RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

May 25, 2017

Shawn Phillips
Emerald Meadows
6117 Charlevoix Woods Ct.
Grand Rapids, MI 49546-8505

RE: License #: AH410343036
Investigation #: **2017A1010037**
Emerald Meadows

Dear Mr. Phillips:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 260-7781
enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH410343036
Investigation #:	2017A1010037
Complaint Receipt Date:	04/17/2017
Investigation Initiation Date:	04/18/2017
Report Due Date:	06/17/2017
Licensee Name:	Providence Operations, LLC
Licensee Address:	18601 North Creek Drive Tinley Park, IL 60477
Licensee Telephone #:	(708) 342-8100
Administrator:	Shawn Phillips
Authorized Representative:	Shawn Phillips
Name of Facility:	Emerald Meadows
Facility Address:	6117 Charlevoix Woods Ct. Grand Rapids, MI 49546-8505
Facility Telephone #:	(616) 954-2366
Original Issuance Date:	08/26/2013
License Status:	REGULAR
Effective Date:	03/07/2017
Expiration Date:	03/06/2018
Capacity:	60
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident showers are not being assisted at the facility. Resident A is often not cleaned after her dirty brief is changed. She has been observed with dry fecal matter on her buttocks and peri area.	Yes
Medication technicians have been observed leaving medication in resident rooms and they do not take their medications as a result.	No
The facility has a very intense smell of urine and feces and staff have been observed throwing trash at each other.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/17/2017	Special Investigation Intake 2017A1010037
04/18/2017	Special Investigation Initiated - Letter Email to the complainant
04/25/2017	Inspection Completed On-site
04/25/2017	Contact - Document Received Resident A's service plan
04/27/2017	APS Referral
05/01/2017	Contact – Document Received Email from assigned APS worker Laura Vannetten
05/02/2017	Contact – Document Received Resident A, B, and C shower logs were received
05/02/2017	Inspection Completed On-site
05/11/2017	Contact – Telephone Call Made Contacted Mr. Phillips
05/15/2017	Contact – Document Received Email from Mr. Phillips regarding agency staff training records.
05/25/2017	Exit Conference

ALLEGATION:

Resident showers are not being assisted at the facility. Resident A is often not cleaned after her dirty brief is changed. She has been observed with dried fecal matter on her buttocks and peri area.

INVESTIGATION:

On 4/17/17, the bureau received the allegations from the online complaint system.

On 4/25/17, long term care ombudsmen Kaye Scholle and I interviewed administrator Shawn Phillips at the facility. Mr. Phillips stated Resident A passed away yesterday at the hospital. Mr. Phillips reported Resident A went to the hospital on 4/13 to be treated for influenza B. The facility is currently under quarantine due to an influenza B outbreak.

Mr. Phillips reported Resident A was able to toilet, transfer, and change her brief independently. Mr. Phillips stated Resident A was toileted by staff every two hours as well. Mr. Phillips denied any knowledge regarding Resident A being left in urine and feces. Ms. Phillips stated Resident A had a history of combative behavior while being bathed.

On 4/25/17, Ms. Scholle and I interviewed director of nursing Danielle Bailey at the facility. Ms. Bailey's statements regarding Resident A were consistent with Mr. Phillips.

Ms. Bailey reported concerns regarding Resident C not being showered regularly were brought to her attention. Ms. Bailey stated Resident C spent a few days at the hospital in March and did not receive a shower for over a week after she returned to the facility. Ms. Bailey stated the resident shower logs are accurate.

On 4/25/17, Ms. Scholle and I interviewed medication technician (med tech) Vonda Schmid at the facility. Ms. Schmid denied any knowledge regarding Resident A being left in urine or feces. Ms. Schmid stated earlier this month Resident B was left in feces by first shift staff while second shift was starting. Ms. Schmid reported there have been some complaints by resident family members regarding residents not getting bathed, however she has no direct knowledge regarding this.

On 4/25/17, Ms. Scholle and I interviewed med tech Tamarisk Williams at the facility. Ms. Williams denied any knowledge regarding resident care needs not getting met by staff. Ms. Williams' statements regarding Resident B were consistent with Ms. Schmid.

On 4/27/17, I made a complaint with Adult Protective Services (APS) through Centralized Intake.

On 5/1/17, I received an email from the assigned APS worker Laura Vannetten.

On 5/2/17, I observed Resident B at the facility. I was unable to engage Resident B in meaningful conversation. Resident B appeared to be clean and I did not detect any foul odors.

