

Division of Quality Assurance – Bureau of Assisted Living  
Assisted Living Serious Violations with Enforcement  
(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)
53. Employees reported that another caregiver had reported to work "drunk" on more than one occasion. The facility manager did not take steps to protect residents and the caregiver remained on the schedule and was assigned to administer medications to residents. (CBRF)
54. The facility manager brought her minor child to work on several occasions and did not provide adequate supervision. The child "ran in and out of resident bedrooms and threw balls at the residents." (CBRF)
55. The facility did not intervene when a resident was frightened by the aggressive actions of a roommate. The resident would not go in the shared bedroom during the day and slept in a recliner in the lounge for weeks. (CBRF)
56. The facility did not address a resident's rapid, unexpected weight loss of 10 pounds in one month (from 106 to 96 pounds) and did not notify the resident's physician. (CBRF)
57. The facility did not obtain a medical assessment for more than 48 hours when a resident was exhibiting acute symptoms of increased lethargy, shortness of breath, and a change of pallor. (CBRF)
58. A resident fell and caregivers reported the resident appeared to have an injured wrist. The facility manager did not obtain a medical assessment or notify the resident's health care proxy. When a family member visited the facility (13 hours later), the resident was transported to the emergency room with a wrist injury. (CBRF)
59. The facility did not ensure a resident was free from chemical restraints. The facility did not assess a resident's anxiety or behavioral symptoms. Lorazepam (psychoactive

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medication) was administered more than 100 times in a 4-month period. The resident experienced multiple falls, including falls with injury. (CBRF)

60. A resident experienced falls with injury including a head laceration that required stitches. After a third fall, a caregiver moved the resident from the floor to the bed and did not report the incident. A hospice worker found the resident in pain and reported the resident's leg "was rotated." (CBRF)
61. A resident was experiencing pain but prescribed pain medication had not been refilled. Staff administered pain medication prescribed for a different resident. (CBRF)
62. The facility did not provide catheter care in a manner to prevent contamination and infection. A caregiver irrigated a resident's urinary catheter with the irrigation syringe of another resident. (CBRF)
63. A family member called the facility after speaking with the resident by telephone to report the resident might be having a stroke (based on slurring words and inability to communicate). Thirty minutes elapsed before the facility called an ambulance and 40 minutes elapsed before the resident received medical care for "symptoms consistent with CVA (stroke)." (CBRF)
64. A resident had an infected/inflamed eye that was diagnosed as Pink Eye (Conjunctivitis), a condition that can be contagious. The eye was symptomatic with "puss and liquid drainage." Six days elapsed before the facility administered the prescribed antibiotic/antibacterial treatment (eight days following the onset of symptoms). While infected, the resident was ambulating about the facility and going into other residents' rooms. (CBRF)
65. On 18 occasions over a 5-day period, the facility administered a resident's prn (as needed), sedating psychoactive medication in dosages higher than prescribed. (CBRF)
66. The facility administered a resident's prn (as needed) antipsychotic medication in excessive doses on 8 days without documented physician orders. Behavioral symptoms or other justification for administering antipsychotics were not documented. (CBRF)
67. The licensee did not investigate after being informed that a caregiver "cut up" a resident's belt and pants. The allegation was reported by another employee who stated the resident was very fond of the belt. The caregiver allegedly destroyed the belt "because it made the resident look like a mental patient." (CBRF)
68. A resident with advanced dementia did not receive adequate supervision and was found outside the facility at night in a snow bank in a kneeling position. The resident "was not dressed for outdoors." Staff notes indicate the resident "was carried inside as [she was] too cold to walk." The high temperature on the date was 20 degrees and the low was 7 degrees. (CBRF)

