Division of Quality Assurance – Bureau of Assisted Living
Assisted Living Serious Violations with Enforcement
January-June 2008

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 caregiver left a dependent resident alone in a van while he/she went into a restaurant to order lunch. The resident has a seizure disorder and requires 24 hour supervision. (AFH)

2. Three residents who require staff assistance did not receive regular showers or baths. One resident, who is incontinent, was not bathed for 10 days. (CBRF)

3. A facility did not have sufficient staff to supervise residents and provide needed services. Two residents with dementia eloped frequently (up to 20 times per shift) while only one caregiver was on duty. The sole caregiver could not leave the building to retrieve residents when they left unsupervised. (CBRF)

4. The facility admitted and retained a resident with dementia and a known history of aggressive behaviors (including previous incidents in the facility) but did not schedule sufficient staff to ensure the protection of residents. During an evening shift, the resident attacked the only caregiver on duty and struck another resident. Because the caregiver was alone, she telephoned her husband and the police. Her husband stayed with her for the remainder of her shift, as no other staff members were available. (CBRF)

5. A facility did not have sufficient staff and the only caregiver on duty "strapped a resident to the couch" to prevent the resident from getting up and injuring himself while the caregiver assisted other residents. (AFH)

6. Although some residents in the home required the assistance of two staff members for transfers (e.g., to and from bed, to the toilet), only one caregiver was on duty during the nightshift (and for periods of time during other shifts). Residents with normal bladder control had to urinate and defecate in their pants and wear adult diapers when the sole caregiver on duty could not assist them to the toilet. In the event of a fire emergency, one caregiver could not safely evacuate the residents from the building. (CBRF)

7. Two residents in a home required the assistance of two staff members for transfers; however only one caregiver was on duty for up to 12 of 24 hours each day. A resident fell at 1:45 a.m. The sole caregiver on duty was unable to assist the resident from the floor. The resident pleaded for help to get up and complained of "hurting all over." The resident remained on the floor for over 5 hours until the day shift staff person arrived. (CBRF)

8. Four residents did not receive sufficient, nutritious food. On the day of survey, each resident received only a bowl of cornflakes (one cup or less of cereal) and a glass of water for breakfast. The planned menu indicated residents would receive cereal, toast, fruit, and milk. One resident was scheduled for an outing and did not have time to finish eating. The resident was told by staff to "take one more bite or they will leave you" because the transport service was ready to go. (The breakfast meal provided only 260 calories, at most, if a full cup of milk was consumed.) (AFH)

9. A nonverbal, physically impaired resident who required 24-hour supervision was left alone in the shower while a caregiver went to do laundry. The resident fell and hit his head on the wall, sustaining a closed head injury and neck fractures. Due to these injuries, the resident was hospitalized for 10 weeks, requiring surgery, mechanical ventilation, a tracheostomy, a catheter, and a feeding tube. The resident was then admitted to a nursing home with paralysis. (CBRF)

10. Residents with complex needs were not assessed, prior to or following admission, to determine needed services. One resident did not receive prescribed wound care treatments, repositioning, adequate nutrition, or other measures to promote healing for pressure ulcers on his heel and buttocks. Staff was unaware of another resident's foot deformity that required special care. Without proper care, the resident's foot became "irritated and painful" and the resident could no longer walk. Due to a delay in receiving needed medical attention, the resident required a toe amputation and developed a postoperative infection. (CBRF)

11. A resident recuperating from a fractured hip "yelled out in pain" but did not receive timely pain medication. Two days elapsed before caregivers informed a nurse and the facility manager of the resident's increasing complaints of pain and inability to bear weight. Once reported, a prescription for pain medication was obtained. (CBRF)

12. An incontinent resident who was dependent upon staff for all cares was not changed every two hours as indicated by the service plan. On the day of survey, the resident was in bed from 7:00 to 11:00 a.m. with no personal cares provided. When changed at 11:00 a.m., the resident's incontinence pad was "saturated" with urine and soiled with fecal matter. (CBRF)

13. Staff observed another caregiver abusing and neglecting residents for nearly 4 months and reported several incidents to managers. The managers did not take steps to protect residents from the caregiver. The caregiver swore at residents and called them "foul names." The caregiver "ripped" a call pendant from around a resident's neck and placed it out of reach. The caregiver refused to provide personal cares for incontinence and family members complained when residents were "saturated." During one incident, the caregiver "tugged hard on [the resident's] catheter, which she often did" and later there was blood in the catheter bag. The resident was taken to the emergency room and diagnosed with hemorrhagic cystitis (inflammation of the bladder leading to hemorrhage). The resident later returned to hospital because of large clots of bright red blood in the Foley catheter. (CBRF)

