



ASSISTED LIVING SERIOUS VIOLATIONS WITH ENFORCEMENT – Jan - Dec 2013 Division of Quality Assurance / Bureau of Assisted Living

P-00628 (03/2014)

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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 with dementia and diabetes had a history of going for walks and “getting lost for hours.” Despite the known risks, caregivers did not provide needed 24-hour supervision. The night shift caregiver on duty stated s/he had not checked on the resident and assumed the resident was sleeping. The caregiver said s/he had received no training about monitoring residents at night other than “to just look down the hall.” The night shift caregiver had never met the resident and “had no idea what [s/he] looked like.” The resident walked away from the facility in the middle of the night and was found “lost in the woods” three days later. The resident had fallen over a log and was stuck, calling out for help. (CBRF)
2. A resident experienced a change of condition that was consistent with signs of valproic acid and/or lithium toxicity over a period of six weeks. Staff at the residents’ day program urged facility caregivers to have the resident medically evaluated due to ongoing weight loss, the development of tremors, complaints of dry mouth, lethargy, slurred speech, shaking, dizziness, and unstable gait. The provider did not obtain prompt medical care, and the resident was later hospitalized with a diagnosis of idiopathic normal pressure hydrocephalus, requiring shunt placement, valproic acid toxicity, and lithium toxicity. (CBRF)
3. Residents did not receive assistance with toileting or proper care for incontinence. Residents were “triple padded” with three Depends (incontinence briefs) and were left in wheelchairs for five to six hours at a time without toileting. To change wet or soiled Depends, caregivers had the residents stand from the wheelchair and lean over a bed. Caregivers then removed the first of the three Depends, wiped the resident’s bottom, and applied another (third) Depends brief. (CBRF)
4. A resident’s physician issued an order for a lower dose of lithium. Caregivers continued to administer the higher dose and failed to obtain timely lab tests as ordered by the psychiatrist. The resident experienced changes in mental status, became unstable, fell and sustained a head injury, and required hospitalization for lithium toxicity. (CBRF)
5. A resident with complex mental health needs expressed high levels of anxiety, was overwrought with fear of being punished, and felt desperate to leave the facility. Caregivers did not provide needed supervision. The resident jumped from a second story bedroom window to a paved area. A passerby found the injured resident. More than five hours later, caregivers learned the resident had been hospitalized with both heels shattered and the right leg broken in several places. (CBRF)
6. Despite recurring allegations of abuse, the licensee failed to investigate after a resident was hospitalized with a broken nose. Records indicated that the resident’s “nose appeared to be cracked” and that the resident could not explain the injury. The licensee told the surveyor that “no one saw anything,” so no interviews or further investigation had been conducted. (CBRF)
7. The provider retained a violent resident without assuring the protection of other residents. The resident struck and injured other residents by punching, hitting in the face, breaking glasses, and grabbing hair. Caregivers would barricade passageways in the home with furniture to prevent the aggressive resident from attacking others and to prevent the resident from leaving the home. There were multiple occurrences over time, requiring intervention by law enforcement. (CBRF)
8. A provider did not arrange needed services for residents with unstable diabetes. For example, caregivers did not monitor blood sugar levels for a resident with sliding scale insulin. A caregiver reported, “I don’t know how anyone would be able to give sliding scale insulin if they did not check blood sugar levels.” Caregivers were assigned to administer insulin even though they had not been trained and the task had not been delegated or supervised by a registered nurse. (CBRF)

