GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 11, 2019

Kelsey Hastings
Advantage Living Center-Redford Village
25330 6 Mile Road
Redford Charter Twp., MI 48240

RE: License #: AH820378377
Advantage Living Center-Redford Village
25330 6 Mile Road
Redford Charter Twp., MI 48240

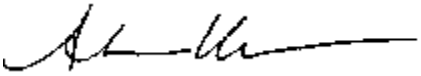
Dear Mrs. Hastings:
Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 from 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 #:	AH820378377
Licensee Name:	Rhema-Redford Village Operating, LLC
Licensee Address:	Ste. 720 25800 Northwestern Hwy Southfield, MI 48075
Licensee Telephone #:	(248) 569-8400
Authorized Representative:	Kelsey Hastings
Administrator:	Dean Rumsey
Name of Facility:	Advantage Living Center-Redford Village
Facility Address:	25330 6 Mile Road Redford Charter Twp., MI 48240
Facility Telephone #:	(313) 531-6874
Original Issuance Date:	10/02/2015
Capacity:	56
Program Type:	ALZHEIMERS AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 04/04/2019 & 04/05/2019

Date of Bureau of Fire Services (BFS) Inspection if applicable: 02/21/2018
Follow-up BFS inspection due*

Inspection Type: ☐Interview and Observation ☐Worksheet ☒Combination

Date of Exit Conference: 04/11/2019

No. of staff interviewed and/or observed 15
No. of residents interviewed and/or observed 25
No. of others interviewed 2 Role resident family members

- 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.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  No applicable 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:6/13/17; 7/20/17; 10/17/18 N/A ☐
- Corrective action plan compliance verified? Yes ☒ CAP date/s and rule/s:
- CAP dated 3/24/2017 to SIR2017A1011004 re: R325.1922(5); R325.1924(1); R325.1924(3); R325.1932(1); R325.1932(3)(g); R325.1921(1)(b); R325.1952(4); R325.1922(1); R325.1942(4).
- CAP dated 3/28/17 to LSR dated 2/28/17 re:R325.1921(1)(b); R325.1922(1); R325.1922(5); R325.1923(2); R325.1931(3); R325.1944(2); R325.1932(3)(b); R325.1932(3)(c); R325.1932(3)(e); R325.1932(4); R325.1932(5); R325.1964(2); R325.1964(12); R325.1976(12); R325.1976(13); R325.1953(1)(2); R325.1954.
- Number of excluded employees followed up? N/A ☒

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

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

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.

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.

Resident service plans were not updated at least annually or when there is a significant change in resident’s care needs. Service plans did not identify the specific care and maintenance, services and activities appropriate 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 examples: Staff Danielle Wafer presented the two service plans posted in Resident N’s bathroom, explaining that staff refer to these plans to provide care. One service plan was dated 4/23/13 and only indicated that Resident N receives showers Monday and Thursday mornings. The other service plan was dated 12/9/11, and in regard to Resident N’s shower was checked “stand by for assist” and “lower help”. Ms. Wafer explained that Resident N, who resides in the memory care unit, is unable to get into the shower, set the water temperature and bathe herself with only stand-by assist and lower help. Resident N will attempt some self-washing, but Ms. Wafer explained and demonstrated how staff hold Resident N’s hands to walk her into the tub and turn to seat her on the shower chair, set the temperature and gather needed items, and provide most of the bathing care. There was no specific information about these needs and no methodology of how to provide this care.

Resident F’s service plan is dated 10/13/18. Other than “Monitor and visual checks every 2 hours” the service plan does not specifically address her elopement from the home on 6/13/17 at 11:00 pm and being brought back by the police at 2:15 am. According to the incident report, Resident F does not possess the ability to be outside

the facility, yet the service plan does not contain this information and is no specific methodology of how to address this behavior.

In an interview, Resident P was observed seated in a motorized wheelchair and she explained that she requires staff assistance with showers in order to get in and out but the staff are not assisting her as needed. Resident P's service plan dated 9/6/18 indicates she is independent in showering. The plan was not updated to her needs.