14. A resident fell and sustained a head laceration. The facility did not send a list of medications, including the medication Warfarin (an anticoagulant/blood thinner), when the resident was transferred with to the emergency room. The resident's primary physician was not notified and the facility did not monitor the resident's condition. Staff did not obtain prompt medical attention on the evening of the fall when the resident's "head laceration began to bleed and sutures appeared torn." The resident was transferred to the hospital the following day due to complaints of extreme head pain. The resident died from a subdural hematoma. (CBRF)

15. The facility did not complete a criminal background check on an employee with illegal drug convictions (e.g., possession of cocaine). The new staff person was assigned to administer medications to residents, including narcotic pain medications. A complainant alleged that medications for which the staff person was responsible turned up missing. No facility investigation occurred. (CBRF)

16. A staff member alleged that another staff person was abusing a resident and the resident was noted with a "large bruise with swelling" after the staff person's shift. The resident was transported to the hospital and diagnosed with a fractured arm due to an "injury of unknown origin." No facility investigation occurred and the staff person was scheduled to work 9 more shifts. (CBRF)

17. A resident was observed coughing for an hour and a half, throughout breakfast. A staff person did not assist the resident and only spoke to the resident to state, "you know you have to swallow." The resident had a physician's order for a mechanical soft diet with thickened liquids. However, the staff person had served a general diet with unthickened liquids. The resident had consumed only ¼ of an egg and ½ bowl of cereal. When the surveyor asked the staff person how much the resident had eaten for breakfast, staff A falsely replied, "all." (CBRF)

18. A doctor's appointment was scheduled for a resident experiencing knee pain. The resident's physician transferred the resident to the hospital where she was diagnosed with a left hip fracture. The resident had fallen at the facility two days earlier and her left leg was "noticeably shorter" on the side of the fracture. The resident did not receive prompt medical treatment following the fall despite pain and signs of injury. In addition, resident 4 was wearing compression boots on both legs. When removed by hospital staff, the boots were found to be "moldy and foul smelling… the skin on her legs was reddened, peeling, and scaly…". The resident was diagnosed with cellulites (inflammation and infection) and required IV antibiotics. (CBRF)

19. A male resident sexually assaulted two female residents with dementia who were unable to defend themselves. The male resident was involved in multiple incidents, including kneeling in front of [a female resident] and holding and sucking on her breast (while his pants were undone) and "rubbing a female resident's thigh and putting his finger near her vaginal area." (CBRF)

20. A resident fell and sustained injuries to his left chest, left arm, left hip and left shoulder. He was "was very uncomfortable all night and in a great deal of pain…he took morphine five times… it was non-effective for pain relief." The resident was not transferred to the hospital until the next day, when he was diagnosed with "3 fractures of the pelvis." (CBRF)

21. A resident with dementia was found outdoors "lying on her side" at 7:50 a.m. one winter morning. Hospital records indicate she was "outside on the ground for about 90 minutes" and had hypothermia. The resident died less than 2 weeks later. (CBRF)

22. A resident with dementia wandered from the facility without seasonal clothing one winter day when the outdoor temperature was 32 degrees. Staff did not know the resident was missing until they were contacted by the police. This incident occurred despite a known risk and previous incidents. For example, police also returned the resident to the facility on 12/23/07 when the outdoor temperature was 16 degrees and it was snowing. At that time, the resident was located 1.2 miles from the facility. The police report included, "Resident had a lightweight jacket… he didn't have any type of hat covering his ears or face and he was not wearing gloves. The windchill was three degrees." (CBRF)

23. A 97 year old resident with dementia wandered from the facility and "walked (with a walker) approximately a mile before a concerned driver stopped to assist." The outdoor temperature was 28 degrees and it was dark outside. "She was found in the eastbound lane of a US Highway and

had to cross through the westbound lane." Traffic on the highway averages 15,400 vehicles in 24 hours. The facility was not aware the resident was missing until police called. (CBRF)

