RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

January 3, 2017

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

RE: License #: AH410343036
Investigation #: 2018A1010006
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) 356-0183.

Sincerely,

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 #:	2018A1010006
Complaint Receipt Date:	12/04/2017
Investigation Initiation Date:	12/04/2017
Report Due Date:	02/03/2018
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?
Residents F and G are a married couple. Resident G often tries to bathe and provide care for Resident F because staff are not responsive.	No
Staff have been found sleeping during their shifts.	No
Resident H was given too much insulin and had to be transported to the hospital.	No
Residents B, D, E often are not groomed well and not showered. Residents are not being toileted every two hours.	No
• Resident sheets are not changed regularly or when soiled. Resident I's bed had to be professionally cleaned because it was soiled. • Resident A and Resident K's share a room and it smells like urine.	No
Water is not being passed during shifts. Water is not provided to residents at lunch time.	No
Resident trash is not emptied and this causes odors. Resident C places her trash in the hall because staff do not empty it.	No
Additional Findings	Yes

III. METHODOLOGY

12/04/2017	Special Investigation Intake 2018A1010006
12/04/2017	Special Investigation Initiated - Letter APS complaint emailed to Centralized Intake

12/04/2017	APS Referral APS complaint emailed to Centralized Intake
12/04/2017	Contact - Telephone call received Received call from assigned APS worker Jennifer Milan to coordinate a joint investigation
12/06/2017	Inspection Completed On-site
12/06/2017	Contact – Document Received I received Resident F and G's service plans and Residents H and J's medication administration records
12/07/2017	Contact - Document Received Email received from Ms. Milan
12/12/17	Contact – Telephone call made I interviewed the Ombudsman's anonymous complaint source by telephone
01/02/2018	Contact – Telephone call made I interviewed a nurse at Resident H's physician office
01/03/2018	Exit Conference

ALLEGATION:

Residents F and G are a married couple. Resident G often tries to bathe and provide care for Resident F because staff are not responsive and take long to answer resident call lights.

INVESTIGATION:

On 12/4/17, the Bureau received the allegations from the Ombudsman's office. The Ombudsman received the allegations from a source who wished to remain anonymous.

On 12/4/17, I made an Adult Protective Services (APS) complaint. I received a telephone call from assigned APS worker Jennifer Milan to coordinate a joint investigation.

On 12/6/17, Ms. Milan and I interviewed administrator Shawn Phillips at the facility. Mr. Phillips reported Resident G has been Resident F's caretaker for several years prior to their arrival at the facility. Mr. Phillips stated as a result, Resident G tries to provide care for Resident F rather than call for staff assistance. Mr. Phillips said staff frequently remind Resident G to call for staff assistance.

Mr. Phillips stated Resident F's last fall was in June. Mr. Phillips reported Resident F was not injured during the incident, therefore an incident report was not sent to licensing. Mr. Phillips provided me with the staff note regarding the incident for my review. The note read, "Housekeeping staff person observed resident on floor. Resident stated he tried to get up to turn the heat up. No injury documented."

On 12/6/17, Ms. Milan and I interviewed director of health care services Rita Dooley at the facility. Ms. Dooley's statements regarding Residents F and G were consistent with Mr. Phillips. Ms. Dooley reported staff have been working with Resident G to ensure she calls for staff assistance when needed.

On 12/6/17, Ms. Milan and I interviewed medication technician and care aide Toniya Crump at the facility. Ms. Crump reported Resident F requires staff assistance and there are times Resident G attempts to care for him herself. Ms. Crump stated Resident G does press her call light for staff assistance when Resident F soils himself or his bed. Ms. Crump reported staff respond to call lights in a timely manner.

On 12/6/17, Ms. Milan and I interviewed medication technician and care aide Chelsea Fuller at the facility. Ms. Fuller's statements regarding Residents F and G were consistent with Mr. Phillips, Ms. Dooley, and Ms. Crump. Ms. Fuller reported staff remind Resident G that she needs to call for staff assistance for Resident F on a daily basis.

