

Division of Quality Assurance – Bureau of Assisted Living
Assisted Living Serious Violations with Enforcement
(January – December 2010)

The Division of Quality Assurance (DQA) maintains information about violations that are issued and sanctions that are imposed, which may include forfeitures against state-licensed, -certified, and -registered assisted living facilities. This report does not include all information contained in a particular survey report or in corresponding documents, and may not reflect changes that occur as a result of the appeal process or due to administrative changes. DQA protects the confidentiality of residents as required by law and no conclusions should be drawn based on the content in the report about the identity of any individual.

1. A resident had symptoms of a urinary tract infection and the physician ordered a urine culture. The facility did not follow-up with the physician order until 12 days elapsed. Symptoms persisted and the resident was hospitalized with septicemia. (Septicemia is a serious, life-threatening infection that gets worse very quickly. It can arise from infections throughout the body, including urinary tract.) (CBRF)
2. A resident with a history of urinary tract infections had a Foley catheter and developed a low grade fever, chills, and weakness. He was hospitalized and required intravenous antibiotics. The facility had not developed an individualized service plan to address catheter care or persistent urinary tract infections. (CBRF)
3. A resident with dementia did not receive needed supervision and left the facility undetected. The resident fell on a county highway approximately one mile from the facility. A passerby called an ambulance and the resident was treated at the hospital for facial trauma. (CBRF)
4. A resident with challenging behavioral symptoms was physically restrained by a caregiver in a dangerous manner and held to the floor. The intervention was not part of an approved plan. The resident sustained abrasions, swelling and bruising to the face and neck areas, including a 3-4 inch rug burn from the forehead to the side of the face. (AFH)
5. A 90+ year-old resident did not receive needed supervision and left the facility undetected after midnight. The facility had only one caregiver on duty and the caregiver was assisting another resident on a different floor. A barking dog alerted a neighbor and the resident was discovered lying in the snow. The resident was transported to the emergency room and diagnosed with a dislocated shoulder. The resident had walked two blocks without a coat (during the month of December). (CBRF)
6. The facility did not provide needed services for a resident with complex medical needs, including diabetes. Following cataract surgery, the facility did not administer the prescribed eye drops. Blood sugar levels were not monitored adequately and the physician was not notified of significant changes. The resident was hospitalized after a caregiver reported the resident was “comatose.” (CBRF)

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7. The facility did not schedule awake staff at night. A resident with dementia did not receive required supervision and left the facility undetected. The resident was discovered outdoors in the month of January at 3:00 a.m. without a coat. Temperatures were below freezing. (CBRF)
8. A resident experienced a significant change of condition, including behavioral symptoms, incontinence, lethargy, impaired balance, falls, and confusion. The facility did not notify the resident's physician. Five days after the onset of symptoms, the resident was admitted to the hospital "in acute distress" and diagnosed with urosepsis, delirium, renal failure, and dehydration. The facility did not inform the hospital of the resident's psychotropic medications and they were not administered as prescribed. (CBRF)
9. The facility did not investigate or timely report abuse of a resident by a family member. Staff witnessed the family member verbally and physically mistreating the resident. The family member threatened the resident and refused to provide oxygen when requested by the resident. Following a visit with the family member, the resident was observed with bruises and skin tears. The resident died the following day and the coroner, upon observing the bruising, contacted police. (CBRF)
10. The facility did not protect the rights of residents and responded inappropriately to behavioral symptoms. For example, if a resident "used profanity," the resident was denied the telephone for a day and was required to do chores such as pulling weeds or raking. While completing chores, the resident "was allowed to come in and warm up for 15 minutes for each 30 minutes of work." In addition, a resident was required to write a one-page letter of explanation "any time there is an incident." If the resident refused to write the letter, the resident was denied use of the telephone. The letter had to be free of any errors. If errors were identified, the resident had to rewrite the letter or "lose privileges until she rewrites the letter with no errors." (AFH)
11. The facility did not provide adequate supervision. An elderly resident with dementia left the facility on five occasions and police were contacted to locate the resident. On one occasion, up to four hours elapsed before the resident was found by police. (CBRF)
12. The facility did not schedule adequate staff and required residents to go to another of the licensee's facilities two full days each week. (AFH)
13. Unlicensed staff were administering insulin injections to residents. Staff reported that the licensee provided training for insulin injections. The licensee is not a registered nurse or licensed health care provider. (CBRF)
14. Despite inadequate space, a licensee permitted four adults (who had been evicted) to move into the facility. Background checks had not been conducted and a resident was required to share a bedroom with one of the individuals. (AFH)

