Division of Quality Assurance – Bureau of Assisted Living
Assisted Living Serious Violations with Enforcement
January 1 – June 30, 2009

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. Prompt notice was not given to a resident's physician or to the professionals responsible for a resident's care when the resident fell to the floor after being pushed by another resident at 6:00 p.m. The resident was experiencing pain and received acetaminophen at 7:00 p.m. Records at 8:30 p.m. indicated the resident had difficulty standing and walking. Increased pain symptoms were reported during the night. When the resident was transported to the emergency room the following morning it was found that the resident had a fractured pelvis. (CBRF)

2. An elderly resident with dementia eloped from the facility in December without winter clothing and was found a mile away by police at 9:00 a.m. Staff had last seen the resident around 7:30 a.m. When the resident was returned, caregivers told police they did not know the resident was missing. The outdoor temperature was 5 degrees with wind gusts up to 16 miles per hour. (CBRF)

3. The facility did not provide appropriate services to address behavioral symptoms. A resident sat inside the facility's van for nearly seven hours (refusing to leave) before staff contacted the program supervisor. The resident received no dinner and had an episode of incontinence while in the van. The resident was then transported by police to a mental health treatment facility. (AFH)

4. A resident who had a history of confusion, wandering, vision impairment, and falls, was left unsupervised on the upper level of the facility while the caregiver on duty was in the lower level of the facility. During this time, Resident 1 fell down a flight of stairs in a wheelchair. The resident had recent falls that were not evaluated or documented. Subsequently, interventions to minimize the risk of injury from falls (e.g., environmental modifications, increased supervision, etc.) were not implemented. Emergency medical care was not sought immediately following the fall. Staff "pulled the resident up the stairs" and called the resident's legal representative before calling 911. The resident was hospitalized with fractures, multiple contusions, and coma and died in the hospital. (CBRF)

5. A frail, elderly resident with dementia had 54 documented falls during the prior year. Most of the falls were unwitnessed and occurred in the resident's bedroom. The resident's bed was placed against the baseboard radiator. In December 2008, following a fall, the resident's feet became caught in the heat register resulting in second degree burns. Notes indicated, "skin peeled off 8 of 10 toes…also marks on both legs (lower)..." (CBRF)

6. Residents received FoodShare benefits (public assistance) and the facility applied funds to the facility's meal program. The licensee did not develop and maintain sound accounting practices or record-keeping. The facility manager was not adequately supervised and monitored and diverted FoodShare benefits to a private account over a

period of 2 ½ years. When the ongoing theft was discovered, the facility failed to conduct a thorough investigation and did not report the misconduct to the department as required. (CBRF)

7. While providing personal cares to a resident, the caregiver did not wash her hands and change her gloves to prevent the potential spread of infection throughout the home. Resident 1's cares included incontinence and perineal care. Multiple problems were identified including that the caregiver answered the telephone, turned door knobs, and handled other surfaces during the provision of personal cares (while wearing the same gloves or failing to wash hands). For example, after providing peri-care, "The caregiver closed the bathroom closet door, turned on the faucet, and rinsed the resident's toothbrush…handed a cup of water to the resident [and] opened the closet door, removed a clean washcloth, and wiped the resident's face." (AFH)
8. A caregiver attempted to draw up 0.5 ml (milliliters) of liquid Risperidone (antipsychotic medication) from the medication's bottle using a small syringe. The caregiver did not use an appropriate technique and the surveyor observed an air bubble located at the tip of the syringe (inaccurate dosage). The caregiver told the surveyor that she did not know how to get rid of the air bubble and that this is how she gives the medication to Resident 1 whenever she passes medications. (AFH)
9. The facility did not ensure that a resident received prompt and adequate treatment following a fall from bed. Night shift staff left the resident on the floor until the day shift worker arrived to assist. No assessment of possible injuries was completed prior to moving the resident from the floor. The resident complained of pain and was admitted to the hospital with a broken knee and was then transferred to a nursing home. (AFH)
10. A caregiver showed a resident "nasty pictures on a cell phone of her boyfriend's privates." The facility did not investigate or document the allegation and did not submit a report to the Office of Caregiver Quality. (CBRF)
11. A resident required supervision due to increased confusion, recent falls, and a prior attempt to exit the facility, unattended. Staff were unaware the resident was missing at 6:30 a.m. until the resident was discovered lying outside on the ground by a dayshift caregiver who was reporting to work. The outdoor temperature was 28 degrees and the resident was barefoot and wearing only a nightgown. The resident required hospitalization for Hypothermia and abrasions on hands, knees, and feet. (CBRF)
12. On the 21st and 22nd of the month, the facility did not contact the physician or make arrangements for needed medical services when a resident experienced a significant change of condition including vomiting, abdominal pain, nausea, disorientation, cold and clammy skin and significant drop in blood pressure. On the 23rd, the resident was admitted to the hospital with a diagnosis of septic shock, peritonitis secondary to acute inflammation or infection of the gallbladder and acute renal failure. The resident required extensive medical management and surgery but remained in poor condition and died in the hospital on the 27th. (CBRF)

