



ASSISTED LIVING SERIOUS VIOLATIONS WITH ENFORCEMENT – Jan - Jun 2013

Division of Quality Assurance / Bureau of Assisted Living

P-00465A (09/2013)

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 a Hoyer lift and the assistance of two caregivers for safe transfers. One caregiver attempted to complete the Hoyer transfer alone and used the wrong size sling. The lift overturned, causing both the resident and the caregiver to fall. The resident was transferred to the emergency room with back pain and injuries. (CBRF)
2. Injuries were not assessed or investigated for a resident who had frequent falls, but also stated he/she had been abused by staff. The resident was hospitalized with more than 40 bruises in varying stages of healing. (CBRF)
3. Caregivers did not intervene appropriately when a resident with cerebral palsy and a history of falling 'dropped' to the floor. Despite signs of pain and an inability to get up without assistance, the resident remained on the floor for eight hours without medical care because staff believed the resident was seeking attention. (CBRF)
4. A resident experienced a significant change of condition over several days, including frequent falls, emotional mood swings, and possible head injury. The facility did not notify the legal guardian of the resident's condition. Upon visiting the facility, the guardian discovered the resident's "eyes were glazed, staring upwards, and she was drooling." When the guardian sought medical care, the resident was diagnosed with compression fractures and multiple bruises. (CBRF)
5. Residents were at risk when a facility failed to complete a caregiver background check that would have revealed prior legal charges for domestic abuse, battery, disorderly conduct, operating while intoxicated (OWI), and use of a dangerous weapon. Police were called to facility while the caregiver was on duty and was intimidating and threatening others. There was a strong odor of intoxicants and the caregiver received a citation for disorderly conduct. (CBRF)
6. For two months, residents were not provided adequate supervision to meet their medication, fall risk, and transfer needs. Residents were left alone with one caregiver, who was not able to pass medications (including PRN pain medications), for several hours at a time during the overnight shift. (CBRF)
7. Developmentally disabled residents were at risk when the facility failed to take immediate steps following several allegations that the manager was being abusive. For example, the manager was seen "hitting a resident with a comb on the head while giving a haircut." The manager would "scream and yell in residents' faces or ears, grab their arms, and pull their faces so they had to look at him/her." Despite reports of mistreatment, the manager was assigned to work with residents with no restrictions for six additional shifts. (CBRF)
8. Over a period of five months, the facility retained a resident who was abusive to three other residents without providing adequate behavioral interventions. The resident would "spit, hit, throw things, takes things from other residents and urinate on them..." At times the resident was found "covered in blood" or with "smeared feces all over the room and his/her body." Residents in the home expressed ongoing feelings of fear and intimidation. (AFH)

