RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

April 13, 2018

David Miller
Harry&JeanetteWeinbergGreenHousesatRivertown
Suite 300
26200 Lahser Road
Southfield, MI 48033

RE: License #: AH820378337
TheHarry&JeanetteWeinbergGreenHouses at
Unit 4
250 McDougall #4
Detroit, MI 48207

Dear Mr. Miller:

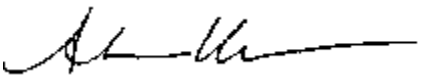
Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific dates 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 home for the aged authorized representative and a date.

Upon receipt of an acceptable corrective action plan and approval by the Bureau of Fire Services, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result.

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 feel free to contact the local office at (248) 975-5053.

Sincerely,



Andrea Krausmann, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(586) 256-1632

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AH820378337
Licensee Name:	Harry&JeanetteWeinbergGreenHousesatRivertown
Licensee Address:	Suite 300 26200 Lahser Road Southfield, MI 48033
Licensee Telephone #:	(248) 281-2020
Authorized Representative:	David Miller
Administrator:	Wenona Breazeale
Name of Facility:	TheHarry&JeanetteWeinbergGreenHouses at
Facility Address:	Unit 4 250 McDougall #4 Detroit, MI 48207
Facility Telephone #:	(313) 446-8742
Original Issuance Date:	03/03/2017
Capacity:	21
Program Type:	AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 04/11/2018

Date of Bureau of Fire Services Inspection if applicable: 02/26/2018

Inspection Type: ☐Interview and Observation ☐Worksheet ☒Combination

Date of Exit Conference: 04/13/2018

No. of staff interviewed and/or observed 5
No. of residents interviewed and/or observed 8
No. of others interviewed No others present Role

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☐ No ☒ If no, explain. No resident funds held
- Meal preparation / service observed? Yes ☐ No ☒ If no, explain.
  No meals prepared/served, however, kitchen and food storage areas were observed.
- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  No applicable home for the aged licensing rules. Bureau of Fire services reviews fire drills.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☒ IR date/s:10/17/17; 10/02/17; 09/27/17 N/A ☐
- Corrective action plan compliance verified? Yes ☐ CAP date/s and rule/s: N/A
- Number of excluded employees followed up? Excluded employees are addressed with the administrator upon receipt of notice. N/A ☐

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:

MCL 333.20173a	**Covered facility; employees or applicants for employment; prohibitions; criminal history check; procedure; conditional employment; knowingly providing false information as misdemeanor; prohibited use or dissemination of criminal history information as misdemeanor; review by licensing or regulatory department; conditions of continued employment; failure to conduct criminal history checks as misdemeanor; establishment of automated fingerprint identification system database; electronic web-based system; definitions.**
MCL 333.20173(a)(2)	**Health facility or agency that is nursing home, county medical care facility, hospice, hospital that provides swing bed services, home for the aged, or home health agency; employees or applicants for employment; prohibitions; criminal history check; condition of continued employment; establishment of automated fingerprint identification system database; report to legislature; web-based system; definitions.** **(2) Except as otherwise provided in subsection (5), a health facility or agency that is a nursing home, county medical care facility, hospice, hospital that provides swing bed services, home for the aged, or home health agency shall not employ, independently contract with, or grant privileges to an individual who regularly has direct access to or provides direct services to patients or residents in the health facility or agency after April 1, 2006 until the health facility or agency conducts a criminal history check in compliance with subsection (4). This subsection and subsection (1) do not apply to any of the following:** **(a) An individual who is employed by, under independent contract to, or granted clinical privileges in a health facility or agency before April 1, 2006. Beginning April 1, 2011, an individual who is exempt under this subdivision shall provide the department of state police with a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (12). An individual who is exempt under this subdivision is not limited to working within the health facility or agency with which he or she is employed by,**

under independent contract to, or granted clinical privileges on April 1, 2006. That individual may transfer to another health facility or agency that is under the same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another health facility or agency that is not under the same ownership, he or she may do so provided that a criminal history check is conducted by the new health facility or agency in accordance with subsection (4). If an individual who is exempt under this subdivision is subsequently convicted of a crime described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under subsection (1)(a), then he or she is no longer exempt and shall be terminated from employment or denied employment.

(b) An individual who is an independent contractor with a health facility or agency that is a nursing home, county medical care facility, hospice, hospital that provides swing bed services, home for the aged, or home health agency if the services for which he or she is contracted are not directly related to the provision of services to a patient or resident or if the services for which he or she is contracted allow for direct access to the patients or residents but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the health facility or agency to provide utility, maintenance, construction, or communications services.

