RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

June 1, 2017

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

RE: License #: AH410343036
Investigation #: 2017A1010039
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 #:	2017A1010039
Complaint Receipt Date:	04/25/2017
Investigation Initiation Date:	04/25/2017
Report Due Date:	06/25/2017
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?
The facility has had an outbreak of the flu. There were no quarantine procedures or notice posted until 4/23. There were no masks available at the facility the weekend of 4/29.	Yes
Resident A has fallen three times within two months. Resident A currently has a large blood blister on one knee and a large patch of skin was missing on the other. It is unknown how she sustained these injuries.	Yes
The facility is short staffed.	Yes
Resident A's pink eye was not properly cared for. New medication the doctor prescribed to treat the pink eye was not administered.	No
Resident A's clothing has not been washed.	No
Additional Findings	Yes

III. METHODOLOGY

04/25/2017	Special Investigation Intake 2017A1010039
04/25/2017	Special Investigation Initiated - On Site
04/25/2017	Contact - Document Received Resident A MAR was received.
04/27/2017	APS Referral
05/02/2017	Contact – Document Received Email from assigned APS worker Laura Vannetten
05/02/2017	Inspection Completed On-site
05/02/2017	Contact – Document Received Resident A service plan, staff schedule, and call light response times received.
05/11/2017	Contact – Telephone Call Made Interviewed Relative A1.
05/17/2017	Contact Telephone Call Made

	Interviewed housekeeping staff person Jane Tucker by telephone
06/01/2017	Exit Conference

ALLEGATION:

The facility had an outbreak of the flu. There was no quarantine procedure or notice posted until 4/23. There were no masks available at the facility the weekend of 4/29.

INVESTIGATION:

On 4/25/17, 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 reported a resident was confirmed to have Influenza B on 4/13. Mr. Phillips stated this was the facility's first confirmed case. Mr. Phillips stated another resident was confirmed to have Influenza B on 4/15. Mr. Phillips reported the local health department was contacted on 4/20 after the second case was confirmed. Mr. Phillips explained the facility started cleaning procedures on 4/17 and posted a sign notifying visitors of the outbreak on 4/20.

Mr. Phillips stated there were ten residents who were admitted to the hospital for Influenza B and two resident deaths as a result of the outbreak.

On 4/25/17, long term care ombudsmen Kaye Scholle and I interviewed the director of nursing Danielle Bailey at the facility. Ms. Bailey reported a sign informing visitors of the influenza B outbreak was posted on 4/21.

On 5/02/17, I interviewed Ms. Bailey at the facility. Ms. Bailey stated when she arrived at the facility to work on 5/1, there was a full box of masks for visitors on the front desk at the main entrance. Ms. Bailey stated these would have been available to visitors over the weekend.

Licensing staff did not receive an incident report regarding the Influenza B outbreak at the facility.

APPLICABLE RULE	
R 325.1924	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: (b) Assure that the home maintains an organized program to

	provide room and board, protection, supervision, assistance, and supervised personal care for its residents.
For Reference: R 325.1901	**Definitions.**
	(16) “Protection” means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident’s service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident’s service plan states that the resident needs continuous supervision.
ANALYSIS:	The facility had a resident confirmed sick with influenza on 4/13. A second resident was confirmed ill with the same illness on 4/15. Interview with the administrator reveals the facility initiated cleaning procedures to prohibit the spread of the illness on 4/17 and then contacted the health department on 4/20 for further guidance. However, the passage of two days from the confirmation of the second infection to the initiation of staff cleaning and the passage of five days before notifying the health department does not seem a reasonable amount of time given the vulnerability of the aged population. The facility lacked an organized infection control program that timely addressed this infection.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Shawn Phillips by telephone on 6/1/17. Mr. Phillips stated the first confirmed case of Influenza B was on 4/17. Mr. Phillips was unable to provide me the date of the second confirmed case. Mr. Phillips reported the local health department was notified on 4/20 after the proper documentation was completed.

ALLEGATION:

Resident A has fallen three times within two months. Resident A currently has a large blood blister on one knee and a large patch of skin was missing on the other. It is unknown how she sustained these injuries.

INVESTIGATION:

On 4/25/17, Ms. Bailey reported Resident A had a UTI that caused her to have increased falls. Ms. Bailey stated a tab alarm was placed on Resident A's wheelchair to notify staff anytime she stood up.

