



## ASSISTED LIVING SERIOUS VIOLATIONS WITH ENFORCEMENT – CY 2012

### Division of Quality Assurance / Bureau of Assisted Living

P-00465 (02/2013)

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 resident required prescription medication, managed by a psychiatrist, to address behavioral concerns. The clinician changed the dosage and frequency of the medication and the licensee waited nearly three months to institute the change. Further, the licensee signed as administering the noon dose of medication even though the resident was not present at the home. When asked about errors with the resident's medication, the licensee stated, "I disagree with [administering] it. [He/she] doesn't need this medication ... [he/she] is just lazy." (AFH)
2. The facility did not monitor the health of a resident with diabetes by failing to perform blood sugar testing as prescribed on 10 consecutive occasions over a five week period. The resident became unresponsive and was transferred to the hospital with a blood sugar reading of 28 (extremely critical). The resident was then admitted to a nursing home under hospice care. (CBRF)
3. Residents required ongoing supervision in the facility and in the community. The facility did not provide needed supervision and three residents left the facility unsupervised on several occasions, including when the only caregiver on duty was assisting other residents. (CBRF)
4. After facility staff improperly inserted a Foley catheter, a resident complained of abdominal pain and had no urinary output for four to five hours. The resident was transferred to the hospital where a new catheter was inserted. The resident released nearly a liter of urine. The hospital report included: "... [facility staff] should be adequately trained to address this type of issue as this is a significant burden to the health care system to take an ambulance out of service and accrue an ER visit charge along with the ambulance charges to have a Foley catheter that was not inserted correctly dealt with in an emergency department ..." (CBRF)
5. A resident developed a pressure ulcer that was bleeding, had draining, and was worsening. The physician prescribed an oral antibiotic twice daily. Six days elapsed and, despite ongoing signs of infection ("the dressing was saturated with old drainage"), staff did not administer the antibiotic until the surveyor asked why the medication had not been provided. (CBRF)
6. Seven of eight employees had not received training in standard precautions/infection control prior to being assigned work as caregivers. Caregivers have the potential to be exposed to blood, body fluids, or infections. The facility experienced a Norovirus outbreak. According to public health officials, 48% of the 59 residents at the facility were infected with the virus. (CBRF)
7. A resident fell and injured a knee. Staff refused to give the resident prescribed pain reliever when the resident complained of severe pain. Staff reported the knee was swollen to twice the normal size. Twelve hours elapsed before the resident was taken to the emergency room (ER) for medical care. The physician noted the resident was being admitted with intractable pain and was unable to bear weight. (CBRF)
8. A resident with dementia did not receive needed supervision. The resident had a history of wandering outdoors and was "unaware of danger." Police located the resident nearly a half mile from the facility. (CBRF)
9. The facility did not implement infection control measures following a suspected viral outbreak. Over a period of five days, 34 residents and nine staff experienced symptoms of gastroenteritis infection. According to health officials, at least 34 residents and 50% of employees contracted Norovirus. (CBRF)
10. Staff did not address challenging behaviors appropriately when providing care to a resident with dementia. Caregivers regularly held the resident's wrists down while providing personal care causing the resident to become more aggressive. During survey, the resident struggled to break free from the manual restraint

stating, "It hurts. My wrist hurts. Get your hands off me." One wrist was swollen and red. Staff stated, "Hospice [workers] provide cares without a problem ... they have a 'way' with [the resident]". (CBRF)

