RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

August 4, 2017

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

RE: License #: AH410343036
Investigation #: 2017A1010056
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 #:	2017A1010056
Complaint Receipt Date:	07/26/2017
Investigation Initiation Date:	07/26/2017
Report Due Date:	09/25/2017
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?
Resident A was scheduled for eye surgery on 7/18/17. Staff at the facility were instructed not to give Resident A food starting at 12:00 am on 7/18, however Resident A was observed eating breakfast. Resident A's eye surgery had to be rescheduled as a result.	Yes

III. METHODOLOGY

07/26/2017	Special Investigation Intake 2017A1010056
07/26/2017	Special Investigation Initiated - Telephone Interviewed the complainant by telephone
07/31/2017	Inspection Completed On-site
07/31/2017	Contact - Document Received Resident A's service plan and documentation regarding the "NPO" notes were received
07/31/2017	Exit Conference
08/01/2017	Contact – Telephone call made Interviewed medication technician Alicia Davis by telephone
08/01/2017	APS Referral APS complaint emailed to Centralized Intake

ALLEGATION:

Resident A was scheduled for eye surgery on 7/18/17. Staff at the facility were instructed not to give Resident A food starting at 12:00 am on 7/18, however Resident A was observed eating breakfast. Resident A's eye surgery had to be rescheduled as a result.

INVESTIGATION:

On 7/26/17, I interviewed the complainant by telephone. The complainant stated Resident A was scheduled to have eye surgery of both eyes on 7/18. The complainant reported the procedure was to correct resident A’s eyelids that were “stretched and rolled down and out.” The complainant explained Resident A’s

eyelids were “stretched and rolled down and out” because of Resident A frequently rubbing her eyes due to chronic pink eye. The complainant did not know the name of the procedure Resident A was scheduled to have.

The complainant explained she sent instructions to the facility regarding Resident A’s procedure via priority mail. The complainant stated the instructions read Resident A was not to be given food starting at 12:00 am on 7/18. The complainant reported Resident A’s surgery was scheduled with Grand Rapids Ophthalmology. The complainant said staff at Grand Rapids Ophthalmology also called the facility and provided the same instruction.

The complainant reported she observed Resident A eating breakfast at the facility in the morning on 7/18 prior to the procedure. The complainant stated that as a result, Resident A’s procedure had to be rescheduled for 8/3. The complainant explained the facility’s administrator Shawn Phillips put the medical abbreviation for no food (NPO) in Resident A’s chart and on the medication cart for care staff. The complainant reported she spoke with medication technician (med tech) Alicia on 7/18 and she said she did not know what the abbreviation “NPO” meant. The complainant did not know “Alicia’s” last name.

On 7/31/17, I interviewed Mr. Phillips at the facility. Mr. Phillips reported he did not know the name of the procedure Resident A was scheduled to have on 7/18. Mr. Phillips stated Resident A’s procedure was to “lift and tighten” her eyelids.

Mr. Phillips stated he wrote instruction for staff not to give Resident A food on their 24 hour report, on the medication cart, and in the Extended Care Professional (ECP) software system staff use. Mr. Phillips provided me with documentation regarding the instruction he wrote for staff. The document read, “Eye surgery on July 18 NPO at midnight (Hold) Amlodipine in the morning rest of meds as ordered.”

Mr. Phillips stated med tech Alicia Davis was on first shift on 7/18. Mr. Phillips reported Ms. Davis did not know what the abbreviation “NPO” meant. Mr. Phillips reported Resident A’s breakfast tray was also sent to the secured memory care unit on 7/18 so staff gave to Resident A as a result.

On 7/31/17, I attempted to interview Resident A at the facility. I was unable to engage Resident A in meaningful conversation. I observed Resident A’s eyelids. Her eyelids were consistent with the complainant’s description. Resident A did not appear to be in pain or discomfort.

On 8/1/17, I interviewed Ms. Davis by telephone. Ms. Davis’ statements regarding Resident A’s scheduled procedure were consistent with the complainant and Mr. Phillips. Ms. Davis reported she did not receive training regarding medical abbreviations at the facility.

On 8/1/17, I made an Adult Protective Services (APS) complaint with Centralized Intake.

APPLICABLE RULE	
R 325.1921	**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:	Interviews with the complainant, Mr. Phillips, and Ms. Davis revealed Resident A was given food prior to her scheduled eye procedure on 7/18. Staff were instructed not to give Resident A food, however Ms. Davis did not know what the medical abbreviation Mr. Phillips used in his instruction notes meant. Resident A's procedure had to be rescheduled as a result. This incident was not consistent with an organized program to provide reasonable protection.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** Special investigation report (SIR) 2017A1010039 dated 6/1/17 Corrective Action Plan (CAP) dated

I shared the findings of this investigation with licensee authorized representative Mr. Phillips on 7/31 at the facility. Mr. Phillips reported a medical abbreviation list was placed on all medication carts in the facility as a result of this incident. I observed the lists on top of the carts. Mr. Phillips stated staff will also receive a training regarding

medical abbreviations. Mr. Phillips reported the kitchen will be instructed to withhold food trays for residents ordered not to eat before medical procedures.

Mr. Phillips explained a note with instruction not to give Resident A food before her rescheduled procedure on 8/3 was entered in ECP. I observed the note and it was clear and easy to understand, no medical abbreviations were used.

IV. RECOMMENDATION

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

8/3/17

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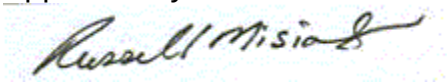
Lauren Wohlfert Date
Licensing Staff

Approved By:



8/3/17

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Russell B. Misiak Date
Area Manager