On 5/2/17, Ms. Bailey stated Resident A has what appears to be a rug burn on her left knee and a healing scrape on her right knee. Ms. Bailey reported staff do not know how Resident A sustained these injuries over the weekend. Ms. Bailey stated an incident report regarding the injuries was completed, however it is documented that staff did not witness Resident A fall and the origin of the injuries is unknown. Ms. Bailey explained she interviewed staff, however staff had no explanation for the injuries.

On 5/2/17, I attempted to interview Resident A at the facility. I was unable to engage Resident A in meaningful conversation. I observed Resident A's right and left knees. Resident A had a dime sized reddened circular rug burn on her left knee and an approximate two inch scabbed scrape on her right knee.

On 5/11/17, I interviewed Relative A1 by telephone. Relative A1 reported she was at the facility on 4/30. Relative A1 stated she observed a rug burn on one of Resident A's knees and a bruise on the other. Relative A1 reported she addressed this with staff. Relative A1 said staff told her they did not know how Resident A received the injuries. Relative A1 explained Resident A has an alarm system on her wheelchair that notifies staff when she gets up, therefore they should have heard and been aware of a fall. Relative A1 reported staff did not notify her that Resident A had the injuries, rather she informed staff of them.

On 5/11/17, I reviewed Resident A's incident report dated 4/30. The *Caregiver Statement Of What was Observed* section of the report read, "was inform about a bruise unknown origin." The *Med Tech Assessment and First Aid/Emergency Services* section of the plan read, "Bruise on both knees brought to attention of med tech. No reported fall – no evidence of fall." The *name of responsible part notified* section of the report read Relative A1 was notified, however there is not a date or time listed.

I reviewed Resident A's incident reports from March 2017. Resident A had six falls during the month of March. The incident reports did not state what corrective measures staff were to take to prevent falls.

On 5/11/17, I reviewed Resident A's service plan. The plan identified Resident A as a fall risk and one person assist with transfers. The plan read resident A "walks with SBA and walker. Resident used wheel chair during periods of illness/weakness." The plan was not updated to reflect Resident A's use of a tab alarm on her wheelchair to notify staff when she stood up. The *fall risk/will not wait for assistance* portion of the plan read, "staff to provide either SBA or CGA as needed with all cares/ambulation." This did not state what assistive devices staff were to use while

she was mobile. The plan did not provide staff instruction regarding how to prevent Resident A from falling or what kind of supervision she required.

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.
For Reference: R 325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Resident A was identified as a fall risk on her service plan. She had several falls that were not witnessed by staff. It is not known whether Resident A's knee injuries were related to a fall. The plan read staff were to provide stand by assistance during transfers. The plan also directed staff to provide stand by assistance while she walked. It does not seem reasonable to believe staff adequately anticipated Resident A's needs as outlined in the plan.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** Special Investigation Report (SIR) 2016A0001013 Corrective Action Plan (CAP) dated 7/8/16

Mr. Phillips stated staff could not prevent Resident A from standing up. Mr. Phillips stated residents have the right to move about as they please. Mr. Phillips stated the only way staff could have prevented Resident A from getting up would be by providing one on one supervision.

ALLEGATION:

The facility is short staffed.

INVESTIGATION:

On 4/25/17, Mr. Phillips stated staff work 12 hour shifts and the hours are 7:00a until 7:30p and 7:00p until 7:30a. Mr. Phillis reported there are two resident care aides scheduled on the dementia unit and two resident care aides scheduled in the general assisted living unit during both shift. Mr. Phillips said there are two medication technicians (med techs) for the facility on both shifts who also assist with resident care when needed. Mr. Phillips explained as a result of staff calling in sick, there are some occasions when they are short staffed a resident care aid and med tech.

Mr. Phillips reported there are currently 42 residents at the facility. There are 15 residents on the dementia unit. Mr. Phillips stated there are currently ten residents who were admitted to the hospital due to Influenza B.

On 4/25/17, Ms. Scholle and I interviewed med tech Vonda Schmid at the facility. Ms. Schmid stated there are times the facility is short staffed due to staff calling in sick. Ms. Schmid reported there were several staff members who called in sick on 4/7. Ms. Schmid explained the nurse administered medications and she had to assist with resident cares as a result.