11. A resident who was at risk for skin breakdown was admitted to the facility in December with no pressure sores. The facility did not implement measures to prevent pressure sores. By February, the resident had developed pressure ulcers on the right knee, left hip, left shoulder, and right hip. The facility had no documentation (e.g., progress notes, assessment, treatment plan) addressing the resident's condition. (AFH)
12. The facility did not administer multiple doses of prescribed medication or treatments for residents with complex medical conditions. An antibiotic was not administered as prescribed for a resident with Clostridium Difficile (intestinal infection). A resident did not receive nebulizer treatments as prescribed for Chronic Airway Obstruction. A resident with Parkinson's Disease did not receive Carbidopa-levodopa as prescribed. (CBRF)
13. On four occasions, the facility "borrowed" a resident's anti-anxiety medication and administered it to another resident. (CBRF)
14. Over a period of six weeks, 11 residents reported missing money or property. The administrator did not take appropriate action and police were not notified of the thefts. (CBRF)
15. The facility did not investigate or intervene following an allegation of two caregivers being intoxicated at work. Approximately one month later, police were called to the facility and the two caregivers were found to be highly intoxicated. One of the staff was taken by ambulance with a blood alcohol level of .31%. Both caregivers had been neglectful of residents while on duty. (CBRF)
16. A facility indicated three residents monitored their own blood sugar levels and self-administered insulin injections, including sliding scale, even though their health examinations indicated the residents did not have the physical and mental capacity to do so. Over time, one of the residents began experiencing shakiness that affected his/her ability to perform blood sugar testing and administer insulin. The facility did not take appropriate action to intervene. (CBRF)
17. Over a period of seven months, the facility retained a resident who was physically and sexually abusive to 15 other residents without providing adequate supervision or behavioral interventions. The resident made "sexually vulgar" comments to female residents and exposed his genitals in common areas and in resident's bedrooms. Residents in the home expressed ongoing feelings of fear and intimidation. (CBRF)
18. A visually impaired resident with dementia did not receive adequate supervision and left the facility undetected on two occasions. Police located the resident at a nearby business and contacted the facility to ask if anyone was missing. The resident was found "confused" with a towel on his/her head and injuries to his/her hand and arm. The outdoor temperature was below freezing. (CBRF)
19. A facility did not assess a resident for pain or symptoms of injury after noting the resident's knee was swollen. The physician was not notified until two weeks had elapsed and the resident was diagnosed with a tibial plateau fracture (a break in the upper surface of the shin bone). (CBRF)
20. The facility did not intervene appropriately after a resident fell. Although the resident verbalized pain, staff proceeded to move the resident to a seated position. The resident was later diagnosed with a proximal right humerus (shoulder) fracture and right wrist fracture. The resident was placed on hospice and died two weeks later. (CBRF)
21. A resident fell five times, including incidents when the resident "hit head on wall," "sustained rib injuries," and "sustained head lacerations and bruising." Multiple medication changes had been made and the resident was not assessed for side effects that may have contributed to falls. Assessments were not completed to address a declining condition or to develop safety interventions. The resident was hospitalized and the physician noted "several medication discrepancies." Facility staff had administered the wrong medications for two weeks. The resident died within days of hospitalization. (CBRF)
22. Residents did not receive needed services, such as assistance with toileting and incontinence. One resident did not receive a shower for nine days. Residents experienced unwitnessed falls due to insufficient staff to provide support and supervision. Family members stayed at the facility overnight or kept an overnight bag in

their car due to concerns that the facility would not provide sufficient staff to meet the needs of residents. (CBRF)

23. A developmentally disabled resident required supervision within "visual distance" of staff. The facility did not provide the required supervision and, as a result, the resident jumped from a second story window sustaining a head injury. On another occasion, the resident left the facility undetected and had sexual contact with an unidentified person in the community. (CBRF)
24. A resident with dementia and diabetes left the facility unattended and was not found until the next morning when located by police over two miles from the facility, sleeping under a bush. The resident was admitted to the hospital intensive care unit in critical condition for treatment of hypothermia and bradycardia. (CBRF)
25. Residents did not receive needed services (e.g., toileting, repositioning, assistance, supervision). A facility scheduled only one caregiver on duty to provide services to 18 residents with dementia and Alzheimer's Disease. The caregiver was responsible for providing personal cares, meals, medication, housekeeping, and activity programming. (CBRF)
26. Staff did not administer multiple doses of prescribed medication for a resident, including medication to treat Parkinson's Disease, stating the "medications were not available" in the facility. The resident's physician was not notified. (CBRF)
27. A resident's physician decreased the resident's dosage of aspirin due to extensive bruising of the hands, wrists, and forearms. The facility continued to administer more than the prescribed dosage for nearly three weeks. (CBRF)
28. A resident was discovered with a large bruise to his forehead and scratch marks on his face. No investigation into the cause of the injuries occurred. (CBRF)
29. A complainant reported that medications were seen on the facility floor during visits. While investigating the complaint, the surveyor discovered medications on the dining room floor. Caregivers were unable to determine which residents had not received their prescribed doses. (CBRF)
30. A resident with dementia left the facility undetected. The resident fell on ice resulting in staples to the head and a fractured elbow which required surgery to place a rod. The only caregiver on duty was assisting another resident and did not hear the alarms go off. (CBRF)
31. Visiting family members found the resident, on more than one occasion, with feces on the body, bed, and walls. The resident would be wearing multiple layers of shirts or pants and soiled clothing was lying about the resident's room. The resident was found outside of the building, unsupervised. The medical record reflected that the resident depends on staff for care and protection. (CBRF)
32. A resident with Alzheimer's Disease experienced diarrhea for three days. Although anti-diarrhea medication had been prescribed, none was administered. In addition, the resident had recurrent back pain and emesis of bile type substance. The facility had not assessed the resident for dehydration and his/her physician was not notified of his/her condition.

