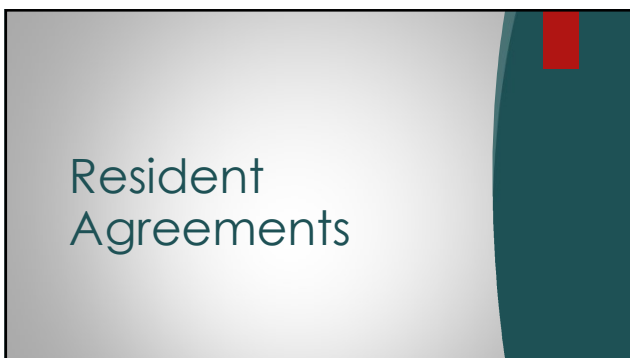




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Resident agreements must be:

- A Written Agreement;
- That is Signed and Dated;
- That Includes Certain Required Components;
- Along With Certain Policies And Procedures of the Organization.

4

The Agreement Must Include:

<p>An explanation of <u>all charges</u>:</p>	<p>Certain <u>required statements</u>:</p> <ol style="list-style-type: none"> 1. "All charges, fines, or penalties that will be assessed against you are included in this resident agreement;" 2. "The basic rate shall not be changed unless 30 days' written notice is given to you, or to your sponsor;" and 3. "We must discharge or transfer you if you need skilled nursing care beyond the limits provided by our facility." 	<p>Explanations of:</p> <ol style="list-style-type: none"> 1. The policy for refunding charges; 2. The services offered; and 3. Who is responsible for payment.
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5

Residents Must Also Be Provided Certain Policies Prior to Admission:

- A Residents' Rights policy;
- A Smoking policy;
- An Advance Directives policy;
- A Special Care Unit policy; and
- The Definition of "Skilled Nursing Care."

6

Special Care Unit Policy:

- A statement of mission or philosophy;
- Admission criteria;
- Transfer and discharge criteria and procedures;
- A weekly staffing plan for the special care unit, if applicable;
- A description of activities offered, including frequency and type;
- A listing of the costs of the services provided by the facility to the resident;
- Specialized staff training and continuing education practices;
- The process used for assessment and the provision of services, including the method for altering services based on changes in condition;
- If necessary, how the facility addresses the behavioral healthcare needs of residents;
- The physical environment and design features to support the functioning of residents;
- The involvement of families and the availability of family support programs for residents; and
- Any services or other procedures that are over and above those provided in the remainder of the facility, if applicable;
- An explanation of the facility's ability to accommodate disabled residents or potentially disabled residents and the facility's policy regarding transferring residents to units that accommodate residents with disabilities; and
- Any other facility policies that residents must follow.

7

Signature Considerations

V. Agreement Authorization

We, the undersigned, have read this agreement; have received a duplicate copy thereof, and agree to abide by the terms and conditions therein.

Dated: _____ (Signature of Resident)

Dated: _____ (Signature of Resident's Representative, if any)

Dated: _____ (Signature of Operator or His Designee)

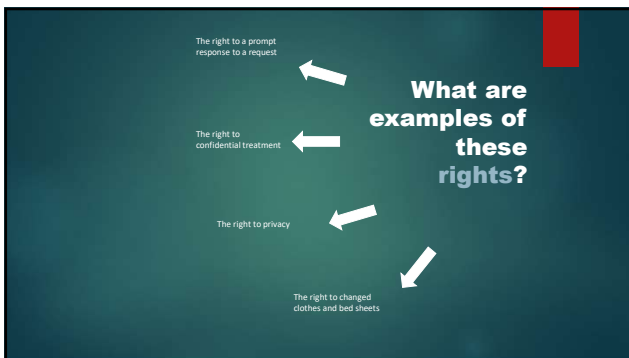
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Resident Rights

9

Residents Are Given Certain Rights By Statute. Your Facility Must Respect These Rights and Act in a Manner to Promote and Enhance Residents' Quality of Life.

10



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Restraints

12

A Residential Care Facility
Cannot Physically,
Chemically, Or Through
Isolation, **Restrain** Residents.

13

There are some limited exceptions...

a facility can
use devices
that assist a
resident in
movement;

a facility can
use
medications
that are
standard
treatment; and

a facility can
provide
residency in
a secured
unit...

without
violating
the rule.

14

Smoking

15

A residential care facility must provide each resident, upon admission, a copy of and explain its smoking policy.

16

But what goes in the smoking policy?