On 4/25/17, Ms. Scholle and I interviewed Resident B at the facility. Resident B reported it takes staff 15 minutes to respond to her call light. Resident B stated it sometimes takes staff longer than 15 minutes to respond when she pushes her call button if the facility is short staffed. Resident B reported it also takes staff longer to respond to her call button if staff are busy assisting other residents.

On 5/2/17, I interviewed med tech Janet Goff at the facility. Ms. Goff the resident census is currently low at the facility because several residents were admitted to the hospital due to Influenza B. Ms. Goff reported staff utilize two way radios if assistance is needed. Ms. Goff stated resident care needs are met with the number of staff scheduled at the facility.

On 5/2/17, I interviewed med tech Elisa Bailey at the facility. Ms. Bailey reported there have been times the facility was short staffed due to staff calling in sick. Ms. Bailey's statements regarding staff at the facility were consistent with Ms. Goff.

On 5/2/17, I interviewed Resident C at the facility. Resident C stated staff respond ""within minutes" when she pushed her call button. Resident C was unable to provide a timeframe in which staff respond.

On 5/2/17, I interviewed Resident D at the facility. Resident D reported it takes staff between 30 or 40 minutes to respond when she pushes her call button. Resident D stated the longest time she has to wait is during the night shift. Resident D explained she sometimes has to wait an hour for staff to respond to get her in bed at night.

On 5/15/17, I reviewed the resident pendant response times for 4/30. There were 19 times during both shifts where it took staff 30 minutes to respond to resident calls for assistance. It took staff 25 minutes to respond at 6:47 pm, 16 minutes to respond at 3:00p, 16 minutes to respond at 12:29p, 28 minutes to respond at 8:43p, and 18 minutes to respond at 4:15p.

On 5/15/17, I reviewed the staff schedule for the week of 4/17 through 4/22. The schedule for 4/16 read there were 3 resident aide vacancies for the 7:00a-7:30p shift. A note read, “both med techs will have to assist with care.” The schedule read there was a med tech vacancy for the 7:00p-7:30a shift due to a call in. The 4/17 schedule read there was one resident aide vacancy due to a call in for the 7:00a-7:30p shift. The schedule for 4/19 read there was a resident aide vacancy during the 7:00-7:30p shift. The schedule for 4/20 read there was a resident aide vacancy during the 7:00p-7:30a shift. The schedule for 4/21 read there was a med tech vacancy on 4/21 during the 7:00a-7:30p shift due to a call in. The schedule for 4/22 read there was a resident aide vacancy during the 7:00p-7:30a shift due to a call in.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Interviews with Residents B and D, along with review of resident pendant response times for 4/30, reveal several occasions when residents had to wait over 15 minutes for assistance. Review of the staff schedule from 4/16 through 4/22 revealed several shift vacancies that went unassigned due to staff calling in sick and no replacement staff available to substitute in their place.
CONCLUSION:	**VIOLATION ESTABLISHED**

Mr. Phillips stated the facility was always staffed according to census. Mr. Phillips was informed there were shift vacancies unfilled due to staff calling in sick. Mr. Phillips stated the facility was still staffed according to census.

ALLEGATION:

Resident A’s pink eye was not properly cared for. New medication the doctor prescribed to treat the pink eye was not administered.

INVESTIGATION:

On 4/25/17, Mr. Phillips reported Resident A was prescribed Tobrex and Ciloxan ointments to treat her pink eye. Mr. Phillips reported staff documented they administered this medication, however the tubes of ointment were still more than half full. Mr. Phillips stated staff who documented they administered the ointment were interviewed and reported they were truthful in their documentation.

On 4/25/17, Ms. Danielle Bailey's statements regarding Resident A's prescribed Tobrex and Ciloxan were consistent with Mr. Phillips.

Ms. Bailey reported Resident A constantly rubs her eyes and this likely caused her to have pink eye. Ms. Bailey stated a family member recently took Resident A see a physician regarding her pink eye not improving. Ms. Bailey reported Resident A was prescribed Gentamicin Sulfate and three Azithromycin tablets after family took her to see a physician. Ms. Bailey stated when she went to enter the prescribed Azithromycin into Resident A's electronic medication administration record (EMAR), it was flagged stating there were concerns it would interact with her other prescribed medications. Ms. Bailey reported she could not have staff administer the medication without getting approval from Resident A's physician.

