



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, state-certified, and state-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 harmful behavior patterns required 24-hour, direct supervision. The resident left the facility unsupervised 20 times, resulting in allegations of inappropriate sexual contact in the community. Neighbors felt unsafe and filed complaints with the police. (CBRF)
2. Over a six-month period, the facility failed to protect residents from abuse. A resident with known behavioral problems, including aggressive outbursts, yelled at, bullied, threatened, kicked, threw objects at, and hit other residents. (CBRF)
3. The provider did not develop a temporary care plan to address transfer needs for a non-ambulatory resident with “foot drop” and a history of leg and knee fractures. During a transfer, the resident sustained an ankle fracture resulting in substantial blood loss where the bone punctured the skin. The resident required surgical repair and blood transfusions. (CBRF)
4. A resident, hospitalized seven times in a two-month period, did not receive adequate treatment for multiple falls with injuries, including head lacerations requiring staples, a neck fracture, and significant urinary tract infections requiring hospitalizations due to sepsis (a severe infection that has spread via the blood stream). Caregivers did not consistently apply a neck brace or adjust the brace to prevent open areas from developing, did not ensure that chair/bed alarms were applied and functioning, and did not provide needed incontinence care to prevent skin breakdown and urinary tract infections. (CBRF)
5. Over a three-month period, staff did not administer pain patches, anxiety medications, and other prescribed medications for a resident with diagnoses of chronic pain and anxiety. (CBRF)
6. The facility did not obtain needed medical care when a resident experienced a significant change of condition over several days, including diarrhea, vomiting, and poor appetite. Upon visiting the facility, a case manager discovered the resident unresponsive. The resident was admitted to the hospital with multisystem organ failure, diarrhea, dehydration, renal failure, mental status changes, low blood pressure, and low oxygen levels. The resident did not respond to treatment and died. (CBRF)
7. A facility’s smoke detection system was disabled and non-functioning for three weeks. The smoke alarms would not have sounded if there had been a fire in the home, jeopardizing the safety of the six residents, including one who required staff assistance to exit the home. (CBRF)
8. Despite knowledge of a resident’s recent suicide attempts and the need for close monitoring, a resident was sent, unaccompanied and unsupervised, on a clinic visit. The resident climbed over a safety railing and jumped to his/her death. (CBRF)
9. A physician ordered a “stat” chest x-ray for a resident with shallow breathing, wheezing, and a moist cough. The facility obtained the x-ray three days after it was ordered. Treatment for pneumonia was delayed for seven days following the onset of symptoms. (CBRF)
10. A resident developed pressure ulcers when caregivers did not apply barrier cream or utilize a pressure relieving cushion as prescribed by the physician. (CBRF)

11. Multiple residents with diabetes did not receive insulin as prescribed. One resident experienced injury, including painful bruising, when caregivers administered injections incorrectly. Another resident did not receive needed insulin because a caregiver was upset about the work schedule and refused to administer the injection. (CBRF)
12. After obtaining blood samples and finger sticks from multiple residents, a caregiver did not follow proper technique to quell the bleeding. The residents shared a 'blood stained' napkin to stop their bleeding. (CBRF)
13. The licensee did not maintain the facility in good repair to ensure the health and safety of residents. Significant water damage was not addressed, creating safety and health hazards. Areas of the ceiling were "hanging down" and discolored by mold. Plumbing problems were not addressed, and there was a strong odor of sewage. (CBRF)
14. Caregivers inappropriately administered lorazepam, a sedative agent, to a resident with dementia. The resident became sedated to the extent that s/he was unable to walk, feed self without assistance, or attend activities. The resident fell, experiencing a head injury that required seven staples to close. (CBRF)
15. A resident with no previous episodes of loss of consciousness was found slumped over the breakfast table. Facility staff observed the resident to be completely unresponsive and cyanotic (bluish in color) for 10 minutes and not fully conscious for a total of 30 minutes. Facility staff did not call 911 to obtain emergency medical assistance or notify a physician of the incident until the following day. (CBRF)
16. Facility staff did not administer 59 doses of medications, including those prescribed for the heart, high blood pressure, mood disorders, and pain. (CBRF)
17. Facility staff did not transport laundry, soiled with MRSA (Methicillin-resistant Staphylococcus aureus – a bacterial infection that is resistant to numerous antibiotics), in a closed plastic bag or container. The contaminated laundry was carried throughout the facility, creating a risk for transmission of MRSA, potentially affecting 41 residents. (CBRF)
18. A facility did not develop a fire safety plan to evacuate residents in a safe and timely manner. In the event the elevator failed to function or was on fire, there was no safe means of evacuation from the top floor for two residents that required wheelchairs. (CBRF)
19. A facility that was not licensed to care for non-ambulatory, cognitively impaired residents retained three residents who required a wheelchair for mobility and two residents described as having "severe dementia" who were unable to evacuate independently. (CBRF)
20. Caregivers did not provide the required direct supervision for a resident with self-injurious behaviors, sometimes violent, including repeatedly punching self and hitting his/her head against the floor, walls, windows, and tables. The resident sustained three head injuries and required stitches. (CBRF)
21. The facility did not develop an effective behavior plan for a blind, autistic resident to address self-injurious behaviors, including punching self, scratching self, and physical aggression toward other residents and staff. Instead, the facility initiated an involuntary discharge. (CBRF)
22. A facility RN instructed staff to video a resident with dementia and behavioral symptoms, who was unable to give consent, during episodes of aggression. Facility staff made two cell phone videos of the resident "acting out" and shared these videos with others. (CBRF)