13. A resident with dementia and chronic respiratory problems became acutely ill. A week elapsed before the resident was examined by a physician. The examining physician (EP) recommended that the resident go to the emergency room. The EP told the surveyor, "When I told the caregiver that I wanted to refer [the resident] to the emergency room she told me that she did not think her boss would approve of that… The person with whom I spoke said that her manager was on the phone and had talked with the resident's primary physician (PP) and that the PP wanted to see the patient." At this point, the examining physician called the primary physician and was told that PP had heard nothing about the resident's condition and no appointment was scheduled. The resident was then transported to the ER. AFH **c**aregivers suggested the resident was "faking it to get attention." The ER note stated, "The patient …has been having these symptoms for over a week and had not been taking her nebulizer treatments at the home and no one has taken [the resident] to the hospital. Resident #1 was admitted to the hospital from the ER. (AFH)

14. The facility did not ensure an 80 year old resident received prompt and adequate treatment after the resident slipped off the bed and was on the floor for 5 hours before morning staff arrived to assist her back to bed. Being left on the floor presented a significant risk due to the resident's medical condition. (The resident's diagnoses included fibromyalgia (muscle and connective tissue pain, is a disorder classified by the presence of chronic wide spread pain and a heightened and painful response to gentle touch), severe degenerative joint disease, and history of erythromelalgia of the feet (a rare disorder in which blood vessels, usually in the lower extremities, are episodically blocked and inflamed). The resident had left and right total knee replacements, right total hip arthroplasty and history of a laminectomy for spinal stenosis (spine operation to remove the portion of the vertebral bone called the lamina). (CBRF)

15. A resident experienced an unwitnessed fall that may have caused a head injury. The resident fell several times within the next couple of days but a prompt medical evaluation was not obtained. The resident's condition deteriorated significantly. Records indicated the resident's speech was impaired. The resident had been fully ambulatory and became unable to bear weight. The resident had been consuming nearly 100% of meals and appetite/intake had decreased markedly. Once a medical evaluation was obtained, the resident was diagnosed with pneumonia, a hip fracture, and a compression fracture of the lumbar vertebrae. Resident #4 died on 2/5/08. (CBRF)

16. Staff B did not properly puree Resident #1's food. In addition, Staff B left the dining area to assist another resident to the toilet and did not provide the needed visual supervision of Resident #1 as she ate her meal. Resident #1 choked on her food and emergency medical technicians extracted a "quarter sized" piece of meat. The resident died 3 days later. (CBRF)

17. Tenant #1 had episodes of confusion. The facility did not verify Tenant #1's location at times requested by the Tenant and family or as directed by the facility's bed check procedure. The facility did not have a system in place to alert staff when Tenant #1 left the building and did not ensure that Tenant #1 could reenter the building if the doors were

locked. In February, Tenant #1 left the facility without staff knowledge and he was unable to reenter the locked building. This resulted in Tenant #1's death. Per the medical examiner report, Tenant #1's cause of death was Cardiac Arrhythmia secondary to Environmental Hypothermia. (RCAC)

18. The licensee and manager were drinking and using drugs in the facility with the residents present. The licensee confirmed that she had purchased illegal drugs while a resident was present in the vehicle. (AFH)