On 12/6/17, Ms. Dooley provided me with Resident F and Resident G's service plans for my review. The *Transfers/Falls/Alarms* section of Resident F's plan read, "Resident requires assistance to be transferred. Often times he will not ring for assistance. Staff to anticipate need and check on resident and wife. Resident wife [Resident G] will attempt to transfer resident." The *Toileting* section of the plan read, "Resident has bouts of incontinence both bowel and bladder. Requires assistance from staff for clean up. Wife will attempt to clean up before asking for help. Ask

resident frequently throughout the day if they need assistance." The *Hygiene* section of the plan read, "Resident requires assistance with cares. This includes promoting queuing and setting up. Resident wife will attempt to provide all cares without the assistance of staff. Staff to check in frequently to assess needs of the resident."

The *Ambulation* section of Resident G's plan read, "Resident able to ambulate and transfer without assistance. Staff to ask if resident needs assistance with anything. Resident known to assist husband who shares room and is non ambulatory. Staff to assist with transfers and toileting husband." The plan read Resident G is independent and able to complete all her own cares.

On 12/6/17, Ms. Milan and I interviewed Residents F and G at the facility. Resident F stated he has no concerns with staff. Resident F reported staff respond to his needs in a timely manner and they "do a good job." Resident F said staff help him bathe and meet his other care needs. Resident F reported a male staff person helped him bathe yesterday.

Resident G's statements regarding staff and Resident F's care were consistent with Resident F. Resident G reported she uses her call light when Resident F needs assistance. Resident G said staff respond in a timely manner.

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:	Interviews with Mr. Phillips, Ms. Dooley, Ms. Crump, Ms. Fuller, Resident G, and Resident F, along with review of Resident G and Resident F's service plans, revealed Resident G has a history of attempting to care for Resident F without staff assistance. This is documented in their plans with staff instruction to anticipate Resident F's needs. Ms. Fuller stated staff remind Resident G to call for staff assistance on a daily basis. Residents F and G reported their needs are met by staff in a timely manner.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff have been found sleeping during their shifts.

INVESTIGATION:

On 12/6/17, Mr. Phillips reported housekeeping staff told him a resident care aide was sleeping in the employee break room. Mr. Phillips stated the employee was on break and chose to sleep during her break time. Mr. Phillips stated employee's can choose how to spend their personal break time in their designated area. Mr. Phillips said he informed the employee sleeping during breaks was discouraged.

On 12/6/17, Ms. Dooley stated housekeeping staff informed her she saw a care aide sitting in the dining room with the lights off. Ms. Dooley reported the staff person did not see the care aide's face to confirm whether or not she was sleeping. Ms. Dooley said she was also given a picture of the care aide sleeping in the breakroom. Ms. Dooley reported the care aide was on break when the picture was taken. Ms. Dooley could not recall the date she received this information. Ms. Dooley said staff are allowed to put their head down during their break time.

Ms. Dooley reported she completes random checks at the facility during the night shift to ensure staff are not sleeping. Ms. Dooley stated her last unannounced check during the night shift was this past weekend and there were no concerns.

On 12/6/17, Ms. Crump denied knowledge regarding staff sleeping during their shift. Ms. Crump stated she has not observed any staff sleeping during her shifts.

On 12/6/17, Ms. Fuller reported she has no firsthand knowledge regarding staff sleeping during their shifts. Ms. Fuller's statements regarding staff sleeping were consistent with Ms. Crump.

On 12/12/17, I interviewed the Ombudsman's anonymous complaint source by telephone. The complaint source reported she saw resident care aide Paige sitting in the dining room at the facility during one of her shifts. The complaint source did not know Paige's last name. The complaint source was unable to verify whether or not Paige was sleeping. The complaint source reported Paige got up and went to the break room and shut the door. The complaint source stated she observed Paige sleeping in the break room and took her picture. The complaint source was unable to state whether or not Paige was on her break when she was observed sleeping.

The anonymous complaint source reported she witnessed all of the allegations first hand at the facility.

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 Mr. Phillips and Ms. Dooley revealed staff are able to spend their personal break time in their designated area as they choose. Mr. Phillips and Ms. Dooley stated the care aide who another staff person observed sleeping was on break in the designated break area. There is not enough evidence to substantiate this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident H was given too much insulin and had to be transported to the hospital.