9. Despite the hospice nurse “educating and re-educating” caregivers about incontinence care and the risks for skin breakdown and discomfort, caregivers “doubled” incontinence briefs on residents at night in lieu of changing a wet brief or providing assistance with toileting. (CBRF)
10. A resident with a brain injury, seizure disorder, and diabetes did not receive needed supervision and was found by a neighbor “in a ditch with [the] wheelchair overturned.” (CBRF)
11. The provider did not conduct an assessment of possible safety risks or ensure proper installation, prior to permitting the use of a Bed Valet (bed rail), for a resident with dementia and mental status change. The resident died from accidental strangulation after becoming entangled in the bed rail. The medical examiner’s report described brain death due to compromised blood flow through the carotid arteries...the resident’s body and covers were noted to be on the floor while the resident’s head was caught in the Bed Cane/Valet.” (CBRF)
12. A resident experienced a series of falls, and the provider did not complete an updated assessment or service plan and did not implement measures to reduce the risk of injuries. Due to continued falls, the resident sustained a fractured vertebrae and a closed head injury. (CBRF)
13. A provider admitted a resident with end-stage renal disease without proper preadmission planning and, within a few weeks, determined they were unable to meet the resident’s needs. Without providing written notice or discharge planning, the provider refused to readmit the resident following a hospital stay. The provider’s failure to plan and provide notice contributed to end-of-life trauma for the displaced resident and his/her family. (CBRF)
14. A provider did not arrange needed supervision for an elderly resident with dementia who was immobile following a stroke, had a seizure disorder, and was legally blind. The resident did not receive needed supervision when left unattended outside the facility. While in a wheelchair, the resident fell over a steep embankment and sustained multiple head lacerations and injuries to hands, arms, and knees. (CBRF)
15. A resident with dementia became entangled in bed rails on multiple occasions with incidents of getting his/her legs “stuck in the rails.” The provider did not address safety concerns despite the high risk for injury or death from entrapment. (CBRF)
16. The provider did not conduct a follow-up investigation after a resident reported a female staff member took the resident “around the corner so no one could see and rammed my head into the wall four times.” (CBRF)
17. The police found a resident wandering in a neighborhood, ringing doorbells. The resident had fallen and “appeared extremely disheveled with grass/dirt stains on pants and shoes on the opposite feet...did not know where [s/he] lived and complained of head pain and discomfort from being out in the cold for an unknown, extended period of time.” When police contacted the CBRF, the caregiver on duty was not aware the resident had been missing. Police “informed the caretaker of [the resident’s] whereabouts and condition.” (CBRF)
18. Twenty-three residents were housed in a locked unit for two months after the Department had denied the provider’s request to operate a secured area. Of five residents reviewed, only one had a court order for protective placement that specified the need to reside on a locked unit. (CBRF)
19. At 3:00 a.m., police contacted the caregiver on duty to ask if [a resident] was missing. The caregiver replied, “[s/he] must be if you got [him/her].” Caregivers were aware the resident had harmful behavior patterns but did not provide the required supervision. (CBRF)
20. A resident with a brain injury and memory loss did not receive needed supervision and was missing from the facility for over two hours until located at a convenience store nearly three miles away. A cab driver who returned the resident to the facility stated the resident was “completely lost.” (CBRF)
21. Caregivers were unaware a resident was missing until a neighbor contacted them to report that a resident had fallen and was on the ground bleeding. The resident was unable to describe where s/he was or what had happened. (CBRF)
22. A resident with diagnoses of mental retardation and schizophrenia reported to two caregivers that s/he had been sexually assaulted by another resident. The caregivers took no immediate action, waiting three hours to discuss

the incident with the oncoming third shift caregiver. The third shift caregiver then contacted the manager. The police were not contacted and medical treatment was not obtained until the next day, a lapse of approximately 18 hours after the alleged assault took place. (CBRF)