On the fourth day, the resident was observed to be lethargic and appeared unwell. An hour later the resident was noted to be nonresponsive and blue by three caregivers. Sixty minutes elapsed before emergency medical care was sought. The resident was pronounced dead at the facility. (CBRF)

33. The facility was not licensed to provide services to residents with mental illnesses. The administrator admitted residents with needs that untrained caregivers were unable to meet. Residents requiring treatment or behavioral interventions exhibited increased anxiety, depression, and inappropriate or aggressive behaviors causing other elderly, frail residents to feel fearful. (CBRF)
34. Caregivers were not trained to safely assist physically disabled residents with transfers, such as to and from the toilet, bed, or wheelchair. Unsafe transfers resulted in resident falls and injuries. The facility did not include essential information in a mobility assessment for the resident, such as a physical therapist's

recommended interventions to decrease the risk of injury during transfers. During a staff-assisted transfer, the resident fell and sustained a fractured leg. (CBRF)

35. The facility failed to provide the supervision necessary to prevent recurring falls, resulting in resident sustaining shoulder and hip fractures. The resident informed hospital personnel that he/she fell at approximately 3:00 a.m. and was not discovered by staff until 6:00 a.m. Prior to the fractures, the resident was mobile, oriented, and independent. When re-admitted to the facility, the resident was unable to communicate, was dependent on staff, and was permanently non-weight bearing, requiring a mechanical lift for transfers. In addition, the resident lost use of his/her left arm, became incontinent of bladder and bowel, and had problems swallowing. The resident experienced significant pain, was at risk for bed sores, and needed to be repositioned every two hours. The facility did not re-assess the resident to address the significant changes in condition. The resident died within a week of the fall. (CBRF)
36. The facility failed to provide services to manage the resident's behavior patterns, which were harmful or disruptive to nine other residents. The resident frequently entered other residents' bedrooms and would take other residents' personal property, undressed in common areas, and got into bed with other residents. The behaviors led to physical altercations and the resident was struck in the neck by another resident. The resident's roommate experienced fear and agitation related to the aggressive behaviors and refused to sleep in the bedroom. (CBRF)
37. The facility provided services for 10 frail, elderly residents. An untrained caregiver was scheduled as the only staff member on duty for more than 40 shifts in a two month period. The caregiver had not completed basic, required training, such as fire safety or first aid. (CBRF)
38. The Department received a complaint that a resident was covered in stool and that diarrhea was caked and ground into the soles of the resident's feet. Resident has Alzheimer's dementia. Staff confirmed that resident had not received a shower for two years. Hospital records indicated the resident was admitted with persistent diarrhea, C diff\*, dehydration, and weakness, complaining of a sore bottom. Blood was present. [\*Clostridium difficile (or C diff) is a specific kind of bacterial infection that causes mild to very severe forms of diarrhea and colitis. C diff is a spore forming bacteria that is easily spread from person to person through touch or contact with contaminated surfaces.]  
  
Staff reported that the resident would take meals in the common dining room with feces on his/her body and feet. The facility manager stated "we don't give showers ... we don't provide cares." A manager confirmed that the resident had diarrhea on and off for months. The hospital nurse told the surveyor there was stool (old/dried feces and fresh) in the resident's socks and shoes and on the bottom of shoes. The nurse stated the resident was tracking feces when walking. The nurse stated, "[Resident] smelled. Then it was diagnosed as C diff, and I was thinking, 'Oh my God, do you know how contagious that is?' [Resident] looked unkempt and dirty. [Resident] did not bathe in a very long time and that was quite obvious." (CBRF)
39. A resident was discovered with bruising on his/her upper arms and shoulders. The facility had no documentation of where the bruising came from or when it first was noted by staff. A family member stated he/she did not believe the bruises were from a fall or an accident. No investigation was conducted, documented, or reported to determine if the resident had been mistreated. (CBRF)
40. A resident was feeling unwell. Without notifying the resident's physician, staff decided not to administer the resident's medications at prescribed intervals. The resident had orders for 15 different medications, including psychotropics, to address several medical and mental health conditions. After the second day without medication and with flu-like symptoms, the resident became unresponsive and was transferred to the hospital. The resident was diagnosed with Severe Anoxic Encephalopathy (brain damage due to lack of oxygen). The resident was placed on Hospice and discharged to another facility where he/she died within two weeks. (CBRF)
41. Staff wake residents at 4:30 a.m. to accommodate staffing patterns instead of the needs and preferences of residents. A note posted in the facility instructed third shift staff to "... change pads and get residents dressed each morning ... Have them dressed and sitting in the living room. Don't let them go back to bed." Interviews confirmed that caregivers wake and dress residents at 4:30 a.m., even if residents do not want to get up. (CBRF)