23. A facility, licensed to serve 28 residents with advanced aged, scheduled only one caregiver on duty between the hours of 10:30 p.m. to 2:00 a.m. The caregiver was responsible for the needs of all residents on two floors. If a resident on the second floor called for assistance, the lone caregiver would leave 14 residents on the first floor dementia unit unsupervised, including those known to wander during the nighttime hours. When the caregiver was completing housekeeping duties on the second floor, the first floor dementia unit was unsupervised for up to an hour. (CBRF)
24. A facility administrator did not conduct an investigation into staff reports that a male caregiver locked himself in the room of an 80-year old, cognitively impaired, female resident for over an hour. The male caregiver refused to respond to staff's verbal requests to unlock and open the resident's door. Despite an allegation of abuse, the male caregiver continued to be scheduled to work with residents. (CBRF)
25. The facility did not investigate injuries of unknown origin when a resident with dementia was discovered with multiple injuries, including large bruises to the chest area, a hand, a wrist, a toe, and a fractured thumb. (CBRF)
26. A resident with memory loss and anxiety experienced behavioral changes, including biting staff, grabbing staff, screaming, swearing, refusing medications, and attempting to hit other residents. The facility did not contact a physician or arrange needed services and, instead, involuntarily discharged the resident. (CBRF)
27. A facility did not have an active, qualified administrator to supervise the daily operations of the facility, including resident care and services, for nearly two years. Caregivers had not completed minimum training requirements, thereby placing the health, safety, and welfare of residents at risk, including those with dementia, advanced age, and/or terminal illness. (CBRF)
28. During the night, a resident with severe dementia and a history of elopement left the facility. The lone caregiver on duty was assisting another resident on the other side of the building. Unable to locate the resident and due to the cold weather (below zero), the caregiver called 911. Police found the resident 35 minutes later, lying in a ditch. The resident sustained frostbite to both hands (which required debridement of the dead tissue) and contusions to elbows, knees, chest, and face. (CBRF)
29. An intellectually disabled resident, who had a legal guardian and a history of elopement, did not receive needed supervision and was discovered two blocks from the facility in a neighbor's garage. The neighbor called police. (CBRF)
30. A resident was not provided physical privacy and dignity while using the bathroom. Surveyors observed staff and residents walk by the bathroom while the resident was on the toilet. No attempts were made to close the door. Staff also sprayed odor ban while commenting, in the presence of residents, on the odor coming from the bathroom. (CBRF)
31. The facility did not provide needed services after admitting a resident with a history of uncooperative, agitated behaviors, who required direct supervision and personal alarms for safety. The resident sustained multiple falls with injuries, including a head injury, abrasions, a rotator cuff injury, and shoulder sprain. The resident's "last fall" at the facility resulted in a fractured disc. The resident was hospitalized and died six days following the fall. (CBRF)
32. Caregivers did not provide pain management for a resident with impaired judgment who was unable to communicate in English. Following a fall, the resident experienced hip and back pain. Staff administered pain medication only twice in 36 hours, with no other pain relief measures provided. The facility did not seek emergency medical treatment when the resident was in severe pain, "writhing in bed, crying, and vomiting," until the resident's POA (power of attorney for healthcare) intervened. (CBRF)

33. A hospice resident was at risk for falls and required two caregivers for transfers due to weakness and narcotic use. At 3:00 a.m., the resident requested to use the bathroom. The caregiver on duty delayed assisting the resident, awaiting the arrival of the next shift caregiver. Twenty minutes later, the resident was found “lying on the floor moaning in pain.” (CBRF)
34. A criminal background check was not completed as required for an environmental service coordinator who was convicted of a third-degree sexual assault, a class D felony/barred crime. For an approximately five-month period prior to termination, this employee had opportunities for regular, unsupervised contact at any time of day or night with residents. (CBRF)
35. The facility did not ensure needed wound care for a resident with diabetes, a history of skin ulcers, and a history of toe amputation. The resident developed two open areas to her/his right foot. A physician noted “tight bandages,” “new ulcer Stage IV,” and “exposed tendons.” Wounds were described as purulent with a foul odor. (CBRF)
36. A care plan indicated that a resident with a history of falls with injuries should have a bed/chair alarm on at all times. The resident’s roommate alerted staff that the resident was trying to get out of bed and fell. Upon entering the room, the caregiver noted the alarm on the dresser with no battery. The resident sustained a fracture. (CBRF)
37. Caregivers neglected to intervene promptly when a resident with dementia fell. Instead, caregivers informed oncoming staff during a verbal shift report that the resident had fallen and was lying on a bedside mat. The resident was found non-responsive with a cut to the head. When rescue personnel arrived, it appeared that the resident had been left on the floor mat, “unchanged” and “smelling of urine,” for an unknown length of time. The resident sustained a laceration on the right forearm that extended about half of the forearm and a skin abrasion above the left eye. (CBRF)
38. A caregiver was aware that a resident fell but did not immediately check the resident for injuries or report the incident to other caregivers. Approximately one hour later, a second caregiver discovered the resident lying on the floor. The resident complained of hip and back pain and was hospitalized with a hip fracture requiring surgery. (CBRF)
39. A facility did not provide adequate supervision for a resident with a history of suicide attempts. The resident was to be observed by a caregiver every 15 minutes. One caregiver was on duty and did not check on the resident for approximately 45 minutes as the caregiver was “working alone” and “very busy.” The resident committed suicide. (CBRF)
40. The licensee did not schedule awake, overnight staff. During the night, a resident with the intellectual abilities of a three- or four-year-old child, who had been protectively placed, left the facility unsupervised. Caregivers did not know the resident was missing for nearly 14 hours. The resident was found approximately 1.5 miles from the facility. (CBRF)
41. A resident with a history of elopement was described as confused and at risk for falls. The resident was left unsupervised on the front porch. The resident wandered away from the facility. (CBRF)
42. A resident with a history of elopement did not receive needed supervision and exited the facility through a window. The resident was discovered when s/he knocked on the front door of the facility wearing only pajamas. On another occasion, the resident was found by a citizen along a busy highway (3,500 vehicles pass this highway on an average day). (CBRF)

43. Supervision was not provided to meet the needs of four residents. In a two-month period, five elopements occurred. The police were contacted by community members four times to assist confused residents back to the facility. On two occasions, a resident was found outside with temperatures of 16 °F and 28 °F respectively. One resident was found outside after slipping on a patch of ice and laid there until a visitor called for an ambulance. One resident was found on a bridge, and the police were called to assist the resident off the bridge through a snowbank. The temperature outside was 33 °F. One resident was found after falling on a sidewalk, and the fire department notified caregivers of the incident. (CBRF)
44. A palliative care resident with severe inflammatory arthritis and chronic back pain did not receive scheduled morphine for pain over a three-day period. The resident experienced pain and withdrawal symptoms, including loss of appetite, vomiting, nausea, and diarrhea. (CBRF)
45. The provider did not obtain prompt medical care for a resident who experienced a fall. The morning following the fall, caregivers noted the resident's right arm was "swollen with bruising." Despite this observation, the resident's family was not notified for over 34 hours. The family arranged for an ambulance to the emergency room where the resident was diagnosed with a right humerus (bone in upper arm) fracture. (CBRF)
46. A resident with Parkinson's disease experienced approximately 12 falls and fall-related injuries, including a fall that resulted in an ER visit for elbow sutures. The resident's care plan incorrectly indicated that the resident "was not at risk for falls." (CBRF)
47. A resident with dementia did not receive needed supervision and left the facility undetected. At 7:00 p.m., staff could not locate the resident. Approximately 20 minutes later, a local citizen pulled into the front parking lot of the facility with the resident in the backseat. (CBRF)
48. A diabetic resident was at risk when, for 22 days, caregivers did not obtain or record blood glucose levels twice daily, per physician order. The caregivers wrote fictitious numbers in the record so it would appear that blood glucose levels had been tested. The resident's physician based the resident's medication needs on false glucose readings. The facility permitted the responsible caregivers to continue working for four days after the allegations of misconduct were reported. (CBRF)
49. A resident with advanced dementia and history of wandering eloped from the facility. Police were contacted and informed that the resident had been missing for 30 minutes. The resident was located near a creek approximately two blocks from the facility and had sustained an elbow injury. (CBRF)
50. A facility that serves non-ambulatory residents did not provide a safe environment for two days, including in the event of an emergency, when the facility's two primary exits from the building were covered with ice and six inches of snow. (CBRF)
51. Over a period of three months, a facility had multiple medication errors affecting nine residents. These errors included omission of medications, double doses of medications, administering incorrect dosages, and failure to notify the physician of medication errors. (CBRF)
52. A facility did not have an infection control plan to prevent the transmission of communicable diseases and infection. Over a two-month period, a facility experienced two outbreaks of Norovirus (viral gastroenteritis), which affected both caregivers and residents. Facility staff returned to work prior to being "symptom free" for the recommended 48 hours. Infection control problems were also identified when food service personnel did not perform appropriate handwashing. (CBRF)
53. A resident with dementia who had a history of elopement and required "10-minute checks" exited the facility unsupervised. Caregivers did not consistently conduct the required checks and were unaware that the resident eloped until police returned him/her to the facility. (CBRF)

