GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 16, 2020

Jeffrey Zylstra
Emerald Meadows
6117 Charlevoix Woods Ct.
Grand Rapids, MI 49546-8505

RE: License #: AH410343036
Investigation #: 2020A1010017
Emerald Meadows

Dear Mr. Zylstra:

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 authorized representative and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 #:** | 2020A1010017 |
| | |
| **Complaint Receipt Date:** | 12/05/2019 |
| | |
| **Investigation Initiation Date:** | 12/06/2019 |
| | |
| **Report Due Date:** | 02/04/2020 |
| | |
| **Licensee Name:** | Providence Operations, LLC |
| | |
| **Licensee Address:** | 18601 North Creek Drive<br>Tinley Park, IL 60477 |
| | |
| **Licensee Telephone #:** | (708) 342-8100 |
| | |
| **Administrator:** | Evan Geels |
| | |
| **Authorized Representative:** | Jeffrey Zylstra |
| | |
| **Name of Facility:** | Emerald Meadows |
| | |
| **Facility Address:** | 6117 Charlevoix Woods Ct.<br>Grand Rapids, MI 49546-8505 |
| | |
| **Facility Telephone #:** | (616) 954-2366 |
| | |
| **Original Issuance Date:** | 08/26/2013 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 03/07/2019 |
| | |
| **Expiration Date:** | 03/06/2020 |
| | |
| **Capacity:** | 60 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Residents do not receive care consistent with their service plans. | No |
| Supervisors are mismanaging medications and there are medications missing. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 12/05/2019 | Special Investigation Intake<br>2020A1010017 |
| 12/06/2019 | Special Investigation Initiated - Telephone<br>Voicemail left for complainant, call back requested |
| 12/16/2019 | Contact - Telephone call made<br>Voicemail left for complainant, call back requested |
| 12/20/2019 | Contact - Telephone call made<br>Voicemail left for the complainant |
| 12/30/2019 | Inspection Completed On-site |
| 12/30/2019 | Contact - Document Received<br>Received Resident A, Resident B. and Resident D's service plans and staff notes |
| 01/03/2020 | Contact – Telephone call made<br>Interviewed administrator Evan Geels by telephone |
| 01/16/2020 | Exit Conference<br>Completed with licensee authorized represent Jeff Zylstra |

**ALLEGATION:**

**Residents do not receive care consistent with their service plans.**

**INVESTIGATION:**

On 12/5/19, the Bureau received the allegations from Adult Protective Services (APS). The complaint was not assigned for APS investigation. The complaint read, “The residents in the facility are being neglected by staff. Several residents sit in wet briefs for eight hours. One staff members [sic] knew a resident had on a poopy brief and left them in the brief for 30 minutes stating it was ok. The facility allowed a resident to move in with bed bugs. They placed his items outside because of the bed bugs. The dementia unit should have two staff members on duty and there is typically only one staff member. Several residents are not being showered and staff state they are refusing even though the residents have not been asked. There are also several residents with yeast infections under their stomach.”

I made several attempts and left messages for the APS complainant. I have not received a telephone call back to date, therefore I was unable to gather additional information.

On 12/30/19, I interviewed director of health care Kim Chambers at the facility. Ms. Chambers reported residents are not left in soiled briefs for extended periods of time. Ms. Chambers reported she had not received any complaints from residents or resident family members regarding residents being left in soiled briefs. Ms. Chambers said staff were trained to change soiled resident briefs as needed and per resident service plans.

Ms. Chambers explained Resident B, who resides in the general assisted living area, often gets combative with staff during the provision of her care. Ms. Chambers said Resident B has experienced a decline that resulted in an increase in her aggressive behavior. Ms. Chambers stated as a result, staff must leave Resident B and re-approach her. Ms. Chambers reported this can take additional time for staff to complete her care needs, such as changing her soiled briefs.

Ms. Chambers provided me with a copy of Resident B’s service plan for my review. The *AGGRESSIVE/COMBATIVE – FULL INTERVENTION* section of Resident B’s plan read, “Constantly supervise and assist resident in redirecting aggressive/combative behaviors. Notify appropriate providers if necessary. Resident is easily agitated and becomes aggressive/combative during cares. If needed, ensure safety and re-approach at later time.”