9. A resident with dementia and a seizure disorder was permitted to smoke cigarettes outdoors, unsupervised, even though he/she had burns on fingers and clothes. The diabetic resident was at high risk for developing complications from the 'blister-like' burns; however, the facility had not sought medical care. (For people with diabetes, wounds heal more slowly and can worsen quickly.) (CBRF)
10. A resident with nighttime incontinence did not receive needed services during the overnight hours. Instead of being assisted by caregivers to use the bathroom, the resident was doubled up with incontinence briefs and was told not to get out of bed at night. (AFH)
11. A resident was denied recreation and socialization as punishment for failing to complete "assigned tasks." Caregivers insisted the resident eat foods the resident disliked until the resident cried and asked, "Why don't you like me?" When the resident requested less food, a full plate was served and the resident had to 'clean the plate' even after stating he/she was full. (CBRF)
12. A resident with history of refusing showers had developed skin rashes that occurred in the folds of the stomach, back, and groin area. The resident did not receive needed skin care or bathing, nor was medicated cream applied as prescribed. The resident was admitted to the hospital with chronic abdominal and left back fungal infection, as well as significant wounds on the abdomen and back. (CBRF)
13. The facility failed to revise a resident's care plan to ensure needed supervision to prevent choking during meals. The resident choked while unsupervised and died. (CBRF)
14. A resident was transferred to a nursing home where staff discovered extensive bruising on the resident's chest, breasts, rectum, and bottom. The facility administrator reported that he/she was not aware of the resident's bruising and was "shocked" when shown photos of the bruising by local law enforcement. (RCAC)
15. The facility failed to protect vulnerable residents after admitting a physically aggressive resident to the facility. The resident (who was a former boxer) hit another resident (who had dementia) several times, requiring police intervention. During a subsequent incident, the two residents were in the parking lot unsupervised when the second resident was punched in the face. The resident fell to the ground, hitting his/her head on concrete. The resident was taken to the hospital and diagnosed with a subdural hematoma and later died from "... complications from a closed head injury - Homicide." The facility retained the aggressive resident without providing additional supervision or services to ensure the protection of others. (CBRF)
16. The facility's only toilet was broken and repairs were not made for two days, during which time residents and employees were directed to urinate and defecate in plastic bags inside a portable commode. Staff disposed of the waste in a garbage can outside of the home. (AFH)
17. Staff drove disabled residents in a van that was in significant disrepair. The wheelchair safety belt and wheel locks were broken for almost a year resulting in an inability to secure the wheelchairs when the van was moving. A staff member stated, "I got used to driving with one arm back, because sometimes (the resident) would roll forward. I had to catch her." The mechanical lift and ramp were rusty and not functioning properly, so the staff had to physically grab and hang onto the top of the lift to lower the wheelchair ramp to the ground; the side door handle was broken and had a white rope tied to it to open and close the door. (AFH)
18. A tenant required the assistance of two caregivers for transfers. Only days after an unwitnessed fall, the tenant was transferred by a single caregiver, causing the tenant to fall again. The tenant died two days later from injuries. (RCAC)

19. The facility did not provide services to address fall prevention. After falling six times, one resident sustained a hip fracture and died following a month in a nursing home. Another resident fell and sustained a humeral (arm) fracture and nasal fracture. The licensee stated, "What do you want me to do --- we're not a nursing home?" (CBRF)
20. A resident with a mental illness diagnosis and a "high potential for elopement" did not receive needed supervision. The resident was found by police walking on the interstate, a mile away from the facility. Caregivers were not aware that the resident was missing. Approximately an hour later, the resident eloped again and was found at a hospital in a delusional state. (CBRF)
21. A resident with diagnoses of developmental disabilities and emotional disturbances required 24-hour supervision due to risk of elopement and a history of getting up during sleeping hours. He/she did not receive needed overnight supervision and left the facility, undetected. The resident was locked out of the building wearing only socks and pajamas in below freezing temperatures until 4:00 a.m., after a concerned citizen contacted the police. (AFH)
22. Caregivers locked a resident in an unauthorized isolation/seclusion room for more than six hours. A second resident, who was taken to the isolation/seclusion room, became increasingly agitated and began to "bang [his/her] head on the door and window." Caregivers restrained the resident with an improper, unsafe physical hold for over three minutes. (AFH)
23. A tenant with diabetes, who was non-ambulatory and dependent on caregivers for all transfers, was left alone and immobile inside an apartment for 21 hours. The tenant was found by a visitor the next morning. He/she "did not receive insulin or any food or care... [the tenant's] clothing and wheelchair seat were soaked with urine." (RCAC)
24. The RCAC service manager did not take appropriate steps when he/she failed to notify the police about thefts in the facility. Thefts continued until two tenants filed a police report. (RCAC)
25. Although a resident hit his/her head during an unwitnessed fall and was showing signs of trauma (bruising and bleeding), the facility did not obtain prompt medical care. The resident was taken to the emergency room over 11 hours later. The resident was diagnosed with subdural hematomas and required hospitalization and surgery. (CBRF)
26. Caregivers had not been trained to monitor a resident with a high risk for choking and failed to recognize symptoms that the resident had aspirated. The resident showed signs of discomfort for several days without staff intervention until becoming non-responsive. An emergency room physician stated the resident "must have had multiple episodes of aspiration while at the facility as evidenced by the quantity and color of the secretions being drained from resident." (AFH)
27. Caregivers did not provide prompt intervention when a resident with complex medical conditions was ill for two weeks and was described as "very out of it; not eating; difficulty swallowing." When the resident was found unresponsive in his/her bedroom, caregivers did not obtain immediate, emergency medical care. When managers arrived at the facility, paramedics were contacted and the resident was pronounced dead. A caregiver stated the resident did not want to be resuscitated. In fact, an advanced directive in the resident's record indicated the resident wanted to be resuscitated. (CBRF)
28. A resident reported that "a caregiver took me around the corner, so no one could see, and rammed my head into the wall four times." The resident was evaluated in the emergency room for a laceration, large bruises, and a bump over his/her eye. The licensee neglected to investigate the allegations or take steps to remove the caregiver from the facility to ensure the safety of the residents. (CBRF)