54. A provider did not investigate allegations of verbal abuse when caregivers called residents by inappropriate names, such as “Shamu,” “Spaz,” and “Smelly Crotch.” (CBRF)
55. A facility was not licensed for non-ambulatory residents but admitted and retained a resident who reported s/he had to “get out of the wheelchair and scoot down the stairs on his/her butt, leaving the wheelchair at the top of the stairs.” (CBRF)
56. The facility did not provide a safe environment for a resident who required a wheelchair for mobility due to a leg amputation. The resident was using an exit with a steep, temporary ramp when his/her wheelchair tipped over, and the resident sustained four rib fractures. (CBRF)
57. A facility did not provide needed interventions, such as pressure relieving devices for the bed or in the wheelchair, for a resident who had developed serious pressure ulcers to the coccyx, hip, and both heels. (CBRF)
58. The provider did not update a resident’s care plan when, after an argument, a resident stabbed a male peer in the face and the back of the neck with a fork. The care plan indicated, “Interacts well with others.” (CBRF)
59. A resident acquired multiple pressure ulcers to his/her heels, tailbone, and hip area. The facility RN failed to conduct comprehensive assessments, identify new interventions, or ensure prescribed treatments were performed. The RN’s documentation of the resident’s condition was not consistent with that noted by physicians and caregivers. (CBRF)
60. The facility did not contact a physician for five days after caregivers noted a wound on a resident’s buttock. The physician then ordered a pressure relieving air mattress. After nearly a week following the order, the surveyor noted that the resident still did not have a pressure relieving mattress on her/his bed. (CBRF)
61. The facility did not provide sufficient staff to meet the needs of residents. A surveyor observed a resident calling out for help “to go potty,” a confused resident attempting to exit the facility, and a resident who did not receive needed assistance with meals. Another resident entered the kitchen, removed a potato from a crock of raw potatoes, and put it into his/her mouth. The resident then spit the potato back into the crock. A family member reported that their loved one was transferred from the facility because, when visiting, the family would “search and search for staff assistance and they simply were not there.” (CBRF)
62. A hospice resident with missing dentures and inability to chew required a pureed diet. Caregivers served the resident a regular diet of chicken, whole broccoli, carrots, and a biscuit. Caregivers did not provide assistance with the meal. Two months elapsed before an appointment was made for replacement dentures. (CBRF)
63. Only one caregiver was scheduled on duty during the night shift although two residents required a two-person transfer, including one that required a mechanical lift. (CBRF)
64. A resident required a pureed diet with thickened liquids due to a history of choking episodes. Caregivers served the resident chicken, whole broccoli, and thin liquids. The resident did not eat any of the food served. (CBRF)
65. A facility experienced a head lice outbreak (lice can be easily spread from person to person with direct contact). The facility did not follow physician ordered treatments or follow the manufacturer’s guidelines to ensure the infestation was eradicated for eight facility residents. (CBRF)
66. A facility did not conduct a safety assessment prior to placing a resident in a Broda (reclining) chair. The resident experienced multiple falls related to the chair and sustained injuries. Despite the resident’s verbal objections, caregivers returned the resident to the chair following a fall. A follow-up physical therapy evaluation determined that the Broda chair was not appropriate. (CBRF)

67. A resident with a sacral pressure ulcer experienced a worsening of the ulcer, including “tunneling” and increased “tissue destruction” when prescribed wound care interventions (repositioning, pressure relief devices, and a walking regimen) were not implemented as needed. (CBRF)
68. A resident with Parkinson’s disease and gait instability experienced multiple falls, including falls with injury, related to tripping on/over a walker. The facility did not assess the resident’s safety needs or incorporate interventions to prevent injuries after more than 16 falls occurred over a two-month period. (CBRF)
69. A provider did not monitor or assess a resident with an open shin wound. The legal guardian arrived at the facility and noticed the sock was full of blood and yellowish stains. The guardian discovered a “very large sore” that was “infected” and took the resident to the emergency department, where s/he was diagnosed with a bacterial skin infection requiring antibiotics. The wound did not improve and the resident was hospitalized for a surgical procedure to remove the infected tissue. (CBRF)
70. A provider did not develop effective interventions for a resident with harmful behavioral symptoms, including hitting other residents and staff, punching, throwing objects, pinching, pulling hair, yelling, and swearing. (CBRF)
71. A legal guardian reported an allegation of sexual abuse of a resident. Two months after the allegation, the administrator still had not conducted an investigation. (CBRF)
72. A facility, licensed to serve residents with developmental disabilities, did not have a qualified caregiver on duty for twenty shifts. Untrained caregivers were assigned to administer medications, provide care/services, and ensure the safety of residents. (CBRF)
73. The licensee did not provide supervision to protect residents from sexual abuse when a former resident reported being sexually abused by a male caregiver who had worked alone on the night shift for three years. Once an investigation ensued, another resident reported being assaulted by the male caregiver on three separate occasions. The resident was afraid to report the allegations earlier as the male caregiver had threatened him/her. (CBRF)
74. Licensed to serve only residents who are ambulatory, the facility retained a resident who required a walker for ambulation and physical assistance from staff to negotiate interior and exterior stairs. The licensee failed to meet accessibility and life safety requirements. (CBRF)
75. A facility did not obtain prompt medical care for a resident with a history of attempted suicide who was exhibiting dangerous behaviors when s/he combined alcohol with over-the counter medications, twice in one evening. Caregivers allowed the intoxicated resident to leave the facility via a taxicab to obtain more alcohol and medications. (CBRF)
76. Over a two-month period a facility did not ensure a qualified caregiver was on duty for 16 shifts. On one occasion, when two untrained staff were working on the night shift, a power outage occurred. The staff did not respond to the emergency or know how to handle the situation, including how to change an oxygen concentrator during the outage for a resident dependent on oxygen. (CBRF)
77. A facility did not provide needed supervision for a resident with dementia and history of elopement. On one occasion, caregivers were unaware the resident exited the building and wandered miles away from the facility and crossed a busy highway. A staff member leaving work observed the resident and returned the resident to the facility. During an investigation, surveyors observed the resident outside, unsupervised, on three separate occasions. (CBRF)