23. Despite a caregiver sticking themselves with a needle while administering insulin to a resident, untrained caregivers were assigned nursing tasks (injections and nebulizer treatment) without proper delegation or supervision by a registered nurse. (CBRF)
24. An elderly resident with dementia did not receive needed supervision and drove away from the facility in a caregiver's unlocked vehicle. The keys had been left in the ignition. The resident ran a red light and struck another vehicle at an intersection located more than 45 miles away from the CBRF. Police were called to the scene and reported that the resident had no recollection of where s/he was, whose car s/he was driving, or that s/he had just been involved in an accident. (CBRF)
25. A provider 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 is keep them (residents) here, and we follow the county instructions. All we want to do is keep them sober." (CBRF)
26. 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. One caregiver could not safely evacuate residents from the building in the event of an emergency. (CBRF)
27. A resident with dementia exhibited behavioral symptoms, including flushing inappropriate items in the toilet. Instead of providing adequate supervision and an effective treatment program, the provider locked the resident's bathroom door. This occurred even though a note was posted in the resident's room as a "cue" for the resident identifying the bathroom location. The resident began urinating and defecating in the wastebasket and on the floor in his/her room. (CBRF)
28. The provider did not arrange sufficient staff to meet the toileting and personal care needs of residents. Residents were urine soaked and developed open sores due to incontinence. (CBFF)
29. 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 sink. (CBRF)
30. 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 frightened. 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)
31. 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)
32. 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 10 hours following the incident. (CBRF)
33. 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)
 34. Two residents were awakened at 4:30 a.m. for the benefit of caregivers. 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)
 35. A resident with diabetes 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 had not trimmed the resident's fingernails or toenails since the time of admission (over three months). (CBRF)
 36. 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 to say the resident had been found by bystanders, unconscious and bleeding, in the dark at 10:00 p.m. The resident sustained facial fractures and a broken arm. (CBRF)
 37. 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)
 38. 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)
 39. A resident with dementia wandered from the facility on several occasions, without needed supervision. On one occasion, a 4½-hour search was conducted before the resident was located eight miles from the facility. Caregivers reported that the resident "would have absolutely no idea how to return home once s/he began walking." (CBRF)
 40. A resident with dementia left the facility, unsupervised. Caregivers didn't know the resident was missing until "a lady pulled up outside with the resident in the passenger seat and said that she had picked him/her up from the side of the road and brought him back." (CBRF)
 41. A resident with dementia fell and sustained a wrist injury and did not receive prescribed pain medication. Staff did not assess the resident's pain despite "severe pain and swelling" over several days. The failure to take steps to alleviate pain caused the resident to become agitated and behavioral outbursts increased. (CBRF)
 42. A resident required a pureed diet due to an impaired ability to swallow. A caregiver served the resident a (whole) ham sandwich. The resident choked, became unresponsive, and was taken to the hospital. Hospital records indicated the resident experienced cardiorespiratory arrest, anoxic brain injury, and aspiration syndrome. The resident died two days later. (CBRF)
 43. A resident reported three specific incidents when a caregiver touched him/her inappropriately, leaving the resident feeling uncomfortable and fearful. No investigations were conducted or documented and the caregiver continued to work alone during the night shift. The administrator reported that supervisory staff had "a talk" with the caregiver and told the caregiver, "Once again, stop doing this." (CBRF)
 44. Caregivers failed to provide proper assistance to a resident who experienced a seizure and fell from a chair to the floor. The resident remained on the floor for seven hours, during which time the resident was incontinent of bowel and bladder. Following the incident, one caregiver stated, "I should have helped, but I didn't." (CBRF)
 45. Caregivers repeatedly used language and approaches that were demeaning and nontherapeutic to address incontinence and behavioral symptoms exhibited by a resident with intellectual disabilities. The resident was told,

“You can’t have soda because you wet the bed.” Caregivers called the resident “naughty,” placed the resident in “time-out,” and “grounded” the resident from social and recreational activities. (CBRF)