According to administrator Wenona Breazeale and the residents' admission contracts, the home grants clinical privileges to PACE [Southeast Michigan Program of All-Inclusive Care for the Elderly] employees that have regular direct access and regularly provide direct services to residents in the facility. These individuals may include, but not be limited to, the PACE physician, the nurse practitioner, the nurse social worker, and therapists. Ms. Breazeale confirmed the home has not conducted criminal history background checks of these individuals, who were granted clinical privileges, in accordance with this statute.

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.

The owner, operator, governing body did not assure that the home maintains an organized program to provide protection, supervision, assistance, and supervised personal care for its residents as evidenced by the following:

At the time of the on-site inspection, it was observed that Resident A had had assistive devices commonly referred to as Noa bars, attached to both sides of his bedframe. Ms. Breazeale said Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, Resident H, and Resident I all have the assistive devices, commonly referred to as Noa bars, attached to their bedframes.

The Noa bars observed revealed one or more areas with distance between the slats (the horizontal supports between the perimeter of grab bar itself) large enough to allow a resident's hand/arm to accidentally become entrapped between the slats. Ms. Breazeale confirmed there are no protective covers to close off the open spaces on any of the devices. It was also noted that one of Resident A's Noa bar devices would rock and appeared loose when grabbed.

Ms. Breazeale also confirmed the facility does not have a physician's order for each device; no manufacturer's instructions to ensure proper installation by a qualified individual; no written policy for use of such devices; they are not addressed in resident service plans with methodology; nor is there any specific staff training for the use of assistive devices on or about the bed. There is no current policy/procedure for monitoring the resident when in the bed with the device and ensuring the resident has a means to contact staff, when needed; no monitoring of the device to always ensure it is secure to the bed frame; and no measuring/monitoring for gaps that may develop between the mattress and device causing potential entrapment zones.

Given the above findings, the facility is not in accordance with the department's Adult Foster Care and Camps Licensing Division technical assistance handbook for R325.1921(1)(b) addressing the use of assistive devices on or about the bed located at:
http://www.michigan.gov/documents/dhs/HFA_Technical_Assistance_Handbook_343632_7.pdf

R 325.1922 Admission and retention of residents.

(1) A home shall have a written resident admission contract, program statement, admission and discharge policy and a resident's service plan for each resident.

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.

The home has not always had a service plan for each resident upon admission. For examples:
Ms. Breazeale said Resident A was considered to be a "respite" resident on 11/17/17, although he received room, board and supervised personal care. He was then considered to be admitted to the facility on 3/1/18, but his service plan is dated 3/3/18.

According to the resident register, Resident J was admitted on 6/9/17 but her service plan was not completed until 6/10/17.

There is no information on Resident A's nor Resident J's service plans indicating the plans were completed in cooperation with the residents and/or their authorized representative or agency responsible for placement into the home.

In addition, the facility's service plans do not meet the definition of a service plan, in that they do not always identify the specific care and maintenance, services, for each 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. For example(s):

Resident A's service plan does not address the use of the bedside assistive devices (commonly known as Noa bars) attached to each side of his bed. The service plan indicates he needs "assistance" with bathing but no additional information as to the specific care and services provided. No methodology is given.

Resident B's service plan also does not address the use of the Noa bars on his bed. Resident B service plan indicates he requires "total assistance" with dressing but

there is no information as to the methods, the resident's preferences and competency in regard to dressing. Resident B's service plan also identifies the behavior of being "depressed" but there is no information as to the specific care, services and methods to be implemented in addressing this behavior.

R 325.1922 Admission and retention of residents.

(6) A home shall require an individual who, at the time of admission, is under the care of a licensed health care professional for ongoing treatments or prescription medications that require the home's intervention or oversight, to provide a written statement from that licensed health care professional completed within the 90-day period before the individual's admission to the home. The statement shall list those treatments or medications for the purpose of developing and implementing the resident's service plan. If this statement is not available at the time of an emergency admission, then the home shall require that the statement be obtained not later than 30 days after admission.

Review of Resident J's record revealed no written statement from the licensed health care professional completed within the 90-day period prior to admission. Ms. Breazeale and Resident J's service plan confirmed that the home staff administers Resident J's medications to her.

R 325.1923 Employee's health.

(2) A home shall provide annual tuberculosis screening at no cost for its employees. New employees shall be screened within 10 days of hire and before occupational exposure. The screening shall consist of intradermal skin test, chest x-ray, or other methods as recommended by the local health authority.

Review of an employee file revealed staff Angela Evans was hired 12/12/16 but her screening for tuberculosis was completed on 10/05/16, not within 10 days of hire.

R 325.1953 Menus.

