

Division of Quality Assurance – Bureau of Assisted Living
Assisted Living Serious Violations with Enforcement
(January – June 2011)

The Division of Quality Assurance (DQA) maintains information about violations that are issued and sanctions that are imposed, which may include forfeitures against state-licensed, -certified, and -registered assisted living facilities. This report does not include all information contained in a particular survey report or in corresponding documents, and may not reflect changes that occur as a result of the appeal process or due to administrative changes. DQA protects the confidentiality of residents as required by law and no conclusions should be drawn based on the content in the report about the identity of any individual.

1. A hospice resident did not receive medication as prescribed to address labored breathing and anxiety. The resident had difficulty swallowing and the medication was not crushed as directed by the physician. Instead, the caregiver placed the medication under the resident's tongue where it did not dissolve and was later "fished out" by caregivers. Staff did not contact the hospice agency or the physician. The resident died within 2 hours. (CBRF)
2. The facility did not ensure residents received a nutritious diet. Meals were not served as planned because needed ingredients were not purchased. Foods were undercooked (e.g., raw bacon) or burned. Residents requested fruits and vegetables but were served hot dogs, fish sticks, and sandwiches. (CBRF)
3. Steps were not taken to promptly replace a resident's narcotic pain medication after 30 pills were stolen. The facility had not submitted a report to the Department and had not contacted law enforcement. After the resident was without pain medication for six days, the resident's family notified the police in an effort to authorize a replacement supply of the medication. (CBRF)
4. Staff were unaware for over an hour that a resident was missing. The resident was found lying in the snow at 11:00 p.m. when the outdoor temperature was 15 degrees. The resident was taken to the hospital with hypothermia and severe frostbite to all 10 digits of the hands. Hospital personnel indicated the resident may require amputations and the resident was not returned to the facility. (CBRF)
5. A facility did not notify a resident's physician during a six-month period when the resident fell 12 times (including falls with injury), had 2 episodes of unresponsiveness, and declined in the ability to stand and walk. The resident was not monitored for adverse reactions to psychotropic medications. (CBRF)
6. A facility did not provide adequate care to address a resident's intense pain and did not monitor side effects for multiple pain medications administered by staff. A significant decline in the resident's condition occurred due to morphine toxicity and injuries from falls. (CBRF)
7. A facility did not monitor the health of a resident receiving Warfarin (blood-thinner) and continued to administer another medication (Cipro) that interacts with Warfarin even

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after the physician issued an order to discontinue the Cipro. The resident was extremely ill over a period of days and died from a gastrointestinal bleed. The coroner's office noted that the facility continued to administer Cipro twice daily for five days, "contributing to a higher risk of severe bleeding." (CBRF)

8. An elderly resident with dementia left the facility on three occasions and was returned by police. During the third incident, the resident drove off in a caregiver's car. (The unattended car was parked outside the facility, still running, with the key in the ignition.) The resident drove 1.7 miles and then parked the car in the middle of the road and walked to a house. Outdoor temperatures were in the 20s and the resident was not wearing gloves. (CBRF)
9. A facility did not have sufficient staff to supervise residents and required residents to go to another facility (operated by the same licensee) on 6 different days. One resident "ran away" from the substitute facility because he wanted to go to his own room and place of residence. (AFH)
10. A facility did not address a resident's chronic pain despite progress notes over a 3-month period indicating the resident was yelling, screaming, and sleeping poorly and that "prn [as needed] medication was not effective." (CBRF)
11. Residents were forced to get out of bed by 4:30 a.m. for showering and to get dressed to accommodate facility staffing patterns. (CBRF)
12. Staff placed a resident in a mechanical lift chair with the chair in a reclined position and then unplugged the chair to impede the resident from getting up on his/her own. (The resident had an unsteady gait and seizure disorder and required close monitoring due to multiple falls in the past.) The resident was found on the floor, in front of the chair, with head injuries (subdural and intracranial hemorrhages) requiring nearly two weeks in the hospital. (CBRF)
13. The only caregiver on duty (housekeeper/cook) did not have the training or qualifications to meet the needs of residents with complex medical conditions. A resident fell and sustained several injuries including a serious head injury (acute subdural hematoma along right frontal, parietal and temporal regions, with significant mass effect on right lateral ventricle). The physician was not contacted and three hours elapsed before the resident was transported to the emergency room. (AFH)
14. A resident who was restless, agitated, and combative (and had a seizure disorder) was placed in serious danger when tied in bed with bedsheets by two caregivers, allegedly to prevent the resident from falling. (CBRF)
15. The facility admitted a resident with aggressive behavioral symptoms who was incompatible with the facility's client group. When an elderly resident unknowingly

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bumped the table and spilled a glass of juice, the violent resident attacked him and choked him until unconscious. The elderly resident died one week later. (CBRF)

