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IMPORTANT BULLETIN
Immediate Jeopardy Issues
Second Quarter 2025

PLEASE BE SURE THAT FACILITY STAFF READ THIS

OHCA has compiled Immediate Jeopardy data for all Ohio facilities surveyed during the second quarter of 2025. Please note that there may be additional June survey results posted in QCOR after this publication. Surveyors found sixteen (16) Immediate Jeopardy citations in fourteen (14) facilities. Surveyors cited two (2) facilities with multiple IJ citations. The Ohio Department of Health cited fourteen (14) citations at a severity level of J, one (1) at a level K, and one (1) at a level L. F689 – Free of Accident Hazards/Supervision/Devices was cited four (4) times, F684 – Quality of Care three (3) times, F600 – Free from Abuse and Neglect twice (2), F678 – CPR twice (2), F760 – Free of Significant Med Errors twice (2), and F580 – Notify of Changes, F624 – Preparation for Safe/Orderly Transfer/Discharge, and F880 – Infection Prevention & Control once (1).

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: **F580 Notify of Changes (J)**
F600 Free from Abuse and Neglect (J)

Immediate Jeopardy began when the Director of Nursing notified the nurse practitioner of a resident's elevated blood glucose level, received an order for additional insulin, but did not notify the nurse practitioner that the resident refused the medication. The 2567 indicates there were no additional checks of the resident's blood glucose level documented in the medical record. The resident was found on the floor the next day, was not answering questions, and presented with a swollen face. The DON indicated that a neurological assessment and additional notifications were not conducted. The resident was later found to have abdominal breathing, edema to their head and a bluish skin tone. The resident was transferred to the hospital, where it was noted that they had an elevated blood sugar, acute encephalopathy, multiple metabolic/infectious abnormalities and acute metabolic acidosis. The resident passed away while in the hospital. This incident was cited at a "J" level under both F580 and F600.

Facility B: F880 Infection Prevention & Control (L)
Immediate Jeopardy began when the facility received water testing results which were positive for legionella. The 2567 states the facility failed to take immediate action and implement effective corrective actions. Approximately two weeks later, additional water testing showed that legionella levels continued to rise with no evidence of corrective action to mitigate the risk for Legionnaire's disease. Please note that while the 2567 does show that multiple residents presented with respiratory symptoms, it does not indicate that any residents contracted Legionnaire's disease. This incident was cited at an "L" level.

Facility C: F689 Free of Accident Hazards/Supervision/Devices (J)
Immediate Jeopardy began when a transportation driver failed to safely secure and position a resident's wheelchair appropriately. During a trip, the resident's left wheelchair arm broke and the resident fell to the floor of the bus. The resident hit her head during the fall, and the transportation driver drove her to the emergency room for evaluation. A CT scan revealed that the resident had a subdural hematoma and subarachnoid hemorrhage, and she was subsequently admitted to the ICU. This incident was cited at a "J" level.

Facility D: F760 Free of Significant Med Errors (J)
Immediate Jeopardy began when a resident did not receive a physician ordered anticonvulsant medication three times within a 24-hour period. The medical record indicated that the medication was not available and the facility was waiting for the medication from the pharmacy. There was no indication that the physician was made aware of missed doses of medication. The resident began having seizure activity later that night and was transferred to the hospital. The resident required intubation and was life flighted to another hospital for Neuro ICU treatment. This incident was cited at a "J" level.

Facility E: F760 Free of Significant Med Errors (J)
Immediate Jeopardy began when a nurse applied a second Fentanyl patch to a resident without reporting that the previously administered Fentanyl patch could not be located. The 2567 states that the nurse then failed to complete a thorough assessment of the resident after they were found to be lethargic, unable to walk, or sit upright. EMS arrived to take the resident to the emergency room and administered Narcan. They found the second Fentanyl patch and removed it before transporting the resident to the hospital. This incident was cited at a "J" level.