Resident S is 83 years old. Resident S's service plan is dated 9/13/18 and reads, "[Resident S] manages her own medication except for narcotics. [Resident S] advise staff when non-narcotic medications are needed to be reordered…Nurse/resident aide to reorder narcotic medications. To monitor BP [blood pressure] as patient will allow." Resident S's medication administration record (MAR) revealed she is prescribed approximately 20 medications including Donepezil HCL for diagnosis of dementia, Divalproex Sod for diagnosis of seizure, Trazodone for insomnia, three medications - Clonidine HCL, Losartan Potassium, Metoprolol - that are administered according to blood pressure readings and Amlodipine Besylate for diagnosis of blood pressure. Resident S maintains most all of these medications in her room and is expected to administer independently. Resident S's MAR includes her diagnoses including but not limited to congestive heart failure, syncope, renal insufficiency, hypertension, cerebrovascular accident, bipolar, bradycardia, depression, anxiety, dementia, seizure, and low potassium. The service plan provides no methodology for assessment and monitoring of the resident's ability to maintain/secure/re-order/administer her own medications.

Interviews with various staff, including resident aide staff Judy McDaniel, revealed not all staff knew of residents' service plans nor where they were located.

Repeat rule violation established [Reference: Special Investigation Report (SIR)2017A1011004 with Corrective Action Plan (CAP) dated 3/24/17; and Renewal Licensing Study Report (LSR) dated 2/28/17 with CAP dated 3/28/17]

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.

In separate interviews Resident P, Resident S, Resident X and Resident Y each said they are not receiving showers twice a week, as they were told they would receive.

Review of March 2018 Bath/Shower Day sheets revealed the following:
Resident P received showers on 3/4, 3/11, 3/18, and 3/25/19. Resident P's 9/6/18 service plan did not address shower frequency, preference of day or evening, nor had

it been updated to include the assistance that Resident P said she requires, as noted above in R325.1922(5).
Resident S received a shower on 3/12/19, and on 3/25/19 it is documented “I asked her three times & she refused”. There was no evidence that Resident S was offered any more showers during the month.
Resident X received showers 3/5, 3/8, 3/12, and 3/22/19. This indicates more than a week between showers.
There were no Bath/Shower Day sheets for Resident Y. Resident Y’s service plan dated 9/6/18 reads, “[Resident Y] prefers her showers on Monday and Thursday during the AM she is able to wash herself adequately, she may require 1-2 staff to assist with transferring in and out of shower.”
Resident Y said she definitely needs assistance with transferring in and out of the shower, but staff are not always available.

Resident interviews and Bath/Shower Day sheet documentation revealed residents are not provided showers as often as expected and consistent with their service plans.

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: 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.

A sample of incident reports revealed they do not include all required information. For examples:

An incident report for Resident Q on 2/16/19 reads, “Observe resident saying she slap BM out of her”. In the section titled *Extent of injuries, if known:* staff wrote “Known” with

no explanation. The report also indicates that the resident's authorized representative and an on-call nurse at PACE organization was called. Staff documented the nurse's instructions as "Known" with no explanation. There was no information as to persons involved, extent of injuries, effect on resident, and no corrective measures to prevent recurrence.

An incident report for Resident W that occurred on 2/14/19 indicates a fall occurred. There was no time of the incident, no effect on the resident and no extent of injuries documented. However, 911 was called and arrived at 5:20 am. The report indicates X-rays and a CT scan were completed at the hospital but no specificity of what part of the body. The report indicates the CT scan was negative but X-rays had not yet been reported. The incident report had no corrective measures to prevent recurrence.

Repeat rule violation established [Reference: SIR2017A1011004 with CAP dated 3/24/17]

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.

The home is not always reporting incidents to the department. For examples: Resident Q's incident on 2/16/19 and Resident W's incident on 2/14/19 (both described above) were not reported to the department.

Repeat rule violation established [Reference: SIR2017A1011004 with CAP dated 3/24/17]

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: Employees; general provisions.
R 325.1931

(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 3/29-4/4/19 revealed the schedule did not include the types of personnel and did not always identify the supervisor of resident care for each shift.