16. A resident was attacked by another resident and sustained “scratches, gouges, and abrasions to the back, torso, and buttocks.” The caregiver on duty was not qualified to assess the resident’s injuries and no medical attention was sought for two days after the incident when the physician was contacted. (AFH)
17. The facility did not have a plan to address the needs of a resident with unstable diabetes. The resident required sliding scale insulin and had a physician’s order for “no concentrated sweets.” During the survey, the resident was served peaches in heavy syrup with cottage cheese and Kool-aid for lunch. (AFH)
18. A resident received a burn after a compress was boiled and placed on the resident’s abdomen. The facility had no documentation of medical care or monitoring of the burn. (AFH)
19. A resident with Alzheimer’s Disease left the facility undetected at 3:00 a.m. during December. When found one hour later, the resident was hospitalized with hypothermia. (CBRF)
20. An unlicensed caregiver conducted blood sugar tests and administered insulin to two residents without wearing gloves or washing hands in between. (CBRF)
21. A resident experienced swelling to her face and lower legs. The physician ordered an increased dosage of diuretic; however, staff continued to administer the lower dose for three days until the resident required hospitalization for lower extremity cellulitis. The resident was then transferred to a nursing home. (RCAC)
22. An elderly resident with congestive heart failure and diabetes did not receive sliding scale insulin as ordered by the physician. The incorrect dose of insulin was administered over 30 times in a three-month period. The incorrect type of insulin was administered 24 times in the same three-month period. An unlicensed caregiver responsible for administering medication got the resident “mixed up” with another resident. (RCAC)
23. Records indicated a resident needed staff present during toileting for safety. The resident was left alone in the bathroom and fell from the toilet sustaining a head/facial injury. (CBRF)
24. A resident alleged that a caregiver touched him/her inappropriately. The manager did not investigate or document the allegation because the manager did not believe the resident and did not want to upset the caregiver. (CBRF)

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25. A resident with dementia left the facility on several occasions without staff knowledge. In January at nightfall, the resident was found by a visitor lying in the snow by the road. (CBRF)
26. The facility did not administer a prescribed antibiotic to a resident with a urinary tract infection until three days after it was ordered by the physician. The resident had worsening symptoms including an elevated temperature, loose stools, combative behavior, and “pale, clammy skin.” (CBRF)
27. A resident was not afforded privacy with bathing. The caregiver on duty stated the bathroom door is kept open – with the resident in view of other residents – so the caregiver could complete chores and “cue” the resident to complete bathing. (AFH)
28. A facility did not ensure a resident received assessments and interventions to address the risk of injuries from falls after the resident had fallen 13 times. Due to repeat falls, the resident sustained multiple bruises, facial swelling/bruising, and a head laceration that required stitches. (CBRF)
29. The Department investigated a complaint that improper infection control practices occurred in the facility and a resident developed Cryptosporidium (a gastrointestinal illness that occurs in the feces of infected animals or humans). During the investigation, several infection control problems were observed. For example, a caregiver assisted a resident with oral hygiene and personal hygiene, flushed the toilet, and gathered soiled linens before going to the laundry room and then to the kitchen. Without sanitizing or washing hands, the caregiver rinsed out a resident’s thermos and filled it with ice and water. (CBRF)
30. A resident with weight and nutritional concerns received a physician’s order for a nutritional supplement (three times daily). The facility did not implement or follow the order and the resident did not receive the supplement for 7 months. At the time of survey, the resident was thin and frail and required oxygen support. (AFH)
31. A resident experienced chest pain, stomach pain, weakness, and abnormal bowel movements (loose, black in color). Several days elapsed before the physician was contacted. The physician ordered laboratory tests (complete blood count [CBC]). Seven days later, the surveyor requested to see documentation regarding the resident’s status and the facility had not made arrangements for the laboratory tests. (CBRF)
32. The facility did not respond timely when a resident’s foley catheter was not draining urine. After two days the resident was discovered “lethargic and his/her abdomen was firm and distended” requiring transport via ambulance to the emergency room. The resident’s bladder was drained of 2000 cc (2 quarts) of urine. The average urine output for adults is approximately 1.5 liters (1.58 quarts) per day. (CBRF)