24. A resident with dementia had a tendency to lean while in bed to "play with the curtains." Staff knew this and the resident had a bed alarm due to a known risk of falling from the bed. The bed was placed "flush" against the wall, window, and metal heat register. The resident was discovered "between the bed and wall" with his feet on the register. A caregiver reported that his "feet were bloody and there was skin [from the resident's feet] on the register. In addition, the resident's catheter had "pulled" and there was "blood in his depends" [adult incontinence pad]. Abrasions, lacerations, and multiple burn areas with "full skin loss" were present on the resident's feet. Wound complications developed including cellulitis (inflammation, infection) and "black eschar," (dead skin tissue). (CBRF)

25. A caregiver permitted a resident with impaired judgment to walk to WalMart in January when the outdoor temperature was – 9 degrees. The resident was not wearing gloves and returned to the facility with frostbite. (CBRF)

26. The licensee grabbed a disabled resident by the lapels and "threw" her onto a cement driveway. The resident cried out "Please don't hit me again!" "Are you going to hit me in the head again?" The resident was observed lying on the ground for 5 to 7 minutes calling out "Someone please help me." The licensee and her husband then "picked up the resident and slammed her" into a white plastic chair. (AFH)

27. Despite multiple requests by the staff of a resident's vocational day program, the licensee did not send the resident's seizure medication or the physician's recommendations for seizure protocols from November 2007 through April 2008. The resident experienced a seizure and required medication which "could not be administered as [day program] did not have it." (AFH)

28. A facility had not completed criminal background checks for an employee responsible for transporting residents. After the driver was involved in an accident while transporting residents, it was discovered that the driver had arrests or charges that included "battery," "speeding," and "operating [a vehicle] while revoked." Following the accident, residents were transported to the hospital where they were "checked out and sent home." (CBRF)

29. A resident with osteoporosis and a prior history of a hip fracture fell and was found on the floor "with her left leg bent into Indian style." The resident complained of "severe pain" following the fall but no medical attention was sought until the following day when the resident was admitted to the hospital with a hip fracture. (CBRF)

30. A resident fell and sustained a head injury at 5:00 a.m. Staff did not report the injury to the facility director or physician. When significant adverse changes in the resident's physical and mental condition were observed by staff on the day shift, resident 1 was transported to the hospital by ambulance. Information about the resident's fall and head injury was not conveyed to the resident's family or to emergency medical staff.. Resident 1 died at the hospital of an acute intracranial hemorrhage. (CBRF)

31. In an event witnessed by two other caregivers, Staff B "made a resident stand in the hallway until she said 'F***.'" The resident, who has dementia, had been up at night and asked Staff B some questions. Staff B said, "you ain't going back to bed unless you say

'F***." "Twenty-five minutes later, (Staff B) gave up because (the resident) wouldn't say it." Staff B stated, "good thing she has Alzheimer's because tomorrow she'll forget this ever happened." The abusive caregiver worked for an additional 5 shifts before the administrator was aware of the occurrence. (CBRF)

32. A facility assigned only one caregiver on duty for 15 residents with complex needs. While the caregiver was assisting another resident who was ill, a resident eloped from the facility and was found in the road by "passersby" and was "bleeding from the head." The injured resident "did not have her walker and had left shuffling footprints in the snow to indicate a slow gait." The elopement and fall resulted in a fracture of the resident's eye socket and nose and fluid accumulation around her brain." The resident was admitted to a nursing home and is no longer ambulatory. (CBRF)

33. A resident did not receive prompt or adequate treatment to address a painful pressure sore that progressively worsened. The physician was not contacted and no medical assessment was obtained for over a month until the resident was hospitalized with "an 8x5 cm necrotic ulcer with some surrounding erythema… a full-thickness black eschar." The physician debrided the wound and the resident required IV antibiotics. Upon discharge from the hospital nearly two weeks later, the resident returned to the facility with Hospice services. (CBRF)

34. Several medication errors occurred at a facility including that a resident received an excessive dose of Coumadin (blood-thinner) over a period of 3 days. Subsequently, the resident experienced bruising on both arms and the resident's catheter bag was "full of bright red blood." (CBRF)

35. An ambulatory resident was improperly restrained. The types of restraints that were utilized included: a wheelchair affixed with a seatbelt, raising the foot rest of a reclining chair to prevent the resident from exiting a recliner, a gait belt used to strap the resident in the recliner, and a ratchet-type strap (from the garage) used around the resident's upper abdomen and/or around the resident's lower legs to impede mobility. (AFH)