29. A facility did not monitor or obtain proper health care for a resident with diagnoses of edema, cellulitis, and dementia. The resident's foot became gangrenous, requiring amputation. The resident's changing condition had not been assessed or documented. Staff did not obtain consultation with a vascular specialist as ordered by the resident's physician. The resident died in the hospital following the amputation. (CBRF)
30. The guardian and a caregiver at the day program reported to the facility that a resident with profound developmental disabilities had right arm and shoulder pain and bruising. Six days elapsed before the resident received medical care and was diagnosed with a fractured right humerus (arm). Caregivers could not explain how or when the injury occurred. (CBRF)
31. Criminal background checks were not completed, as required, for an administrator who was hired by the licensee to oversee three facilities. The employee had been convicted of defrauding the Wisconsin Shares Program (state's taxpayer-financed child care program) of over \$950,000 and a court order prohibited the employee from working in or for an entity that received public funding. (CBRF)
32. A resident with a traumatic brain injury and history of elopement did not receive needed supervision and left the facility undetected after stealing medications that were not properly secured. The resident's whereabouts were unknown for 17 days. (CBRF)
33. A resident required the use of a Hoyer lift for safe transfers. A caregiver transferred the resident without the Hoyer lift causing the resident to fall and hit his/her head. The resident was transferred to the emergency room several hours later and was diagnosed with a traumatic brain injury, subarachnoid hemorrhage, and right humeral fracture. (CBRF)
34. The licensee was the only caregiver on duty 24-hours a day, 7 days a week, without back up or respite support to care for four elderly residents, all of whom required significant assistance with ADLs (activities of daily living) and needed continuous supervision. (CBRF)
35. Regardless of individual preferences, a resident who needs the assistance of two caregivers for transfers was required to remain in bed until 10:00 a.m. when a second caregiver arrived on duty. Caregivers put the resident back in bed at the end of the second caregiver's shift. Caregivers could not explain how the resident would be evacuated in an emergency when only one caregiver was on duty. (CBRF)
36. The facility did not provide adequate staffing to meet the needs of a resident who had multiple falls and required overnight care and supervision. The resident fell at 4:30 a.m. and sustained an injury. ("He/she had a carpet burn and was unstable on his/her feet.") The resident was left on the floor until the next shift when a second caregiver arrived. (CBRF)
37. A caregiver placed a Nitro-Patch, medication used to prevent chest pain in individuals with a heart condition, on a resident for whom the medication was not prescribed. Caregivers did not notify the resident's primary physician of the medication error. The patch found on the resident was neither initialed nor dated according to protocol to determine dosage or duration of the medication error. (CBRF)
38. Caregivers implemented a nontherapeutic, punitive behavior management program that caused a resident's aggression to escalate. As a therapeutic approach, residents earn "stars" as incentives for positive behaviors. Instead, caregivers would take the resident's "stars" if the resident was determined by staff to be "uncooperative or inappropriate." In addition, the resident was on a fluid restriction program to address incontinence. The facility did not have a plan to allow fluids upon

request and frequently denied fluids, which exacerbated the resident's anxiety and behavioral symptoms. In his/her distress, the resident ran away (eloped) from the facility. (CBRF)