INVESTIGATION:

On 12/6/17, Mr. Phillips stated Resident H was not given too much insulin. Mr. Phillips reported Resident H is a brittle diabetic and there are times when his blood sugar gets low. Mr. Phillips said Resident H did go to the hospital because his blood sugar was low. Mr. Phillips was unable to recall the date this occurred. Mr. Phillips stated Resident H has not had any medication errors.

On 12/6/17, Ms. Dooley reported Resident H is prescribed insulin on a sliding scale based on his blood sugar. Ms. Dooley stated Resident H is prescribed two insulins, Lantus and Novolog. Ms. Dooley reported Lantus is a long acting insulin. Novolog is a fast acting insulin.

Ms. Dooley provided me with an observation note for Resident H dated 11/15 for my review. The note read, “This writer was notified that resident was reporting weakness and being very tired. Upon assessment and gathering of blood glucose it was discovered that resident had a blood glucose level of 37. Due to these findings resident was offered 8 ounces of orange juice with 2 teaspoons of sugar in 15 minute intervals x3. Resident family member was notified of low blood glucose and was told to send resident out to St. Mary’s. Life EMS was contacted resident was sent to St. Mary’s Hospital. Resident blood sugar was 47 when checked by the EMS. Resident Go Bus was cancelled for today.”

On 12/6/17, Mr. Phillips provided me with Resident H’s November medication administration record (MAR). The MAR read Resident H is prescribed Lantus Solostar 100 Unit/ml with instruction to “inject 14 units subcutaneously once daily in the morning.” Resident H is also prescribed Novolog 100 unit/ml flexpen with instruction to “inject up to 10 units subcutaneously once daily as instructed if blood sugars are: 70-199 do not give. If blood sugars are 200-299 administer 1 unit, 300-399 administer 2 units, 400 or above administer 3 units.”

Resident H’s MAR read his blood sugar was 85 on 11/15. Resident H’s MAR read staff administered his prescribed Novolog. On 12/15, Ms. Dooley reported via email the electronic MAR system the facility uses prompts medication technicians to enter an amount of Novolog administered when checking resident blood glucose levels, even when Novolog is not actually given. Ms. Dooley stated this occurred on 11/15 as Resident H’s Novolog was not administered.

On 12/7/17, Ms. Milan went to the facility and interviewed Resident H. Ms. Milan reported Resident H "barely remembers going to the hospital or why."

On 1/2/18, I interviewed the nurse at Resident H's physician office. It was confirmed that Resident H is diabetic. The physician's office was notified that Resident H went to the emergency room (ER) on 11/15 due to his very low blood sugar. It was reported that Resident H does not have a history of low blood sugar. The physician's office was unable to determine if Resident H's low blood sugar on 11/15 was the result of an insulin error. The physician's office stated Resident H has not been seen at the ER or by his physician for low blood sugar since 11/15.

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:	Review of Resident H's observation notes and interviews with Mr. Phillips and Ms. Dooley revealed Resident H was sent to the hospital on 11/15 for low blood sugar. Resident H's physician office was unable to confirm Resident H's low blood sugar was the result of an insulin error. Resident H's blood sugar got as low as 37 on 11/15, however it cannot be determined that this was caused by a medication error.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents B, D, E often are not groomed well and not showered. Residents are not being toileted every two hours.

INVESTIGATION:

On 12/6/17, Mr. Phillips reported residents are bathed twice a week or more if they choose. Mr. Phillips stated it is the facility's policy to toilet residents every two hours or more if needed.

On 12/6/17, Ms. Dooley stated Residents B, D, and E are bathed twice a week. Ms. Dooley reported Residents B and D require staff to stand by and assist if needed when bathing. Ms. Dooley denied knowledge regarding Residents B, D, and E not being well groomed or bathed. Ms. Dooley stated Residents B, D, and E can be combative when bathing, however staff redirect and re-approach when this occurs.

On 12/6/17, Ms. Crump's statements regarding resident bathing schedules and Residents B, D, and E were consistent with Mr. Phillips and Ms. Dooley.

On 12/6/17, Ms. Fuller's statements regarding resident bathing schedules and Residents B, D, and E were consistent with Mr. Phillips, Ms. Dooley, and Ms. Crump.

On 12/6/17, I observed Resident B eating lunch in the dining room. Resident B had clean clothing on and was well groomed.