46. Multiple problems were identified at a facility due to insufficient staffing patterns. For example, a resident required assistance with toileting, turned on a call light, and waited so long that the resident was incontinent of bowel in the wheelchair. The resident stated, “I felt humiliated.” (CBRF)
47. Over the course of one year, there were seven documented incidents of a resident with Alzheimer’s dementia being outside the facility without supervision and whereabouts unknown. On one occasion, the resident was a mile away from the facility, fell to the ground, and sustained a head injury. On two occasions, the resident was returned to the facility by police. On two occasions, the resident was found and returned to the facility by concerned citizens. (CBRF)
48. A caregiver assisted a resident to the toilet and changed a soiled brief. Without washing his/her hands, the caregiver provided personal cares, including brushing the resident’s teeth. (CBRF)
49. The facility nurse took a resident to the bathroom to observe an open area on the resident’s buttocks. In the bathroom, the nurse pulled down the resident’s pants, exposing the buttocks and a soiled brief. The nurse said s/he was disappointed to see the brief was soaked and the resident’s buttocks looked “much worse than the last time.” Instead of assisting the resident to the toilet or changing the urine soaked brief, the nurse pulled up the wet brief and pants. Wearing the soaked brief, the resident was taken to a group activity. When assistance with toileting had not yet been provided for more than two hours, the surveyor reported the concern to staff. (CBRF)
50. The provider did not administer medication (prednisone) for five months (more than 125 omitted doses), prescribed to address a resident’s pain from polymyalgia rheumatica. The resident’s condition declined until a wheelchair was required and the resident became “severely” incontinent of urine. As progressive, worsening pain persisted, the resident developed behavioral disturbances for which psychotropic and narcotic medications were prescribed. The resident became increasingly unstable, refused to leave his/her room, and developed skin breakdown. (CBRF)
51. Two residents developed skin breakdown and pressure ulcers when caregivers did not apply barrier cream, as prescribed, to protect from incontinence. Caregivers did not utilize pressure relieving cushions, as prescribed by the physician, to reduce pressure. Residents were left for extended periods in urine soaked briefs and bed sheets. (CBRF)
52. A resident with diabetes had blood sugar readings higher than those addressed by the physician orders for sliding scale insulin (readings ranging from 420-475). Caregivers did not contact the resident’s physician and did not administer insulin as needed. High blood sugars can contribute to complications such as kidney disease, stroke, heart attacks, poor circulation, and nerve damage. (CBRF)
53. After a resident set his/her hair on fire and sustained scalp burns, the provider failed to notify the guardian and waited two days to contact the primary physician. The prescribed treatment cream was not obtained or administered until two weeks after the incident. The facility did not document the incident or the follow-up care. (CBRF)
54. A resident required a surgical procedure to remove a tumor from his/her bladder. The resident experienced a rapid decline in physical health (falls, increased confusion, hallucinations, poor appetite, pain, etc.) following the procedure. The provider did not notify the physician of the significant changes in condition. Although the resident was a “full code,” emergency medical care was not obtained when the resident was found on the floor, unresponsive. Instead, caregivers left a message for an “on call” medical examiner. The deceased resident remained on the floor for over four hours until the medical examiner arrived at the facility. (CBRF)
55. Caregivers did not obtain prompt medical care for a resident experiencing falls with injury and a stroke. The clinic reported that two weeks had elapsed before the resident was medically evaluated for symptoms of a stroke (left sided weakness) and before evaluated for a head injury due to a “fall out of bed...[after] bruises developed on [his/her] face.” (CBRF)

56. A provider did not arrange needed supervision for a resident with dementia. The sole caregiver on duty was not aware the resident was missing for more than 75 minutes when contacted by resident's family, who reported the resident had been picked up by the police. (CBRF)
57. A resident, who required supervision and had a history of falls, was found by police in a nearby ditch at 3:30 a.m. The sole caregiver on duty called police when s/he discovered the resident missing as s/he had to remain in the building with other residents. The missing resident sustained multiple injuries including a fractured jaw, broken nose, and scalp lacerations. (CBRF)
58. A resident fell when caregivers failed to use a gait belt as addressed in the service plan to prevent a fall or reduce the risk of injury. The resident was taken to the emergency room and diagnosed with three fractured ribs and compression fracture of the spine. Upon returning to the facility, the resident continued to experience severe pain that was not properly managed. The resident was admitted to hospice care and died within three weeks. (CBRF)
59. A resident had worsening, persistent behavioral symptoms over a period of two weeks, including self-injurious behaviors such as head banging and hitting self. The resident was agitated, displayed excessive screaming and pacing, and experienced extreme distress. The administrator told the surveyor that the resident's physician and psychiatrist had been contacted about the resident's worsening condition. However, the surveyor learned that the physician and psychiatrist had not been notified. When psychiatric care was obtained, medication dosages were revised to alleviate the resident's symptoms. (CBRF)
60. A resident with dementia and incontinence had impaired mobility (wheelchair bound) and did not receive services to prevent pressure ulcers. The resident developed several open wounds on the buttocks. Caregivers did not provide or document wound care treatments as prescribed. Wounds were identified as stage 2-3 on the coccyx, spreading to buttocks (as large as 10 x 7 cm), with whitish tissue slough and granulation. (CBRF)
61. The provider did not arrange adequate services over a period of several months to address a resident with frequent falls, including a fall from the wheelchair when the resident "fell forward and hit head on ground." The resident sustained multiple injuries, a hip fracture, and facial bruising. (CBRF)
62. A resident's hospice care plan required CBRF caregivers to monitor bowel movements. The monitoring did not occur nor did caregivers provide or document health monitoring. The resident developed a bowel obstruction that was listed as a cause of death. (CBRF)
63. The facility did not have a delegating or supervising nurse. Untrained caregivers administered medications via a resident's gastrostomy tube and rectally and administered nebulizer treatments. (CBRF)
64. A resident did not receive medication or monitoring to address chronic constipation despite exhibiting symptoms and distress over 24 days. A family member reported that the resident was hospitalized with a fecal impaction and doctors stated "this could explain (the resident's) discomfort, weight loss, refusal to eat, agitation, and pain." A nurse at the hospital said the resident's colon was "so impacted that it was pushing on [the resident's] lungs." (CBRF)
65. A resident with Downs Syndrome and dementia did not receive needed care to prevent and treat pressure sores. The licensee stated, "I never should have readmitted [him/her] from the hospital," indicating the facility was unable to meet the resident's needs. Sores developed on the resident's heel, ankle, sacrum, coccyx, buttocks, scrotum, and groin area. There was no plan of care to address skin breakdown or wound treatments. (CBRF)
66. Witnesses confirmed an incident during which the administrator was holding a baseball bat and was saying to a resident, "Do you want to go a round, mother fucker? Come on." Witnesses said the resident tried to escape and the administrator grabbed the back of the resident's shirt and dragged the resident to his/her room by the feet. The resident "was trying to stop it by grabbing the handrails in the hall." The handrails "broke off" the wall. Other residents and caregivers reported that the administrator enjoyed pushing people around, stating "it was [his/her] way or the highway." One caregiver reported the administrator had a resident on the ground "and was hitting him all over." During another incident, the administrator "threw [a resident] to the ground...[the resident] hurt his shoulder and had to go to the hospital." (CBRF)

