GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 7, 2020

Brenda Moore
KAM Caring Service Inc.
915 Capital Ave. S.W.
Battle Creek, MI 49015

RE: License #: AS130360627
Investigation #: 2020A0581023
Jean Lane

Dear Ms. Moore:

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.

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 615-5190

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS130360627
Investigation #:	2020A0581023
Complaint Receipt Date:	02/14/2020
Investigation Initiation Date:	02/19/2020
Report Due Date:	04/14/2020
Licensee Name:	KAM Caring Service Inc.
Licensee Address:	915 Capital Ave. S.W. Battle Creek, MI 49015
Licensee Telephone #:	(269) 209-0773
Administrator:	Brenda Moore
Licensee Designee:	Brenda Moore
Name of Facility:	Jean Lane
Facility Address:	532 Jean Lane Battle Creek, MI 49015
Facility Telephone #:	(269) 964-4094
Original Issuance Date:	05/16/2014
License Status:	REGULAR
Effective Date:	11/16/2018
Expiration Date:	11/15/2020
Capacity:	5
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was admitted into the facility with no Adult Foster Care (AFC) paperwork completed.	Yes
Family and friends are unable to visit with Resident A.	No
Resident A's weight is not being recorded.	Yes
The administration of Resident A's medications isn't being documented.	Yes
Resident A is refusing medications; however, the facility is not addressing her refusals.	Yes
Resident A isn't being bathed.	No
Additional Findings	Yes

III. METHODOLOGY

02/14/2020	Special Investigation Intake 2020A0581023
02/19/2020	Special Investigation Initiated - Telephone Interview with Complainant.
02/21/2020	Contact - Document Received Received additional allegations.
02/27/2020	Inspection Completed On-site
03/27/2020	Inspection Completed-BCAL Sub. Compliance
03/27/2020	APS Referral via email
03/30/2020	Contact – Telephone call made Interview with Guardian A1
03/30/2020	Contact – Telephone call made Interview with direct care staff, Tosha Carrier.
04/01/2020	Exit conference with licensee designee, Brenda Moore.

ALLEGATION:

Resident A was admitted into the facility with no Adult Foster Care (AFC) paperwork completed.

INVESTIGATION:

On 02/14/2020, I received this complaint through the Bureau of Community Health Systems (BCHS') on-line complaint. There was no additional information in the complaint relating to documentation not being completed when Resident A was admitted into the facility.

On 02/19/2020, I interviewed Complainant. Complainant confirmed there had been no AFC paperwork completed at the time of Resident A's admission.

On 02/27/2020, I conducted an unannounced on-site investigation at the facility. The facility's licensee designee, Brenda Moore, showed up shortly after I arrived. Ms. Moore stated Resident A's AFC paperwork was not completed at the time Resident A was admitted because Ms. Moore stated she (Ms. Moore) became ill with the flu approximately one week after Resident A moved into the facility. She stated Resident A's AFC paperwork was signed when Resident A moved out of the facility. Ms. Moore stated she believed she had 30 days to complete all AFC resident documentation. She denied Resident A being an emergency admittance. She stated once she completed the paperwork in January 2020, she gave the paperwork to Resident A's family; however, it was not signed until Resident A moved out.

Ms. Moore stated Guardian A1 provided her with a medical appointment after visit summary, dated 07/11/2018, which informed her of Resident A's medical needs. Ms. Moore stated she utilized this document, as well as, several in person interviews with Resident A's family to conduct an assessment of Resident A prior to her being admitted.

Ms. Moore provided me with Resident A's resident file, which she stated had everything in it related to Resident A. I reviewed Resident A's *Assessment Plan for AFC Residents* and her *Resident Care Agreement (RCA)*. Both documents were signed by the licensee designee, Ms. Moore, on 01/18/2020, but were not signed by Resident A's guardian, Guardian A1, until 02/22/2020. According to Resident A's RCA, Resident A was discharged from the facility on 02/21/2020.

I also reviewed Resident A's *Health Care Appraisal (*HCA*)*. Upon review of the HCA, I determined the document was an obsolete form used when Licensing and Regulatory Affairs was associated with the Department of Social Services instead of BCHS. In addition, this HCA was completed and signed by Ms. Moore on 12/20/2019 instead of Resident A's own physician, physician's assistant or registered nurse who would have knowledge of Resident A's current health and health care needs.

