations.

Staff training on handling surveyor interviews, from management to direct care staff, is vital to successful survey management. When surveyors interview management-level staff, OHCA suggests that facilities try to have another witness present and take detailed notes regarding the discussion. This documentation ensures that the information provided is understood and avoids "verifying" information you did not intend to verify.

In cases where surveyors have identified an ongoing Immediate Jeopardy, a revisit survey may be required for the survey team to abate the immediate Jeopardy. Therefore, the facility must have evidence that the immediate Jeopardy's condition no longer exists during the initial visit. Facilities are permitted only two revisits without prior approval from the regional office. A third revisit may be approved only at the discretion of the regional office. State Operations Manual Chapter 7-Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf. CMS provides surveyor guidance for citing immediate Jeopardy in Appendix Q of the SOM. CMS released QSO 19-09-ALL Revisions to Appendix Q, Guidance on Immediate Jeopardy, https://www.cms.gov/Medicare/Provider Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-09-ALL.pdf.

If you have an adverse occurrence in your facility, OHCA recommends that the incident be immediately thoroughly investigated and reviewed by the QA Committee. The facility should implement a QAPI plan even if the facility believes that there is no evidence of noncompliance and that the facility followed all facility policies and procedures. Implementing a timely and thorough action plan may limit the time frame that the facility needs to be in compliance with if a survey team disagrees with the facility's conclusion or identifies an instance of noncompliance. In an immediate jeopardy situation, a timely and thorough action plan may demonstrate that the alleged noncompliance is fully corrected and as evidence of past noncompliance. * If the status of the deficiency is "past noncompliance," and the severity is Immediate Jeopardy, then points associated with a 'G-level" deficiency (i.e., 20 points) are assigned.