78. The facility did not provide adequate services for a resident with complex medical needs, including recurrent urinary tract infections and hospitalizations due to “sepsis” (blood stream infection), skin breakdown, and falls with injuries, including fractures of a vertebra in the neck, a fractured finger, and scalp lacerations. Despite the home care nurse educating and reeducating caregivers, caregivers did not apply or keep a C-collar (used for neck fracture) on the resident and were not adjusting the C-collar to prevent it from rubbing. The resident developed open areas to the sides of his/her neck. Caregivers did not consistently apply a chair alarm and the resident’s bed alarm did not work for weeks. Staff did not assist the resident to the toilet at least every two hours as directed and the resident was often found saturated in urine and stool. (CBRF)
79. Over a three-month period, a resident did not receive Fentanyl patches for pain, Lorazepam for anxiety, and eight other medications as prescribed. A resident was administered Oxycodone (pain medication) more frequently than prescribed on multiple occasions and staff continued to administer Hydrocodone (pain medication) after the physician put the medication on hold. (CBRF)
80. Employees administered medications using their “discretion” and withheld prescribed medications, despite practitioners’ orders and without contacting the physician. (CBRF)
81. Two residents with multiple risk factors experienced a series of falls and the provider did not implement measures to reduce the risk of injuries. Due to continued falls, one resident sustained rib fractures, declined in health, and died. Another resident sustained a hip fracture and did not return to the facility. (CBRF)
82. A hospice resident who required total assistance did not have adequate clothing and did not receive needed care when left undressed due to all available clothing being soiled. The resident was not permitted to leave his/her room and did not receive a breakfast or lunch meal. Caregivers stated, “We were told not to bring [a meal tray] in [to the room].” When hospice personnel arrived, the resident was “naked, shivering, and begging for juice.” (CBRF)
83. The provider failed to review or update a resident’s care plan to address falls. The resident, who had dementia, experienced two falls in a two-day period and both resulted in head injuries. After the second fall, the resident was hospitalized and returned to the facility under hospice services and died ten days later. The cause of death was listed as “accident/fall – subdural hematoma” (collection of blood outside of the skull). (CBRF)
84. A resident experienced an unwitnessed fall and caregivers did not monitor for possible head injury. After several days, caregivers noted a “bruise, bump” to the resident’s head. Four days following the fall, the resident’s “response was poor and lips were swollen with excessive drooling noted.” The resident was hospitalized and a CT scan identified a hematoma (collection of blood outside of the skull) to the right side of his/her head. (CBRF)
85. Over a three-month period, a provider did not take steps to protect a resident and others when the resident had episodes of eloping, hitting other residents (and causing injury), and throwing objects at others. (CBRF)
86. A facility did not notify a physician when, over a two-month period, a resident repeatedly refused medications and medical treatments. The resident’s physician ordered wound care for a Stage III wound on the left foot. Six weeks following the order, caregivers had not completed wound care dressing changes and the physician was not notified. (CBRF)
87. A resident experienced changes in condition, including an infected toe, an ER visit for “pus” in urine, and an ER visit for a bleeding stoma. The facility did not monitor or document these significant changes. (CBRF)
88. A resident experienced a choking episode during a meal. The physician ordered a speech therapy evaluation. One month later, the speech evaluation had yet to be obtained. No measures had been implemented to reduce the resident’s risk for choking. (CBRF)

89. Caregivers did not intervene when blood sugar readings for a diabetic resident exceeded the parameters established by the physician. As a result, the resident was transferred to the ER where the physician prescribed medication to treat diabetes. Caregivers failed to administer the medication as prescribed. (CBRF)
90. Although a resident hit his/her head during a witnessed fall and fell again one hour later, the facility did not obtain prompt medical care. The resident experienced decreased awareness and five days elapsed before the resident was transported to the hospital with an altered mental state. The resident was diagnosed with “acute-on-chronic subdural hematomas with a bleed” and died three days later. (CBRF)
91. Over a period of four months, a resident experienced 21 falls, including falls with injuries (head injuries, hand injuries, abrasions, bruises etc.). The facility did not assess the resident’s safety needs or implement preventive interventions. Subsequently, the resident fell again and sustained a head injury and a subdural hematoma. The resident died due to the injuries sustained in the fall. (CBRF)
92. A facility did not provide needed services for a resident with Alzheimer’s disease. The resident, wandering and confused one night, walked out an exit door located in his/her room directly to the outdoors. The resident, who could not get back inside, fell and was found in a snowbank approximately 30 to 45 minutes later. The wind-chill was between -15° F and -18° F. The resident suffered severe frost bite, resulting in the loss of the use of his/her hands and mobility, and required amputation of some fingers. (CBRF)
93. The licensee failed to protect vulnerable residents by retaining a resident with harmful behavior patterns without providing needed supervision. The resident wandered in/out of residents’ rooms and was found “sitting on top of residents” when trying to get into their beds. The resident “pulled” other residents, attempting to assist them in an unsafe manner. As a result, one resident, when being pulled from the bed, fell and fractured his/her leg in three places. Five days following the incident, the resident died from complications related to the injuries. (CBRF)
94. For nearly five months, a provider failed to protect cognitively impaired residents from a resident with a known history of inappropriate sexual behavior. The resident repeatedly engaged in intrusive, invasive sexual conduct, including exposing genitals in common areas and being found naked in other residents’ beds. During one incident, the resident had [placed] another resident’s hands down his/her pants. (CBRF)
95. A resident with a history of elopement exited the facility unsupervised and was observed wandering alone outside. Caregivers documented on a “15-minute” check monitoring sheet that the resident was in the “dining room” at the time. (CBRF)
96. The provider did not obtain immediate medical care for a resident who experienced a fall resulting in a head injury. The resident expressed pain and was unable to bear weight. No emergency care was sought and staff waited 35 minutes before contacting the resident’s family. One hour later, caregivers assisted the resident into a family member’s vehicle. The resident was diagnosed with a head laceration and a hip fracture. (CBRF)
97. The facility did not provide adequate medical care when a resident with severe Alzheimer’s disease displayed a change in condition, including poor oral intake, low blood pressure, skin changes, and diminished responsiveness for four to five days. The resident was hospitalized with multiple Stage III pressure ulcers, severe dehydration, and neglect. Hospital records reflected “concern that [the] facility has not been providing adequate care.” The resident died nine days after the hospitalization. (CBRF)
98. A resident with a known history of falling experienced more than 15 falls over a 16-month period and was not reassessed by the facility for interventions to reduce subsequent falls. Subsequently, the resident fell forward out of a wheelchair, striking his/her head and sustaining a neck fracture. The resident died the following day. (CBRF)