I reviewed the after visit summary for Resident A, which was provided to Ms. Moore by Guardian A1. The document confirmed Resident A was seen by her medical doctor on 07/11/2018. There were no additional medical documents in Resident A's resident file confirming she had been seen by a medical professional 90 days prior to being admitted into the facility.

On 03/30/2020, I interviewed Guardian A1 who confirmed never signing any AFC paperwork like the RCA, assessment plan or reviewing a HCA. Guardian A1 stated the RCA and assessment plan were only signed after Resident A left the facility.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's *Assessment Plan for AFC Residents* was completed and signed by the licensee, Brenda Moore, on 01/18/2020 and by Guardian A1 on 02/22/2020 despite Resident A being admitted into the facility on 12/30/2020. The licensee, Ms. Moore acknowledged Resident A's admission was not an emergency; therefore, an assessment plan was not completed for Resident A at the time of her admission, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and

	which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.** **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.** **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.14315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.**
ANALYSIS:	Resident A's *Resident Care Agreement* was completed and signed by the licensee, Brenda Moore, on 01/18/2020 and by Guardian A1 on 02/22/2020 despite Resident A being admitted into the facility on 12/30/2020. An RCA was not completed for Resident A at the time of her admission, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Resident A did not have a *Health Care Appraisal* completed by her physician, physician assistant or registered nurse. It was instead completed by the licensee, Brenda Moore. Despite Ms. Moore being a RN, she is not Resident A's primary care physician or Resident A's registered nurse. In addition, the HCA completed and signed by Ms. Moore was done on an obsolete form.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Family and friends are unable to visit with Resident A.

INVESTIGATION:

The complaint stated Resident A's family was asked not to visit the facility for a week after she was moved in to allow Resident A to get acclimated to the facility.

On 02/18/2020, I interviewed Complainant who stated the licensee told Resident A's family members they were not able to visit with Resident A the week after she moved in. Complainant acknowledged Resident A's family visiting with her since that time.

On 02/27/2020, during the on-site investigation, Ms. Moore stated she had been in contact with Resident A's family members, which included Guardian A1, prior to

Resident A being admitted into the facility. She stated they called her four times prior to being admitted and she met with them twice. Ms. Moore stated she never denied Resident A's family from visiting with Resident A but requested Resident A's family visit between 10 am and 7 pm so Resident A had time to get up in the morning and had time to get ready for bed in the evening. She stated Resident A's family visited "almost daily" with Resident A. She stated Resident A's family could also speak to her on the phone as well, if they wanted. Ms. Moore stated the facility did not have a sign in sheet for visitors so there was no way to track who visited with Resident A.

I was unable to interview Resident A during the on-site investigation as she was no longer residing at the facility.

I reviewed Resident A's *Assessment Plan for AFC Residents*, dated 01/18/2020, which had no restrictions on family or friends visiting with her. The assessment plan stated, "family very supportive & cooperative."

On 03/30/2020, I interviewed Guardian A1, via telephone. Guardian A1 stated the licensee asked Resident A's family members not to visit the first week Resident A was admitted into the facility so she could get acclimated. He stated he was able to call and visit regularly after that first week.

On 03/30/2020, I interviewed direct care staff, Tosha Carrier, via telephone. Ms. Carrier stated she was only working at the facility for approximately one to two weeks before Resident A left the facility. She stated during that time, Resident A's family visited daily with Resident A.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(k) The right to have contact with relatives and friends and receive visitors in the home at a reasonable time. Exceptions shall be covered in the resident's assessment plan. Special consideration shall be given to visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	There is no evidence the licensee, Brenda Moore, denied Resident A's family from contacting or visiting with Resident A while she resided at the facility. Based on my interviews with Ms. Moore, Complainant and Guardian A1, Resident A's family visited with her almost daily the last several weeks she resided in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's weight is not being recorded.

INVESTIGATION:

The complaint alleged Resident A's weight was supposed to be taken once a week.

During the on-site investigation, I requested to review Resident A's weight records. Ms. Moore provided me with staff notes pertaining to Resident A, which had two weight numbers recorded on 02/14/2020 and 02/15/2020. Ms. Moore was unable to provide any additional weight records for Resident A and I did not observe any weight records in Resident A's resident record provided by Ms. Moore.