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69. A resident with Alzheimer’s disease wandered outside in February and was found in the snow. The outdoor temperature was 26 degrees. No medical attention was sought to assess the resident’s condition. (CBRF)
70. A resident had behavioral symptoms relating to autism and severe mental retardation and would chew on his clothes. A licensee put “NaturVet Bitter Yuck! No chew Dog Spray” on the resident to prevent him from tearing his clothing with his teeth. (AFH)
71. A resident with behavioral symptoms and a seizure disorder was described as frequently “dropping, falling, or throwing himself” onto the floor and furniture. No interventions were provided to protect the resident from head injuries. After the resident experienced a seizure and “appeared dazed and disoriented,” no medical attention was obtained for more than 30 hours. The licensee stated the resident struck his head 3 or more times a week until the time of the resident’s death from a head injury. (AFH)
72. A resident was found at the bottom of a stairwell with a gash on his forehead, blood on his face, and a missing tooth that was “knocked out root and all.” No medical attention was sought for the resident until the following day when he collapsed, stopped breathing and turned blue. Emergency room staff documented the resident’s death as “due to cardiac arrest, cause unclear but head injury is suspicious as the most likely cause.” (AFH)
73. Staff did not notice that a resident (who had exhibited increased confusion) was missing for more than 3 hours. The resident was discovered by police more than 2 miles from the facility. (CBRF)
74. A caregiver witnessed a co-worker slipping a resident’s narcotic pain medication into her pocket. Another caregiver witnessed the co-worker putting a resident’s medication “in her own mouth” during a medication pass. The incidents were reported to the manager but no investigation was conducted and the co-worker remained on the work schedule, assigned to administer medications. (CBRF)
75. A newly admitted resident in fragile health was at risk for developing pressure sores due to physical immobility and incontinence. The facility did not assess risk factors or implement measures to prevent or minimize pressure sores from developing. Within two months of admission, the resident developed pressure ulcers and required skilled nursing care. (CBRF)
76. The facility did not implement needed supervision and monitoring when a resident with a history of suicide attempts expressed recurring thoughts of self-harm. The resident committed suicide in the facility and 4 hours elapsed before the resident’s body was discovered. (CBRF)

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77. A resident with dementia did not receive adequate care and services. Within three weeks of admission to the facility, the resident became unresponsive and was admitted to the hospital with dehydration and malnutrition. The resident's service plan indicated the resident required weekly weights, monitoring for fluid intake, and nutritional support. The physician asked to be contacted if the resident was refusing meals. The facility had not obtained any weights, had not monitored fluid intake, and did not notify the resident's physician or case manager when the resident refused meals for several days. (CBRF)
78. The facility did not have sufficient staff to supervise residents with dementia. When a confused resident was missing, the only caregiver on duty left the premises to search for the resident, leaving all other residents in the home unattended. While the caregiver was searching for the missing resident, a second resident with dementia wandered outside the home. (CBRF)
79. The facility did not provide adequate services to protect residents from another resident's violent outbursts. Other residents were fearful. On one occasion, the aggressive resident "began tipping over and pushing dining room tables and chairs, smashing glass vases ...one of the tables [landed on] another resident" who required medical care. The injured resident obtained a restraining order; however, the violent resident was retained by the facility for another six weeks. (CBRF)
80. The facility did not monitor the skin condition of a resident with a history of pressure sores. During survey, the nurse surveyor observed pressure wounds and asked staff about the resident's condition. The nurse and manager were unaware of the pressure sores and no treatment had been initiated prior to the survey. (CBRF)
81. Procedures were not followed to prevent the spread of infection. Caregivers removed a resident's incontinence pad and, without washing hands, provided personal cares and wound care to the buttocks and abdomen. The caregiver did not wash hands after touching the resident's buttocks and proceeded to administer the resident's medications. (CBRF)
82. A resident did not want to shower so two staff forcibly put the resident in the shower. The resident became agitated and began to struggle, her extremities hitting the shower walls and knocking over the shower chair. Staff then called a third caregiver to assist in forcing the resident to shower, generating more trauma for the resident and creating a heightened risk for injury. The resident was admitted to the hospital the following day and was diagnosed with two broken legs. (AFH)
83. The facility did not provide needed safety measures after a resident experienced 6 falls in 12 days. After the sixth fall, the resident, who was taking Coumadin (blood thinning medication), complained that her neck hurt. The resident began to experience a change of condition (drowsy, non-responsive). More than 13 hours elapsed before the resident

