RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

April 5, 2018

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

RE: License #: AH410343036
Investigation #: 2018A1010027
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

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 #:	2018A1010027
Complaint Receipt Date:	03/13/2018
Investigation Initiation Date:	03/14/2018
Report Due Date:	05/12/2018
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
• Personal care items are sitting on top of the medication cabinet in the secured memory care unit. • Food for the residents in the memory care unit should be cut up, however staff are not doing this.	No
Staff gave Resident G his stool softener twice a day and it is unknown why.	No
There was fecal matter on Resident G's sheets.	No
Resident G's bathroom was very dirty, visitors had to ask staff to clean his toilet.	No
Additional Finding	Yes

III. METHODOLOGY

03/13/2018	Special Investigation Intake 2018A1010027
03/14/2018	Special Investigation Initiated - Letter APS complaint emailed to Centralized Intake
03/14/2018	APS Referral APS complaint emailed to Centralized Intake
03/23/2018	Contact - Telephone call made I interviewed the complainant by telephone
03/23/2018	Inspection Completed On-site
03/23/2018	Contact - Document Received Received Resident A's service plan, medication list and medication administration instructions, MARs, and shower log documents
03/27/2018	Contact – Document Received Residents A, B, C, D, E, and F's service plans received via email from Ms. Dooley

04/05/2018	Exit Conference

ALLEGATION:

- **Personal care items are sitting on top of the medication cabinet in the secured memory care unit.**

- **Food for the residents in the memory care unit should be cut up, however staff are not doing this.**

INVESTIGATION:

On 3/13/18, the Bureau received this complaint from the online system.

On 3/14/18, I contacted Centralized Intake and made an Adult Protective Services (APS) complaint.

On 3/23/18, I interviewed the complainant by telephone. The complainant reported she visited Resident A at the facility several times. The complainant stated she observed Resident A's personal care items, such as shaving cream, above the medicine cabinet in his bathroom. The complainant said these items are supposed to be locked in the cabinets above the resident sinks in their bathrooms. The complainant reported Resident A resided in the memory care unit, therefore he should not have had access to his personal care items.

The complainant reported staff in the memory care unit did not cut up the residents' food during mealtimes. The complainant said staff did not check on Resident A regularly while she visited him at the facility, therefore it appeared staff did not complete rounds to check on residents. The complainant said staff at the facility often let residents sleep all day.

On 3/23/18, I interviewed the director of health care services Tarita Dooley at the facility. Ms. Dooley reported any items that are considered harmful to residents in the memory care unit are secured. Ms. Dooley stated resident personal care items are not left on medication carts or unsecured. Ms. Dooley said these items are secured in cabinets.

Ms. Dooley reported there are residents in the secured memory care unit who are on a mechanical soft and pureed diet. Ms. Dooley stated the residents' food is prepared according to their diet needs in the kitchen. Ms. Dooley said staff in the secured memory care unit also assist residents by cutting their food when necessary.

Ms. Dooley reported residents in the memory care unit are checked on regularly by staff because they have higher acuity levels. Ms. Dooley stated there are 12 residents in the memory care unit.

On 3/23/18, I interviewed kitchen manager Ben Gibbs at the facility. Mr. Gibbs reported he maintains a list of residents in the memory care unit who are on a mechanical soft diet and pureed diet. Mr. Gibbs showed me the white board in the kitchen where this information is maintained. The board read Residents A, B, C, D, and E are on mechanical soft diets. The board read Resident F is on a pureed diet. These residents all reside in the memory care unit. Mr. Gibbs stated the mechanical soft diet and pureed foods are prepared in the kitchen and delivered to the memory care unit on heated carts. Mr. Gibbs said staff in the memory care unit then give the residents their meals and assist them as needed.

On 3/23/18, I interviewed resident care aide Regina Hacket at the facility. Ms. Hacket reported resident personal care products, such as shaving cream and razors, are locked in the cabinets in their bathrooms. Ms. Hacket stated these items are not left out due to the safety risk they pose to residents in the memory care unit. Ms. Hacket denied knowledge regarding these items being left unsecured.