If your facility allows smoking, then the smoking policy must be in accordance with the Ohio Administrative Code, which allows smoking only in "properly designated areas," prohibits smoking where oxygen is stored or in use, and requires certain "no smoking".

17

Guardianships

18

If a resident is legally "incompetent" a probate court may assign a "guardian" to care for and manage the resident's assets and interests. This guardian must execute all agreements for the resident and will need to be notified of all policies and procedures to the same extent the resident must be notified.

19

What else should you know?

You should know how a guardian is different than a power of attorney ("POA").

What are other important distinctions?

"Incompetency" vs. "Incapacity"

Guardianship of a Person vs. Guardianship of a Estate

A Durable Power of Attorney for Health Care vs. a General POA

20

Transfers & Discharges

21

Residents are entitled to notice of transfer or discharge at least thirty days in advance of the proposed transfer or discharge unless certain circumstances apply.

The notice must contain certain elements and the transfer or discharge can only be for certain reasons.

22

Elements of a Discharge Notice:

- Reason(s) for proposed discharge
- Proposed date of discharge
- Proposed location for discharge
- Resident has the right to be discharged elsewhere
- Resident has the right to a hearing
- No discharge before the date in the notice
- Language and addresses for various representatives

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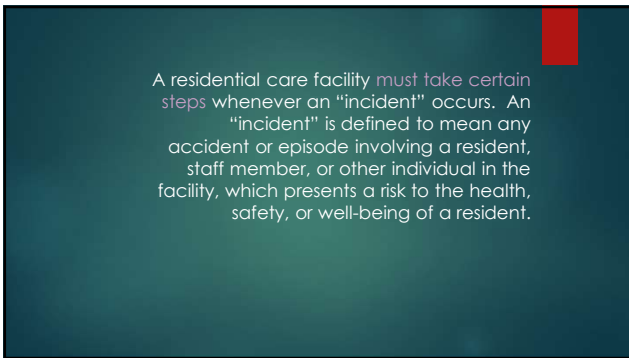
Reasons for Transfer/Discharge

- ▶ Charges for the resident's accommodations and services have not been paid within thirty days after the date on which they became due;
- ▶ The mental, emotional, or physical condition of the resident requires a level of care that the facility is unable to provide;
- ▶ The health, safety, or welfare of the resident or of another resident requires a transfer or discharge;
- ▶ The facility's license has been revoked or renewal has been denied;
- ▶ The owner closes the facility; or,
- ▶ The resident is relocated as a result of a court's order.

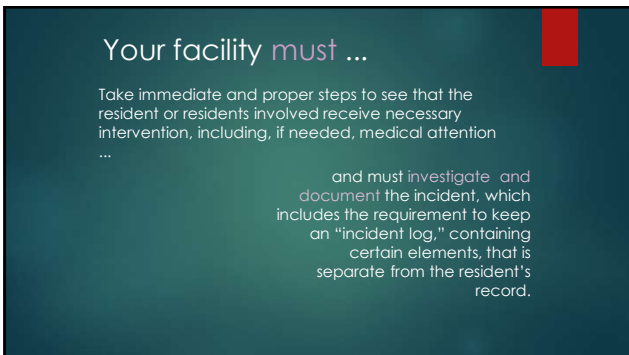
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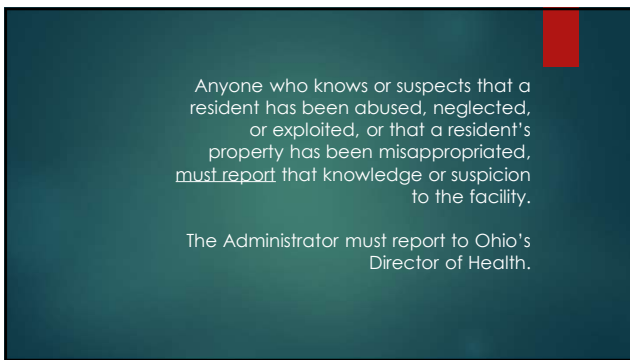
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Before an individual is admitted as a resident, the administrator shall search for the individual's name in the internet-based sex offender and child-victim offender database.

31

If the search results identify the individual as a sex offender and the individual is admitted to the home:

1. You can have a policy to not allow admission.
 - If RCF is within 1000 feet of school/childcare center you cannot admit.
2. If you do admit, develop a **plan of care** to protect the other residents' rights to a safe environment and to be free from abuse;
 - Notify all other residents and their sponsors and include in the **notice** a description of the plan of care;
 - Direct the individual to **update his registration address** and help them do so if necessary.