On 12/6/17, Ms. Milan and I interviewed Resident C at the facility. Resident C stated she bathes weekly at the facility. Resident C reported she has a roommate who frequently requests additional showers during the week. Resident C said staff meet her roommate's request and give her a shower more than twice a week. Resident C reported to her knowledge, all residents are bathed weekly.

On 12/6/17, Ms. Milan and I interviewed Resident D at the facility. Resident D's statements regarding staff timeliness at the facility were consistent with Residents F and G. Resident D reported staff help him shower regularly at the facility. Resident D had clean clothing on and was well groomed. I did not detect any foul odors coming from Resident D or his room.

On 12/6/17, I was unable to engage Resident E in meaningful conversation due to his hearing loss. Resident E had clean clothing on and was well groomed.

On 12/6/17, Ms. Milan and I interviewed Relatives E1 and E2 at the facility. Relatives E1 and E2 reported Resident E is always clean and well-groomed when they visit him at the facility. Relative E1 stated she is Resident E's Power of Attorney (POA) and visits regularly. Relative E1 stated she and Relative E2 are aware Resident E can be combative when staff attempt to bathe him. Relative E1 and E2 stated they do not have any concerns regarding staff not bathing Resident E. Relatives E1 and E2 reported they are satisfied with the staff and the care Resident E receives at the facility. Relatives E1 and E2 said they would move Resident E out of the facility if he was not receiving adequate and appropriate care.

Ms. Milan and I observed several residents in the dining room in the general assisted living area and in the dining room on the secured memory care unit. The residents were clean and well groomed, no foul odors were detected.

APPLICABLE RULE	
R 325.1933	**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:	Interviews with Mr. Phillips, Ms. Dooley, Ms. Crump, Ms. Fuller, Resident C, Resident D, and Relatives E1 and E2, along with resident observation revealed residents are being bathed weekly and are adequately groomed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Resident sheets are not changed regularly or when soiled. Resident I's bed had to be professionally cleaned because it was soiled.**
- **Resident A and Resident K's share a room and it smells like urine.**

INVESTIGATION:

On 12/6/17, Mr. Phillips stated resident sheets are changed on resident shower days each week. Mr. Phillips reported resident sheets are also changed when a resident soils or has an accident in bed.

Mr. Phillips stated Resident I was recently placed on a diuretic medication which has increased her urine output. Mr. Phillips reported a mattress pad was placed on Resident I's bed to protect it from urine. Mr. Phillips said staff were incorrectly putting the mattress pad on Resident I's bed. Mr. Phillips reported Urine got on Resident I's mattress as a result. Mr. Phillips stated this was quickly identified and staff were shown how to correctly put the mattress pad on. Mr. Phillips explained Stanley

Steamer was contacted to clean Resident I's mattress and there has not been an issue since.

On 12/6/17, Ms. Milan and I observed Resident I in the secured dementia unit at the facility. Ms. Milan and I were unable to engage Resident I in meaningful conversation due to her dementia diagnosis. Resident I was clean and well groomed. Ms. Milan and I also observed Resident I's room. The room was clean and no foul odors were detected.

On 12/6/17, Ms. Milan and I interviewed resident care aide Tammy Carter at the facility. Ms. Carter denied knowledge regarding Resident I's mattress. Ms. Carter reported she was not working when Stanley Steamer was at the facility to clean Resident I's mattress. Ms. Carter stated residents on the secured dementia unit are toileted every two hours. Ms. Carter reported residents are changed as needed when accidents occur and sheets are changed regularly.

On 12/6/17, Ms. Crump reported care staff are responsible for changing resident sheets on their scheduled shower days. Ms. Crump's statements were consistent with Mr. Phillips.

On 12/6/17, Ms. Fuller's statements regarding resident sheets were consistent with Mr. Phillips and Ms. Crump.

On 12/6/17, Ms. Milan and I interviewed housekeeping staff person Jane Tucker. Ms. Tucker's statements regarding resident sheets were consistent with Mr. Phillips, Ms. Crump, and Ms. Fuller.

On 12/6/17, Ms. Milan and I interviewed Resident A at the facility. Resident A's statements regarding staff were consistent with Resident D, Resident F, and Resident G. Resident A reported her sheets are changed weekly by staff.

On 12/6/17, Resident C's statements regarding her sheets being changed were consistent with Resident A.