Facility F: F689 Free of Accident Hazards/Supervision/Devices (J)
Immediate Jeopardy began when a cognitively impaired resident exited the third-floor memory care unit through a door with a malfunctioning alarm, and entered a stairwell. An electrician later discovered that the wires controlling the door alarm and door control panel had been eaten through by rodents. Prior to the resident exiting the unit, they were assessed as being at high risk for elopement; however, no care plan was implemented to address the resident's cognitive impairment, or risk for elopement. A CNA found the resident in the stairwell at the bottom of the landing, after they had fallen down 11 cement stairs and suffered multiple fractures and other injuries. This incident was cited at a "J" level.

Facility G: F624 Preparation for Safe/Orderly Transfer/Discharge (J)
Immediate Jeopardy began when a resident was refused access to the facility and the facility issued an emergency discharge based on allegations from two other residents that he was in possession of a

firearm. When the resident left the facility in the morning, the community packed his belongings in garbage bags and did not locate a firearm. Upon the resident's returning from leave, he was not allowed in, and the police were called. The police searched the resident for a weapon, and did not find one. Police then escorted the resident off of the property and staff placed the resident's personal items by the garbage dumpster. The 2567 indicates the resident was not provided with a safe discharge destination. This incident was cited at a "J" level.

Facility H: F678 CPR (J)
Immediate Jeopardy began with a resident, who was a full code, was found without vital signs. The registered nurse failed to initiate CPR immediately and stopped CPR prior to the arrival of Emergency Medical Services. The resident expired at the hospital. The nurse's notes indicated that 911 was called, and CPR was immediately started, at 8:00 AM, continuing for 20 minutes until EMS arrived and began compressions. A review of the Fire Department notes revealed that 911 was not called until 8:05 AM, and EMS arrived at the facility at 8:11 AM. Upon their arrival, they found the resident on the floor, apneic, and pulseless. No CPR was being done upon arrival. When the nurse aides were questioned by EMS, they stated the nurse completed one cycle of CPR and made the statement, "I am going to call this, and we are going to stop CPR." CPR was not being completed on the resident for approximately 5 minutes before EMS arrived. Also complicating the situation, the oxygen tank on the crash cart was empty, and the mouthpiece to the Ambu bag was missing. This incident was cited at a "J" level.

Facility I: F678 CPR (J)
Immediate Jeopardy began when the LPN was informed that the resident, who was a full code, appeared to not be breathing. The nurse assessed the resident, and called for another nurse to verify that the resident was not breathing and absent of vital signs. Without initiating CPR, calling 911, or seeking direction from a physician, the two LPNs called the resident's time of death, stating the family, at bedside, refused life-saving measures. A call with the resident's daughter, who was the POA, revealed that the she was not at the bedside when the resident passed, and did not refuse life-saving measures. The resident's granddaughter was present, but denies refusal of life-saving measures. This incident was cited at a "J" level.

F689 Free of Accident Hazards/Supervision/Devices (J)
Immediate Jeopardy began when a visitor entered the code to the locked front door, entered the facility, and the resident, with a known risk for elopement, was able to exit out the front door without staff knowledge. The resident ambulated through the door, leaving her wheelchair with the attached alert bracelet inside the lobby. The resident walked approximately 0.2 miles from the facility, and staff members did not know that she had exited the facility, until a CNA, who was on break, incidentally discovered the resident sitting on the floor of a carryout. At the time, the resident was hallucinating and stating the facility kidnapped her. Prior to this incident, the resident had multiple recent episodes of going outside without staff supervision. The resident also had a physician order for every fifteen-minute safety checks; however, staff were not aware she was missing until approximately one hour had passed. This incident was cited at a "J" level.