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15. The facility did not complete a caregiver background check for an employee. Allegations of abuse were made against the employee, and the facility did not investigate or report. After a background check was completed (by the surveyor), it was discovered that the employee had an extensive criminal record including a felony charge of battery and a charge of habitual criminality related to battery. (CBRF)
16. A resident was in imminent danger related to the use of bed rails. The facility had not completed an assessment or obtained department approval. At one point the resident “was found caught between the bed rail and the [bed] frame. On another occasion, the resident was found “out of bed and on the floor” while the rails were raised. During a third incident, the resident was found with the lower body “hanging out the side of the bed . . . leg wedged . . .” with an open wound on the knee. [Two resident deaths occurred in assisted living facilities last year related to entanglement in bed rails.] (AFH)
17. The facility did not obtain a timely medical evaluation when a resident’s foot became swollen and red. The resident was taken to the emergency room with a diagnosis of cellulitis (a diffuse inflammation of connective tissue with severe inflammation of dermal and subcutaneous layers of the skin) and required antibiotics. (AFH)
18. A resident did not receive a modified diet, as prescribed, to address a swallowing impairment. The resident choked on an orange slice, became unresponsive, and died at the hospital. (CBRF)
19. A resident was at risk for choking and did not receive a modified diet, as prescribed. The resident was served a hamburger and began choking. Staff performed the Heimlich maneuver. The resident expelled “three large chunks of unchewed hamburger.” (CBRF)
20. The facility did not provide adequate supervision or interventions to address a resident’s frequent falls, including falls with injury. Staffing patterns were insufficient and when falls occurred, the resident was left on the floor until the next shift arrived or staff contacted local police to help lift the resident from the floor. (CBRF)
21. A resident did not receive prescribed treatments for a head laceration, and staples were not removed timely. The physician indicated the resident should return to the clinic in 7 days for removal of staples. The facility did not follow-up and staples remained 27 days past the physician ordered removal date. (CBRF)
22. A resident with increased confusion did not receive adequate supervision and left the facility undetected when the outdoor temperature was 27 degrees Fahrenheit. The resident walked along a busy highway for 1.2 miles until a concerned passerby stopped to assist. The daily traffic count on the highway is nearly 6000 vehicles. (CBRF)

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23. A resident did not receive adequate services to address the risk of injury from falls. In two months, the resident experienced 11 falls and sustained broken bones requiring hospitalization. Staffing patterns were insufficient and caregivers called emergency medical services on eight occasions to assist in lifting the resident from the floor. (CBRF)
24. A resident with dementia and psychosis did not receive adequate supervision and left the facility undetected. The resident caught a bus and traveled nearly three miles to a transfer station. (CBRF)
25. All residents (including those with cognitive and physical impairments) were left alone in the facility on a daily basis when the only caregiver on duty was called to the building next door to assist residents. (CBRF)
26. The facility did not report caregiver misconduct as required after an employee used a resident's credit card (charging over \$1000 in merchandise), was reprimanded for sleeping while on duty, and was disciplined for transporting residents while under the influence of prescription pain medication. (CBRF)
27. The facility did not provide adequate supervision of residents. A resident left the facility and was found in a neighbor's home where the resident had picked up and was holding a baby. (CBRF)
28. A resident complained of a bad cough and chest pain. Facility staff did not notify the resident's physician. Symptoms persisted for three days until the resident became dizzy and vomited and required hospitalization. (CBRF)
29. The facility did not provide prompt and adequate treatment. A resident with a history of congestive heart failure experienced weight gain from fluid retention and complained of shortness of breath. The Licensed Practical Nurse (LPN) on duty took a pulse oximetry reading which indicated that the resident had a markedly low oxygen saturation level in her blood. The LPN did not assess for vital signs and did not notify the physician. On the following day, the resident collapsed and was transferred to the hospital where she passed away. (CBRF)
30. A pain assessment and interventions were not developed for a resident experiencing persistent and worsening pain over a three month period. Conditions contributing to pain that were not adequately assessed or addressed included arthritis, diverticulosis, prolapsed bowel, open sores on buttocks, and yeast infection in groin area. (CBRF)
31. A facility serving residents with developmental disabilities, mental illness, and traumatic brain injury imposed penalties and inappropriate restrictions to address behavioral symptoms. For example, records indicated a resident was required "to complete chores without staff assistance and MUST NOT have any verbal or physical aggression to earn an outing!!!! Monday through Sunday." Another resident was required to exercise daily.