99. Inexperienced caregivers had been assigned to transfer a resident with MS (Multiple Sclerosis) from the bed to a wheelchair with a Hoyer lift. The resident was not properly positioned and the resident's leg became entangled between the bed and wheelchair. Once in the wheelchair, the caregiver pulled on the Hoyer sling for repositioning and a "loud pop" was heard. The resident had sudden, severe, leg pain and was admitted to the hospital with a fractured femur. (CBRF)
100. A resident had a witnessed fall resulting in bruising and worsening pain. The facility did not seek prompt medical care until two days later when a family member insisted on medical care. The resident was admitted to the hospital with four fractured ribs and returned to the facility with hospice care. The resident died the same month. (CBRF)
101. A resident, who had needle scratches across his/her stomach, was not assessed for the safe self-administration of insulin injections. When being "coached" by a caregiver, the resident was verbally cued to keep the insulin needle inserted until all the insulin was injected. Upon completion of the injection, the resident handed the insulin pen in an unsafe manner to the caregiver "needle first." (CBRF)
102. A facility did not provide adequate services to manage a resident's harmful behaviors, including increasing violence. On one occasion, the resident was involved in a physical altercation with another resident causing the other resident to fall and fracture a leg. (CBRF)
103. A resident did not receive needed supervision and eloped from the facility, undetected. Police returned the resident to the facility and informed staff that the resident attempted to break into a house and several vehicles, including one vehicle that was in operation. The resident had been telling people that s/he was a "serial killer." Following the incident, the facility did not increase monitoring and, 30 minutes later, the resident eloped again and was returned by police after attempting to break into two more homes. (CBRF)
104. A resident had vomited blood prior to being taken to the hospital. The blood was observed on the carpet and mattress. Bloody clothing had been bagged, but remained on the floor. The room was not decontaminated for seven days following the incident, potentially exposing residents, caregivers, and others to contaminants. Caregivers were not aware of procedures or available personal protective equipment. (CBRF)
105. A facility did not complete assessments or implement effective interventions for a resident who experienced 10 falls; including three that resulted in injuries (scalp and facial lacerations requiring staples and a cervical fracture). (CBRF)
106. A resident choked in the dining room, became unresponsive, and --- after multiple, unsuccessful Heimlich maneuver attempts --- staff called 911. On-duty caregivers began CPR, which was performed against facility policy. The resident, who had a DNR (Do Not Resuscitate) order, was not wearing his/her DNR identification bracelet. The resident was resuscitated, placed in ICU, and maintained on mechanical ventilation for approximately 24 hours when the family decided to withdraw the mechanical support and the resident died. (CBRF)
107. A caregiver breached private and confidential information by "texting" to an off-duty caregiver about a choking incident which led to a resident's hospitalization on life support and subsequent death of the resident. (CBRF)
108. A facility did not ensure that staff followed infection control standards after providing personal cares for a resident. Caregivers were observed disposing of soiled gloves in the resident's room, exiting the room and entering the kitchen area, washing their hands in a sink used for food preparation, and not disinfecting the sink. There was no soap or hand sanitizer available to caregivers in resident rooms or bathrooms. (CBRF)
109. Two residents' medication blister packs were found to be tampered with, replaced with other pills, and "taped over" on the back. A pharmacy identified that a resident's hydrocodone (a narcotic pain medication) had been removed and replaced with Excedrin (non-narcotic pain medication). A second resident's Lorazepam (anti-anxiety medication) had been replaced with Seroquel (an antipsychotic medication). The facility did not report the tampering or theft to the police until eight days later. (CBRF)

110. A resident experienced five falls with injuries, including cuts, skin tears, facial lacerations with sutures, and nasal/sinus fractures. The provider did not complete an assessment for safety interventions and did not ensure that alarms utilized to alert staff were functioning properly. On one occasion, a resident's bed sensor alarm was not working and was "sent home with a caregiver" for a friend to "fix it" with no alternative interventions implemented. (CBRF)
111. Caregivers did not conduct hourly checks and were not aware that a resident left the facility until a family member contacted the facility to indicate that the resident was "sleeping" at their home. The resident left the facility through a garage door that was to be alarmed, but the alarm was broken and had not been repaired or replaced. The resident had walked approximately six miles in the dark on a highway that averaged up to 8,500 vehicles per day. (CBRF)
112. A resident eloped from the facility three times in a three-week period. In all three incidents, facility staff were not aware of the resident's whereabouts. During one incident, a neighbor alerted the facility that the resident was in their living room "looking for work." (CBRF)
113. A non-ambulatory resident with dementia and diabetes required total care, but did not receive services to prevent skin breakdown and promote wound healing. The resident developed eight pressure ulcers over a several-month period. The legal representative was "appalled" about the pressure ulcers and was not aware of the severity of the wounds. Wounds were identified in varying stages and varying locations (heels, coccyx, calf, foot), as large as 4 x 2 inches, "very deep," with eschar "black" tissue (dead tissue), "blistered" and "red meat-like" in appearance. (CBRF)
114. A resident with multiple wounds and diabetes did not receive a breakfast meal until a surveyor brought the concern to the caregivers. The facility identified their breakfast meal as 8:00 a.m. At 9:30 a.m., a surveyor entered the resident's room. The resident informed the surveyor that s/he was feeling "terrible." The resident stated that s/he had not yet had any breakfast and was hungry. (CBRF)
115. A resident with dementia was incontinent, identified as "a fall risk," and required hourly checks. The resident was "locked" in his/her room for a "six to eight hour" period. Caregivers stated that their "key would not open the door." Caregivers did not notify management and took no steps to ensure the resident's care and safety. (CBRF)
116. A facility failed to investigate or report injuries of unknown origin when a resident was found by caregivers in bed with "chipped and/or missing teeth, blood in mouth, new bruising to the forehead and cheek, a large bruise to the arm, and a bruise to the hip." Hospital records also indicated that the resident had a "clavicle (collarbone) fracture." The resident was transported to the hospital and died within 24 hours. (CBRF)
117. Caregivers witnessed another caregiver being verbally and physically abusive to residents and did not report the incidents until at least five days elapsed and more abuse occurred. One witnessed event included: "[the caregiver] pushed a resident onto the bed, while pressing both hands onto the chest area, taking the resident's face into hands and screaming, 'You're the devil's spawn, and you're going straight to hell.'" Another incident occurred after a resident dropped a plate of food and the resident "had their head and neck forced down toward the floor," while the abusive caregiver was yelling at the resident. This same caregiver pulled a resident's pants up to her breast area and roughly put her in a chair and her pants were "clearly too tight, creased, and put undue pressure in crevice of buttocks." The resident responded, "ouch, stop" and "got up from the chair, pulled up her shirt. The caregiver said, 'Oh, you want to show your boobies off, here we go' and pulled up the resident's bra and placed his/her hands under the resident's breasts and literally lifted the breasts and juggled them saying, 'Okay, now everyone can see them.'" (CBRF)