Facility J: F689 Free of Accident Hazards/Supervision/Devices (K)
Immediate Jeopardy began when the HVAC system of the facility malfunctioned, causing a drop in temperature. Space heaters were placed in four resident rooms, and one resident sustained full-thickness burns to his left leg from below his outer knee to the top of his left foot, as a result of the

heater. The resident's wounds were treated with a topical antibiotic, and he was admitted to the hospital Intensive Care Step Down Unit after the Wound Nurse noticed a change in the left leg. The left foot had three black toes from the middle toe to the pinkie toe. This incident was cited at a "K" level.

Facility K: F684 Quality of Care (J)
Immediate Jeopardy began when a resident, who had a tracheostomy, had complaints of shortness of breath which led to unconsciousness, loss of respiration and pulse. When the resident had complained of shortness of breath, the Assistant Director of Nursing proceeded to check all oxygen tubing and connections and increased the oxygen level. The nurse instructed an LPN to stay with the resident, while she called EMS. EMS later arrived at the facility and the resident was found to be alone, pale, and with cyanotic hands and feet. The resident was in a semi-Fowler's position with no supplemental oxygen in place, and no pulse was detected. The resident was transported to the ER, where she was pronounced deceased. This incident was cited at a "J" level.

Facility L: F600 Free from Abuse and Neglect (J)
Immediate Jeopardy began when a resident accessed a CNA's unsecured purse behind the nurses' station and ingested up to twenty 37.5 mg tablets of Adipex (stimulant medication) resulting in a condition change. The resident experienced confusion, hypertension, the inability to stand/walk, and rapid pulse. The resident was not transferred to the emergency room until approximately 5 ½ hours later, where she required CPR, intubation, and ultimately expired. This incident was cited at a "J" level.

Facility M: F684 Quality of Care (J)
Immediate Jeopardy began a resident reported a low blood glucose level to the CNA at 12:18 AM. The CNA provided a snack to the resident, but did not report the change of condition to the nurse on duty. The nurse admitted to not completing rounds on the resident throughout the night. At approximately 6:30 AM, the resident's husband found her to be unresponsive, not breathing and with no pulse. CPR was initiated, EMS was called, and a blood glucose reading registered as "low." The resident was pronounced deceased by EMS. This incident was cited at a "J" level.

Facility N: F684 Quality of Care (J)
Immediate Jeopardy began when the therapy staff identified that the resident had experienced a decline and change in condition, which included hypoxemia, increased sleepiness/somnolence, lethargy, and tachycardia with an inability to continue therapy. Therapy communicated the change in condition to the nurse; however, there was no evidence that a comprehensive assessment of the resident's condition was conducted, and interventions were not put in place. Later that night, EMS was called due to the resident was in cardiac arrest. CPR was initiated; however, the resident was pronounced deceased after approximately 20 minutes. This incident was cited at a "J" level.

Comments/Recommendations:

F580 – Notification

- Upon recognition of a change in resident status, the physician or physician extender, as well as the resident's responsible party should be informed.
- Immediate notification of a change in condition allows the physician to intervene with interventions which may mitigate the resident's risk and reduce negative outcomes.

- Nursing staff must notify the physician/Nurse Practitioner (NP) immediately when a resident refuses critical medications (e.g., insulin). Refusal must be documented and alternative interventions discussed with the provider.

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.

F624 - Preparation for Safe/Orderly Transfer/Discharge

- Provide clear and understandable information regarding the reasons for the transfer or discharge, the new location, the services available and any potential changes the resident’s plan of care.
- Involve the resident and their representative in the process, when able. Actively seek their input and preferences regarding transfer or discharge.
- Clearly inform residents and their representatives about their rights regarding transfers and discharges.
- Safeguard the resident’s belongings and work closely with the resident and their representative to ensure that all personal possessions are accounted for and transferred safely to the new location, preventing loss or being left behind.