39. A developmentally disabled resident reported that [co-owner] "screamed and yelled at him/her to 'Wake the f _ _ _ up, you son-of-a-bitch'." Staff members verified that the "[co-owner] screamed at [resident], making [resident] cry." Despite reports of abuse, allegations were not investigated or reported and steps were not taken to protect residents for three months after the incident occurred. (CBRF)
40. A resident with advanced Alzheimer's disease did not receive adequate supervision and left the facility undetected in frigid temperatures (a low of 7 degrees). The resident was wearing only slacks, a shirt, and slippers. Although resident required scheduled checks of his/her whereabouts, caregivers did not check on the resident after 1:00 a.m. and he/she was discovered deceased outside at 8:05 a.m. (CBRF)
41. The licensee did not schedule awake caregivers at night. A resident with severe mental illness did not receive adequate supervision overnight and left the facility undetected, at least eight times in a two-month period, requiring police intervention. During one incident, the resident was found 4.8 miles from the facility. (CBRF)
42. The facility failed to monitor blood pressure readings and administer antihypertensive medications for three consecutive days. On the fourth day, the resident was hospitalized with dangerously elevated blood pressure and complaints of blurred vision and weakness. The resident was diagnosed with a left occipital lobe CVA (stroke) and atrophy. (CBRF)
43. A resident with poor hand control had a history of spilling hot coffee on his/her abdomen. The resident was left alone after being given a cup of hot coffee and was subsequently heard yelling. The coffee spilled on his/her right arm and chest wall. The resident was taken to the hospital with first and second degree burns. (CBRF)
44. Twenty-two days elapsed before the facility obtained a new prescription medication to relieve a resident's anxiety and agitation. (CBRF)
45. The facility did not follow infection control practices when a tenant was diagnosed with Clostridium difficile (C-diff) for the third time. (C-diff can be highly contagious. It is easily spread from person to person through touch, from contact with contaminated objects or surfaces.) The tenant was incontinent of loose stools and propelled the wheelchair throughout the facility, "leaking feces," for several days. (RCAC)
46. Over a period of two months, the facility retained a resident who was repeatedly physically and sexually abusive to other residents. Other residents were injured and expressed ongoing feelings of fear and intimidation. The resident exposed genitals in common areas and punched a female resident in the face. During an aggressive outburst, a female resident was "pinned to the wall." The resident held his/her hands over the mouths of other residents, saying, "Shut the hell up." The resident kicked, slapped, and spit on other residents without provocation. (CBRF)
47. A facility admitted residents from multiple client groups, including residents who were assaultive and violent, thereby creating conditions of risk for frail, elderly residents and those with dementia. Police were called to the facility and, on different occasions, used a taser to subdue a resident and placed residents in handcuffs. The licensee stated, "All we do (the facility) is keep them (residents) here and we follow the county instructions. All we want to do is keep them sober." (CBRF)