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(continued) “Staff must sign and write what exercise [he/she] did. If [he/she] loses any points, needs to start over!!!!!!” The exercise form was numbered 1-20. (CBRF)

32. A resident reported having a bleeding rectum and “if [staff] find one little spot of blood (on the toilet), I get a two week restriction.” As a consequence for messes in the bathroom, staff required the resident to leave the bathroom door open (for a two week period) whenever the resident used the toilet or showered. (CBRF)
33. A resident required 24-hour supervision and had a history of trying to leave the facility. While the sole caregiver in the facility was assisting another resident, the resident left the facility undetected. The resident was found lying in a parking lot two blocks from the facility and was transported to the emergency room with a fractured arm. (CBRF)
34. A resident who required 24-hour supervision left the facility unattended and went to a neighbor’s home. The resident asked the neighbor to call a cab which came to pick up the resident. Facility staff were unaware the resident was missing until the neighbor came to the facility to report what had happened. (CBRF)
35. Residents in a facility experienced multiple falls including falls with serious injuries (fractures). Assessments and interventions to address the risk of injury from falls were not developed. Following a fall, a resident with a fractured coccyx became ill from pain medications and was transferred to the hospital with pain, dehydration, and nausea. The resident was unable to return to an assisted living setting. (CBRF)
36. A facility did not provide adequate services when a resident became weak, experienced falls, and had loose stools. A family member found the resident in a recliner with no pants, wearing only a soiled [diaper]. He was described as very ill and “could hardly talk.” There was a “poop filled” garbage can nearby. The resident had a fever of 102 degrees Fahrenheit. A medical diagnosis revealed the resident had C-Diff (Clostridium difficile, a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon). (CBRF)
37. A resident did not receive adequate services after falling more than 30 times in ten months. Fall assessments and interventions were not developed. Seven of the falls required medical treatment and injuries included head and facial trauma. (CBRF)
38. A developmentally disabled resident had a history of bowel obstruction. The resident’s care plan listed nausea, gagging, and not eating as a possible symptoms and indicated that immediate medical intervention should be obtained. Over a period of two days, the resident vomited five times. Symptoms over the preceding week included bloody discharge from the rectum, difficulty breathing (gaspings), and changes in behavior. After a delay in medical care, the resident was hospitalized and diagnosed with a bowel obstruction and died while in the hospital. (AFH)

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39. A facility was licensed to serve clients of advanced age, physical disabilities, or developmental disabilities and did not protect a resident (who had paralysis and used a wheelchair) from the sexual advances of another resident (described as aggressive and threatening). The resident felt endangered and contacted the police twice for protection, including once from a neighbor's home. The aggressive resident was removed from the facility by police after assaulting others. The surveyor conducted a background check that revealed the resident had been convicted of armed robbery in 2004. His probation was revoked in 2008 and he spent over two years in prison prior to admission to the facility. (CBRF)
40. A facility did not ensure that residents received prescribed medications. A resident did not receive pain medication "off and on" for periods of time lasting up to a month and would "yell nonstop." A resident did not receive antipsychotic medication as prescribed and became combative and began having mood swings and hallucinations. (CBRF)
41. Staff did not implement planned interventions to address a resident's risk for falls (e.g., motion sensor pad). The resident fell and sustained a fracture. (CBRF)
42. A resident did not receive proper care or hygiene and developed a red, "crusty" groin and skin breakdown. When taken to the hospital records indicated there were dried, caked areas in the groin and the physician had to cut matted hair and clean the area in order to allow the resident's legs to open. (CBRF)
43. Staff did not change a resident's colostomy bag and clean the area at least every three days as required. On multiple occasions, four to eight days elapsed before the bag was changed and the area cleaned. The resident developed an open area near the stoma (a surgically created opening of the bowel or urinary tract to a body surface). (CBRF)
44. Residents (with advanced age, dementia, and physical disabilities) were left in the facility, unattended, for approximately one hour while a caregiver was washing his/her car in the driveway and the other two caregivers (on duty) were talking with him/her. Photographs were taken by a neighbor. (CBRF)
45. Residents in the facility require 24-hour, awake staff. Two caregivers were discovered sleeping on duty and residents were "soaked with urine." (CBRF)
46. The rights of residents were not protected and appropriate behavioral interventions were not employed. Personal belongings and food were withheld by staff in response to behavioral symptoms. For example, after a resident appeared to act stubbornly (would not get up from the floor), the resident was denied a snack and staff took the resident's radio. Behavioral symptoms worsened as a result. (AFH)
47. After a resident was incontinent of stool, a caregiver "screamed and pulled [the resident] by the arm . . . grabbed the shower seat and threw [the resident's] shampoo and soap all