42. The facility did not implement an infection control program. There was a Norovirus outbreak that resulted in 75% of the residents (9 of 12) contracting the virus and experiencing symptoms of nausea, vomiting, and diarrhea. There were no paper towels in the bathrooms for hand washing. Residents' toothbrushes were co-mingled in a common container. No hand washing occurred during the noon med pass when medications were administered to 12 residents. Residents were served family-style meals in the common dining room when experiencing flu-like symptoms. (CBRF)
43. The facility did not maintain accurate documentation on the medication administration records for a resident. The resident's physician prescribed a transdermal (patch) narcotic pain medication and caregivers applied twice the prescribed dosage. The resident experienced confusion, slurred speech, and lethargy. (CBRF)
44. A resident has developmental disabilities and impaired mobility. The resident relies on staff for personal care and is at risk for developing pressure sores. The only caregiver on duty was unfamiliar with the resident's care needs. As a result, the resident was left in a bed that was "saturated" with urine while complaining of being hungry. (AFH)
45. The only caregiver on duty was called to a neighboring facility, leaving residents in the facility alone and unsupervised. While the caregiver was away, two residents had an altercation leading to one resident choking the other. (AFH)
46. The facility did not schedule sufficient staff to meet the needs of 20 elderly residents with Alzheimer's Disease. Several residents had complex medical conditions and were at risk for developing skin breakdown. Residents were not assisted as needed with toileting, bathing, dressing, and meals. Activity programs were posted but were not provided. (CBRF)
47. A resident was incompetent and had a legal guardian. A caregiver provided the resident with medications and allowed the resident to leave with a friend for three nights. No contact was made with the legal guardian and the caregiver did not get the name or contact information from the friend. There was no way to contact the resident and staff were unable to identify the person with whom the resident left. (CBRF)
48. A resident with diabetes and dementia did not receive needed supervision or assistance with hygiene and dressing. The resident stated, "My toes are falling off." The case manager found the resident wearing four pair of socks and that the second and third toes had open areas and drainage with a foul odor present. The resident had Stage III to IV pressure sores and required surgery for a partial amputation on the left foot. (CBRF)
49. A caregiver was observed using a common lancing device and a common glucometer to test the blood sugars for four residents. The caregiver did not clean or disinfect the glucometer after each use. According to the CDC, "Unsafe practices during assisted monitoring of blood glucose ... that have contributed to transmission of hepatitis B virus (HBV) or have put persons at risk for infection include using fingerstick devices for more than one person and using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses." (CBRF)
50. A resident has dementia and was not provided adequate leg care, resulting in hospitalization after developing open areas which were contaminated with maggots. Caregivers said they were not aware of the need to change wound dressings (bandages) and there was no evidence this had been done. (CBRF)
51. A resident had diagnoses including mental retardation and cognitive impairment with a known pattern of stealing food and eating too rapidly. The resident was left unsupervised in the facility while the caregiver was outdoors. The resident took a bagel from the kitchen, choked on it, and became unresponsive. The resident died due to "airway obstruction." (CBRF)
52. For more than 20 consecutive days, a resident received medications that had been prescribed for another resident and did not receive his/her own prescribed medications. (CBRF)
53. Following an allegation that a caregiver was stealing from a resident, the licensee scheduled the caregiver to work four upcoming shifts, unsupervised. The caregiver was later identified in video footage at the bank cashing the resident's checks. The resident experienced depression and expressed fear of retaliation related to coercion by the caregiver. (CBRF)