Ms. Carrier stated resident weight records are kept for every resident and are documented in resident binders. She stated weight records were kept for Resident A, as well.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	There was no documentation confirming Resident A's weight was recorded when she was admitted to the facility on 12/30/2019 and monthly thereafter, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The administration of Resident A's medications isn't being documented.

INVESTIGATION:

The complaint alleged the facility doesn't have a medication log for Resident A's medications and direct care staff aren't documenting when medications are being given.

I interviewed Ms. Moore during the on-site investigation. Ms. Moore stated Resident A's medications were administered to her and documented on her Medication Administration Record (MAR); however, she acknowledged Resident A was given an inhaler, but this was not documented on Resident A's MAR. Ms. Moore did not provide an explanation why the inhaler treatments were not documented.

I reviewed Resident A's resident record, which was provided to me by Ms. Moore. I reviewed an after visit summary for Resident A, dated 07/11/2018, which confirmed Resident A was prescribed two inhaler treatments. These inhaler treatments were identified as Budesonide (or commonly known as Pulmicort), .5 mg/2 mL nebulizer treatment to be given once daily, and Ipratropium-albuterol (commonly known as Duo-Neb), .5 mg – 3 mg/3 mL nebulizer solution to be taken on an as needed basis for shortness of breath.

I reviewed Resident A's resident record, which only contained MARs for January and February 2020. Neither one of these MARS contained any entries for the inhaler treatment medications.

In my review of Resident A's MARs, I observed one MAR sheet with no identified month or year on it with the following entries:

- at Bedtime 22 units SQ Gargine
    - Identified time to be administered was "Bedtime"
- Humalog Pen covrage[sic] – units
    - Identified time to be administered was "AM", "NOON", and "Bedtime"

There were initials under the dates, 9, 10, and 11, indicating the medication had been administered by a direct care staff on those dates; however, there were no other initials under any other date indicating the medication had been administered.

Ms. Moore confirmed the medications listed on the unidentified monthly MAR were to address Resident A's diabetes. She stated these medications were administered to Resident A, despite not having a MAR to confirm this.

I reviewed the after visit summary for Resident A, which confirmed Resident A was taking the following medications to control her diabetes:

- Basaglar Kwikpen (generic drug: insulin glargine) U-100 Insulin, inject 22 units subcutaneously at bedtime

- Insulin Lispro (commonly known as: HumaLOG KwikPen Insulin) 100 unit/mL injection, use as directed for meal and correction coverage up to 30 units a day

Ms. Moore stated she and direct care staff were documenting Resident A's sugar levels on notebook paper. She provided me with these documents from Resident A's resident record. These records were handwritten on a sheet of notebook paper and included four separate columns. The first column included the date, which started on 01/15/2020, while the remaining three columns were titled "Morning", "Noon" and "Dinner". Under each column were two handwritten numbers. Ms. Moore stated the first numbers were Resident A's sugar level and the second set of numbers were how many units of insulin Resident A was administered. The document did not contain the name of the medication that was being administered, the label instructions for use, the time in which it was administered, or the initials of the person who administered the medication.

While going through Resident A's resident record, I observed another handwritten document on notebook paper that looked similar to the first document Ms. Moore provided to me. Ms. Moore stated she took these numbers and "rewrote them" for a cleaner version, which was the first document she provided to me regarding Resident A's insulin medication. This document was titled, "[Resident A] Blood Sugar". This document also had four similar columns; however, the first date listed was 12/30 and the medication, "Humilog" was written at the top of column titled "Breakfast". The numbers listed under each column were similar to the first document Ms. Moore provided to me; however, there were 17 spots in this document where no entry was put in confirming either Resident A's sugar level, the number of insulin units administered to her, or both. The 17 missing spots were between 12/30 and 01/15.

Due to Resident A no longer residing in the facility, I was unable to review her medications at the facility.

Guardian A1 stated Resident A was prescribed two separate medications that were nebulizers. He stated one was to be given twice a day and the other was on an as needed basis. He stated he never observed any documentation showing Resident A received the nebulizer treatments while at the facility. Guardian A1 confirmed Resident A had diabetes and required insulin injections.