118. A facility maintenance worker was observed “hugging and kissing a resident.” During a second incident, witnesses reported the worker was in the bathroom with the resident and the door was closed. A caregiver knocked on the door and waited for “a minute to a minute and a half.” When the door opened, the worker came out quickly and went down the hall. Upon entering the bathroom, the caregiver observed the resident with “pants unbuttoned, pants and undergarment rolled together, and a portion of the resident’s upper buttocks showing.” The employee was permitted to continue working, without monitoring, for 26 more days. (CBRF)
119. Residents were billed for “as needed” narcotic pain medication that they denied receiving. The facility did not investigate or report possible drug diversion when it was discovered that one caregiver had been documenting that residents received these medications. (CBRF)
120. A facility did not provide needed care and services for a resident with complex medical needs, including multiple pressure sores and weight loss. Pressure relieving devices were not provided as prescribed by the physician. Weight loss was not monitored because the facility “did not have the proper scale to weigh a resident who was unable to stand and bear weight.” The facility continued to send the resident to a day program despite his/her markedly frail condition. Hospital records indicated the resident was “severely malnourished” with 14 pressure sores, including one wound that was described as a “Stage IV pressure ulcer with bone exposed, with no viable tissue noted...and odor. In the patient’s current state, there is little hope that s/he will heal any wounds.” The resident was discharged with hospice services. (CBRF)
121. The facility did not provide needed care for a resident who experienced severe pain for more than two weeks. When the resident’s family took the resident to the doctor, s/he was hospitalized with a pelvic fracture. There was no investigation to determine the potential cause of the pelvic fracture. Despite the resident’s ongoing pain, which at times was described as “unbearable” and caused the resident to cry out, staff did not administer pain medication as prescribed. (CBRF)
122. Residents did not receive assistance with personal cares, grooming, or nutritional needs. Residents were observed with greasy, uncombed hair; unshaven; and with unclean hands and dirty fingernails. During a meal in which chicken was served, a resident was not given a knife as requested to cut the chicken and had to use his/her “hands to tear off pieces to eat.” One resident with a pureed diet did not receive assistance and his/her food “fell” out of the mouth and “ran down” his/her face. (CBRF)
123. An unsupervised resident with a history of falls, recent medication changes, seizure history, and unsteady gait fell down the basement stairs and sustained a head injury. (CBRF)
124. A diabetic resident experienced a change in condition, low blood sugars, poor appetite, difficulty walking, dry heaves/vomiting, difficulty swallowing, and slurred speech for four days prior to the resident’s physician being notified. Approximately seven hours after the physician was notified of this change, the resident was pronounced deceased. (CBRF)
125. A resident was being transferred from a bed to a wheelchair via a Hoyer lift. Caregivers failed to fully open the lift’s base to ensure proper balance and safety. While moving the lift backward and then turning the lift, with the resident suspended in mid-air, the lift tipped forward, dropping the resident to the floor, resulting in a fractured hip. (CBRF)
126. A resident fell and complained of pain in the shoulder and arm. The caregiver was working alone and could not lift the resident off the floor. The resident remained on the floor for seven hours and was then transported to the emergency room and diagnosed with a fractured arm. (CBRF)

127. Staffing patterns were not sufficient to meet the needs of multiple residents. Residents were seated at the dining room table for an hour before the meal was served. There was a high noise level in the room with residents yelling, whistling, and pounding on tables. Staff did not intervene or assist when residents were stealing or giving food to each other and licking food items that belonged on the plates of other residents. One resident, who was eating rapidly, did not receive assistance and started coughing, choking, and expelling food from his/her mouth. (CBRF)
128. A facility did not provide needed supervision to prevent recurring injuries for a resident with dementia who experienced 10 falls in a six-week period, many unwitnessed by staff, that resulted in head injuries, a laceration requiring nearly 20 staples, and a clavicle fracture. (CBRF)
129. Three residents in the facility had bite marks from bedbugs that caused itching, scratching, and distress. Weeks elapsed before physicians were notified of the bites and, when treatment orders were obtained, the treatments were not administered. More than three months elapsed before the administrator took needed steps to eradicate bedbugs despite ongoing concern from direct caregivers and recurrent bites and rashes covering resident's extremities. Progress notes state, "[residents] came to staff, very upset [with] fresh bite marks to arms-legs-thigh areas, very red, complained it itches...scratching arms, behind neck, breasts...causing skin to bleed...no [medication] for itchiness...[a resident had] three bedbugs crawling on her face, one crawled from her mouth and fell onto the pillow." (CBRF)
130. A resident with Alzheimer's disease had a history of elopement and required ongoing supervision. The resident left the facility in unsafe conditions. The lone caregiver on duty was assisting another resident in the bathroom and could not leave other residents to retrieve the missing resident. The outdoor temperature was 43° F and police tracked footprints in the snow to locate the resident on the porch of a nearby home. (CBRF)
131. A frail, elderly (totally dependent) resident was taken to the emergency room with false reports by facility staff that the resident experienced a "sudden" change of condition. Hospital records reported "inconsistencies with information provided by the CBRF" and stated the resident had facial bruising and swelling, was disheveled with crusted food on face and under nails, vaginal area swollen, abrasions over hip, labia abrasions, severe dehydration, urinary tract infection, and pneumonia." Records further stated, "...mucous membranes were very dry...tongue was cracked and there was a white round pill lodged between the lower lip and the anterior gums. The left eye had tan drainage coming from it with a healing laceration to the upper eye lid, as well as bruising and swelling noted to various parts of her body, including her labia." The hospital contacted the Adult Protective Services agency and the police. (CBRF)
132. A facility did not ensure needed assistance and supervision for a resident with dementia, behavioral symptoms, impaired mobility, and coronary disease. The resident was permitted to attend a community function, unaccompanied, via a cab. Following the event, the resident was found nonresponsive; "in the street, limp, with his face cold." The resident had a heart attack and died two days later. (CBRF)
133. The facility did not ensure prompt treatment for a resident who had recent surgery for fractured femur and a history of recurring cellulitis (skin infection caused by bacteria). Caregivers noted the resident's leg was "very red from the knee down to her ankle...weeping clear fluid...very itchy and...burning...foot quite swollen." Six days elapsed before the resident received medical care. After being transported to the emergency room, "the resident was taken to the operating room for incision and drainage (I&D) of her femur incision...and underwent additional irrigation and washout of surgical incision." The resident was found to have multiple pressure sores. "When the surgeon came out of surgery, his first question was 'Why wasn't I notified sooner?'" Following surgery, the resident required inpatient rehabilitation. (CBRF)