54. The police department was contacted by a local grocery store clerk who reported that a resident of the facility was in the store and had stolen a candy bar. The resident was nonverbal and was covered in feces. When the resident was returned to the facility, police officers reported that staff were surprised to discover the resident was not in the home. (CBRF)
55. A resident has diagnoses that include autism and mental retardation. Two employees witnessed a caregiver grab the resident's arm and place it behind his/her back. The caregiver raised the resident's elbow toward the ceiling stating, "Are you going to come now?" The resident's response indicated he/she was in pain. (AFH)
56. The facility was not homelike. Resident bedrooms had no window coverings and there were holes in the walls in several rooms. One resident's window was covered with a bed sheet. The window in the kitchen did not have blinds or curtains, but did have a covering over the glass which appeared similar to chicken wire. The home was unkempt and dark. The back yard of the home was fenced in and "barren." There were no trees, plantings, or outdoor furniture. Three residents use the fenced area frequently to spend time outdoors. The living room contained only a couch and television stand without a television. Door frames were splintered and broken. (AFH)
57. A resident was transported to the hospital because his/her arm was badly bruised and swollen. There was no documentation in the resident's record regarding the injury or source of injury. The facility did not conduct an investigation. Medical personnel noted the resident's arm was "broken (fractured), red (and) purple underarm ... swollen very much so." (CBRF)
58. Staff administered narcotic pain medication to a resident although the medication was not prescribed. The resident was hospitalized with "respiratory depression, was unresponsive and pale presumptively as a consequence of the pain medication administered in the facility." The resident was given another medication to reverse the effects of the respiratory depression. Side effects caused the resident to become violently agitated requiring the administration of two additional medications, Haloperidol (antipsychotic) and Lorazepam (antianxiety, sedative). The ER notes stated, "Keeping in line (with) family wishes to continue Hospice Care after treating this acute overdose. Admit for obs (observation) ..." (CBRF)
59. A resident has diagnoses that include autism and mental retardation. The resident sustained scald burns to his head, neck, shoulder, buttock, and posterior thigh from hot water in the shower. Facility staff did not immediately seek medical care, did not notify the legal guardian, and did not provide pain relief and protection of the burned area. A police report indicated: "Victim was injured while being showered by personal caregiver due to water being too hot, causing the victim to sustain first/second degree burns to head, neck, back, leg, and groin area." More than four hours elapsed before the resident received medical care and was transported to a burn center where treatment continued for nearly 20 days. (AFH)
60. The facility did not safeguard a resident who fell down a flight of stairs in his/her wheelchair. The resident died four days later. (CBRF)
61. A resident experienced a fall and was unable to bear weight and complained of pain. The facility did not assess the resident's significant change in condition. On the following day, the resident was diagnosed with a fractured tibia. (CBRF)
62. The facility did not provide food as prescribed for a resident, which included cutting the food into small pieces. An emergency room report indicated the resident choked on a large piece of food and died due to respiratory arrest, Anoxic Brain Injury-Post Cardiac Arrest. (CBRF)
63. A resident fell and hit his/her head on a table. Medical care was not sought until the following day when the resident received stitches to his/her eye and was diagnosed with an abrasion to the left cornea and a fracture to the left eye orbital bone. (CBRF)
64. A resident with dementia left the facility undetected at 2:00 p.m. and was not located until 9:00 p.m. (CBRF)
65. The facility did not complete a preadmission assessment or service plan for a resident with complex conditions and needs, including mental retardation, diabetes, depression, and a shuffling/unsteady gait. The resident was nonverbal and could not feed him/herself. (CBRF)