On 12/6/17, Resident F and G's statements regarding their bed sheets were consistent with Residents A and C.

On 12/6/17, Ms. Milan and I interviewed Resident K at the facility. Resident K's statements regarding staff were consistent with Resident D, Resident F, Resident G, and Resident A. Resident K's statements regarding sheets being changed at the

facility were consistent with Resident A, Resident C, Resident F, and Resident G. Resident A and K's room did not smell like urine.

On 12/6/17, Relatives E1 and E2 reported Resident E's sheets are clean when they visit him at the facility. Relatives E1 and E2 denied concerns regarding Resident E's sheets being dirty and not changed.

On 12/6/17, Ms. Milan and I interviewed maintenance supervisor Scott Bayle at the facility. Ms. Bayle reported Resident H's sheets were dirty this morning. Mr. Bayle stated staff have made resident beds with dirty sheets on in the past.

On 12/6/17, Ms. Milan and I observed Resident H's sheets. The sheets were clean and no spots were observed. Ms. Milan and I were not able to interview Resident H because he was at a medical appointment outside of the facility.

On 12/7/17, I received an email from Ms. Milan. Ms. Milan stated she completed an unannounced visit at the facility to interview Resident H on this date. Ms. Milan reported Resident H was clean. Ms. Milan said Resident H estimated his sheets are changed "about every other day." Ms. Milan reported Resident H said staff treat him well and he has no complaints.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing**
	(1) Bedding shall be washable, in good condition, and clean, and shall be changed at least weekly or more often as required.
ANALYSIS:	Interviews with staff along with Residents A, C, F, G, and K, Relative E1 and E2 revealed resident sheets are changed weekly and more often as needed. Ms. Milan and I walked the entire facility and did not observe dirty bedding or sheets. I observed Resident A and K's room. It was clean and did not smell like urine.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Water is not being passed during shifts. Water is not provided to residents at lunch time.

INVESTIGATION:

On 12/6/17, Mr. Phillips reported staff pass water to residents during both 12 hour shifts at the facility. Mr. Phillips stated there are water and ice machines available for resident use in the main dining room and down one of the resident halls in the general assisted living area. Mr. Phillips said water is also given to residents during meals.

On 12/6/17, Ms. Dooley's statements regarding water for residents were consistent with Mr. Phillips.

On 12/6/17, Ms. Crump's statements regarding water for residents were consistent with Mr. Phillips and Ms. Dooley.

On 12/6/17, Ms. Fuller's statements regarding water for residents were consistent with Mr. Phillips, Ms. Dooley, and Ms. Crump.

On 12/6/17, Ms. Carter's statements regarding water for residents were consistent with Mr. Phillips, Ms. Dooley, Ms. Crump, and Ms. Fuller.

On 12/6/17, Ms. Milan and I observed residents in the main dining room and in the dining room on the secured dementia unit during lunch. I observed each resident had a glass of water with their meal. I observed the water and ice machines in the main dining room and in the resident hallway. There was also water available for visitors in the lobby area.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.

ANALYSIS:	Interviews with staff and my observation of residents during lunch revealed water is served and available to residents. I observed the ice and water machines in the facility that residents and visitors can access.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident trash is not emptied and this causes odors. Resident C places her trash in the hall because staff do not empty it.

INVESTIGATION:

On 12/6/17, Mr. Phillips reported resident trash is emptied during both 12 hour shifts at the facility. Mr. Phillips stated resident trash is also emptied as needed if it contains a dirty brief.

On 12/6/17, Ms. Dooley's comments regarding resident trash were consistent with Mr. Phillips.

On 12/6/17, Ms. Crump's statements regarding resident trash were consistent with Mr. Phillips and Ms. Dooley.

On 12/6/17, Fuller's statements regarding resident trash were consistent with Mr. Phillips, Ms. Dooley, and Ms. Crump.

On 12/6/17, Ms. Carter's statements regarding resident trash were consistent with Mr. Phillips, Ms. Dooley, Ms. Crump, and Ms. Fuller.

On 12/6/17, Ms. Tucker's statements regarding resident trash were consistent with Mr. Phillips, Ms. Dooley, Ms. Crump, Ms. Fuller, and Ms. Carter.