For examples: There was no supervisor of shift named for day shift weekdays 3/28, 3/29, 4/1, 4/2, 4/3 and 4/4/19. According to staff, Ronni Griz is the supervisor of day shift during weekdays, however Ms. Griz's name was not on the schedules for these dates. In addition, Ms. Griz did not report for work on 4/3 and 4/4/19; and there was no other supervisor of day shift identified 6 am to 2 pm for these two dates.
Also, there was no supervisor of shift identified on afternoon shift schedule 2 pm to 3:30 pm on 4/2/19.
Similarly, 4/3/19 identifies a supervisor from 1 pm to 9 pm and another supervisor from 10 pm until 6 am. However, there is no supervisor assigned from 9 pm to 10 pm on 4/3/19.

Also, some staff work as aides and some work as med techs. This type of personnel information is not specified on the schedule.

Repeat rule violation established [Ref: LSR dated 2/28/17 with CAP dated 3/28/17]

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.

Medications were not always given pursuant to labeling instructions or orders by the prescribing licensed health care professional. For examples:

The medication administration record (MAR) for Resident Q revealed staff initials entered on 4/2/19, to indicate she received her morning dose of Fexofenadine, Lisinopril, and Pantoprazole. However, the blister pack still contained the medications for this 4/2/19 am dose and had not been punctured/procured.

According to the MAR, Resident T is to receive Lantus insulin injection 34 units under the skin at bedtime. There were no staff initials on the MAR to indicate Resident T received the medication on 4/1 and 4/2/19.

It could not be determined whether staff were administering Resident T's Novolog insulin in accordance with the physician's orders. According to the MAR Resident T is to receive 0 units for blood sugar 0-249; 2 units for blood sugar 250-300; 4 units for blood sugar 301-350; and 6 units for 351-400. If the blood sugar is over 400, call PACE program, presumably to notify the resident's physician there. Staff documented some blood sugar levels and initialed the MAR as having administered the Novolog but did not always record the number of that were administered.

On 4/1/19, Resident T's am and pm blood sugar readings read 201 and 197 respectively. According to the MAR, no Novolog would have been administered, however, staff initialed for having administered the Novolog and initialed for using the

Trueplus insulin syringes at these times as well. Likewise, on 4/2/19 am staff recorded Resident T's blood sugar reading as 239 and wrote "Ø" below it, presumably to indicate no units were to be given. However, this same individual also initialed the MAR to indicate Novolog was administered and initialed that a syringe was used. On 4/2/19 dinner reading staff documented Resident T's blood sugar as 430 and initialed that Novolog was administered but there is no indication how many units were given nor whether PACE was notified of this blood sugar reading above 400.

According to the MAR, Resident U is to receive Basaglar kwikpen 48 units once daily. Staff initials indicate it was administered four times on 4/1, and two times on 4/2 and 4/3/19.

Resident U is also to receive Humalog kwikpen 100 unit/ml according to a sliding scale of 0 units for blood sugar 0-249; 2 units for blood sugar 250-300; 4 units for blood sugar 301-350; and 6 units for 351-400. If the blood sugar is over 400, call PACE program. On 4/1 am Resident U's blood sugar was recorded as 180 and dinner blood sugar was 175, on 4/2 am the blood sugar was 180, on 4/4 am the blood sugar was 167 and on 4/3 dinner time the blood sugar was 190. All of these blood sugar readings would indicate no units of Humalog were to be administered. Staff also wrote "O" on 4/1 am; and "Ø" on 4/2 am and 4/4 am. However, staff initialed that indicates they administered the Humalog on all these dates/times.

According to the MAR, Resident J has an order for Renagel 800 mg one tablet to be administered three times daily with meals. Staff initials on the April 2019 log indicate it was administered one or two times daily, with the third dose showing encircled staff initials. Staff Chantel Price stated these encircled initials indicate the medication was not administered as ordered for am doses on 4/1, 4/2, 4/3, 4/4/19. There was no reason written for not administering the 4/1 am dose; but staff wrote the reason for not administering the 4/2, 4/3, and 4/4 am dose as "No food NG". Ms. Price explained that this represents no food therefore, not given. Ms. Price affirmed that there is always food available to give to residents. It was also noted that Resident J's MAR did not coincide with the Renagel 800 mg. medication label on the bottle that read take 3 tablets by mouth with meals. Therefore, it cannot be determined whether the MAR or the bottle label is in accordance with the physician's order.