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over the floor . . . yelled and screamed and forced the [the resident] into the shower.” This was witnessed by another employee who reported that the resident had also been mistreated by the caregiver before. (CBRF)

48. A resident sustained three injuries of unknown origin, including facial bruising and a leg fracture. The injuries were not investigated by the facility or reported to the Department as required. Timely medical care was not obtained and records indicate the resident “cried out all night long.” (AFH)
49. Staff routinely applied two incontinent briefs when dressing a resident, one over the other, to contain urine instead of providing assistance with toileting on a schedule adequate to meet [the resident’s] needs. (CBRF)
50. The caregiver on duty was in the office with her boyfriend (with the door closed) when two residents had an altercation with one threatening to kill the other. A resident knocked on the office door for staff intervention and “staff did not respond.” By the time the caregiver responded to the altercation, police intervention was necessary and one of the residents was removed from the facility. (CBRF)
51. A facility did not complete assessments and develop interventions after a resident experienced nearly 20 falls, including 7 falls with injury. The resident fell and sustained a hip fracture. (CBRF)
52. A resident did not receive prompt medical care following a fall. The resident experienced unsteadiness and complained of pain in the days following the fall. When hospitalized six days later, the resident was diagnosed with a hip fracture. The facility did not document an assessment of injuries from the fall until eight weeks *after* the fall occurred (six weeks following the death of the resident). (CBRF)
53. One caregiver was scheduled during each shift. Residents with complex needs (e.g., dementia, nonambulatory), were routinely left unattended while the on-duty staff member went outdoors to shovel snow, water plants, and take smoking breaks. (CBRF)
54. Arrangements had not been made for a resident to receive dental care since 2003. As the resident’s oral health deteriorated, a dental exam was obtained and records indicated “massive plaque...teeth are badly broken and decaying...hospital for thorough exam, fillings, extractions.” (AFH)
55. A resident did not have privacy for phone conversations. Caregivers listened to the resident during phone calls and then sent a letter to a family member to address the perceived negative content of the calls. (CBRF)
56. A facility did not investigate (or report to the department) an allegation of caregiver misconduct after a resident reported an injured shoulder. X-rays revealed the resident’s shoulder was fractured. (CBRF)