67. The licensee falsified documents to restrict communication between residents and surveyors. Surveyors were told that legal guardians had submitted documents prohibiting surveyors from talking with their wards. One letter, for example, stated "To whom it may concern: I am the legal guardian for my sister... I would appreciate it if someone from your staff would contact me before speaking with (resident) when doing your surveys...considering (resident's) conditions and moods at times, I feel it best to contact me before interviewing/contacting (resident)." Surveyors contacted the guardian who had no knowledge of the letter and had neither written nor signed it. (CBRF)
68. Although a resident's care plan indicated s/he preferred a bed bath, the resident requested showers and was denied when caregivers told him/her "you're not on the schedule." The resident did not receive assistance with a shower for over two years and developed a red, sore rash under the breasts. (CBRF)
69. A licensee did not provide 24-hour supervision as needed. The licensee resided in the basement and was the only caregiver on duty during the night shift. Residents reported summoning for help at night and receiving no response. A suicidal resident needed emergency help and, after trying to summon the licensee without success, called the county crisis worker. Two residents engaged in a violent altercation and police were called to the facility by another resident. The licensee told surveyors s/he was aware of the altercation but couldn't respond at the time as s/he was soaking his/her feet. (CBRF)
70. The licensee did not maintain the facility in good repair. Problems with the roof and ceilings were not addressed and, whenever it rained, water dripped onto residents in their beds. (CBRF)
71. The licensee admitted a resident with hepatitis C. Staff had not received training in infection control practices and the facility did not have a written infection control program. Infection control problems were identified with food preparation in the kitchen and with laundry practices. Caregivers used a common nail clipper for all residents without sanitizing the clippers between uses, a potential source for blood contamination. (CBRF)
72. A resident required the assistance of two caregivers. Frequently, only one caregiver was available, causing the resident to become incontinent or sit on the commode for up to two hours. The resident expressed frustration and humiliation at having to soil him/herself due to insufficient help, stating, "I don't like to shit my pants. I'm a grown [person]." (CBRF)
73. Over a period of four months, a resident experienced a decline in ambulation with 12 falls, including falls with injury. The facility did not assess the resident's safety needs or incorporate interventions to prevent injuries. The resident eventually fell and sustained a head laceration and a large intraparenchymal hemorrhage (bleeding within the brain). The resident died due to the injuries sustained in the fall. (CBRF)
74. The provider did not arrange needed supervision and interventions for a resident who experienced 18 falls in the facility from the time of admission until death, a period of four months. As a result of the falls, the resident sustained multiple injuries, including head injuries, lacerations, abrasions, and skin tears. The resident died after a fall caused bilateral subdural hematomas. (CBRF)
75. A resident acquired "bilateral open heel wounds." Caregivers failed to monitor the status of the pressure ulcers, take steps to elevate the feet and relieve pressure, and did not perform prescribed treatments. (CBRF)
76. A resident fell twelve times in a period of six months. The facility did develop effective interventions to address safety needs and the resident sustained multiple injuries including lacerations requiring sutures, head injuries, contusions, and fractured ribs. (CBRF)
77. A resident was admitted to the facility under hospice care; however, the provider failed to coordinate services with the hospice agency. The resident fell on the day of admission and was unable to stand or walk, yelling out in pain