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received medical care and was diagnosed with a large, acute hematoma. The resident died the following day. (CBRF)

84. The facility retained a resident with a declining condition for more than 5 months without providing needed care and services. The resident developed increased confusion and impaired mobility and experienced a 27-pound weight loss (weighing 75 pounds). After being hospitalized with multiple skin ulcers and malnutrition, the resident was admitted to a hospice facility and died a short time later. (RCAC)
85. The facility did not provide or arrange services for a resident with complex needs. The resident was at risk for poor nutrition and skin breakdown and lost more than 12 pounds within 3 weeks of admission. The resident was hospitalized with severe dehydration and pressure sores. (CBRF)
86. A resident became ill and was incontinent of diarrhea in her room. The resident was admitted to the hospital and returned to the facility 5 days later. Upon return, the diarrhea had not been cleaned up and the room had not been sanitized. While in the hospital the resident was diagnosed with *Clostridium difficile* - a bacterial infection. C.diff can be highly contagious and is easily spread from person to person through touch or from contact with contaminated objects or surfaces. (CBRF)
87. The facility did not notify family that a resident's diet had been changed to pureed due to a choking risk. When family members took the resident out for dinner and ordered steak, the resident began choking. (CBRF)
88. Within 10 days of admission to the facility, a resident was transferred to the hospital with diagnoses of weight loss, failure to thrive, septic shock, and decubitus ulcers. Staff had not contacted the resident's physician regarding open sores and a weight of 91 pounds. After hospitalization, the resident was transferred to a nursing home. (AFH)
89. The facility admitted residents with needs that exceeded the facility's license class. The two-story wood frame building did not have a sprinkler system. Two residents with impaired ambulation resided on the 2<sup>nd</sup> floor and were not capable of physically and mentally responding to a fire alarm and exiting without physical assistance (as required by the facility's license). (CBRF)
90. In a review of nearly 500 shifts of duty, residents were left unattended (no staff on the premises) more than 100 times. Residents in the home required staff assistance and supervision due to diagnoses including Alzheimer's disease, Schizophrenia, and Huntington's Chorea. (AFH)
91. The facility permitted a caregiver to continue working, alone on the night shift, for 14 days after an allegation of misconduct was reported. The caregiver was then suspended. A resident who was targeted by the caregiver became increasingly anxious due to the caregiver's bullying, threats, and intimidation and "feared for his life." (CBRF)

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92. A resident was secluded to the bedroom for exhibiting behavioral symptoms of a progressive disease, Huntington's Chorea. Although caregivers knew the resident did not like to be in her room, the resident was placed in "time out" in a wheelchair that the resident was unable to propel on her own. Residents in the home were left unsupervised while meals were taken to a nearby facility. The resident with Huntington's Chorea was dependent on staff for mobility and was vulnerable to injury when left alone in the facility. (AFH)
93. A resident required tube feedings four times daily. This was not addressed on the resident's care plan and four days elapsed following admission before the resident received the tube feedings. In addition, nearly 30 dates were identified when tube feedings were not provided as prescribed. Accurate nutritional intake and output records were not maintained. (CBRF)
94. A resident had a physician's order to receive Oxycodone (pain medication), one hour prior to radiation treatments. Staff did not administer the correct dosage prior to treatments and also administered the medication at times other than those ordered by the physician. (CBRF)
95. Interventions and supervision were inadequate for a resident at risk for falls due to diagnoses of dementia and arthritis, impaired functional mobility, sedating medications, and generalized pain. The resident fell at the facility and was hospitalized with a fractured sacrum (bone at the base of the spine). Within 3 days of returning to the facility, the resident fell again and was hospitalized with a pelvic fracture. The resident died one week later. (CBRF)
96. A resident with dementia did not receive needed supervision and left the facility on two occasions, walking along a 4-lane highway to a neighbor's house. The neighbor called the police, who returned the resident to the CBRF. (CBRF)
97. A resident under hospice care did not receive needed pain medication from CBRF caregivers. The resident would moan and "yell out" in pain. Staff did not administer prescribed morphine, stating they did not want the resident to be "sleepy." At the time of survey, the resident was observed lying in bed on a urine-soaked pad. Staff reported the resident remained in bed because "she has very bad pain and does not want to move." Medication for break-through pain was not administered. The resident's care plan did not address pain, dependence on staff for hygiene and personal needs, or impaired mobility. (AFH)
98. Several allegations were made that a caregiver was going into residents' rooms at night and touching them inappropriately. The facility manager did not conduct an investigation and no protection occurred until a report was filed with the corporate office. (CBRF)