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57. A facility manager displayed multiple episodes of anger and intimidation toward residents such as forcefully removing residents from the dining room and placing them in their rooms, “facing the wall.” Other witnessed occurrences included “yelling, throwing coffee cups, and slamming fists on the table” in angry outbursts toward residents. The manager stated the approach was necessary to diffuse residents’ behavioral symptoms. (CBRF)
58. The facility did not obtain prompt medical care for a resident who sustained injuries (facial and head swelling, bruising) following several falls. The resident complained of not feeling well and the resident’s condition declined for six days before medical care was sought. The resident was admitted to the hospital and died in less than two weeks. (CBRF)
59. A resident experienced recurrent urinary tract infections so the physician discontinued the resident’s Foley catheter. The CBRF licensee did not want the catheter removed and told the resident “we discussed this” and “reminded the resident” that caregivers could not change/toilet the resident if the Foley catheter was removed. (CBRF)
60. The facility did not arrange services to address a resident’s aggressive behavioral symptoms. Other residents in the facility were fearful and would not leave their rooms. (CBRF)
61. A caregiver did not maintain boundaries and asked a resident to rub her back, allowing the resident to “tickle her and brush her hair.” When another caregiver reported the misconduct, the facility did not take immediate steps and allowed the caregiver to continue working (including scheduling the employee to work alone on the night shift). (CBRF)
62. A caregiver used gray, filmy water from a sink filled with dirty dishes to wash his/her hands in between administering medications to four different residents. (CBRF)
63. Staff did not respond promptly when a male resident sexually assaulted a female resident. Twenty-four hours elapsed before medical care was sought and police were contacted. The male resident was observed “touching” another female resident on the same day as the initial assault. (CBRF)
64. The facility did not investigate (or report to the department) when a resident had bruised wrists and had alleged that a staff person was rough with her. In addition, the facility did not follow up when an allegation was made that a staff person pushed a hand into a resident’s face. (CBRF)
65. A facility did not provide adequate supervision. A resident left the home when the average outdoor temperature was 28 degrees Fahrenheit. The resident was struck by a vehicle and sustained a broken leg. When the resident was observed missing, the only caregiver on duty, took all the other residents in a facility van to look for the missing resident. (CBRF)

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66. A resident had a fever, raspy cough, reduced appetite, and difficulty swallowing for three days before the facility obtained medical treatment. The resident was hospitalized with pneumonia and subsequently died. (AFH)
67. Prompt medical attention was not sought for more than two weeks when a resident refused meals and became weak, exhibiting confusion and delusions. The resident consumed large amounts of fluids, began losing hair, and was hospitalized due to vomiting. (CBRF)
68. The facility did not provide the prescribed diet for a resident with dysphagia (difficulty swallowing). The resident choked on food and became unresponsive. Emergency technicians administered cardiopulmonary resuscitation and the resident was hospitalized and required intubation and ventilator support. (CBRF)
69. The facility did not take immediate action when a report was made that a female caregiver was acting inappropriately toward a male resident (hugging and kissing the resident). The caregiver remained on the weekend schedule and observations were made regarding “touching butts” and “grabbing breasts.” The caregiver allegedly assisted the resident in the shower although he didn’t require assistance. (CBRF)
70. The facility did not conduct an investigation or report to the Department, as required, when a resident was observed being pulled out of a vehicle and slapped in the face by the facility Administrator. (CBRF)
71. Residents with diabetes did not receive needed services or nutrition. There was not an adequate food supply in the home and residents were not provided lunch. One diabetic resident received Pop-Tarts for breakfast and reported there are no eggs or hot foods for breakfast. A staff member reported “we don’t have food to work with.” A resident had blood glucose readings over 200 (including a reading over 500) on multiple occasions. The physician was not notified. (CBRF)
72. Staff did not permit tenants to make choices about ambulation and deliberately moved a tenant’s wheelchair and walker out of reach. Falls with injury occurred when the tenant made attempts to ambulate without the assistive devices. (RCAC)
73. Staff removed a resident’s personal phone from the bedroom to prevent the resident from repeating a call to 911. The phone was withheld for four days until a family member insisted the phone be returned. An investigation revealed that the county 911 provider had no record of a 911 call being made from the facility. (CBRF)
74. Needed assistance with meals was not provided for a resident with swallowing difficulties. Staff fed the resident larger bites of food and liquid from a cup instead of teaspoon as instructed. The resident began choking. Caregivers argued while the resident was choking. One caregiver inappropriately attempted to raise the resident’s arms over the resident’s head. The resident had impaired range of motion. (CBRF)