66. The facility did not provide needed supervision for a resident who was at risk for choking and required monitoring when eating. The resident choked while eating a peanut butter sandwich and died at the hospital. (AFH)
67. The licensee did not provide a bedroom for a resident. The resident's bed was placed in the dining room area. The room contained the facility staff computer and medical records. There were no privacy doors. The resident was observed being transferred from bed with his/her lower body exposed. (AFH)
68. The facility administered additional doses of prescribed anti-psychotic medication to a resident causing the resident to become lethargic, incoherent, and ill. The resident was hospitalized for treatment of "altered mental status secondary to medication overdose." (CBRF)
69. A resident who has multiple sclerosis and is totally dependent upon staff was observed in bed with a call cord in his mouth. The resident stated he/she is unable to use his/her hands to activate the call cord, so staff places the cord in his/her mouth. The resident told the surveyor that the cord had fallen out of his/her mouth the previous night and he/she had no way to summon help. The resident was frightened when unable to contact staff. (CBRF)
70. A resident experienced several incidences of "rough" physical handling from a non-caregiver (spouse). The spouse inserted a rectal suppository while facility caregivers observed and was "rough" during the insertion of the suppository, causing discomfort which resulted in the resident crying. Staff noticed a large, red hand mark on the resident's left upper thigh; [spouse] was trying to spread the resident's legs to get him/her to have a BM (bowel movement). The facility did not investigate or respond appropriately to an allegation of abuse by a non-caregiver. (CBRF)
71. The facility did not assess a resident's harmful behavior patterns or develop an appropriate treatment and safety plan. A resident obtained a pellet gun, brought it to the facility, shot holes in a wall, and threatened and shot at other residents. (AFH)
72. The facility did not provide adequate supervision for residents during an emergency evacuation. After being evacuated, one of the residents could not be found. The fire department received a call from a nearby apartment complex reporting the resident had wandered into the building. The resident was found in one of the fire trucks. (CBRF)
73. A resident did not receive proper care when he/she experienced a change in condition, including difficulty swallowing, pocketing medications, increased fatigue, and diminished awareness. Symptoms persisted for a week before the resident was admitted to the hospital with dehydration and a urinary tract infection. The resident was placed on hospice care and died within two weeks. (CBRF)
74. The facility did not provide needed supervision and assistance for a tenant with dementia and significant memory loss. The tenant is often searching for his/her parents (deceased) or his/her babies (now grown). The tenant wanders away from the facility at all hours of the day and night. There are numerous documented dates when he/she left the building or attempted to leave. There were at least four incidents when facility staff did not know that the tenant had left the building. (RCAC)
75. A resident was described as confused and required supervision for safety. The resident was issued a wanderguard bracelet to monitor exit-seeking behavior and prevent departures from the facility. Following a call to the local police department by a concerned citizen, the resident was found 0.68 miles away from the facility, and it was determined that the facility did not ensure the wanderguard system functioned effectively. (CBRF)
76. A resident who is described as confused and delusional did not receive needed supervision and left the facility undetected on five occasions. On one occasion, the resident was found walking down the street at 10:10 p.m., nearly a mile from the facility. (CBRF)
77. Family members arrived at the facility and discovered a belt was tied to the resident's bedroom doorknob and then to the corridor railing. The resident, who has a diagnosis of Dementia and displays exit-seeking behaviors, had been secluded in a locked room instead of receiving needed supervision and therapeutic interventions. (CBRF)

78. The facility did not ensure residents were protected from possible incidents of caregiver misconduct. A staff member identified and reported two injuries of unknown origin on a resident's upper extremity immediately after overhearing another resident "scream" and another caregiver slamming his/her door. The staff member also noticed a bruise on the resident's finger and wrist. The administrator confirmed that the resident had a recent bruise (bright purple) on his/her chest and said the caregiver "can sound harsh" when speaking to residents. The administrator said he/she did not identify this as misconduct. (CBRF)
79. The facility did not provide adequate staff to meet the needs of residents. As a result, a resident was left in bed for extended periods without repositioning and developed a bed sore. When family members asked why the resident was left in bed, staff reported, "We don't have enough hands." Residents, who required assistance and supervision with meals, including a resident who was at high risk for aspiration, were left unsupervised for extended periods. (CBRF)
80. The facility did not administer medications as prescribed. A resident receiving hospice services for end-of-life care did not receive morphine for pain relief or a prescribed anti-anxiety medication. Family members and caregivers described the resident's distress indicating the resident was in pain and moaning. (CBRF)
81. A resident is oxygen dependent and has COPD (Chronic Obstructive Pulmonary Disease). He/she has had numerous hospitalizations due to an inability to breathe and exacerbations of COPD. Caregivers did not administer medications, inhalers, and nebulizer treatment as prescribed. During a three week period, the nebulizer treatment was omitted over 30 times. (CBRF)
82. A resident had unsafe smoking habits and required supervision. Ten oxygen tanks were stored in the resident's room. Supervision was not provided and the resident lit a cigarette while using oxygen, sustained serious burns to his/her face, chest, and hands and required hospitalization. (CBRF)
83. The facility did not provide needed services to manage a resident's harmful behavior patterns. Over a period of several months, the resident physically assaulted (hit, slapped, and grabbed) other residents, causing injury. (CBRF)
84. Untrained caregivers were scheduled to work alone, providing services for eight residents for nearly 120 shifts over a period of two months. (CBRF)
85. The facility did not provide treatments and dressing (bandage) changes as prescribed for wounds on a tenant's feet. (RCAC)
86. The facility did not obtain a psychiatric evaluation for a resident with harmful behavior patterns, even though the resident's physician had ordered an evaluation. As a result, antipsychotic medication was administered inappropriately to sedate a resident with dementia. The dose was increased twice and the facility also utilized restrictive clothing and a physical restraint in attempts to control behavioral symptoms. (CBRF)
87. Tenants did not receive needed services which led to the development of pressure sores and significant weight loss. (RCAC)
88. Caregivers did not use proper infection control practices and multiple problems were identified. For example, a caregiver provided personal cares to residents, including incontinence care, and proceeded to brush a resident's teeth without proper hand washing. (CBRF)
89. A caregiver allegedly "snapped a resident's neck and kept yelling at [the resident]." Other complaints against the caregiver had been filed. Allegations were not investigated or reported and steps were not taken to protect residents. The caregiver was scheduled to work alone for more than 60 shifts over a four month period after the complaints were filed against him/her. (CBRF)
90. Caregivers did not respect a resident's right to privacy. Staff searched a resident's personal belongings on multiple occasions and made copies of the resident's writings. (AFH)
91. The facility did not investigate an injury of unknown origin after a resident was observed with a black eye. (CBRF)