The MAR revealed Resident J did not receive other medications as ordered. Staff encircled their initials for 9 am doses on 4/1, 4/2, 4/3/19; and for 9 pm dose on 4/2/19 for Eliquis prescribed every 12 hours. Staff wrote on the back "N/A N/G" on 4/1, which according to Ms. Price, represents the medication was not available and therefore, not given. Ms. Price explained that Resident J's family brings in her medications and sometimes the medications run out. Ms. Price also explained that Resident J's daughter-in-law said the Eliquis was discontinued by her physician, so staff wrote "D/C per doctor" on the MAR and stopped passing the medication after 9 am dose on 4/3/19. Ms. Price checked Resident J's record and confirmed there was no written physician's order for this discontinuation.

Resident J's MAR revealed other medications not given as ordered:
Vitamin B-12; Folic Acid, Allopurinol; Symbicort inhaler; and Hydralazine on 4/1, 4/2, 4/3 and 4/4/19. Again, staff wrote "N/A NG" indicating not available and not given. Ms. Price confirmed these medications were not available in the storage cart.

Repeat rule violation established [Reference: SIR2017A1011004 with CAP dated 3/24/17]

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:

(b) Complete an individual medication log that contains all of the following information:

(i) The medication.

(ii) The dosage.

(iii) Label instructions for use.

(iv) Time to be administered.

(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.

(vi) A resident's refusal to accept prescribed medication or procedures.

A sample review of the medication administration records (MAR) revealed the logs did not contain all the required information. For examples:

Resident V's MAR was not initialed by staff for administration of bedtime doses of the following medications: Donepezil on 4/2; Trazodone on 4/1 and 4/2; and DOK on 4/2/19.
Also according to the MAR, staff are to document removal of Resident V's Lidocaine 5% patch that is to be worn for only 12 hours. Staff did not initial the MAR to confirm removal on 4/2/19.

Resident P's Gabapentin prescribed three times daily was not initialed as having been administered morning 4/2, 4/3, and 4/4/19; also no initials recorded for administering noon dose on 4/2, 4/3, and 4/4/19.

Resident S's medication log includes medications to be administered and/or withheld according to blood pressure readings. For examples:
Resident S has Clonidine HCL give twice daily as needed for systolic blood pressure greater than 180; Losartan Potassium one tablet daily but withhold if systolic blood pressure is less than 110; and Metoprolol give one tablet daily but withhold if systolic blood pressure is less than 100. There were no blood pressure readings recorded for Resident S day and evening on 4/1/19; and no blood pressure reading recorded for evening on 4/2/19. Resident S administers her own medications, with the exception of

narcotics that staff administer, and it is imperative that she knows her blood pressure readings to administer the three medications in accordance with physician orders. Resident S said staff do not always check her blood pressure as needed.

According to the MAR, Resident J has an order for Renagel 800 mg one tablet to be administered three times daily with meals. Resident J's MAR did not coincide with the Renagel 800 mg. medication label on the bottle that read take 3 tablets by mouth with meals. Therefore, it cannot be determined whether the MAR or the bottle label is in accordance with the physician's order.

Repeat rule violation established[Ref: LSR dated 2/28/17 with CAP dated 3/28/17]

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

A sample review of the medication logs revealed staff did not always record the reason for each administration of medication that is prescribed on an as-needed basis. For examples:

Resident U has an order for Senna Plus take 1 to 2 tablets once a day at bed time as needed for constipation. Staff initialed Resident U's MAR for administering the Senna Plus on 4/2 and 4/3/19, but did not record the number of tablets administered nor the reason for administering.

Resident R has an order for Ventolin inhale 2 puffs every 6 hours as needed for shortness of breath no more than 4 times daily. Staff initialed Resident R's MAR as having administered Ventolin on 4/1, 4/2, 4/3 and 4/4/19, but did not record the reason for administering nor the times that it was administered to ensure 6 hours between doses.

Resident V's MAR has an order for Acetaminophen-Codeine 1 tablet every 8 hours as needed for pain. Staff initials reveal it was administered twice on 4/1 and 4/3, and administered once on 4/2 and 4/4/19; however, no reasons for administering were recorded on the MAR for any of these dates. Also, no times were recorded as to when the medication was administered, to ensure sufficient time elapse between doses.

Resident V also has an order for Gabapentin 1 capsule 3 times a day for pain. Staff initials reveal it also was administered twice on 4/1 and 4/3, and once on 4/2 and 4/4/19; however, no reasons for administering were recorded on the MAR.