19. A developmentally disabled resident had symptoms of illness and complained of being sick, slept for long periods, experienced a fall, and had a poor appetite. Caregivers indicated they contacted the facility manager but medical attention was not sought. The manager discounted the resident's condition telling a caregiver, "[It's] because [Resident 1] was partying like a rock star this weekend." (In fact, the resident had been ill during the weekend visit with her family and her mother reported the symptoms of illness to caregivers.) Prompt medical attention was not obtained and Resident 1 was found on the floor "with no pulse or respirations" and was pronounced dead at the hospital. (AFH)

20. The facility had not completed an assessment and individualized service plan for Resident 1, a resident with multiple sclerosis and a known history of sacral decubitus ulcer. No service plan had been developed to address the risk of developing pressure sores. Following admission to the facility, the resident developed a pressure ulcer described at the hospital as: "Right ischial Stage III pressure ulcer (full thickness skin loss involving damage to or necrosis (dead) of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with undermining of adjacent tissue)." (AFH)

21. Within one week, Resident 1's condition declined from being able to feed himself and ambulate to no longer bearing weight and being fed by staff. Staff A refused to have the resident medically evaluated. It was reported that Staff A told caregivers to let Resident 1 feed himself as he was being "lazy." When Resident 1 became unresponsive, a family member told staff to call 911. Staff A allegedly yelled at staff for calling the ambulance. "She lied to the emergency technicians telling them nothing had been wrong with [Resident #1]." Hospital records indicated the resident was dehydrated and was admitted to ICU. He was then transferred to a nursing home. (CBRF)

22. A resident did not receive pain medication (fentanyl patch on her back) every 72 hours as prescribed. Patches were applied in error several times with applications between 48 hours and 104 hours. Staff placed a patch on the resident's forehead instead of her back. The resident became very ill and was transported to the emergency room (ER). ER staff found 3 fentanyl patches on Resident 1's back in addition to the patch that had been removed from the forehead. While in the ER, she required intravenous fluids and medication to stabilize her condition. (CBRF)

23. The facility did not fully investigate, report to the department, or take steps to protect residents after several allegations of caregiver abuse were raised. Residents sustained bruises (including bruises to the face and lips), complained of being fearful, and stated

the caregiver slapped them. The caregiver allegedly withheld water and placed call cords out of reach. (CBRF)

24. A resident fell outdoors in February. The temperature was 35 degrees and staff could not lift the resident into a wheelchair. The resident had been incontinent and was wet and cold. After the resident lay on the snow and ice-covered ground for more than an hour, staff asked the resident to crawl up the ramp to the facility. Staff did not call 911. The resident was taken to the hospital the next day with bruises and a leg injury. He was then admitted to a nursing home for rehabilitation. (AFH)

25. A facility placed an assistive device on a resident's bed (partial bed rail) to prevent the resident from falling from bed. The resident was mobile and restless in bed and had fallen off the edge of the bed previously. The resident became entangled in the device and died of "asphyxia due to strangulation." The facility did not assess the potential safety risks and did not include the assistive device in the resident's service plan. Assessments and care planning were not adequately coordinated with Hospice to address the bed rail. The rail had not been assessed to determine if it constituted a restraint that would require department approval. (CBRF)

26. A resident with dementia and a known history of elopement did not receive adequate supervision. The resident was found at restaurant, several blocks from the facility, by a citizen in an area of heavy traffic (up to 18,800 vehicles daily). (CBRF)

27. A resident experienced adverse side effects from psychotropic medication. The facility did not monitor or document the resident's symptoms. Effects of the medication interfered with the resident's speech and sleep patterns. In addition, the resident was hospitalized and the record at the facility contained no documentation pertaining to hospitalization. (CBRF)

28. The facility did not monitor and obtain timely medical services for a resident who was unable to communicate symptoms of illness. Over a period of 4 days, the resident experienced a change of condition that included behavioral symptoms, coughing, and "rough breathing." Medical care was not sought until the resident was "lying in bed with large amounts of secretions, almost foaming at the mouth." The resident died in the hospital with diagnoses that included sepsis with underlying urinary tact infection and pneumonia. (CBRF)

29. A facility did not provide adequate supervision for two residents with dementia. Both residents left the facility and were located by police. One resident was found in the middle of an intersection. (CBRF)

30. While recovering from a fracture, a resident required the assistance of two caregivers to use the bathroom. The facility did not ensure adequate staffing patterns. The resident – who would have been continent with toileting – was required to urinate in Depends when in bed. (CBRF)