(1) A home shall prepare and post the menu for regular and therapeutic or special diets for the current week. Changes shall be written on the planned menu to show the menu as actually served.

The home did not prepare and post the menu for regular and therapeutic or special diets for the current week. The home posted an April 2018 calendar listing food items to be provided at dinner minus the dessert for dinners. Staff Angela Evans said the facility provides daily meals to residents with various diets required including

regular, mechanical soft, diabetic, etc. However, none of these menus were prepared and posted for the current week.

R 325.1954 Meal and food records.
The home shall maintain a record of the meal census, to include residents, personnel, and visitors, and a record of the kind and amount of food used for the preceding 3-month period.

Ms. Evans confirmed the home has not maintained a record of the meal census, to include residents, personnel and visitors, nor has the home maintained a record of the kind and amount of food used for the preceding 3-month period.

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:
(a) The name of the person or persons involved in the incident/accident.
(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.
(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.
(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.
(e) The corrective measures taken to prevent future incidents/accidents from occurring.

For reference: Definitions.
R 325.1901

(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.

The facility's incident reports do not contain all the required information.
For incident report examples:

10/17/17 staff documented Resident D tripped and fell walking from wheelchair to bed. She bumped her head and her nose was bleeding. An on-call PACE nurse was called. She would be sending MedStar ambulance service out to "check her out". There was no documentation of the hour (time of incident), no name, date and time the physician and authorized representative were notified, and no corrective

measures to prevent recurrence. Also, there was no documentation of the department having been notified.

10/02/17 Resident D was laying on floor, blood present from hand injury. Resident was sent to the hospital via 911 call. There was no hour (time of incident), no name date and time the physician and authorized representative were notified, and no corrective measures to prevent recurrence. Also, there was no documentation of the department having been notified.

9/27/17 Resident D slid off the side of the bed and complained of lower right back pain. “Contacted on call, they are sending MedStar out to assess elder” was written. There was no hour (time of incident), no location, no name, date and time physician and authorized representative were notified, and no corrective measures to prevent recurrence. Also, there was no documentation of the department having been notified.

It should also be noted, the rule requires document of both the effect on the resident as well as the extent of injuries, if known. The facility’s incident report form includes a section titled “Effect on Resident” but omits a section for “extent of injuries, if known”. In these three reports, the staff documented Resident D’s injuries into the “Effect on Resident” section and did not document the effect on the resident.
In addition, the facility’s incident report form includes a section titled “Corrective Measures Taken” but omits a section for “medical attention sought”. Consequently, staff documented the medication attention sought information into the “Corrective Measures Taken” space and failed to include any corrective measures to prevent recurrence.

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.

According to Ms. Breazeale, the home does not immediately notify the resident’s physician of reportable incidents. The home has been instructed to notify a PACE nurse during regular business hours, and to notify MedStar ambulance services at all other times. The MedStar ambulance services then contacts PACE’s on-call nurse who will decide whether to give instructions to the home staff or the PACE nurse will obtain instruction from the resident’s physician. This practice does not meet compliance with the rule that the home shall immediately report an incident/accident to the resident’s physician.

R 325.1944 Employee records and work schedules.
(1) A home shall maintain a record for each employee which shall include all of the following:

(d) Summary of experience, education, and training.

For reference: R 325.1931 **Employees; general provisions.**

(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following:

(a) Reporting requirements and documentation.
(b) First aid and/or medication, if any.
(c) Personal care.
(d) Resident rights and responsibilities.
(e) Safety and fire prevention.
(f) Containment of infectious disease and standard precautions.
(g) Medication administration, if applicable.

For reference: R 325.1981 **Disaster plans.**

(1) A home shall have a written plan and procedure to be followed in case of fire, explosion, loss of heat, loss of power, loss of water, or other emergency.
(2) A disaster plan shall be available to all employees working in the home.
(3) Personnel shall be trained to perform assigned tasks in accordance with the disaster plan.

Review of Angela Evans' employee file revealed the file did not contain documentation of training completed on resident service plans, first aid, and containment of infectious disease and standard precautions, although Ms. Breazeale said Ms. Evans completed all required training.

R 325.1944 **Employee records and work schedules.**

(2) The home shall prepare a work schedule showing the number and type of personnel scheduled to be on duty on a daily basis. The home shall make changes to the planned work schedule to show the staff who actually worked.

For reference: R 325.1931 **Employees; general provisions.**

(3) The home shall designate 1 person on each shift to be supervisor of resident care during that shift. The supervisor of resident care shall be fully dressed, awake, and on the premises when on duty.