On 12/6/17, Ms. Milan and I walked the entire facility, including resident rooms. I did not observe any full trash cans and no foul odors were detected.

On 12/6/17, Resident A reported staff frequently empty her trash and it is never left overflowing.

On 12/6/17, Resident C's statements regarding her trash were consistent with Resident A.

On 12/6/17, Resident D's statements regarding his trash were consistent with Residents A and C.

On 12/6/17 Relatives E1 and E2 reported the facility is clean when they visit Resident E. Relatives E1 and E2 denied concerns regarding the cleanliness of the facility.

On 12/6/117, Resident F and G's statements regarding their trash were consistent with Residents A, C, and D.

On 12/6/17, Resident K's statements were consistent regarding her trash were consistent with Residents A, C, D, F, and G.

On 12/7/17, Ms. Milan stated she observed Resident H's trash. Ms. Milan reported the only item in his trash was a pair of gloves. Ms. Milan did not observe trash in the resident hallways and did not detect any foul odors in the halls.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Interviews with staff and residents, along with my observation, revealed trash is regularly taken out. I walked through the entire facility, including resident rooms, and did not observe any full trash cans in rooms or hallways. I did not detect any foul odors in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITONAL FINDINGS:

Ms. Dooley reported staff have intentionally entered incorrect information in Resident H's MAR due to a system flaw. Ms. Dooley stated this occurred on 11/15 when staff initialed his Novolog was given when staff did not actually administer it. Ms. Dooley

said the system prompted staff to enter an amount of Novolog given when confirming Resident H's blood glucose was checked. Ms. Dooley reported staff entered the Novolog was administered, however it was not actually given to Resident H.

Ms. Dooley also entered her initials in Resident H's MAR to show she administered his Lantus on 11/15. Ms. Dooley did not administer Resident H's Lantus on 11/15, medication technician Page Stokes administered it. An observation note for Resident H dated 11/15 read, "residents Lantus was not administered by Tarita Dooley. However it was confirmed by Page Stokes that Lantus was administered. Tarita Dooley signed out medication as noted in ECP."

I reviewed Resident H's November MAR. The MAR was missing staff initials for Resident H's morning doses of Norvasc 10 mg tablet on 11/15, Liptor 40 mg tablet on 11/15, Coreg 25 mg tablet on 11/15, Apresoline 50 mg on 11/15, Renal Caps Softgel capsule on 11/15, Effexor Xr 150 mg capsule on 11/15. It is unknown whether or not the medication was administered, there were no notes in the MAR to provide an explanation. Resident a was sent to the hospital in the morning on 11/15, however this was not documented in his MAR.

Resident H's evening dose of Novolog 100 unit flexpen on 11/9 was not initialed by staff. There was no explanation in his MAR regarding this.

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, board, protection, supervision, assistance, and supervised personal care for its residents.**

ANALYSIS:	The interview with Ms. Dooley, as well as review of Resident H's observation note dated 11/15, revealed staff entered inaccurate information in Resident H's MAR. Ms. Dooley reported staff intentionally entered Resident H's Novolog was administered on 11/15, however it was not actually given. Ms. Dooley entered her initials showing she administered Resident H's Lantus on 11/15, however staff person Page Stokes administered the medication. This practice is not consistent with an organized program of protection.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SPECIAL INVESTIGATION REPORT (SIR) 2017A1010056**

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Resident H was sent to the hospital on 11/15. Resident H's MAR was missing staff initials for his morning medications on 11/15. There was no explanation provided on the MAR, therefore it is unknown whether or not the medications were administered. Staff initials were also missing for Resident H's evening Novolog on 11/19. There was not documentation regarding this on the MAR.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Shawn Phillips on 1/3/18. Mr. Phillips stated Ms. Dooley is working with the pharmacy to resolve the flaw in the facility's electronic system that requires inaccurate information to be inputted in resident MARs. Mr. Phillips stated staff will be re-educated on initialing and documenting in resident MARs.

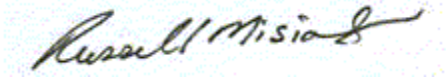
IV. RECOMMENDATION

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

1/2/18

Lauren Wohlfert — Date
Licensing Staff

Approved By:



1/2/18

Russell B. Misiak — Date
Area Manager