Ms. Carrier also confirmed Resident A was administered four nebulizer treatments a day, which were given in the morning, lunch, dinner and before bedtime. She stated these treatments were documented in Resident A's medication chart. Ms. Carrier also stated Resident A was diabetic and required insulin injections.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she 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 administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Based on my investigation, Resident A was prescribed two nebulizer medications, Budesonide and Albuterol upon admission into the facility; however, neither of these medications were listed on Resident A's Medication Administration Records (MAR) for January and February 2020 indicating they had been administered or provided to Resident A while she resided in the facility, as required. The licensee, Ms. Moore, direct care staff, Tosha Carrier, and Guardian A1 all confirmed these treatments were being provided while Resident A was residing in the facility. In addition, Resident A required daily insulin treatment with the medications, Basaglar and Lispro. These medications were also not being documented on Resident A's January and February 2020 MARs; despite, Ms. Moore and Ms. Carrier confirming she received them. Though there was documentation associated with Resident A's Lispro medication (or commonly known as HumaLog), these documents did not contain pertinent information like the name of the medication that was provided, the dosage, the label instructions, the time in which the medication was provided, and the initials of the person who administered the medication, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is refusing medications; however, facility is not addressing her refusals.

INVESTIGATION:

The complaint did not provide additional information from the allegations.

On 02/18/2020, Complainant stated Resident A was not taking her medications at the facility. Complainant stated Resident A was hiding her medications and they were being found in her pockets, in couch cushions, under chairs, and in her bed. Complainant stated Ms. Moore had been informed Resident A was hiding her medication; however, the issue was not being addressed to ensure Resident A received the medications.

Ms. Moore stated during the on-site investigation she "never had an issue with [Resident A] taking her medication". She stated Resident A "always took them"'; however, it was later discovered Resident A was "pocketing" her medications. She stated she and direct care staff would find the medications in Resident A's pant pockets, sweater pockets or on the facility's floor. She stated Resident A had "the right to refuse" her medication. Ms. Moore acknowledged meeting with Resident A's family about Resident A hiding the medication; however, she denied contacting Resident A's physician. Ms. Moore stated Resident A had a family member come to the facility and tell her she needed to ensure Resident A took the medication by giving the medication to Resident A, then opening Resident A's mouth and having Resident A stick out her tongue to confirm the medication was taken, but Ms. Moore stated she wasn't going to force Resident A to take her medications. She stated Resident A expressed to her she was taking too many medications and she had never taken so many medications before.

My review of Resident A's January and February MARs indicated Resident A took her medication every day.

Resident A's *Assessment Plan for AFC Residents*, dated 02/22/2020, stated Resident A does "not always" follow directions and "hides meds"; however, there was nothing indicated on the assessment plan dictating how staff would address this issue.

Guardian A1 stated he had been informed by direct care staff at the facility within the first week of Resident A residing at the facility that they were finding Resident A's medications. He stated it had been addressed with Ms. Moore; however, she told Guardian A1 she "had it covered" and would address it. Guardian A1 stated Ms. Moore had been informed prior to Resident A's admittance into the facility that Resident A may have a difficult time taking medication from people she wasn't familiar with; however, there was no discussion for how this would be handled.

Direct care staff, Ms. Carrier, stated Resident A “liked to hide meds”. She stated she would “get mad and angry” and would “sometimes throw [the medications] away”. She stated Resident A was “very sneaky with medications”. Ms. Carrier stated Ms. Moore was aware of Resident A hiding her medications. She stated Resident A’s doctor was asked about crushing Resident A’s medication; however, Ms. Carrier stated the facility “never heard back from the doctor.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	Based on my interviews with the licensee, Brenda Moore, direct care staff, Tosha Carrier, Guardian A1 and Complainant, there is evidence indicating Resident A wouldn’t take her medication because she was “pocketing” them. Based on my interviews, it was well known Resident A would hide her medications in the pockets of her clothes, throw them on the floor or hide them in furniture or even verbally refuse to take them. Though the licensee, Brenda Moore, discussed the issue of Resident A pocketing and refusing her medication with Resident A’s family and Guardian A1; there was no documentation provided to me indicating the appropriate health care professional was contacted about the refusals, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A isn’t being bathed.