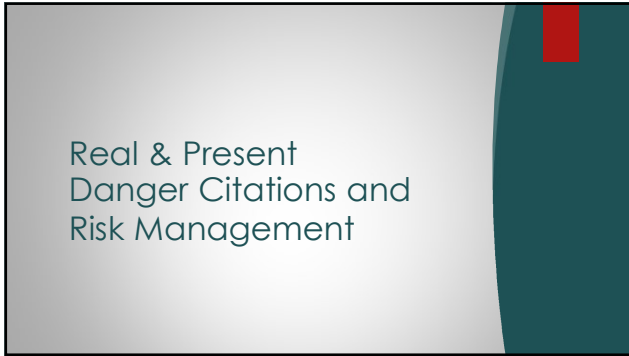
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A sex offender is defined as any "person who is convicted of [or] pleads guilty to ... any sexually oriented offense."

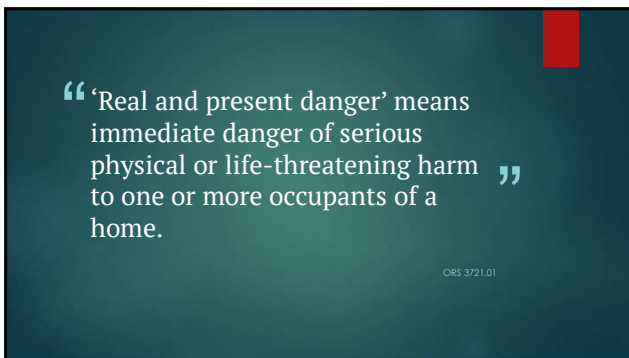
Individuals living within 1000 feet of a sex offender must be notified.

A sexual predator however is defined as any "person who commits a sexually violent offense and is likely to engage in the future in one or more sexually violent offenses."

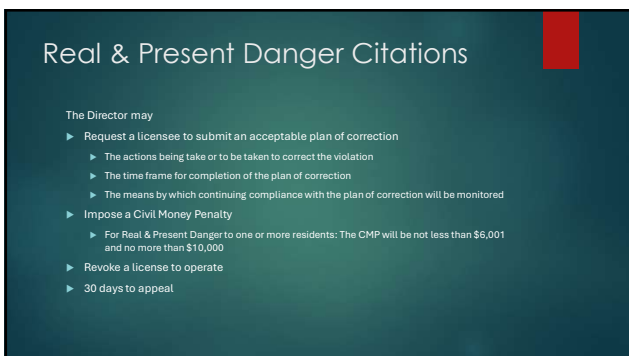
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Sexual Abuse

- ▶ Facility allegedly failed to protect residents from sexual abuse, as evidenced by incidents among cognitively impaired residents that lacked necessary supervision and intervention.

37

Alleged Findings

- ▶ Staff did not report all allegations of sexual abuse.
- ▶ Reports of abuse were raised by Ombudsman and observed by staff but not communicated to administrators.
- ▶ Failure to document and investigate these incidents allowed ongoing risk.
- ▶ Direct care staff witnessed additional non-consensual interactions, yet administration remained uninformed and uninvolved.

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Alleged Findings

- ▶ No assessments were done to determine residents' capacity to consent to sexual relations.
- ▶ Inadequate or absent interventions allowed repeat incidents.
- ▶ Lack of staff action created an unsafe environment, posing Real and Present Danger.
- ▶ -Risk of psychosocial and emotional harm extended to all residents in the memory care unit

39

Fall & Alleged Neglect

- ▶ Facility staff failed to provide essential incontinence care and safe positioning for a resident who relied on a Broda chair.
- ▶ Allegations:
 - ▶ Staff Negligence: A nurse and caregivers did not reposition or provide incontinence care for the resident during their entire 12-hour shift.
 - ▶ Inadequate Supervision: The resident was left unsupervised in her room in a reclined Broda chair, leading to the fall and subsequent injuries.
 - ▶ Medical Outcome: The resident was hospitalized with a mild/moderate TBI and required medical intervention.

40

Real & Present Danger

- ▶ Real and Present Danger presented risk of severe injury, worsened health outcomes, or death for the resident.
- ▶ Additional two residents who used Broda chairs daily were similarly at risk due to being on the same care assignment.

41

Environmental Hazards

- ▶ A hot water line froze and broke, causing water damage to a facility hallway and exposing residents to environmental hazards, including damaged drywall, exposed insulation, bare wood studs with protruding nails, and exposed electrical junction boxes and smoke detectors.
- ▶ The facility failed to initiate a fire watch after removing damaged smoke detectors, increasing the risk of electrocution, injury from exposed elements, and fire safety delays, impacting 10 residents in the affected hallway and placing an additional three residents at risk.