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99. A licensee falsified staff training records. Untrained caregivers were assigned to residents with complex needs due to advanced age, developmental disabilities, physical disabilities, dementia, mental illness, and traumatic brain injury. Staff had not received client-specific training, fire safety, or first aid training. (AFH)
100. Staff did not provide needed care for a resident with diabetes. Low blood sugar levels (hypoglycemia) were not reported timely to the resident's physician. The resident became nonresponsive due to a hypoglycemic reaction and was transferred to the hospital. Although the resident had been independent with Activities of Daily Living (ADLs), the resident sustained brain damage and now requires a feeding tube and cannot walk, talk, or feed herself. (CBRF)
101. A resident with dementia did not receive needed supervision and left the facility three times. During each incident, staff were unaware the resident had left the building. The resident fell outdoors, sustained a severe facial fracture and respiratory distress and had to be transported by med-flight to a trauma center. (CBRF)
102. The facility provides services to 4 residents with developmental disabilities, including a resident with severe mental retardation and cerebral palsy. The licensee used the resident's personal funds to purchase groceries, gas, a tanning gazebo, pool cleaning chemicals, camping equipment, items from New York, and campground reservations. (AFH)
103. A resident did not receive nutritional supplements ordered by the physician and was hospitalized due to deteriorating health (inability to ambulate, skin breakdown, difficulty breathing, and lethargy). Hospital records indicated a 10-pound weight loss in one month and a loss of 20 pounds since the facility had last recorded the resident's weight, about 10 weeks prior. The resident required intravenous fluids at the hospital. (CBRF)
104. Residents in the facility have complex needs, including risk of elopement, dementia, self-abusive behaviors, agitation, and unstable health conditions that require close monitoring. Untrained caregivers were scheduled for more than 100 different shifts in a 3-month period. (CBRF)
105. A resident was noted to have "foul smelling, grayish drainage" and 24 days elapsed before medical treatment was obtained. The resident became progressively weaker and stopped taking food and fluids prior to being hospitalized with a urinary tract infection and impacted bowel. (CBRF)
106. The facility did not inform a resident's physician or psychiatrist when the resident experienced changes in mental status and threatened self-harm. The resident committed suicide. Had they been notified, clinicians indicated they would have evaluated the resident to determine the need for inpatient treatment or a more secure setting. (CBRF)

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107. The facility did not conduct a pre-admission assessment and did not develop an effective treatment plan to meet the needs of a resident whose aggression was a danger to the resident and others. In addition, the facility did not address the resident's medical concerns (back pain, swollen feet, multiple medications) and impaired communication. These problems exacerbated the resident's behavioral symptoms. Within one month, the resident had to be discharged to an alternative setting. (CBRF)
108. Forty hours elapsed before a resident received a medical assessment after falling, despite complaints of pain in her left wrist. The resident was diagnosed with a fractured wrist and sprained elbow. Pain medication was not administered as prescribed. (CBRF)
109. A resident did not receive needed supervision despite progress notes indicating the resident was becoming weaker and more confused. The resident was outdoors alone when ejected from a wheelchair after rolling down a steep incline outside the facility into the street. Emergency room records described significant facial and head injuries and "a large amount of hemorrhagic blood loss at the scene." (CBRF)
110. The facility retained residents who were physically abusive to others without ensuring sufficient resources to care for the residents and protect others. For example, one resident grabbed a knife and began swinging it. When the resident attempted to attack a peer, staff "put the other resident in the administrator's office" for protection. During another incident, police were called and an agitated resident demanded to use the officer's gun "to shoot [a caregiver]." (CBRF)
111. A resident did not receive needed supervision. Staff did not know the resident was missing until contacted by police, who stated they had located an elderly woman who was confused and didn't know where she lived. Staff then searched the building and confirmed one of the CBRF residents was missing. (CBRF)
112. The manager was notified that a staff member was observed slapping a resident with an open hand. No investigation was conducted and a report was not submitted to the department as required. (CBRF)
113. Caregivers did not know which precautions to take or how to care for two tenants who were diagnosed with MRSA (Methicillin-resistant Staphylococcus Aureus). The manager told the surveyor that the caregivers "do not have the right to know when a tenant has MRSA." Manager A said the corporate office decided not to tell the caregivers because they would "freak out." (MRSA is a type of staph bacteria that is resistant to certain antibiotics...More severe or potentially life-threatening MRSA infections occur most frequently among patients in health care settings.) (RCAC)
114. A resident fell and complained of pain for 13 days before being evaluated by a physician. The resident was diagnosed with a fractured rib and hematoma of the left hip. (CBRF)