INVESTIGATION:

The complaint alleged Resident A was soiling through her incontinence briefs and pants, “smelled bad”, and was not being bathed.

On 02/18/2020, Complainant confirmed the allegations. Complainant also stated direct care staff had reported Resident A was “independent” and capable of showering; however, Resident A was refusing to do so.

On 02/27/2020, during my on-site investigation the licensee designee, Ms. Moore stated Resident A had designated bath days on Monday and Friday and this was communicated to Resident A’s family. She stated Resident A was elderly and “didn’t need to bathe every day” but stated if she was soiled then direct care staff would clean her up. She stated Resident A had “good potty habits” though. Ms. Moore stated Resident A required assistance from direct care staff with showering, but her overall hygiene was good. She acknowledged Resident A’s family coming to the facility when Resident A just had a bowel movement and there was an odor; however, Resident A was changed and cleaned up. Ms. Moore stated residents would have an unpleasant odor if they experienced a bowel movement. Ms. Moore also stated Resident A’s family could shower Resident A anytime they wanted to.

I observed a “bath schedule” at the facility; however, due to Resident A no longer residing in the facility, she was not listed on the bath schedule.

I observed the remaining four residents in the facility, whom all appeared clean. I also did not smell any unpleasant odors in the facility indicating residents were in needs of showers or toileting.

Resident A’s *Assessment Plan for AFC Residents*, dated 02/22/2020, which stated Resident A requires assistance with showering “for safety”. There was no additional information on the assessment identifying what that assistance entailed.

Direct care staff, Tosha Carrier, stated Resident A received bathes at least twice a week and her family would often give her a third one when they visited. She stated if Resident A’s family wanted to give more bathes to Resident A then they could. She stated Resident A would also be washed up and cleaned if she soiled herself or was in need of being bathed. Ms. Carrier stated staff would completely assist Resident A in showering, which included washing her hair and body.

Guardian A1 stated being informed by direct care staff Resident A was refusing showers. Guardian A1 stated staff were supposed to let Resident A’s family know if she was refusing showers; however, this was not being done. Guardian A1 stated it had been agreed upon that Resident A get at least two showers at the facility per week.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and

	personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	There is no evidence to indicate Resident A wasn't being bathed at least once a week while at the facility, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

During the on-site investigation, I requested to review the facility's resident register. Ms. Moore provided me with the resident register; however, Resident A was not listed on the register; despite Ms. Moore confirming she had been a resident in the facility. Subsequently, the register did not show Resident A's admit date, discharge date or forwarding address.

APPLICABLE RULE	
R 400.14210	**Resident register.**
	A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(a) Date of admission.** **(b) Date of discharge.** **(c) Place and address to which the resident moved, if known.**
ANALYSIS:	Resident A was not listed on the facility's resident register; therefore, the resident register was not being maintained, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the on-site investigation, Ms. Moore showed me Resident A's former bedroom. As I was walking through the facility, I observed the door to the facility's laundry and furnace room to be propped open; therefore, preventing the door from automatically self-closing.

This violation was corrected during the on-site investigation by Ms. Moore closing the door.

APPLICABLE RULE	
R 400.14511	**Flame-producing equipment; enclosures.**
	(2) Heating plants and other flame-producing equipment located on the same level as the residents shall be enclosed in a room that is constructed of material which has a 1-hour-fire resistance rating, and the door shall be made of 1 3/4-inch solid core wood. The door shall be hung in a fully stopped wood or steel frame and shall be equipped with an automatic self-closing device and positive-latching hardware.
ANALYSIS:	The door to the facility's furnace and laundry room was observed to be propped open; therefore, preventing it from automatically self-closing, as required. This violation was corrected during the on-site investigation by Ms. Moore closing the door.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/01/2020, I conducted an exit conference with the licensee designee, Brenda Moore, via telephone. Ms. Moore acknowledged my findings and stated she would provide a corrective action plan upon receiving the report. I informed Ms. Moore I would send her a copy of an updated Health Care Appraisal for future use.

IV. RECOMMENDATION

Once an acceptable plan of corrective is received, I recommend no change in the current license status.

04/01/2020

Cathy Cushman Date
Licensing Consultant

Approved By:

04/07/2020

Dawn N. Timm Date
Area Manager