Resident V also has an order for Cetirizine HCL to be administered one tablet every day as needed for rhinitis. Staff initials indicate it was administered on 4/1, 4/2 and 4/3/19. There are no reasons for administering documented.

Repeat rule violation established [Reference: LSR dated 2/28/17 with CAP dated 3/28/17]

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 examples: According to the medication administration log, Resident J has an order for Acetaminophen 2 tablets every 6 hours as needed; and an order for Ventolin inhale 2 puffs every 6 hours as needed.
There are no instructions as to the circumstances or parameters to alert and inform staff when these medications would be "needed".

Resident U's MAR includes an order for Senna Plus take 1 to 2 tablets once a day at bed time as needed for constipation. There are no instructions clarifying when to administer one tablet versus when to administer two tablets.

Resident V's MAR has an order for Acetaminophen-Codeine 1 tablet every 8 hours as needed for pain and an order for Gabapentin 1 capsule 3 times a day for pain. There are no instructions clarifying if/when Acetaminophen-Codeine would be administered versus Gabapentin for pain; whether they are prescribed for different pains or different levels of pain; whether both medications are to be administered together, separately, in tandem, etc. Staff initials indicate both medications have been administered on the same dates, but no times were recorded on the MAR to indicate whether the medications were given together or in tandem. Also, without times recorded, it cannot be determined whether there was sufficient time between doses.

Resident V also has an order for Cetirizine HCL to be administered one tablet every day as needed for rhinitis. This is a diagnosis that would need to be determined by a prescribing health care professional. There are no instructions as to the circumstances or parameters to alert and inform staff when this medication would be needed.

Repeat rule violation established [Reference: LSR dated 2/28/17 with CAP dated 3/28/17]

R 325.1932 Resident medications.

(4) If a resident requires medication while out of the home, then the home shall assure that the resident, or the person who assumes responsibility for the resident, has all of the appropriate information, medication, and instructions.

Resident R's medication log revealed encircled staff initials and documentation on the back on 4/2, 4/3, and 4/4/19, that his noon time Sevelamer Carbonate was not administered because the resident was at the PACE program.

Therefore, according to the medication log, the home did not assure that Resident R or the person who assumed responsibility for him on 4/2, 4/3, and 4/4/19, had all the appropriate information, Sevelamer Carbonate medication, and instructions.

Repeat rule violation established [Reference: LSR dated 2/28/17 with CAP dated 3/28/17]

R 325.1932 Resident medications.

(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.

The home has not taken reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed as evidenced by the following:

Resident S reportedly administers her own medications, with the exception of narcotic medication Xanax that staff maintain and administer. On 4/5/19, there were multiple blister packages and bottles of prescription medication unsecured in various areas about her room, on a desk, on a side table and on a dresser. Resident S said she has been unable to lock the door to her room for months because the lock is broken, and at times, she leaves the room unlocked and unattended. Resident S said she reported it to maintenance several times, but it has not been repaired. Also, the furnace in Resident S's room does not respond to the temperature controls making the room excessively hot. Consequently, Resident S said she has to leave the door to her room open most all of the time, even when she is asleep.

To ensure narcotic medication is not used by a person other than the resident for whom the medication is prescribed, the facility implemented a procedure of maintaining a *Controlled Medication Shift Change Sign In/ Sign Out* sheet for all narcotic medications. However, staff are not following that procedure. According to med tech staff Rochelle Henry and Lorenzia Brown, at the change of each shift the staff person who is about to leave their shift will meet with the staff person arriving for the next shift. Together, the two staff persons will manually count every narcotic

medication and ensure that the number of medications available matches the number on accountability sheets. Then, both staff persons are to sign the *Controlled Medication Shift Change Sign In/ Sign Out* sheet indicating they are in agreement with the count.

However, review of 2 pm day/afternoon shift change on 4/4/19 revealed two separate day shift staff signed the sheets for D hall and for E hall narcotics, and then left the facility without conducting the narcotic medication counts with the incoming staff. Both Ms. Henry and Ms. Brown said their signatures were not on the sheets at 2 pm on 4/4/19, because the day shift left without conducting the counts with them and without doing rounds together to check on the residents. Afternoon shift supervisor Chantal Price then signed the *Controlled Medication Shift Change Sign In/Sign Out* sheet for E-Hall, after my interview with Ms. Brown.