134. A facility did not provide needed supervision to protect vulnerable residents from inappropriate sexual contact by another resident. While unsupervised, a male resident with a known history of sexually-inappropriate behaviors was found in the bedroom of a “total care” resident with dementia who was unable to call for help. When discovered by staff, the male resident had his pants down and genitals exposed. The female resident was in bed and the male resident had pulled her pants down and had his hand on her brief. A second incident occurred during which the male resident was found in the bedroom of another cognitively-impaired resident. The male resident had his pants down and genitals exposed. He was hovering over the female resident who was on the bed, naked. (CBRF)
135. A resident with traumatic brain injury and a history of elopement required 24-hour supervision. While unsupervised, the resident left the facility. Approximately one hour later, staff noticed the resident was missing and saw footprints in the snow. An immediate search was not conducted, as only one staff member was on duty. The resident was discovered deceased in a wooded area five days later. The cause of death was hypothermia due to environmental exposure. (AFH)
136. Despite more than 30 incidents in a four-month period, the facility did not have an effective plan to manage a resident’s self-injurious behaviors, including attempts to exit a moving vehicle, choke self with cords, and cut self. To intervene, caregivers placed the resident in dangerous, physical holds for up to seven minutes at a time. When restrained, the resident struggled and became more agitated, resulting in nose bleeds, a broken hand, and a shoulder injury. (AFH)
137. Caregivers did not provide needed supervision for a resident with a history of self-injurious behaviors, including attempting to burn self. While unsupervised, the resident held a cigarette to his/her wrist and sustained a dime size burn. (AFH)
138. The facility did not develop a safe, effective treatment plan for a resident with a history of suicide attempts. When the resident attempted self-injury, such as wrapping an ace bandage, electrical cords, or stockings around her/his neck; cutting at wrists with a broken CD; and walking toward busy traffic, caregivers physically restrained the resident in dangerous, unauthorized “basket holds.” (AFH)
139. A resident with anxiety and seizure disorders experienced 25 seizures without medical intervention over an eight-month period, despite seizures lasting up to three hours. (AFH)
140. A concerned neighbor contacted police for repeated incidences of disturbances during which staff were yelling and using profane language toward a resident. Caregivers who observed the verbally abusive treatment did not promptly report the abuse. (AFH)
141. A nonverbal resident with cerebral palsy did not receive medical care despite four days with a fever, vomiting, and other symptoms. The resident was hospitalized for 15 days with aspiration pneumonia, then placed in hospice care, and died the following week. (AFH)
142. A facility did not have an effective behavior plan for a resident with aggression towards staff and other residents. Behaviors included yelling, hitting walls (causing damage), hitting staff, inappropriately touching staff, and performing “pelvic thrusts” on female staff in the presence of other residents. (AFH)
143. During a period of several weeks, a resident made suicidal threats to staff, including threats to hang her/himself so that “no one would be able to get the knot untied.” The resident refused to eat, informed staff of feeling depressed and not wanting to live anymore, expressed boredom, and stated she/he would “rather be dead.” Facility staff did not report these statements to a physician. Upon entering the resident’s room, staff found the resident had committed suicide. (AFH)

144. During transport to an activity, a resident recorded a licensee repeatedly using angry, foul language toward residents, such as: “Nobody in the fucking car appreciates it.” “Every fucking week it’s like this.” “You fuckers don’t appreciate it.” The licensee’s verbally abusive remarks intimidated that future privileges and activities would be withheld. (AFH)
145. Caregivers punished a nonverbal, intellectually disabled resident for “not behaving” by placing the resident in “time-outs” and by withholding the resident’s favorite personal belongings. (AFH)
146. The facility had not implemented a behavior treatment plan for a resident with aggression. The resident was injured and sustained bruising when caregivers physically restrained the resident on multiple occasions without authorization or training. (AFH)
147. Over a period of two months, a facility retained a resident with a history of violence and disruptive behaviors toward other residents without implementing an effective plan to ensure the protection of others. There were nearly 40 documented incidents where the resident would “wake up at night, pace, loudly stomp feet, slam doors, slam dresser draws, enter other resident rooms, holler, swear...hit a resident, argue with residents..., all while the other residents were fearful and trying to sleep.” (AFH)
148. A resident did not receive prompt medical care despite having a fever and being described as “unsteady and shaky, couldn’t stand, and unable to hold a cup or utensils when eating.” The resident fell, sustaining a gash to her/his nose, and was left on the floor for five hours. Approximately 48 hours later the resident was admitted to the hospital. (AFH)
149. A licensee did not investigate misappropriation of resident funds when ledgers revealed that a facility manager had reimbursed herself over \$3,000.00 of resident monies for unaccounted purchases. (AFH)
150. Caregivers used “duct tape” to fasten a resident’s legs/feet to the footrests on his/her a wheelchair. (AFH)
151. A licensee did not provide a safe, emotionally stable environment for residents when repeated police calls were made due to resident-to-resident and resident-to-staff altercations. Several altercations resulted in injuries. Police issued disorderly conduct citations to both the licensee and a caregiver. In addition, the licensee was present at the facility during an incident when the police needed to intervene and s/he was observed to be intoxicated. (AFH)
152. A licensee did not adequately assess residents before admission or develop behavior plans that were effective for controlling two residents described as aggressive and violent. Incidents included threats to stab another resident with a knife, resident-to-resident physical fighting, punching caregivers, throwing objects, and police interventions with residents being jailed. Caregivers were not sufficiently trained to deal with challenging, aggressive behavioral symptoms. (AFH)
153. A provider did not maintain equipment in good operational condition. While transporting a resident, the van “safety lip” did not lock and a resident’s wheelchair brakes were not working properly. The resident fell three feet from the suspended lift and sustained a head injury. Service providers had not received training for safely transporting residents. (AFH)
154. A resident left the facility without staff supervision for over three hours. There was only one caregiver on duty and other residents in the facility required supervision. The resident was found six miles from the facility with scratches on his/her neck. The resident reported that a caregiver had “grabbed” the resident by the neck. The legal guardian immediately removed the resident from the facility. (AFH)
155. A resident with mental illness eloped from the facility after becoming upset. The resident was found by police the next day after spending the night outdoors in a wooded area. Without adequate supervision, the resident eloped again and police were contacted by a citizen who reported seeing the resident in the bluff area. (AFH)