- with any movement. Caregivers continued to transfer and move the resident, who was experiencing severe pain, without seeking medical treatment. X-rays were obtained two days after the fall and the resident was diagnosed with a fractured leg and a fractured arm. The resident died two weeks later. (CBRF)
78. The provider did not arrange adequate protection for a 90-year-old resident with Alzheimer's dementia. On more than one occasion, the resident left the facility unsupervised and walked to an intersection where 6,800 vehicles pass each day. The resident was at risk for injury or death each time s/he left the facility without supervision. (CBRF)
 79. The provider did not obtain prompt medical care for a resident who experienced a fall resulting in pain and an inability to bear weight. The resident's family was not notified for over ten hours and the physician was not contacted for more than 24 hours. The resident was diagnosed with a fractured pelvis and was discharged to a skilled nursing facility. (CBRF)
 80. The provider did not have care plans for residents with behavioral symptoms and did not take steps to protect residents. Residents were hitting one another, throwing furniture, yelling, slapping, and punching without meaningful interventions by trained caregivers. (CBRF)
 81. The provider did not develop a care plan for a resident who was admitted to the facility following a suicide attempt. The resident told caregivers that h/she felt lonely and depressed. In the absence of planned interventions, the resident took an overdose of pain and anti-anxiety medication. (CBRF)
 82. A resident with dementia and auditory hallucinations did not receive needed supervision and left the facility on several occasions, without shoes. On one occasion, the resident was found wandering near a highway without pants or shoes. The resident had fallen and an ambulance was called. (CBRF)
 83. Injuries were not assessed or investigated for a resident who had frequent falls, but also stated s/he had been abused by staff. The resident was hospitalized with more than 40 bruises in varying stages of healing. (CBRF)
 84. Caregivers did not intervene appropriately when a resident with cerebral palsy and 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 caregivers believed the resident was seeking attention. (CBRF)
 85. A resident experienced a significant change in condition over several days, including frequent falls, emotional mood swings, and possible head injury. The provider 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)
 86. 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 intimidating and threatening others. There was a strong odor of intoxicants and the caregiver received a citation for disorderly conduct. (CBRF)
 87. 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)
 88. Residents with developmental disabilities 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)

89. A resident with dementia and a seizure disorder was permitted to smoke cigarettes outdoors, unsupervised, even though s/he 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)
90. 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 s/he was full. (CBRF)
91. 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)
92. The provider 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)
93. The provider 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)
94. The provider did not arrange 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)
95. 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)
96. 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)
97. 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)
98. 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)
99. A provider 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)

100. 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)
101. Criminal background checks were not completed as required for an administrator, hired by the licensee to oversee three facilities. The administrator 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)
102. 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)
103. 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)
104. The licensee was the only caregiver on duty 24 hours a day, 7 days a week without backup 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)
105. 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)
106. The provider did not arrange 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. ("[S/he] 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)
107. 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)
108. 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)
109. A resident with developmental disabilities 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)
110. A resident with advanced Alzheimer's disease did not receive adequate supervision and left the facility undetected in frigid temperatures (a low of 7°F). The resident was wearing only slacks, a shirt, and slippers. Although the resident required scheduled checks of his/her whereabouts, caregivers did not check on the resident after 1:00 a.m., and s/he was discovered deceased outside at 8:05 a.m. (CBRF)
111. 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)