48. The facility had only one caregiver on duty, despite admitting and retaining a resident who required the assistance of two staff members. The resident was assisted from bed only during changes of shift (when the caregiver for the upcoming shift arrived). Although normally continent, the resident was required to urinate in bed when the sole caregiver on duty could not assist the resident to the toilet. In addition, the resident could not be safely evacuated from the building in the event of an emergency. (CBRF)
49. A resident with dementia exhibited behavioral symptoms, including putting foreign objects in the toilet. Instead of providing adequate supervision and an effective behavior support program, the facility locked the resident's bathroom door. This occurred even though a note was posted in the resident's room reminding the resident of the bathroom's location. The resident began urinating and defecating in the wastebasket and on the floor in his/her room. (CBRF)
50. The facility did not provide sufficient staff to meet the toileting and personal care needs of residents. Residents were urine-soaked and developed open sores due to incontinence. (CBFF)
51. A caregiver provided personal care to a resident in the following sequence without properly washing hands or using hand sanitizer: emptied a catheter of urine, washed the resident's perineal area and buttocks, assisted the resident with dressing and grooming, transported the resident to the dining room, and then washed hands in the kitchen. (CBRF)
52. The licensee admitted residents from incompatible client groups (advanced age, sex offender, substance abuse) and failed to provide supervision and services to ensure safety. There were multiple incidents of violence involving other residents and police were called to the facility on several occasions. Elderly residents said they were scared. An emergency room nurse stated, "Would you want your family member in a room next to someone making homicidal threats and ... having flashbacks to his incarceration ...?" (CBRF)
53. Caregivers did not administer prescribed medication to treat hepatic encephalopathy, a condition that can lead to coma and death. Hepatic encephalopathy is caused by an accumulation of toxic substances in the blood stream, including ammonia. Untrained caregivers did not understand the significance of failing to provide treatment. The medication promotes peristalsis (movement of stool) and decreases ammonia levels within the colon. The resident experienced a significant change of condition, including disorientation and disturbed gait, and required hospitalization. (CBRF)
54. Caregivers did not take steps to prevent injury for a resident who rolled from bed multiple times. The resident fell and struck his/her eye on the edge of a dresser (sustaining dark red bruising, which extended over the upper and lower lids and across the left cheek). The sole caregiver on duty left the resident on the floor for an undetermined period of time until a second caregiver returned to the facility to assist. Caregivers did not notify anyone of the incident. Arrangements for medical evaluation of the resident's head injury were not made for nearly ten hours following the incident. (CBRF)
55. A resident experienced worsening bed sores on the buttocks, elbow, and spine for more than two weeks before the facility contacted the resident's physician. (CBRF)
56. Two residents were awakened at 4:30 a.m. for the benefit of staff. The residents were showered, dressed, and placed back in bed by night shift caregivers. One resident, described as "a night owl [who] sometimes does not like to get up early in the morning," was forced to wake for showering before 5:30 a.m. for a period of two years. (CBRF)
57. A diabetic resident had a physician's order to have fingernails trimmed weekly and toenails trimmed every two weeks. The resident also had an order for a special glove to prevent bruising and

scratching. Caregivers did not trim the resident's fingernails or toenails since the time of admission (over three months). (CBRF)

58. A resident with Alzheimer's disease and impaired vision did not receive needed supervision. The resident wandered from the facility and fell in a store parking lot. The caregiver on duty was not aware the resident was missing until a family member called at 10:00 p.m. to say the resident had been found by bystanders, unconscious and bleeding. The resident sustained facial fractures and a broken arm. (CBRF)
59. A caregiver was witnessed being verbally and physically abusive to a resident, including pinning the resident's arms behind his/her head, resulting in extensive bruising. The administrator did not investigate or report the abuse. The abusive caregiver was assigned to work with residents in a different facility. (CBRF)
60. Residents did not receive needed showers. One resident was assisted with showering only once in a two-month period. Another resident required weekly showers and was assisted only three times in an eight-week period. (CBRF)
61. A resident with dementia wandered from the facility in unsafe conditions several times. On one occasion, a 4½-hour search was conducted before the resident was located eight miles away from the facility. Caregivers reported the resident, "would have absolutely no idea how to return home once he/she began walking." (CBRF)
62. A resident alleged that a caregiver hit the resident in the face during a shower stating he/she (caregiver) told the resident that he/she "wanted to draw blood." A reddened area was observed on the resident's face. The facility denied that abuse occurred; however, an investigation conducted by the resident's case manager substantiated abuse. (AFH)