Ms. Bailey stated she told Relative A1 this information, however Relative A1 got upset and administered two Azithromycin tablets to Resident A at the facility. Ms. Bailey reported after staff got the approval to administer the medication from Resident A's physician, the third tablet was administered.

On 4/25/17, Ms. Schmid denied documenting she administered Resident A's prescribed Tobrex and Ciloxan without physically administering it. Ms. Schmid stated she has never falsified documentation on a resident's EMAR. Ms. Schmid denied knowledge regarding other staff doing this. Ms. Schmid reported she administers medications as prescribed and documents accordingly.

On 5/2/17, Ms. Goff's statements regarding Resident A's prescribed medications were consistent with Ms. Schmid. Ms. Goff reported documenting a resident medication was administered without actually administering it would be against the facility's policies and procedures.

On 5/2/17, Ms. Elisa Bailey's statements regarding Resident A's prescribed medications were consistent with Ms. Goff.

On 4/25/17 and 5/2/17, I observed Resident A's eyes. They appeared to be clear and free from swelling.

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:	Staff documented they administered Resident A's prescribed Tobrex and Ciloxan as prescribed in her EMAR. Ms. Schmid, Ms. Goff, and Ms. Bailey stated it would be against the facility's policies and procedures to falsify a resident's EMAR. Although Mr. Phillips and Ms. Bailey expressed concern regarding the amount of Tobrex and Ciloxan that was left after staff documented they administered the medication, there is no evidence to prove staff did not administer it.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's clothing has not been washed.

INVESTIGATION:

On 5/2/17, Mr. Phillips reported Resident A's clothing is washed once a week. I observed an adequate supply of clean clothing in Resident A's closet and dresser at the facility.

On 5/11/17, Relative A1 reported she was at the facility approximately a month and a half ago. Relative A1 stated she went into the laundry room on the dementia unit to wash some of Resident A's clothing because she didn't have any that was clean. Relative A1 explained she saw towels and wash clothes that had fecal matter on them.
On 5/17/17, I interviewed housekeeping staff person Jane Tucker. Ms. Tucker stated clothing and/or towels with fecal matter are bagged and brought to the laundry room. Ms. Tucker stated there are two basins in the laundry room where the clothing is thoroughly rinsed before being placed in the washer. Ms. Tucker explained white clothing and towels are soaked in a bucket of bleach and water in one of the basins before being placed in the washer. Ms. Tucker reported an extra cycle is ran in the washer to clean it as needed.

Ms. Tucker reported the facility has one laundry room that is located in the general assisted living area. Ms. Tucker stated the door is not locked and family can access the room when they chose.

On 5/17/17, Mr. Phillips' statements regarding resident laundry were consistent with Ms. Tucker.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(3) The home shall make adequate provision for the laundering of a resident's personal laundry.
ANALYSIS:	On 5/2, I observed an adequate supply of Resident A's clean clothing in her closet and dresser. I observed the facility to be in compliance with this rule. Interviews with Ms. Tucker and Mr. Phillips reveal staff thoroughly rinse clothing and towels with fecal matter on them before it is placed in the washer.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of Resident A's plan revealed that it was not updated to reflect Resident A's use of a tab alarm on her wheelchair. Therefore, staff had no guidance or direction as to what their responsibility was to ensure proper use and maintenance of this assistive device to ensure Resident A's safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

Mr. Phillips stated all resident service plans will be updated to properly reflect their care needs.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall

	contain all of the following information: (e) The corrective measures taken to prevent future incidents/accidents from occurring.
For Reference: R 325.1901	**Definitions.**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	Review of Resident A's six incident reports for March revealed staff did not document corrective measures to prevent future falls.
CONCLUSION:	**VIOLATION ESTABLISHED**

Licensing staff did not receive an incident report regarding the Influenza B outbreak at the facility.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	Licensing staff did not receive an incident report regarding the influenza B outbreak at the facility. Interviews with Mr. Phillips revealed some residents died as a result of the outbreak. The residents at the facility were at risk of harm as a result of the outbreak.
CONCLUSION:	**VIOLATION ESTABLISHED**

Mr. Phillips stated staff will be re-trained on incident report requirements.

IV. RECOMMENDATION

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

6/1/17

_____

Lauren Wohlfert Date
Licensing Staff

Approved By:

6/1/17

_____

Russell B. Misiak Date
Area Manager