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33. An investigation was not initiated until four days after a resident alleged she was sexually assaulted in the facility bathroom by another resident. When the allegation was reported to law enforcement, the police expressed concern about “gathering viable evidence when the alleged assault occurred four days before the police are notified.” (CBRF)
34. A caregiver was permitted to work in the facility (with the residents she allegedly abused) for 5 days after the facility became aware of the allegations. The facility then terminated the caregiver for “resident abuse” but did not report the misconduct to the Department. (CBRF)
35. Residents’ service and safety needs were unmet (e.g., residents were not toileted, repositioned, assisted, or supervised properly, etc.). The facility scheduled only two caregivers on duty to provide services (including personal cares, meals, medication management, housekeeping, and activity programming) to 20 residents with dementia. (CBRF)
36. A resident with a known choking history had symptoms of aspiration pneumonia for over a week before receiving medical care. The resident was then taken by her daughter to the emergency room and required IV antibiotic treatments. (CBRF)
37. A resident was at high risk for falls and had fallen multiple times without assessment or intervention by the facility. Following an unwitnessed fall the resident was “found lying face down on her stomach, legs fully extended...right arm above her head covered with blood... night gown wrapped around both legs. The resident had a laceration to her forehead and was bleeding from that site.” In addition to the head injury, hospital x-rays revealed a fractured pelvis. (CBRF)
38. A resident fell and called for help. The primary caregiver admitted she heard the resident call for help but chose not to respond. Another caregiver found the resident on the floor. The resident complained of pain and was moved without an assessment for possible injury. The administrator and legal guardian were not contacted and no medical care was obtained until 3 hours elapsed. The resident sustained a fractured femur and required surgery. In addition, the resident was dehydrated and had a urinary tract infection. The resident died within a week of returning to the facility. (CBRF)
39. The facility was out of needles to administer insulin so the Administrator instructed a caregiver to administer insulin to a resident with one of the previously used needles, which was obtained from a sharps container [disposal unit for contaminated, single-use needles] The used needle was retrieved from among other discarded needles, used insulin injection pens, and lancets [needles or blades used to obtain blood for testing]. (CBRF)
40. A resident did not receive adequate supervision and medications were not stored securely. The resident ingested another resident’s medications, became unresponsive, and was transferred to the hospital. (CBRF)

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41. A resident with a seizure disorder was at high risk for falls and fell more than 20 times in a year. Six falls resulted in injuries, including a head injury requiring stitches. The facility had not developed interventions to address falls. (CBRF)
42. A resident received an injury of unknown origin and complained of shoulder pain. The resident was moved about by caregivers and toileted throughout the day. No medical attention was sought for five hours, when the resident was transferred to the hospital and diagnosed with a fractured arm. (CBRF)
43. A resident was hospitalized with poor hygiene, poor hydration, and extensive bruising covering the resident's body. The bruising occurred over a period of more than 20 days and the facility had not investigated. (CBRF)
44. A resident did not receive monitoring or prescribed treatment for constipation and was hospitalized with a high colon stool impaction. The hospital course included exploratory laparotomy, colostomy, fecal disimpaction, acute respiratory failure which required intubation after surgery, rapid atrial fibrillation after surgery, malnutrition and low albumin which required Total Parenteral Nutrition, urinary retention, acute renal failure, acute blood loss requiring blood transfusion, and electrolyte imbalance. Hospital records indicated "Last bowel movement unknown – no records kept at [the group home]". (CBRF)
45. A resident who required supervision and assistance with toileting was left alone and in the bathroom and fell and sustained a head injury. (CBRF)
46. The facility did not implement procedures to ensure the safety of the home following a sexual assault. Two individuals entered the home. One took residents and visitors to a separate room in the house. The other sexually assaulted a caregiver in a back bedroom. (AFH)
47. A resident became unresponsive and was taken to the hospital, where the resident died. The facility had not maintained any records for the resident. There was no documentation describing the incident, staff response, or when emergency medical services were contacted. (AFH)
48. The facility did not provide needed supervision to ensure the safety of a resident with dementia. The resident was found on the sidewalk, pulseless and not breathing. Emergency personnel initiated lifesaving efforts and transferred the resident to the hospital where the resident was pronounced dead. (CBRF)
49. A resident required the assistance of two caregivers for transfers. Because only one caregiver was on duty, the resident remained in bed for long periods and received meals in bed. When confined to bed, the resident was unable to use the toilet. Or, the resident was required to remain in the wheelchair without repositioning or incontinence care for an entire shift. (CBRF)

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50. A facility retained an aggressive resident over a period of months without providing needed protection or services. The resident had schizophrenia and made repeated threats, frightening other residents with disturbing comments about killing and raping. It wasn't until a resident received 30 sutures to the face after being attacked (and "blood [was] spurting everywhere") that intervention occurred. (CBRF)
51. The facility had only two bathrooms for use by residents, staff, and visitors. During the entire day of survey no hand soap was available in either bathroom for use (after toileting) for caregivers, residents, and others. Caregivers were responsible for providing direct care to residents and for meal service. (CBRF)
52. The facility improperly admitted a male respite resident. Although there was a double room in the home, it was occupied by a female resident (with one full-size bed). There was no available bed (or room) for a male resident. Without consideration for the privacy of the resident or others, the male resident had to stay in the common areas of the home and sleep in the living room on the couch. (AFH)