It was also noted that no incoming midnight staff signed the D Hall *Controlled Medication Shift Change Sign In/ Sign Out* sheet with Ms. Henry at 10 pm on 4/2/19; and no staff signed the D Hall sheets for 6 am and 2 pm on 4/3/19. One incoming midnight staff signed at 10 pm on 4/3/19 for D-Hall narcotics medications but no outgoing afternoon shift staff signed at that time.

Repeat rule violation established [Reference: LSR dated 2/28/17 with CAP dated 3/28/17]

R 325.1964 Interiors.

(12) A floor, wall, or ceiling shall be covered and finished in a manner that will permit maintenance of a sanitary environment.

The floor in the kitchen was missing large sections of tile. It exposed the rough subfloor including rusty drainage areas.

Repeat rule violation established [Reference: LSR dated 2/28/17 with CAP dated 3/28/17]

R 325.1976 Kitchen and dietary.

(12) Food service equipment and work surfaces shall be installed in such a manner as to facilitate cleaning and be maintained in a clean and sanitary condition, and in good repair.

The memory care unit kitchen had dried-on dirty wipe marks/splashes and grime on the appliances and cabinets. The inside of the refrigerator was sticky with spilled liquid, loose food scraps and smears. The gasket surrounding the refrigerator door was torn and loose. There was no thermometer to monitor the temperature of the refrigerator. Some kitchen cabinet doors in this memory care area had loose hinges and did not close properly. One cabinet drawer would not track the glides and fell

forward when pulled open. Inside the cabinets was a significant build-up of debris. Loose hair nets were stored with serving spoons.

Repeat rule violation established [Reference: LSR dated 2/28/17 with CAP dated 3/28/17]

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.

Staff Tina Howard was observed and affirmed that she washes dishes used by Heritage Court residents in the memory care unit dishwasher. Ms. Howard provided no method to ensure and demonstrate that the multi-use utensils are thoroughly clean and sanitized after each use, other than viewing the chemicals in bottles in the adjoining cabinet that feed into the dishwasher.

Repeat rule violation established [Reference: LSR dated 2/28/17 with CAP dated 3/28/17]

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 only posted a regular diet menu, in the assisted living dining area of the facility, although various diets were served. The menu contained multiple dates listed for each day. Facility chef Teia Tennille said she maintains a rotation of menus seasonally and explained that the posted menus had multiple dates, as they were used for multiple weeks.

Changes were not written on the menu to show the meal as actually served. On 4/4/19, Ms. Tennille changed the lunch menu from roast beef to hot dogs but did not make the change on the menu. Resident P and Resident X were interviewed separately, and both expressed their frustration and disappointment that staff said roast beef was not available, although it was listed on the posted menu.

There was no menu posted in Heritage Court, the facility's memory care unit.

There were no weekly menus for the regular and therapeutic or special diets posted in either location. Ms. Tennille confirmed that the home serves various therapeutic or special diets such as concentrated carbohydrate, renal diet for individuals on dialysis, mechanical soft and pureed. According to her service plan, Resident O is lactose

intolerant and has diverticulitis requiring a specific menu of no dairy including no butter, cheese, milk-based gravies or dressings and no seeds, nuts, corn, tomatoes, and/or fruit containing seeds. There was no such special diet menu posted.

Repeat rule violation established [Reference: LSR dated 2/28/17 with CAP dated 3/28/17]

R 325.1953 Menus.

(2) A home shall maintain a copy of all menus as actually served to residents for the preceding 3 months.

As the menus were not specifically dated each day and with changes made to show the menu as actually served, Ms. Tennille confirmed that the home did not maintain a copy of all menus as actually served for the preceding 3 months.

Repeat rule violation established [Reference: LSR dated 2/28/17 with CAP dated 3/28/17]

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. Tennille said she has not maintained a record of the kind and amount of food used for the preceding 3-month period.

Repeat rule violation established [Reference: LSR dated 2/28/17 with CAP dated 3/28/17]

R 325.1952 Meals and special diets.

(5) A home shall prepare and serve meals in an appetizing manner.

