My name is Sandra Ketterman I have been a Registered Nurse for 46 years

Last summer I worked in Life Enrichment as an activity aide in an Alzheimer facility in Ohio. This was when families and visitors were only permitted scheduled window visits during the pandemic.

I observed resident right violations occur daily.

One female resident would be tied tight with her waist restraint to her wheelchair then wedged between a table and a wall to prevent her from standing in the wheelchair. One day she was crying and said she couldn't breathe. I summoned a nurse to help. I was told by the nurse if she could get one finger under the restraint she was alright. The restraint was loosened.

I had several discussions with the DON and Administrator uneaten food should not be left on counters hours after meals since ambulatory residents were helping themselves to discarded food trays from other residents.

Many residents requiring assistance to eat were not being fed due to insufficient staff. Much of the food landed on the floor or in their laps.

The facility did not have adequate staffing to meet the needs of residents in our most aggressive combative unit to ensure residents were free from abuse. In June 2019 state substantiated an abuse complaint in this unit.

On this same unit I saw something so horrific it made me physically ill. A female resident in her 80's had fallen many times and was now non weight bearing. During the day she was put in a common area with a mattress on the floor, out of view of nurses or staff. A rubber pad was next to the mattress. She would constantly roll onto the floor and crawl on her hands and knees or log roll 20 feet on a dirty linoleum floor to reach the door to beg for help. I voiced my concern to 2 nursing supervisors, the Social Worker and Administrator this is abuse and neglect. Many times I would find her laying on the floor with her head outside the door in the hall. This unit had many residents that paced the halls using rolling walkers and wheelchairs. I informed the Administrator she was now at risk for severe head trauma.

One morning I found her on the floor in the dinning room, asleep on top of her breakfast dishes and uneaten food. A STNA was in the room sitting in a chair playing on her phone. When she heard me gasp, she responded "It is her choice to be on the floor. It is care planned and there is a DR's order."

This resident was causing self harm on a daily basis.

I observed multiple bruises, scrapes on elbows and knees where she was crawling seeking help. Red marks on her throat and chest. She asked me "Why are they doing this to me?" and "Sandi, I don't want to live this way." I promised her I would let her husband know. Some staff felt he was not being fully informed of her living conditions condoned by mgmt.

I followed our facility policy and filed a grievance report citing her resident right to be free from physical, verbal, mental and emotional abuse and to be treated at all times with courtesy , respect and full recognition of dignity and individuality was being violated.

I received this letter from the Administrator

I quote the last sentence:

Your concerns have been investigated and after investigation I do not believe that we have violated any stated ethical and resident right policies.

I was then forced to do something staff are afraid to do. I found the husband's information online and knocked on his door. I told him he needed to get her transferred to a hospital. He informed me he did not know how his wife was being treated.

On July 23, 2020 I sent a detailed 9 page complaint to the Ohio Dept of Health. I described specifically what to look for on each unit and which staff I thought would possibly be willing to answer questions honestly.

Staff are afraid to help state investigators during complaint investigations. Most staff are “at will employees” and can be fired for any reason or no reason at all. This explains why families have such difficulty having their complaints substantiated.

There is a documentation protocol I was taught in 1975 and nurses are still taught,

“If it isn’t documented it didn’t happen.” To document the observations I described earlier would be career suicide for any nurse in this work environment.

In my experience, the state is generally required to witness allegations to substantiate complaints.

In August when state investigated, staff seemed equally frustrated and actually helped in the investigation allowing most of my allegations to be substantiated. It took me until April of this year to obtain their surveys since they are private pay and are not required to post surveys online. My main complaint, the resident made to crawl for help is not mentioned, I was informed by Rick Hoover Survey Operations Administrator this part of my complaint is still under investigation. This resident passed in August of 2020.

I hope you now understand families need the ability to monitor their loved ones’ care because staff are often unable to protect residents.

If I have left any doubt this notebook contains evidence to support my testimony.