Ms. Hacket's statements regarding residents on mechanical soft and pureed diets were consistent with Mr. Gibbs. Ms. Hacket reported she and the other resident aides help residents and cut their food as needed during meal times. Ms. Hacket said residents in the memory care unit are not given knives because they have poor safety awareness.

On 3/23/18, I interviewed resident care aide Tammy Carter at the facility. Ms. Carter's statements were consistent with Mr. Gibbs and Ms. Hacket.

On 3/23/18, I observed the lunch meal that was served in the memory care unit. I observed Residents A, B, C, D, and E's food was prepared and served consistent with their mechanical soft diet. I observed Resident F's food was pureed. I observed Ms. Hacket and Ms. Carter cut the food for residents who were not on a mechanical or pureed diet. Ms. Hacket and Ms. Carter were attentive, queued, and helped residents eat as needed.

I observed the cabinets in each resident bathroom in the memory care unit. I observed all cabinets were locked and no personal care products were left out. I also observed the medication cart. There were no personal items or hazardous items left unsecured on the cart.

On 3/27/18, I received Resident A, B, C, D, E, and F's service plans. I read the *Dietary* sections of their plans addressed their mechanical soft and pureed diets.

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.
ANALYSIS:	Interviews with Ms. Dooley, Mr. Gibbs, Ms. Hacket, and Ms. Carter, along with inspection of the memory care unit revealed items considered hazardous to residents are secured. I observed the cabinets in resident bathrooms that contained personal items were locked. I observed Resident A, B, C, D, E, and F's meals were prepared and served as outlined in their service plans. The facility is in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff gave Resident G his stool softener twice a day and it is unknown why.

INVESTIGATION:

On 3/23/18, the complainant stated staff at the facility gave Resident G his stool softner twice a day, once in the morning and once in the evening. The complainant reported she did not know if Resident G had physician orders for the stool softner.

On 3/23/18, Ms. Dooley reported Resident G's stool softner was administered as ordered by his physician. Ms. Dooley stated she worked with Resident G's family when he was admitted to get his medications on a schedule similar to what he had at home.

Ms. Dooley provided me with Resident G's medication list and medication administration records (MARs) for my review. The *Medications Orders* document read Resident G was prescribed Natural Veg. Laxative one tablet by mouth daily and Senna Concentrate one tablet by mouth every evening. Senna Concentrate is also a laxative. The document read the Natural Veg. Laxative was prescribed on 1/16 and the Senna Concentrate was prescribed on 12/21.

Resident G's December, January, February, and March MARs read his Natural Veg. Laxative and Senna Concentrate were administered as prescribed.

On 3/23/18, I was unable to interview Resident G because he no longer resides at the facility.

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:	The interview with Ms. Dooley and review of Resident G's medication list and MARs reveal Resident G's prescribed laxatives were administered as prescribed by the facility. The facility is in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There was fecal matter on Resident G's sheets.

INVESTIGATION:

On 3/23/18, the complainant reported she observed feces on Resident G's sheets approximately a month or two ago. The complainant stated Resident G did not have feces in his pants when he got up, therefore there are concerns his sheets weren't changed.

On 3/23/18, Ms. Dooley reported resident sheets are changed by care staff on the days they are bathed. Ms. Dooley stated residents are bathed twice a week or more depending on their preference. Ms. Dooley said care and housekeeping staff also change resident sheets when they see they are soiled or dirty. Ms. Dooley explained Resident G was independent with toileting, however he had difficulty wiping and cleaning himself after using the bathroom. Ms. Dooley reported Resident G's family told staff he had feces on his sheets when they visited once. Ms. Dooley said staff immediately changed his sheets once this was brought to their attention.

Ms. Dooley provided me with a copy of Resident G's service plan for my review. The *Laundry Service* section of the plan read, "Full assistance required. Provide laundry needs. Gather dirty/soiled clothes/linen and wash/dry/fold and put away properly."

On 3/23/18, Ms. Hacket's statements were consistent with Ms. Dooley.

On 3/23/18, Ms. Carter's statements were consistent with Ms. Dooley and Ms. Hacket.

On 3/23/18, I interviewed housekeeping staff person Jane Tucker at the facility. Ms. Tucker's statements were consistent with Ms. Dooley, Ms. Hacket, and Ms. Carter.