Ms. Chambers provided me with a copy of Resident B’s staff notes for my review. Notes dated 11/4, 11/5, 11/6, 11/8, 11/9, 11/10, 11/13, 11/15, 11/17, 11/19, 11/21, 11/24, 11/25, 11/29, 12/6, 12/21, 12/22, and 12/30 read Resident B refused care and was agitated and combative towards staff.

Ms. Chambers reported Resident A came from a facility that had an issue with bed bugs. Ms. Chambers stated that as a precaution, staff brought Resident A’s bags of clothing into the facility one bag at a time. Ms. Chambers said his clothing was placed in the dryer to “heat treat” them as a precaution. Ms. Chambers reported no

bed bugs were observed on Resident A or his clothing. Ms. Chambers explained Resident A did not have any furniture when he moved into the facility.

Ms. Chambers stated there are two aides scheduled in the secured memory care unit on first and second shift to meet resident needs consistent with their service plans. Ms. Chambers said there are three aides total scheduled in the building on third shift. Ms. Chambers reported there are currently 12 residents in the secured memory care unit.

Ms. Chambers explained a staff person was recently terminated for falsely documenting she showered residents after she did not complete the care. Ms. Chambers reported residents are bathed at least once a week. Ms. Chambers stated she has not received any complaints from residents or resident family members regarding residents not being bathed at least once a week.

Ms. Chambers reported Resident D had redness and irritation on the skin folds in her stomach. Ms. Chambers stated Resident D's physician was notified and she was prescribed Diflucan to treat the issue. Ms. Chambers said the medication was effective and Resident C no longer has redness or irritation.

On 12/30/19, I interviewed shift supervisor Madonna Hause at the facility. Ms. Hause's statements were consistent with Ms. Chambers.

On 12/30/19, I interviewed medication technician Rick Wilson at the facility. Mr. Wilson reported he also provides direct resident care. Mr. Wilson's statements were consistent with Ms. Chambers and Ms. Hause.

On 12/30/19, I interviewed Resident A at the facility. Resident A reported staff meet all his care needs. Resident A denied concerns regarding care staff. Resident A stated staff were timely and always available to assist him. Resident A reported he did not have an issue with bed bugs at the facility. Resident A said staff clean his room and do his laundry at least once a week. Resident A stated he showers twice a week. I observed Resident A was well groomed and in clean clothing.

On 12/30/19, I attempted to interview Resident B at the facility. I was unable to engage Resident B in meaningful conversation. I observed Resident B was well groomed and in clean clothing.

On 12/30/19, I interviewed Resident C at the facility. Resident C's statements were consistent with Resident A.

On 12/30/19, I attempted to interview Resident D at the facility. I was unable to engage Resident D in meaningful conversation. I observed Resident D was well groomed and in bed.

On 12/30/19, I interviewed Resident E and Resident F at the facility. Resident E and Resident F are a married couple and reside together. Resident E's statements were consistent with Resident A and Resident C. I was unable to engage Resident F in meaningful conversation. I observed Resident E and Resident F were well groomed and in clean clothing.

On 1/3/20, I interviewed administrator Evan Geels by telephone. Mr. Geels' statements were consistent with Ms. Chambers and Ms. Hause.

| **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 Ms. Chambers, Ms. Hause, Mr. Wilson, Mr. Geels, Resident A, Resident C, and Resident E, along with my observations of Resident B, Resident D, and Resident F revealed resident care needs are met consistent with their service plans. There is insufficient evidence to suggest resident personal needs, including protection and safety, are not met by staff. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Supervisors are mismanaging medications and there are medications missing.**

**INVESTIGATION:**

On 12/5/19, the complaint read, "the supervisors are mismanaging medication and possible stealing medication. When meds are prepped, they will prep several resident's medication at time [sic], however they should only do one at a time. Resident will go without meds for a month either because the medication has not been ordered or they will state residents are refusing medication even when not asked. A staff member was observed checking medication. The medication sheet stated the resident had 11 ml of Haldol, but there was only 8 in the bottle. The staff member wrote down there was still 11 ml in the bottle."