92. A facility did not provide sufficient staff to meet the needs of the residents. The license capacity at the facility is 15 residents with dementia and/or advanced age. Residents did not receive needed assistance with toileting, walking, personal cares, or activities. In addition, staffing patterns (one caregiver on duty) were not sufficient to ensure a safe evacuation of the facility in the event of a fire emergency. (CBRF)
93. When the facility did not have sufficient staff to meet the needs of residents, some residents were required to go to another facility to receive care and supervision. Three residents with dementia were left in the facility with no staff present. (AFH)
94. The facility did not take steps to protect a resident from falls and injury due to a seizure disorder. The resident had a history of dropping to the floor when having a seizure. The resident experienced a seizure at the top of an open stairway and fell down a flight of stairs, sustaining a fractured neck. (AFH)
95. Untrained staff were assigned to work alone at night and were responsible for administering medications. Due to errors, tenants did not receive medications as prescribed. (RCAC)
96. The facility maintained personnel files for only three of 11 staff members. Records addressing criminal background checks and qualifications were unavailable. (CBRF)
97. A resident was described as paranoid and had no legal guardian or personal representative. The facility admitted the resident even though the resident refused to sign any paperwork. (CBRF)
98. A caregiver gave a resident 12 medications belonging to a different resident. Later in the day, the resident experienced a seizure and required hospitalization. (AFH)
99. Two bird cages were kept within five feet of the dining table and kitchen counters. One cage is kept open, permitting the bird to fly over the food preparation area and over the dining room table during meals. (CBRF)
100. Caregivers did not check the safety and well-being of a resident by completing scheduled rounds. The resident requires staff assistance and was seated on the toilet for over eight hours until discovered by day shift staff the following morning. The resident reported hollering and banging on the wall to no avail. He/she was "cold and uncomfortable ... tired and tried to sleep ... legs went numb." (CBRF)
101. A Molotov cocktail was thrown into a car on the property. The car belonged to a visitor staying overnight in the facility. Fire from the car damaged the siding on the building. The licensee did not report the incident to the Department as required. (AFH)
102. A resident was taken to meals in a shower chair and was not properly dressed or covered. The resident was not treated with respect when a caregiver said, "Got a muzzle? [He's/she's] wild this morning." (AFH)
103. A licensee intentionally abused a resident and was arrested and convicted. (AFH)
104. A resident with dementia left the facility undetected and was found by the local police department's K9 unit (police dog). The resident was found lying in a remote field of tall grass and was unable to get up or stand unassisted. (CBRF)
105. A tenant experienced a decline in condition and the facility did not provide needed services. The tenant developed a pressure ulcer on his/her buttocks. (RCAC)
106. A resident was suspected of ingesting medications which belonged to another resident. The resident's physician instructed that staff monitor the resident's condition. The facility took no further action even though the resident spent the entire day and night in bed, speaking little. At noon the following day, the resident was found unresponsive and was hospitalized. The resident was diagnosed with a stroke and never regained consciousness. (CBRF)
107. The facility did not ensure trained caregivers were on duty for more than 30 night-time shifts. Qualified staff were not on duty when a resident left the building undetected and was discovered after having fallen in the street several blocks away. (CBRF)