On 5/2/17, Ms. Bailey reported Resident B was not left in feces by first shift staff. Ms. Bailey explained Resident B was aggressive with first shift staff when they were attempting to clean him after he had fecal matter on him earlier this month. Ms. Bailey stated it took her and several other staff a long time to de-escalate Resident B and clean him. Ms. Bailey reported she and other staff were still cleaning Resident B when shift change occurred. Ms. Bailey stated staff from the oncoming shift had to help get Resident B cleaned.

On 5/2/17, I observed Resident C at the facility. I was unable to engage Resident C in meaningful conversation. Resident C appeared to be clean and I did not detect any foul odors.

On 5/10/17, I reviewed Resident A's shower log. The log read Resident A went over a week without a shower on three occasions. Resident A went over a week without receiving a shower from 2/27 until 3/13, 3/16 until 3/27, and 3/27 until 4/6.

On 5/10/17, I reviewed Resident B's shower log. The log read Resident B went over a week without a shower on four occasions. Resident B went over a week without a receiving a shower from 2/28 until 3/17, 3/17 until 3/31, and 4/7 until 4/17.

On 5/10/17, I reviewed Resident C's shower log. Resident C returned to the facility from the hospital on 3/21 and did not receive a shower until 4/5.

On 5/10/17, I interviewed Relative C1 by telephone. Relative C1 reported Resident C was admitted to the hospital from 3/16 until 3/21. Relative C1 reported she went to visit Resident C at the facility on 3/25 and observed Resident C's hair was greasy. Relative C1 stated she returned to the facility on 3/27 and inquired about the last time Resident C was bathed. Relative C1 reported she was informed Resident C's last shower at the facility was on 3/8. Relative C1 stated she addressed this with Mr. Phillips and there has not been an issue since.

APPLICABLE RULE	
R325.1932	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.

ANALYSIS:	Review of Resident A, B, and C's shower logs and interviews with Ms. Bailey and Relative C1 revealed these residents went over a week without being bathed. The facility is not in compliance with this rule.
CONCLUSION:	**Violation Established**

ALLEGATION:

Medication technicians have been observed leaving medication in resident rooms and they do not take their medications as a result.

INVESTIGATION:

On 4/25/17, I interviewed Witness 1 by telephone. Witness 1 reported she observed a med tech on third shift leave a resident's medication on their dresser without watching them ingest it. Witness 1 was unable to recall the med tech's name. Witness 1 stated she observed this on more than one occasion.

4/25/17, Mr. Phillips denied any knowledge regarding staff leaving resident medications in their room. Mr. Phillips stated med tech are trained to watch residents ingest the medication they administer.

4/25/17, Ms. Bailey's statements regarding staff administering medication was consistent with Mr. Phillips. Ms. Bailey reported staff can lock medication in their cart when a resident refuses it. Ms. Bailey stated staff attempt to administer medications three times after a resident refuses. Ms. Bailey reported staff then destroy the medication if the third attempt fails.

On 4/25/17, Ms. Schmid denied any knowledge regarding staff leaving medication in resident rooms. Ms. Schmid reported she secures medication in her cart when a resident refuses to take it and attempts to administer it again later.

On 4/25/17, Ms. Williams' statements regarding staff leaving medication in resident rooms were consistent with Ms. Schmid.

On 4/25/17, Ms. Scholle and I interviewed Resident D at the facility. Resident D stated she has not had any issues or concerns regarding staff administering her medications.

On 5/2/17, I interviewed med tech Janet Goff at the facility. Ms. Goff denied knowledge regarding staff leaving medication in resident rooms. Ms. Goff reported this practice is not consistent with how she was trained to administer medications. Ms. Goff stated she was trained on the six rights of medication administration.

On 5/2/17, I interviewed med tech Elisa Bailey at the facility. Ms. Bailey's statements regarding administering resident medications were consistent with Ms. Goff. Ms. Bailey explained when she administers resident medications, she watches them ingest it before she moves on to the next resident.

On 5/2/17, I inspected every resident room at the facility as well as the medication room and all medication carts. I did not locate any medications.

On 5/2/17, I interviewed Relative E1 by telephone. Relative E1 reported she found a pill in Resident E's room approximately a week ago. Relative E1 expressed concern regarding Resident E not taking her medications as staff are not properly administering them.

On 5/5/17, Relative E1 sent me a picture of the pill that was found in Resident E's room.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Interviews with staff revealed they were not aware how this medication was left in the room. Considering my inspection of the entire facility and interviews with staff, the finding of one pill appears to have been an isolated incident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility has a very intense smell of urine and feces and staff have been observed throwing trash at each other.

INVESTIGATION:

On 4/25/17, I inspected the entire facility. I detected a strong smell of urine throughout. I observed three large garbage bags that were full sitting in the hallway against the wall near resident rooms on the memory care unit. I observed several staff members walk by the garbage bags without removing them.