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115. Facility staff administered the incorrect sliding scale dose of insulin to a resident 7 times in 11 days. The resident was hospitalized due to unstable blood sugar levels. (CBRF)
116. Caregivers were scheduled to work alone before completing minimum training requirements. An unqualified caregiver was on duty 74 shifts in a 3-month period. Multiple problems were identified with the care and services provided to residents. (CBRF)
117. A licensee was charged with two counts of attempted first-degree intentional homicide by use of a dangerous weapon. (AFH)
118. Police were called to the facility on ten occasions. The licensee stated calls had been made due to suspected drug dealing in the neighborhood (observed from the living room window) and due to gunshots heard in the area. A resident in the home is developmentally disabled and non-verbal. (AFH)
119. Caregivers witnessed another staff member hug and kiss a resident who was being discharged from the facility. The staff member said to the resident “keep in touch even if it’s just for a roll in the hay.” (AFH)
120. A resident with dementia did not receive needed supervision and left the facility on three occasions. Police contacted the facility when the resident was found outside a restaurant at approximately 1:30 am with abrasions to the right side of the face. The first contact to the police department was initiated by an employee of the restaurant after a concerned citizen reported that an elderly [person] was standing in the rain near the intersection of two busy roads and appeared confused. (CBRF)
121. A resident was at high risk for pressure sores due to paralysis of the lower limbs, severe mental retardation, and a history of skin breakdown. Four months elapsed before the resident received medical treatment for an open sore. The wound was initially a “small sore” that progressed to “... a full thickness ulcer...50-cent sized with gray/yellow pus and red skin around the edges.” (CBRF)
122. The licensee refilled and stole 50 bottles of narcotic pain medication prescribed for a resident with developmental disabilities who was unable to communicate. When investigated by law enforcement, the licensee confessed that she had never given the pain medication to the resident in the 8 years she provided care. (AFH)
123. A resident with a history of colon cancer (and colon re-section) was at risk for developing bowel and abdominal problems. The resident was receiving blood thinning medication and medication that could cause constipation. The resident became acutely ill over a period of days. No medical assessment was obtained until the resident was transported to the emergency room “with over a week long history of severe abdominal pain, nausea and vomiting... [tests] demonstrated a bowel obstruction with

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pneumonosis intestinalis.” Surgery was performed and the resident sustained acute respiratory failure, acute renal failure and septic shock. The resident died shortly afterward. (CBRF)

124. A resident had a prescription for Oxycodone to treat pain. Compartments in the unit dose package had been cut open and the narcotic had been replaced with over-the-counter Tylenol. Documentation indicated prn (as needed) medications were administered during the night shift when residents were sleeping and had not requested medication. Employee drug testing was conducted and a caregiver on the night shift tested positive and was terminated. (CBRF)
125. The facility did not obtain immediate medical attention when a resident began exhibiting acute signs of alcohol poisoning (vomiting, increasingly nonresponsive). Nearly 90 minutes elapsed before an ambulance was called. Results of a breath alcohol test were 0.413. The legal limit of blood alcohol is 0.08. Readings above 0.40 are considered potentially fatal. (AFH)