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75. The facility did not take steps to protect residents after a caregiver was observed being abusive to residents. In addition, the caregiver slept on duty and residents' personal care needs were neglected. The caregiver was permitted to continue working during the night shift and no report of alleged misconduct was made to the Department, as required. (CBRF)
76. The facility admitted a resident with ureterostomy needs without ensuring trained caregivers were available. Staff did not know how to change the urostomy bag or care for the stoma and the resident remained wet with urine, daily, for extended periods. One morning the resident's socks, shirts, and pants were soaked at 10:30 a.m. and the resident was not cleaned or changed until 3:30 p.m. (CBRF)
77. The facility waited four days to administer medication that had been prescribed twice daily to treat a resident with MRSA. (CBRF)
78. The facility did not provide adequate supervision to protect a resident from sexual assault by another resident (who had a known history of sexual misconduct). (AFH)
79. The facility did not respond appropriately when 11 of 13 residents and 4 employees became ill with vomiting, nausea, and diarrhea for a period of 10 days. One caregiver reported, "We had to clean explosive diarrhea from the walls and carpet. I got sick the next day." The outbreak was not reported to the local health department. In addition, dishes were hand-washed and no sanitizing solution was used. (CBRF)
80. The facility did not monitor a resident's condition or obtain medical care when there was minimal urinary output in the resident's catheter bag. The resident's abdomen became distended and "rock hard" creating an imminent health risk. Staff waited nearly 30 hours before obtaining medical care after the resident had no urinary output. Once an assessment was obtained, a nurse emptied 3,000 cc's of urine from the resident. (A healthy body urinates approximately 400 cc's.) (At this time, the nurse also noted the resident had a puffy, inflamed foot which had not been adequately monitored by the facility. The resident was transferred to the emergency room with a diagnosis of cellulitis.) (AFH)
81. Appropriate care and interventions were not provided for a resident who experienced multiple falls over a 6 month period, including falls with head injuries (bruised eye, bleeding head laceration) for which no medical attention was sought or medical care was delayed. (CBRF)
82. A facility did not complete a pre-admission assessment prior to admitting a resident with complex service needs (Schizoaffective Disorder, Dementia, Diabetes). (CBRF)
83. A resident preferred his/her meals served in the resident's room and had received in-room meals for more than a year. Staff did not serve meals in the room for seven days as a way of disciplining the resident for not returning dirty meal trays to the kitchen. (CBRF)

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84. A resident required quarterly visits with a psychiatrist and none were scheduled for more than a year. (CBRF)
85. Service providers knew the building call system was not working and did not ensure a plan was in place to respond to the needs of tenants. A tenant used the call button (pendant) after falling in the bathroom and sustaining a fractured shoulder. The tenant was not found until the following morning (more than 6 hours later). (RCAC)
86. The facility provides services to residents with physical and cognitive impairments. Safety hazards were identified in the home, including large tears in the carpet and flooring (over thresholds) that had been repaired with duct tape. (CBRF)
87. A resident reported being physically abused by staff. No action was taken until 18 hours after the allegation had been reported. (CBRF)
88. A resident was permitted staff assistance only once in a two hour period. If the resident used the call system or required staff assistance more than one time in a two hour period (even to request a glass of water), the facility initiated a charge of \$100 for each request. (CBRF)
89. A facility refused to arrange or provide assistance with range of motion exercises recommended by a resident's occupational therapist contributing to a decline in the resident's condition. (CBRF)
90. A resident was dragged across the floor when the resident would not do what the caregiver directed. (AFH)
91. No medical care was obtained when a resident complained of pain and experienced difficulty walking for more than seven days including "screaming in pain, grabbing at crotch area, unable to stand, refusing to eat." When the resident was transferred to the hospital, x-rays revealed a hip fracture and pubic fractures. (CBRF)
92. A facility did not have sufficient staff to meet the needs of residents. A resident required supervision and frequently left the facility. On these occasions, other residents were required to ride in the van with the sole caregiver to locate the missing resident. (AFH)
93. Service plans were not reviewed and revised to develop and implement protective measures to address the needs of residents who were experiencing frequent falls. After falling six times, one resident sustained a hip fracture and died following a month in a nursing home. Another resident sustained a humeral (arm) fracture and nasal fracture. The licensee stated, "what do you want me to do . . . we're not a nursing home." (CBRF)
94. A facility imposed a curfew, withheld food from residents, and required residents to leave the facility daily to go to other homes operated by the licensee for staffing purposes. (AFH)

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95. Four residents (described as frail and elderly with cognitive impairments) were required to be out of bed, dressed, and in their wheelchairs at 4 a.m. before night shift staff went off duty. In addition, when residents required assistance with meals, staff labeled the residents “feeders.” (CBRF)

96. A resident’s hair was cut against the wishes of the resident and the resident’s family. When the resident, who is Native American, was admitted to the facility, the family expressly stated no haircuts should be given due to the resident’s heritage. (CBRF)