F678 – Cardio-Pulmonary Resuscitation (CPR)

• With one limited exception (e.g., a hospice patient with a DNR under the care of a hospice nurse), RNs and LPNs cannot pronounce death in Ohio. Therefore, if a resident does not have a DNR order, the facility must initiate CPR and call 911, even if it appears to the nurse that the resident is deceased.
• CPR requirements must be part of nursing staff education.
• Staff must administer CPR and activate 911 promptly for any resident without a DNR order.
• Under Ohio law, Nurse Practitioners and Physicians can pronounce death in a nursing home. Staff should initiate CPR until that pronouncement is made.

- Best Practice: Conduct unannounced mock codes at least quarterly to test readiness, proper sequencing of events (call 911, initiate CPR, use AED, prepare crash cart), and teamwork under pressure.
- Best Practice: following a code event, conduct an investigation that includes staff interviews, timeline reconstruction, and a full chart review. Use the findings to complete a root cause analysis and implement corrective actions with the QAPI process.

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.
• 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.

- Direct care staff should never independently manage critical symptoms (e.g., giving a snack for low blood glucose) without notifying licensed staff for assessment and follow-up.

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 – Wheelchair Transport

• Residents should be secured in wheelchairs with seatbelts during transport to prevent falls or injuries, even when the wheelchair is attached to the bus.
• Maintenance should regularly evaluate the bus and equipment needed to transport residents and document the evaluations. If equipment malfunctions or is missing, it should be replaced immediately.
• Train staff on safe driving practices, including how to secure a resident for transport, and provide training to handle emergencies.

- Consider conducting a safety check list before departure to confirm securement of chairs, functioning of lifts, and condition of wheelchair parts (e.g., arms, brakes, and footrests).

F689 – Burns

• The use of space heaters in nursing facilities is not recommended.
• Ensure that the policies for emergency preparedness address situations in which facility temperatures may be out of the required ranges.

- Ensure that supplies are available in the event of a heating emergency.

F689 – Drug Overdose

• The facility nursing staff should identify if a resident has a known history of substance abuse and establish a person-centered care plan to help monitor for concerns of self-medicating. This may include offering counseling services, support visits from social workers, care conference meetings, and identifying if residents had support in the community.
• If substance abuse is suspected, the facility should implement safety measures and notify the MD for further clinical guidance.
• Implementing proactive staff training regarding potential signs and symptoms of drug use and how to respond to situations with potential overdose will help prepare staff to respond appropriately.

F689 – Unsecured Firearms

• The facility management should educate all staff on its firearm policy.

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.

- If a medication is unavailable or missed, staff must notify the physician. Determine if an alternative medication can be ordered. Document the time, content, and response to all physician communications. Lack of documentation is treated as though no notification occurred.

F880 - Infection Control

- Ensure that the facility infection control policies and procedures address the risk of legionella and Legionnaire's disease, and any preventative interventions the facility will implement.
- Consider a facility-specific risk assessment to determine potential locations where legionella and other waterborne pathogens could grow and spread within the water systems.

- Ensure that the facility policies and procedures address what steps will be taken if legionella is detected, and ensure that all necessary supplies, including emergency water, will be available.
- Conduct regular maintenance and inspections of all water system components.
- Educate staff members on the signs and symptoms of Legionnaire's disease.
- As soon as positive Legionella results are received, the facility must take immediate corrective action, such as restricting resident use of affected water sources (e.g., showers, faucets) and providing safe alternatives.
- Collaborate with local and state health departments for additional resources.
- Consider creating a scenario for a tabletop disaster regarding legionella. How would your team respond?

Root Cause Analysis
(RCA) is essential during surveys because it demonstrates that a facility not only identifies what went wrong but also drills down into ***why*** it happened and how to prevent it from happening again. By conducting a structured RCA, leadership can uncover system failures, gaps in communication, or training deficiencies that led to an incident. CMS surveyors often apply "hyperfocus" when reviewing serious events, meaning they will scrutinize every detail of staff response, documentation, and corrective actions. Having a clear RCA process and being able to show surveyors how findings translate into corrective action plans may help mitigate citation severity.

General Comments/Recommendations:

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.

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