GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 4, 2021

Rhonda Hendrickson
University Living
One Town Center Rd, Suite 300
Boca Raton, FL 33486

RE: License #: AH810401699
Investigation #: 2021A0784052
University Living

Dear Ms. Hendrickson:

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.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810401699
Investigation #:	2021A0784052
Complaint Receipt Date:	09/07/2021
Investigation Initiation Date:	09/07/2021
Report Due Date:	11/06/2021
Licensee Name:	Ann Arbor Senior Housing OPCO, LLC
Licensee Address:	Ste 310 One Town Center Rd Boca Raton, FL 33486
Administrator:	Kelly Hardy
Authorized Representative:	Rhonda Hendrickson
Name of Facility:	University Living
Facility Address:	2865 S. Main Street Ann Arbor, MI 48103
Facility Telephone #:	(734) 665-2819
Original Issuance Date:	05/26/2021
License Status:	TEMPORARY
Effective Date:	05/26/2021
Expiration Date:	11/25/2021
Capacity:	90
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident B was provided inadequate care and supervision	Yes
Resident A was improperly transferred	Yes
The facility did not seek adequate medical attention for Resident A.	No
Resident A was not treated with dignity	No
Resident A and B did not receive their medications	Yes
Additional Findings	Yes

III. METHODOLOGY

09/07/2021	Special Investigation Intake 2021A0784052
09/07/2021	APS Referral
09/07/2021	Special Investigation Initiated - Letter Referral to APS
09/08/2021	Inspection Completed On-site
09/08/2021	Inspection Completed-BCAL Sub. Compliance
11/04/2021	Exit Conference – Telephone Conducted with authorized representative Rhonda Hendrickson, administrator Kelly Hardy and regional nurse specialist Dana Dickens.

ALLEGATION:

Resident B was provided inadequate care and supervision

INVESTIGATION:

According to the compliant, Resident B lived at the facility from 8/24/21 until 9/4/21. On one occasion, nurse Luna Delgado reported Resident B had wheeled

himself up to the second floor and was going to attempt to throw himself out a window. Resident B is not capable of transferring himself into his wheelchair, using an elevator or propelling himself in the wheelchair. Resident B required the use of a foley tube which is inserted into the bladder to drain urine. On one occasion his foley tube was observed to be disconnected with the tubing “wrapped around a leg or arm of the chair with the bag set on the chair”. While it is possible Resident B removed the tubing in agitation, it is unknown how the tubing and bag became misplaced in such a manner as Resident B Lacks the dexterity to do so. On another occasion it was discovered that Resident B had been brought outside and left to sit in his wheelchair for hours when it was 82 degrees outside. He was found having slid out of his wheelchair, was brought back inside, put in bed and later found unresponsive. When questioned about this nurse Luna stated that the facility is an assisted living, and they don’t stay with residents when outside. On several occasions Resident B was reported to have “lowered himself” to the floor from his bed. It is believed Resident B had actually fallen. Resident B required assistance from staff to feed him his meals and it is believed this was not done.

On 9/8/21, I interviewed regional nurse specialist Dana Dickens at the facility. Ms. Dickens stated she does not always work at the facility; however, she was familiar with Resident B. Ms. Dickens stated she was notified by an advocate of Resident B that he somehow was on the second floor of the building and apparently reported he was going to attempt to commit suicide. Ms. Dickens stated she did not know the exact date of this situation. Ms. Dickens stated Resident B was capable of using his feet to scoot himself in his wheelchair. Ms. Dickens stated that she did feel Resident B would have needed some help from someone in order to go from the first floor, where his room was, onto the elevator and to the second floor where he was apparently found. Ms. Dickens stated there were no windows where Resident B was reported to have been found and there is no way to jump out of a window on the second floor. Ms. Dickens stated Resident did have some issues related to his foley tube. Ms. Dickens stated that the original foley tube Resident B had would not stay connected to the collection bag he had. Ms. Dickens stated Resident B would sometimes become agitated and pull on the tube and that eventually the connection would not hold. Ms. Dickens stated that ultimately, she requested a new collection bag from hospice which once connected, Resident B was unable to pull off. Ms. Dickens stated that while the facility waited for hospice to provide the new collection bag, staff were instructed to put a brief on Resident B and have the foley tube directed into the brief. Ms. Dickens stated she was not aware of a time that the foley tube was wrapped around the arm or leg of the chair with the collection bag in the chair. Ms. Dickens stated no one had reported this issue to her. Ms. Dickens stated that on 8/31/21, Resident B was outside in the enclosed courtyard in his wheelchair. Ms. Dickens stated Resident B was outside for approximately 30 minutes when he was found. Ms. Dickens stated Resident B was initially observed, by Ms. Delgado, to have slid out of his wheelchair and was slumped over sitting directly in front of his chair. Ms. Dickens stated that at times, Resident B would become agitated and sometimes attempted to get up and fall. Ms. Dickens stated Resident B was unable to transfer or walk on his own. Ms. Dickens stated that when Resident B was found