Lunch served to residents in the memory care unit on 4/4/19 consisted of a hot dog on a bun, French fries with catsup, cake and a beverage. There were no eating utensils provided, so residents ate their entire meal with their hands. No napkins were provided to the residents. Therefore, lunch was not served in an appetizing manner.

R 325.1952 Meals and special diets.

(6) A home shall provide a table or individual freestanding tray of table height for a resident who does not go to a dining room.

On 4/5/19, staff delivered a late breakfast to Resident S in her room. Staff brought a bowl of cereal and a cup of milk. No spoon was provided and no table or freestanding

tray of table height was provided. Resident S said she will eat the cereal on her lap with a spoon that she had kept in her pocket. Resident S's service plan reads "Prefers to have room trays. She is encouraged to join her peers in the dining room but often declines. [Resident S] will provide staff with completed menus. Staff delivers and removes room trays from her room." There was no provision of a table or freestanding tray of table height for Resident S to dine in her room.

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.

The home's disaster plan did not include a complete written plan and procedure to be followed in case of fire, other than an evacuation plan that is designated by "The Administrator to the Administrative person in charge is the only person who can order the total evacuation of this facility". This does not address fire when the administrator is not in the building.

Also, the evacuation floor plan posted in hallways includes an exit through a door that had a sign posted "Not an exit".

There was no written plan and procedure to be followed in case of explosion. The plan for loss of heat reads to move residents to a warm spot in the building and inservice on signs/symptoms of frostbite. This information does not provide sufficient plan and procedure to address a loss of heat.

In regard to loss of water, the plan reads, "The drinking water is located in the Patterson boiler room anyone (sic) on the maintenance team has keys to open the boiler room door." Minimally, this does not account for no water to the sprinkler system, water to the toilets, the dishwashing machines, cleaning procedures, bathing procedures, laundry, etc. Also, there are no instructions for replacement of stored water to ensure potability.

In regard to the loss of power, the plan is to check the generator's oil, water and amp readings but it does not specify who will check nor where to check these gauges. If gauges are not where expected someone is to call "Jerry" immediately, but it does not give Jerry's last name or phone number. The plan reads that the generator does not power the entire building but does not specify the items the generator does power nor give instructions as to which items will need to be addressed without power i.e. alarm system, magnetic locks, HVAC system in common areas and in resident rooms, phones, lighting in common areas and resident rooms, power plugs, kitchen appliances, laundry appliances, etc.

R 325.1981 Disaster plans.

(2) A disaster plan shall be available to all employees working in the home.

Interviews with various staff including med tech staff Lorenzia Brown revealed staff were unaware of where the disaster plan can be located.

R 325.1981 Disaster plans.

(3) Personnel shall be trained to perform assigned tasks in accordance with the disaster plan.

Interviews with various staff revealed they were not trained to perform assigned tasks for fire, explosion, loss of heat, loss of power, and loss of water. Staff said they were told what to do in case of tornado warning.

A sample review of staff med tech Jayla Eubanks' employee file revealed no evidence of training to perform tasks in accordance with the facility's disaster plan other than a reference to fire training. Upon interview, Ms. Eubanks said she received some training about the fire plan but she could not recall any training about explosion, loss of heat, loss of power and loss of water.

R 325.1979 General maintenance and storage.

(1) The building, equipment, and furniture shall be kept clean and in good repair.

The hallway of Heritage memory care unit had worn/frayed carpeting that created a trip hazard.

The furnace in Resident S's room did not respond to the temperature controls making the room excessively hot.

The door lock to Resident S's room was broken.

The light fixture above Resident S's built-in dresser had a burned-out bulb.

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

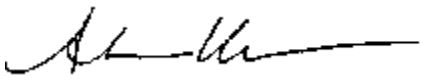
minimum of 10 air changes per hour of continuously operated exhaust ventilation that provide discernable air flow into each of these rooms.

When tested by the facility's maintenance employee Dan Young, the exhaust ventilation was not functioning in the Heritage memory care toilet room, the D-hall janitor closet, and the H-hall janitor closet. There was no exhaust vent located in the E-hall janitor closet as required.

On 4/11/19, I reviewed the findings of this report with authorized representative Kelsey Hastings by telephone.

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.



4/11/19

Andrea Krausmann Date
Licensing Consultant