112. The provider 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)
113. 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)
114. Twenty-two days elapsed before the provider obtained a new prescription medication to relieve a resident's anxiety and agitation. (CBRF)
115. Over a period of two months, the provider 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)
116. 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)
117. A resident was at high risk for developing pressure sores due to vascular insufficiency and had already undergone a leg amputation. The resident developed an open wound on the other leg. Caregivers did not provide the prescribed treatment for wound care until 19 days after the treatment was ordered by the physician. Caregivers did not notify the physician when the resident complained of pain and the wound had drainage and looked bloody. (CBRF)
120. A tenant was admitted and retained at the facility despite memory loss and frail health. Steps were not taken to obtain a legal surrogate, advocacy, or protection for the tenant during months of decline. Multiple unwitnessed falls occurred, including falls resulting in a brain hemorrhage, scalp laceration, skin tears, head contusions, buttocks pain, and stitches. Prior to the tenant's death, the tenant spent nights sleeping in a Broda chair in the common area. (RCAC)
121. Caregivers 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 and is easily spread from person to person through touch and 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)
122. The provider retained a tenant with Alzheimer's dementia who did not have a legal guardian and who was unable to make decisions. The tenant's mental and physical condition declined significantly and the tenant had multiple falls with injury. After months of falling, the tenant was found by another tenant lying on the dining room floor. Caregivers were summoned from the adjoining nursing home and the resident was hospitalized with a subdural hematoma. When asked how long the tenant had been in the dining room, the RCAC manager stated there was no way of knowing as staff had not been present in the area since the prior evening. (RCAC)
123. 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 s/he was not aware of resident's bruising and was "shocked" when shown photos of the bruising by local law enforcement. (RCAC)
124. A tenant, with increasing confusion, did not receive needed supervision and had walked away from the facility previously, falling and scraping [his/her] face and hands. On another occasion, the tenant wandered two blocks from the facility and fell in the street. He/she was found by police with a bloodied nose and face and was transported by ambulance to the hospital. (RCAC)

125. 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)
126. 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. S/he “did not receive insulin or any food or care... [The tenant’s] clothing and wheelchair seat were soaked with urine.” (RCAC)
127. The RCAC service manager did not take appropriate steps when s/he failed to notify the police about thefts in the facility. Thefts continued until two tenants filed a police report. (RCAC)
128. A resident with mental illness was left alone in the home, day and night. The licensee did not prepare meals or provide daily services. Food was “dropped off” a few times a week. The resident expressed being fearful, especially in the dark, but the licensee instructed the resident to keep the lights off and use a flashlight. The surveyor discovered the resident in the home, alone, with appliances unplugged and very little food available. For example, there were two boxes of macaroni and cheese; however, no milk for the preparation. There were two jars of peanut butter, but no bread. There was no meat, fresh fruit, or vegetables in the home. There were canned goods, but the can opener was broken. The licensee had told the resident s/he would return in three days. The resident was unable to self-administer medications safely. (AFH)
129. Caregivers did not provide needed monitoring for a resident with a history of fecal impactions and constipation. The resident required surgery for a bowel obstruction. (AFH)
130. A resident alleged that a caregiver hit him/her in the face during a shower. The resident said the caregiver stated s/he “wanted to draw blood.” A reddened area was observed on the resident’s face. The provider denied that abuse occurred; however, an investigation conducted by the resident’s case manager substantiated abuse. (AFH)
131. A resident with an intellectual disability spilled bleach on his/her shirt and then hid the shirt. As “punishment,” the licensee made the resident miss a day of work and stay in his/her bedroom for the day. The licensee made the resident wear the bleach-stained shirt and “look in the mirror to see what s/he had done.” (AFH)
132. Caregivers did not provide residents with privacy. A resident was observed lying on his/her bed naked following a shower. The door had been left open and the resident was in full view of passersby. Another resident had been assisted to the toilet by a caregiver and was observed sitting on the toilet with the door open. (AFH)
133. The provider did not have an adequate inventory of food to provide nutritious meals. Groceries were not purchased for meals listed on planned menus. One resident with an intellectual disability had experienced an unanticipated weight loss of nearly 30 pounds over the course of a year and began exhibiting food seeking behaviors, including grabbing food from other residents and eating inappropriate items such as food wrapping and banana peels. (AFH)
134. A legal guardian made an unannounced visit and found a resident (the guardian’s ward) sitting on a metal chair at the bottom of the basement steps, crying hysterically and pleading with the guardian to take the resident somewhere else to live. The resident reported being made to stay in the chair for several consecutive days. The county adult protective service agency removed the resident from the home. Caregivers confirmed the resident was in the basement for four to eight hours at a time “due to behaviors” and was seated in a metal chair after being incontinent in a recliner. (AFH)
135. A provider did not ensure that a resident with diabetes had needed supplies for blood sugar testing. Although the resident required sliding scale insulin, no insulin was administered on days when blood sugar was not tested due to unavailable testing strips. In addition, the provider did not obtain or administer the resident’s inhaler four times daily, as prescribed for respiratory illness. (AFH)
136. A provider, licensed to serve four residents with developmental disabilities, left residents alone in the home for six hours each day despite safety risks. Residents did not know how to respond in the event of an emergency or evacuate the building. One resident, for example, stated he would get water “and put the fire out.” A resident stated that if someone broke into the home, s/he would grab their arms and drag them out. Residents did not