On 3/23/18, I interviewed housekeeping staff person Sherry Halstead at the facility. Ms. Halstead's statements were consistent with Ms. Dooley, Ms. Hacket, Ms. Carter, and Ms. Tucker.

On 3/23/18, I observed the sheets that were on resident beds in the memory care unit. I observed all the beds were made and the bedding and sheets were clean.

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 Ms. Dooley, Ms. Hacket, Ms. Carter, Ms. Tucker, and Ms. Halstead reveal resident sheets are changed when residents are bathed and when staff find them soiled or dirty. Housekeeping staff assist care staff when requested or when soiled or dirty sheets are observed. I observed all of the resident beds in the memory care unit. The beds were made and the bedding and sheets were clean. The facility is in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident G's bathroom was very dirty, visitors had to ask staff to clean his toilet.

INVESTIGATION:

On 3/23/18, the complainant stated she observed the toilet in Resident G's bathroom was dirty with feces stains on several occasions. The complainant reported staff cleaned the toilet when she asked. The complainant said it appeared staff were not cleaning Resident G's toilet regularly.

On 3/23/18, Ms. Dooley reported that since Resident G toileted himself, he used his bathroom at different times during the day. Ms. Dooley stated housekeeping staff clean resident bathrooms and toilets daily. Ms. Dooley said care staff also clean resident toilets when they observe them to be dirty.

I reviewed the *Bowel Movement Monitoring* section of Resident G's service plan. The plan read, "Monitor and document their bowel movement. Resident is continent of bowel. May require assistance with clean up." The *Toileting* section of the plan read, "As needed. Provide verbal prompting as well as physical assistance as needed with toileting needs. Resident will require reminders about toileting and next steps for clean up. Staff to monitor and cue resident to execute toileting on their own. Resident may require assistance with clean up if bowel movement occurs."

On 3/23/18, Ms. Hacket's statements were consistent with Ms. Dooley.

On 3/23/18, Ms. Carter's statements were consistent with Ms. Dooley and Ms. Hacket.

On 3/23/18, Ms. Tucker's statements were consistent with Ms. Dooley, Ms. Hacket, and Ms. Carter. Ms. Tucker reported care staff do a good job of communicating when they need assistance cleaning resident toilets. Ms. Tucker stated some staff are better at communicating this than others, however toilets are not left unclean.

On 3/23/18, Ms. Halstead's statements were consistent with Ms. Dooley, Ms. Hacket, Ms. Carter and Ms. Tucker.

On 3/23/18, I walked through the memory care unit, including resident rooms and bathrooms. I observed the unit was clean and free of odors. I observed Ms. Tucker and Ms. Halstead with their cleaning cart cleaning resident bathrooms.

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 Ms. Dooley, Ms. Hacket, Ms. Carter, Ms. Tucker, and Ms. Halstead reveal resident rooms and bathrooms are cleaned daily. I observed the entire memory care unit, including resident rooms and bathrooms. Resident G's service plan provided staff instruction regarding his toileting needs and assistance. The facility is in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

Staff did not initial or document anything regarding the administration of Resident G's Senna Concentrate on 2/19. Staff did not initial or document anything regarding the administration of Resident G's Natural Veg. Laxative on 2/4, 2/19, and 3/12.

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:	Review of Resident G's February and March MARs revealed staff did not properly initial or document anything regarding the administration of his Senna Concentrate on 2/19 and his Natural Veg. Laxative on 2/4, 2/19, and 3/12. The facility is out of compliance with this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation Report (SIR) 2018A1010006**

I shared the finding of this report with licensee authorized representative Shawn Phillips by telephone on 4/5/18. Frequent review of resident MARs will be done by staff to ensure they are complete per licensing rules.

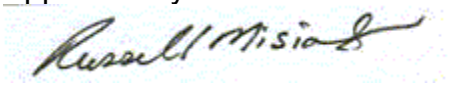
IV. RECOMMENDATION

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

4/5/18

Lauren Wohlfert Date
Licensing Staff

Approved By:



4/5/18

Russell B. Misiak Date

Area Manager