42

Alleged Findings

- ▶ Exposed wiring and damaged smoke detectors compromised fire safety.
- ▶ Physical hazards like exposed nails and uncovered electrical boxes created immediate risks for residents and staff.
- ▶ The facility allegedly did not implement a fire watch, leaving residents vulnerable to undetected fire hazards.

43

Ponds, Smoking, Supervision

- ▶ The facility failed to ensure the safety of a resident who was outside after dark, with insufficient staff monitoring. Resident, last seen going outside to smoke around 4:30 a.m. on 02/16/24, was found at approximately 8:05 a.m., partially submerged and unresponsive in a facility pond. This incident presented Real and Present Danger with life-threatening risks, impacting one resident directly and placing 72 others at potential risk. The facility's population at the time was 75.

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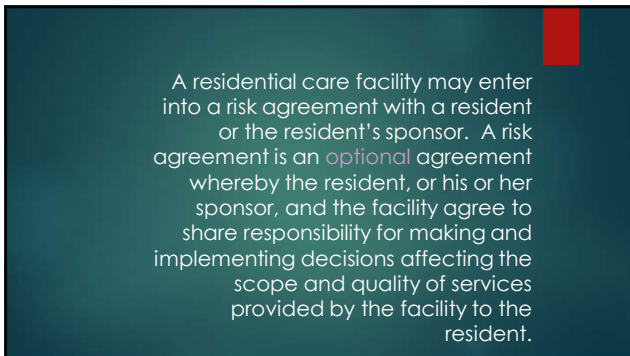
Alleged Findings

- ▶ At approximately 4:30 a.m. on 02/16/24, Resident was last seen going outside alone. Staff failed to ensure his re-entry.
- ▶ He was found unresponsive at approximately 8:05 a.m. near the facility pond after another resident noticed an empty wheelchair nearby.
- ▶ Emergency services confirmed the resident's death shortly after being found, and an investigation was conducted to determine the cause of death.
- ▶ It was noted that residents sometimes placed objects like rocks to keep doors open, bypassing the automatic locks.

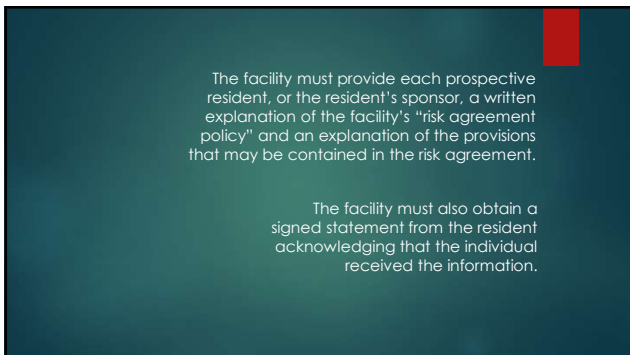
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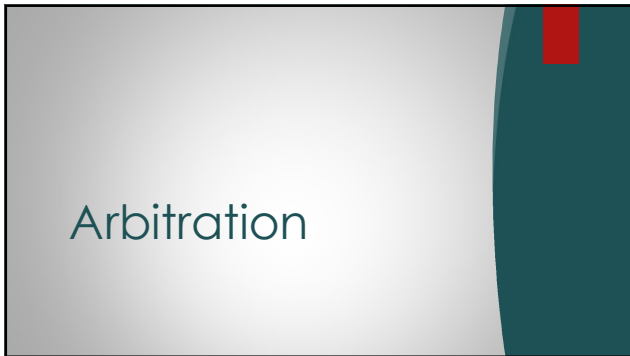
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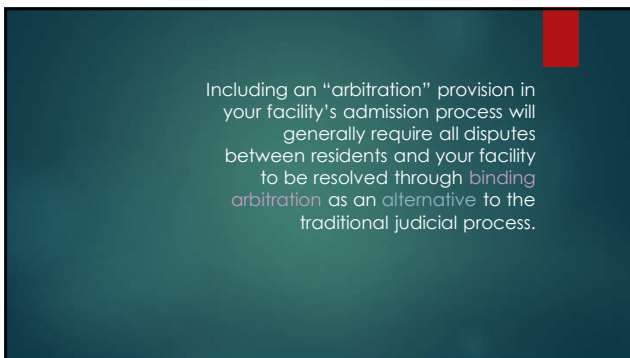
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