156. A resident fell from a wheelchair during transport in a van and sustained an abrasion over his/her eye. The staff member driving the van indicated he had not received training on securing residents with wheelchairs in the van. (AFH)
157. Caregivers implemented a punitive behavior program that caused an intellectually disabled resident's symptoms to escalate. During behavioral incidents, caregivers would take away the resident's favorite, personal belongings, causing the resident to become distraught. (AFH)
158. Despite being aware of multiple allegations that a caregiver refused to assist residents with showers, would not allow a resident to use his/her blanket when s/he was cold, denied a resident food and liquids, wheeled an unclothed resident in his/her chair throughout the facility at an unsafe speed, showered a resident in their wheelchair, and left the resident in the wet chair as "punishment," placed a bean bag chair in front of a resident's door to prevent the resident from leaving the room, and took away personal possessions as punishment, the program manager did not start an investigation until six weeks after the allegations were reported. (AFH)
159. A licensee did not protect residents from another resident's abusive behavior, including 72 documented incidents in six months; e.g., persistent aggression toward peers; striking, kicking, spitting on, scratching; releasing others' seatbelts and attempting to hit peers during transport; choking a peer; and, then, attempting to push the peer down a stairway. Residents stated they were afraid because they had been assaulted and the resident remained in the facility. (AFH)
160. The facility did not ensure needed services for a resident, who was incontinent of urine and developed skin breakdown. A care plan was not developed to promote healing and prevent new sores from developing or to address toileting and incontinence. (AFH)
161. A caregiver, who was spit on by a resident, slapped the resident's face, attempted to put the resident's hood over his/her head, and threw the resident to the ground. The caregiver then placed his/her knee on the resident's face, would not allow the resident to get up, and slapped and punched the resident in the stomach. A second caregiver participated by placing his/her foot on the resident's ankle. The resident was then taken to his/her bedroom and caregivers held the door closed. The resident could be heard crying behind the door. Two caregivers who witnessed the incident failed to report it. (AFH)
162. A caregiver failed to activate the door alarms and was sleeping on duty. A resident with intellectual disabilities left the facility, improperly dressed for the weather, and was exposed to dangerous conditions that included passing through an area with high traffic volume, freezing temperatures, darkness, and a physical location where the resident was not likely to be seen or helped by passersby. The resident, who had fallen and broken his/her elbow, was discovered by a sanitation worker in a commercial area. The worker contacted the police. (AFH)
163. A resident with complex behavioral needs did not receive needed supervision and exited the facility on multiple occasions without staff knowledge. During one such incident, the police responded when the resident was wearing a "Halloween mask, carrying a fake machete type knife, and pounding on a neighbor's door." Caregivers did not provide the needed supervision when the resident cut his/her arm with a razor, attempted to cut staff with a knife, broke windows, and struck out at peers. (AFH)

164. A licensee failed to provide proper care and treatment for a developmentally disabled resident. The licensee would not allow the resident to dress him/herself as “it was quicker to just do it.” The surveyor observed the licensee “abruptly” thrust a tooth brush into the resident’s mouth without forewarning or explanation. The resident’s head “jerked back” and the resident repeatedly verbalized wanting the licensee to “stop.” The licensee responded by asking if the resident wanted his/her teeth “pulled out instead.” The licensee acknowledged pressing a “cold gallon of milk” on the resident’s stomach, putting “ice” down the resident’s shirt, and pulling the back of the resident’s shirt over the top of his/her head to purportedly “redirect” behaviors and “improve mood.” The licensee also stated that the residents “are really just kids in adult bodies and they need to be treated like children.” (AFH)
165. The provider did not arrange for adequate services for a resident with dementia who required 24-hour supervision. On more than one occasion, the resident left the facility, unsupervised. Once, the resident was discovered missing when a basement door alarm was “not in working order.” During another incident, staff discovered the resident’s bed against the wall with the window screen “popped out.” The resident was found outdoors, “shoeless,” and carrying a box of his/her belongings. On a third occasion, the resident was missing for five hours until returned to the home by police. (AFH)
166. A licensee stopped at the mall to run an errand, leaving two residents sitting in the car with the car running and the keys in the ignition. One of the residents “took off” in the car with the second, frightened resident as a passenger. The residents were found 24 hours later by the police in another state. (AFH)
167. A facility failed to develop effective interventions to address a resident’s behavioral symptoms (related to Downs Syndrome) and did not assess, monitor, or track behavioral incidents. The case manager was not notified of behavioral problems. In fact, when the facility last contacted the case manager (three months prior), the resident was described only as “having ups and downs.” The facility contacted the legal guardian on a Saturday and discharged the resident the following day (Sunday), with no preparation. (AFH)
168. A diabetic tenant required sliding scale insulin based on a blood glucose reading before each meal. The tenant’s record did not consistently document the units of insulin that were administered. During a six-week period, there were 150 opportunities for sliding scale insulin to be administered and only 53 opportunities were documented. (RCAC)
169. An insulin-dependent resident with peripheral vascular disease experienced a toe injury and then developed an ulceration. The tenant’s service agreement was not updated to reflect the wound or related complications and service needs, including pain, increased edema, changes in mobility, and prescribed wound treatments. (RCAC)
170. While being transported in a wheelchair without footrests, a tenant’s leg became entangled beneath the chair. The caregiver continued to push the wheelchair forward while the tenant, who had osteoporosis, called out in pain. The tenant was hospitalized the following day and diagnosed with a severe fracture to the left femur. (RCAC)
171. A facility did not provide a safe environment for tenants during a parking lot resurfacing project. A tenant, using an alternate exit, fell down concrete stairs and sustained a dislocated shoulder and a cut to the forehead. The alternate exit did not have handrails. (RCAC)
172. An RCAC retained a tenant with progressive Parkinson’s disease and urinary incontinence who required the assistance of two caregivers for all mobility, including transfers, toileting, ambulation, and evacuation in the event of any emergency. At times, the tenant required the use of a mechanical lift. Despite significant changes in health and safety needs, the tenant’s assessment had not been revised in nearly two years. (RCAC)

173. An RCAC retained a tenant without ensuring needed services after the tenant became increasingly confused and agitated, searching for his/her spouse (who was deceased). At one point, the tenant left the building in unsafe winter conditions and returned only when staff threatened to call the police. Despite significant changes, the RCAC had not assessed the tenant's health or safety needs since a pre-admission assessment was completed, nearly 18 months earlier. (RCAC)
174. An RCAC employee was verbally inappropriate when telling a tenant about his pornography addiction. In addition, a week prior to this, the tenant reported feeling "stalked" by the employee and stated the employee "brushed across" the tenant's breasts. The operator did not take immediate steps to protect the tenant (or others) and allowed the accused to work the day after the allegation was reported. (RCAC)
175. A tenant with a history of lumbar and pubic fractures fell at 1:00 a.m. and requested a pain pill for "arm pain." Approximately five hours later, the tenant became "unresponsive, very groggy," reported not feeling well, and upon sitting up, started "gagging and vomiting." The tenant "went stiff" and had a blank stare that lasted for approximately 30 seconds. There was no indication that medical personnel were contacted to report this change in condition. Approximately eight hours after the fall, the tenant had another period of unresponsiveness where s/he "fell back into bed and became unresponsive for two minutes." The tenant was hospitalized and diagnosed with a pelvic fracture, shoulder fracture, and elbow fracture. (RCAC)