On 4/25/17, Ms. Scholle and I interviewed maintenance staff person Scott Bayle at the facility. Mr. Bayle reported two agency staff persons left garbage bags on the

memory care unit recently. Mr. Bayle stated he brought the bags to the main door at the facility and asked the staff persons to take the trash out as it was their responsibility. Mr. Bayle explained he had to tell the staff persons where the dumpsters were located. Mr. Bayle denied trash was thrown during the incident. Mr. Bayle reported there has been an issue regarding staff agreeing to take garbage bags out to the dumpsters.

On 5/2/17, I inspected the facility again. Although the smell had somewhat improved, some resident rooms still has a strong smell of urine. I observed a large trash bag sitting by the trash can in the dining room on the dementia unit. Mr. Phillips stated lunch had recently finished and staff were going to take the garbage bag to the dumpster.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	I detected a strong smell of urine throughout the facility on 4/25 and 5/2. I observed bags of trash that were left sitting out on 4/25 and 5/2 as well. The interview with Mr. Bayle revealed staff have not been cooperating regarding taking trash to the dumpster.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

Ms. Bailey reported Resident A was supposed to have her oxygen on at all times. Ms. Bailey stated she received a telephone call on 4/11/17 from a staff person stating Resident A's oxygen was below 90 which was low. Ms. Bailey explained the staff person informed her that an agency staff person that was on during that shift was not being cooperative about making sure Resident A's oxygen was on her. Ms. Bailey reported she told the staff person to call her back if Resident A's oxygen did not stay above 90. Ms. Bailey explained the staff person did not contact her back that night.

Ms. Bailey explained she checked on Resident A when she arrived at the facility at approximately 6:45 am. Ms. Bailey reported Resident A's oxygen was not on her, the tubing was wrapped around the machine. Ms. Bailey stated Resident A's oxygen was 82 when she arrived and her oxygen machine was set at 5 liters when it was supposed to be set at 2 liters.

Ms. Bailey stated she contacted the staffing agency and told them the staff person who was on overnight was no longer allowed to work at the facility. Ms. Bailey reported she monitored resident A until her oxygen was at the appropriate level.

On 5/10/17, I reviewed Resident A service plan. The *Toileting* section of the plan read, "resident to be offered toileting every two hours while awake. Resident able to toilet self and change brief. Check and change every two hours while in bed. Occasional urinary incontinence. Resident can change brief. Will not call for help when needed. Staff to check sheets daily. Remove any urine soaked clothes to prevent foul odors."

The *Medication Administration* section of the plan read, "oxygen 2L per NC with humidification at all times."

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Resident A's service plan read she was supposed to have her oxygen set to 2 liters and on at all times. Ms. Bailey reported on 4/11, she was informed Resident A's oxygen level was low. Ms. Bailey stated she observed Resident A without her oxygen when she arrived at the facility. Resident A's oxygen was also set at the incorrect amount. This placed Resident A at risk of harm.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** Special Investigation Report (SIR) 2016A0001013 Corrective Action Plan (CAP) dated 7/8/16

ADDITIONAL FINDING:

INVESTIGATION:

On 5/2/17, Ms. Bailey stated the med techs do not have any documentation in their files demonstrating they were trained on medication administration.

On 5/11/17, I interviewed Mr. Phillips by telephone. Mr. Phillips reported med techs complete a web based training for medication administration. Mr. Phillips stated the program does not generate a certificate stating staff completed the training, therefore there is no record in their employee file.

On 5/12/17, I received an email from Mr. Phillips stating the facility no longer has the training records for current agency staff working at the facility. Mr. Phillips reported the documents were kept in a binder, however it was suspected the former director of nursing placed the documents into the shredder box. Mr. Phillips stated the former director of nursing resigned on 5/5 “in a less than amiable manner.”

APPLICABLE RULE	
R 325.1944	**Employee records and work schedules.**
	(1) A home shall maintain a record of each employee which shall include all of the following: **(d) Summary of experience, education, and training.**
ANALYSIS:	Ms. Bailey and Mr. Phillips were unable to provide training documentation to verify med techs were properly trained in medication administration. Mr. Phillips stated the facility no longer has current agency staff records. The facility was unable to provide this documentation, therefore they were not in compliance with this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** Special Investigation Report (SIR) 2016A0001013 Corrective Action Plan (CAP) dated 7/8/16, SIR 2016A0001014 CAP dated 6/30/16

I shared the findings of this report with licensee authorized representative Shawn Phillips on 5/25. Mr. Phillips stated the facility identified employees who were not carrying out their job duties. Mr. Phillips explained these individuals resigned before they were going to be terminated.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

5/17/17

Lauren Wohlfert — Date
Licensing Staff

Approved By:

5/17/17

_____

Russell B. Misiak Date
Area Manager