On 12/30/19, Ms. Chambers denied supervisor mismanagement of medications. Ms. Chambers reported resident medications were administered as prescribed. Ms.

Chambers stated staff were trained not to “preset” resident medications. Ms. Chambers said staff know to administer resident medications one at a time.

Ms. Chambers reported the resident medication “bubble packs” have the last five days sectioned off so staff know to contact the pharmacy for a refill. Ms. Chambers stated the stickers are removed from the “bubble packs” and placed on a medication order sheet and sent to the pharmacy. Ms. Chambers said the facility’s medication re-order procedure is effective and residents do not go several months without their medications.

Ms. Chambers denied knowledge regarding the liquid Haldol count being inaccurate. Ms. Chambers reported Resident G was prescribed liquid Haldol through her Hospice provider. Ms. Chambers stated Resident G is deceased and the liquid Haldol is no longer at the facility as a result.

On 12/30/19, Ms. Hause’s statements were consistent with Ms. Chambers.

On 12/30/19, Ms. Chambers, Ms. Hause, and I completed a narcotic medication count. All narcotic medications were present and accounted for in the facility.

On 12/30/19, Mr. Wilson’s statements were consistent with Ms. Chambers.

On 12/30/19, Resident A reported he received his medications on time from staff daily. Resident A stated there have been no known issues with his medications at the facility.

On 12/30/19, Resident C’s statements were consistent with Resident A.

On 12/30/19, Resident E’s statements were consistent with Resident A and Resident C.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1932** | **Resident Medications.** |
| | **(1) Medication shall be given, taken, or applied pursuant to labeling instructions or signed orders by the prescribing licensed health care professional.** |
| **ANALYSIS:** | The interviews with Ms. Chambers, Ms. Hause, and Mr. Wilson, along the count of narcotic medications at the facility, revealed there is insufficient evidence to suggest staff mismanaged or took resident medications. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDING:**

**INVESTIGATION:**

On 12/30/19, Ms. Hause reported there has been a resident medication documentation issue in the computer program the facility uses. Ms. Hause explained when a medication is ordered and being filled it is displayed with the other resident medications that need to be administered. Ms. Hause stated this has caused some confusion with staff and staff have marked the medication as administered, despite the medication not being onsite from the pharmacy yet. Ms. Hause stated staff were trained to document the medication is being filled rather than administered, however some staff have not done so. Ms. Hause showed me a prescribed eye drop for Resident A that was ordered and was in the process of being filled, however it has not been received from the pharmacy yet. Ms. Hause showed me that a staff person marked the medication as administered even though it is not present in the facility yet.

| **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:**<br>**Complete an individual medication log that contains all of the following information:**<br>**(i) The medication.**<br>**(ii) The dosage.**<br>**(iii) Label instructions for use.**<br>**(iv) Time to be administered.**<br>**(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.**<br>**(vi) A resident's refusal to accept prescribed medication or procedures.** |
| **ANALYSIS:** | The interview with Ms. Hause revealed staff incorrectly documented resident medication was administered when it actually was not. Ms. Hause reported there were instances when a resident's medication was in the process of being filled and not received from the pharmacy yet, however staff documented it was administered. |

| | |
|---|---|
| | The review of Resident A's medication administration record (MAR) revealed he had a prescribed eye drop that was ordered and in the process of being filled. The medication was not on hand in the facility, however staff documented that is was administered. As a result, resident A's medication administration record is not accurate. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

I shared the findings of this report with licensee authorized representative Jeff Zylstra by telephone on 1/16.

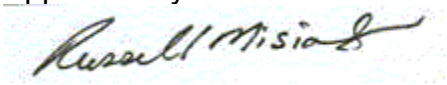
## IV. RECOMMENDATION

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

1/14/20

Lauren Wohlfert — Date
Licensing Staff

Approved By:



1/14/20

Russell B. Misiak — Date
Area Manager