108. The facility did not promote the rights of residents to the least restrictive environment. Staff removed window hardware to prevent residents from opening windows in their rooms and locked a resident's bedroom door to prevent the resident from accessing his/her room. Residents were required to remain in common areas and not return to their bedrooms except during staff assisted cares. (CBRF)
109. The facility did not provide or arrange needed services to address harmful behavior patterns. Police were called to the facility to address four altercations among residents and three suicide attempts. (CBRF)
110. Residents with complex needs were left unattended in the facility while the caregiver on duty routinely went to a next door building to assist another employee. (CBRF)
111. The facility did not monitor a resident's changing condition and did not obtain prompt medical care for vomiting, changes in urinary output, and increased use of anti-anxiety medication. The resident died in the facility after paramedics were called and initiated CPR. (CBRF)
112. Staff removed a cast and discovered an open area, but obtained no treatment for the wound for eight days. (CBRF)
113. The facility did not obtain prompt medical care for a resident with profound developmental and physical disabilities. A caregiver noticed a bruise and swelling on the resident's leg. Medical care was delayed for nearly 24 hours at which time the resident was diagnosed with a fractured leg. (CBRF)
114. The facility informed a resident's family members that the resident would be allowed to remain in the facility on the condition that the family agreed to provide services to manage behavioral symptoms that may be harmful to the resident or others. (CBRF)
115. Over a period of several months, the facility retained a resident with harmful behavior patterns (yelling, hitting, and threatening) that made other residents fearful and required police intervention. (CBRF)
116. The facility did not provide sufficient services for a resident who displayed sexually disturbing behaviors over a period of months, including exposure and direct contact with other residents. (CBRF)
117. A resident with dementia did not receive needed supervision and left the building undetected. The resident was found in a ditch by neighbors and had sustained a fractured pelvis. The resident was found to be wearing multiple layers of clothing and the heat index outdoors was 99 degrees Fahrenheit. Hospital records indicate the resident was scared and anxious. (CBRF)
118. The facility retained a resident with needs that exceeded the facility's license class. The resident was non-weight bearing and relied on staff for mobility. The resident was given a pot and a wooden spoon to summon staff for assistance. (CBRF)
119. After being readmitted from the hospital with an order for pain medication, a tenant was in acute pain for four days before the facility obtained the tenant's prescription medication. (RCAC)
120. A resident was admitted to a facility with skin intact except for a sore on the ear and did not receive needed care and services. In addition, nutritional supplements were not provided as prescribed. Within one month, the resident was taken to the emergency room with six pressure sores, including an unstageable ulcer on the coccyx and three stage III ulcers on the buttocks, ankle, and heel. (CBRF)
121. The facility did not provide adequate staffing to meet the needs of residents on a memory care unit (for residents with dementia), placing residents at risk for falls with injury and contributing to unmet needs. For example, staff were unable to meet the care needs of a hospice resident who required 1:1 staff assistance to eat. Although staffing patterns were insufficient, caregivers on duty were also responsible for laundry, meal service, housekeeping, and medication administration. (CBRF)
122. A resident was having frequent loose stools and was diagnosed with C diff infection (a germ that can cause diarrhea and can spread from person-to-person). The facility did not keep dirty items separate from clean, did not adhere to contact precautions for residents or visitors, and did not implement a cleaning or sanitation program to prevent the spread of infection. (CBRF)

123. The facility did not monitor or respond to a resident's decline in condition that included multiple falls and the sudden loss of ability to walk or bear weight. Three days elapsed before a medical evaluation was obtained and it was revealed that the resident had a fractured hip. (CBRF)
124. A resident with dementia left the facility undetected when the only caregiver on duty was assisting another resident. The resident was found on the ground in a field of grass and brush near railroad tracks. The resident was taken to the hospital with a fractured ankle. (CBRF)
125. The facility did not provide needed services for a resident experiencing falls with injury. The resident was evaluated in the emergency room 11 hours after a fall-related incident during which the resident "struck [his/her] head." It was discovered the resident had bleeding in the brain and required immediate hospitalization for brain surgery. Records indicated the resident had two weeks of confusion related to acute or chronic subdural hematomas. (CBRF)