Review of the facility's work schedule for February, March and April 2018 revealed the schedule did not show the type of personnel scheduled. Specifically, the schedule did not identify the supervisor of resident care on each shift.

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.

Medication was not always administered as ordered. For example, Resident C's April 2018 medication administration record (MAR) revealed Prochlorperazine is ordered every 6 hours as needed for nausea. Ondansetron is ordered every 8 hours as needed for nausea not relieved by Prochlorperazine. Staff initials on the MAR indicate staff administered Ondansetron to Resident C on 4/1/18, without first administering Prochlorperazine as ordered.

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:

(c) Record the reason for each administration of medication that is prescribed on an as-needed basis.

Staff is not always recording the reason for each administration of medication that is prescribed on an as-needed basis. For examples:
Staff initials on the MAR indicate the medication Ondansetron was administered to Resident C on 4/1/18, but there was no reason documented for having administered this as-needed medication. Resident C also has an order for Gnp anti-diarrheal medication ordered as needed. Staff initials indicate the medication was administered eight times during 4/1-4/7/18, but there was no reason documented for any of these administrations.

Resident D has an order for Mucinex as needed for cough. Staff initials indicate the medication was administered six times during 4/1-4/7/18, but staff only recorded the reason for administering it three times.

R 325.1932(3) 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:

(e) Adjust or modify a resident's prescription medication with instructions from a prescribing licensed health care professional who has knowledge of the medical needs of the resident. A home shall record, in writing, any instructions regarding a resident's prescription medication.

The home has not always recorded instructions for “PRN” or “as needed” medications. For example: The home maintains and administers medications to Resident C. According to the medication administration record Resident C has an order for Lidocain prilocaine 2.5% apply topically to port area as needed. There are no instructions as to the circumstances or parameters to alert and inform staff when this medication would be “needed”.

Other medications prescribed “PRN” or “as needed” lack sufficient instructions to ensure the medications are administered as ordered. For instance, a resident is prescribed various medications “as needed” for the same purpose or various doses of one medication “as needed” without sufficient instructions clarifying situations and/or parameters as to when to administer one medication or the other; or to administer one dose or the other. For example: According to the MAR, a resident has orders for two different medications “as needed for pain”. There are no instructions clarifying if/when one medication would be administered versus the other for pain, whether they are prescribed for different pains, whether both medications are to be administered together, separately, in tandem, etc.

R 325.1943 **Resident registers.**

(1) A home shall maintain a current register of residents which shall include all of the following information for each resident:

(a) Name, date of birth, gender, and room.

(b) Name, address, and telephone number of next of kin or authorized representative, if any.

(c) Name, address, and telephone number of person or agency responsible for resident's maintenance and care in the home.

(d) Date of admission, date of discharge, reason for discharge, and place to which resident was discharged, if known.

(e) Name, address, and telephone number of resident's licensed health care professional, if known.

Review of the resident register revealed it did not include all of the required information. For example: The resident register entries for Resident J did not include her room number; left blank the section for her authorized representative’s name, address, phone number; and did not include the address of her physician.

R 325.1964 **Interiors.**

(9) Ventilation shall be provided throughout the facility in the following manner:

(a) A room shall be provided with a type and amount of ventilation that will control odors and contribute to the comfort of occupants.

(b) Bathing rooms, beauty shops, toilet rooms, soiled linen rooms, janitor closets, and trash holding rooms shall be provided with a minimum of 10 air changes per hour of continuously operated exhaust ventilation that provide discernable air flow into each of these rooms.

A sample check of ventilation in various areas of the facility revealed two areas were not functioning. The second floor spa bathing room and second floor janitor closet exhaust vents were not operating.

R 325.1970 **Water supply systems.**

(7) The temperature of hot water at plumbing fixtures used by residents shall be regulated to provide tempered water at a range of 105 to 120 degrees Fahrenheit.

A sample test of hot water at plumbing fixtures used by residents revealed it was not always regulated to provide water between 105ºF and 120ºF. The shower in room 202 read 122ºF and the sink in the same room only reached 97ºF.

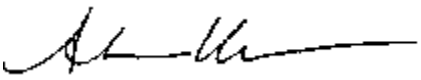
R 325.1976 **Kitchen and dietary.**

(13) A multi-use utensil used in food storage, preparation, transport, or serving shall be thoroughly cleaned and sanitized after each use and shall be handled and stored in a manner which will protect it from contamination.

Other than using the dishwasher, it was confirmed with Ms. Breazeale and Ms. Evans that the home has no method to demonstrate the dishwasher is sanitizing as required.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan and approval by the Bureau of Fire Services, renewal of the license is recommended.



4/13/2018

Andrea Krausmann Date
Licensing Consultant