know emergency phone numbers. One resident would “turn the stove on high and forget to turn it off...on multiple occasions.” Needed assistance with noon medications and blood sugar testing was not provided. (AFH)

137. A resident with developmental disabilities, including autism, did not receive needed supervision, even though the resident had a history of leaving the facility without supervision. On two occasions, the resident was located at a gas station 1.5 miles from the facility. Three gas station employees reported they had witnessed the resident nearly hit by passing vehicles when crossing the four-lane highway. One attendant reported, “Four different vehicles almost plowed into [the resident] and had to stop or go around.” The facility did not notify the resident's legal guardians. The guardians learned of the incidents from a gas station attendant and stated they had been told by licensee, upon admission, that the resident would have a staff member assigned to him/her at all times. (AFH)
138. A resident with developmental disabilities walked away from the facility. The sole caregiver on duty left other residents alone in the home to search for the missing resident stating s/he was “fearful for the [missing] resident's life and concerned [the resident] would be hit by a car.” (AFH)
139. The provider had no documentation to explain a resident's condition or circumstances relating to a resident's transfer to the hospital and subsequent death. The licensee reported, “I wasn't informed on how (the resident) passed. I don't know how the incident happened or what caused (the) death. (The resident) was still alive when (he/she) left [by ambulance], but was very weak.” (AFH)
140. The provider admitted a resident with psychiatric needs and a history of suicide attempts, but did not have an effective treatment plan to address the resident's complex, high-risk needs. Potential weapons had not been secured in the home and the resident took a kitchen knife with a serrated blade and sliced him/herself in the neck three times, requiring emergency transfer to a psychiatric unit. (AFH)
141. A resident with a diagnosis of mental retardation experienced a fall and “could not bear weight, refused to eat, and was crying in pain.” No medical care was sought until the following day, after nearly 20 hours had elapsed. A physician diagnosed the resident with multiple leg fractures requiring immediate surgery. (AFH)
142. The provider did not arrange needed supervision for a resident with Alzheimer's disease who required 24-hour supervision. The resident showed up at a neighborhood home more than a half mile from the facility, wearing only pajamas and slippers at 3:00 a.m. Police returned the resident to the facility and the caregiver on duty was unaware the resident was missing. (AFH)
143. The provider did not obtain medical care for a resident with painful foot conditions that were left untreated for several months. Photographs revealed the resident had persistent foot fungus, blisters, calluses, and “toe nails that were long and curling away from the nail bed.” In addition, the resident experienced a red, scaly rash that covered his/her chest and eyelids for which medical care was not obtained. The resident reported that s/he asked the administrator for help “many times,” but nothing was ever done. (AFH)
144. Residents in the home weren't allowed to sit on furniture except a designated couch. Residents were served lower quality foods than the rest of the family. For example, when the family had a chicken dinner, residents were served hot dogs. Family members had regular plates and silverware. Residents were required to use paper plates and plastic utensils. Residents were not permitted to drink milk or fruit juice; these were for family members only. Residents were served powdered beverages. (AFH)
145. The provider did not ensure residents received a balanced lunch daily, nor were they offered a variety of foods. Packaged Ramen Noodles were served five days a week for lunch and canned ravioli was served two days a week. When Ramen Noodles were served, the residents received no protein, fruit, or vegetables. (AFH)
146. Over a period of five months, the provider retained a resident who was abusive to three other residents without providing adequate behavioral interventions. The resident would “spit, hit, throw things, take things from other residents, and urinate on them...” At times, the resident was found “covered in blood” or with “smear feces all

- over the room and his/her body.” Residents in the home expressed ongoing feelings of fear and intimidation. (AFH)
147. A resident with night time 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)
 148. 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)
 149. 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)
 150. 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)
 151. 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. S/he 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)
 152. 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)