in front of his chair outside, she was summonsed to come help Ms. Delgado and transfer Resident B back into his wheelchair. Ms. Dickens stated Resident B was “alterable but not baseline aroused” at that time. Ms. Dickens stated hospice and Resident B’s authorized Representative (Resident AR) were contacted regarding the circumstances of being found on the ground outside. Ms. Dickens stated Resident B was observed on his floor next to his bed on a few occasions. Ms. Dickens stated it could not be determined if Resident B lowered himself down to the floor or fell as he had not sustained injuries and was not observed to have fallen. Ms. Dickens stated Resident B did require staff assistance with feeding. Ms. Dickens stated that to her knowledge, staff did bring food to him, and he would often not want to eat. Ms. Dickens stated the facility offers levels of care, one to four with four being the highest, and that Resident B was assessed as a level four regarding his care needs. Ms. Dickens stated that after the incident on 8/31/21, Resident B’s family hired a one-on-one companion to sit with Resident B, during hours the family was unable to do so, until he left the facility.

On 9/8/21, I interviewed assistant director of nursing Luna Delgado at the facility. Ms. Delgado recalled the circumstances of Resident B getting on the elevator and taking it to the second floor approximately two weeks ago. Ms. Delgado stated she was walking down the hall toward the memory care at the time to “grab a document for another resident” and observed Resident B attempting to get on the elevator. Ms. Delgado stated Resident B could move in his wheelchair by pushing with his feet. Ms. Delgado stated she witnessed this many times. Ms. Delgado stated that on the day in question, she also observed Resident B reach up and push the elevator button. Ms. Delgado stated she did make several attempts to re-direct Resident B from getting on the elevator, but he was “undeterrable”. Ms. Delgado stated Resident B reported he wanted to go the third floor reporting he wanted to “jump”. Ms. Delgado stated there is no access to the outside from the second or third floors so it would not be possible to jump. Ms. Delgado stated that because Resident B was so insistent, she allowed him to get on the elevator while she went to get the documents, she needed from the memory care with the intention of coming back to check on him. Ms. Delgado stated that when she came back, Resident B was gone. Ms. Delgado stated she went to the second floor and found Resident B sitting in his wheelchair in the hallway and reported “he was fine”. Ms. Delgado stated she was not familiar with the issues related to Resident B’s foley tube as Ms. Dickens addressed that issue. Regarding Resident B being observed outside on 8/31/21, Ms. Delgado stated she had been walking through the hallway by the courtyard doors and noticed Resident B “slouched in his chair” and that he was not initially sitting on the ground at the time. Ms. Delgado stated she could not be certain how long Resident B had been outside but believed it was approximately thirty minutes since she last saw him inside. Ms. Delgado stated she personally observed him in the facility prior to him going outside. Ms. Delgado stated she went outside and approached him asking how he was doing at which time she stated Resident B looked up at her and pushed his feet forcing himself to slide off the edge of his chair onto the ground in a sitting position. Ms. Delgado stated she went to retrieve Ms. Dickens for help transferring Resident B back into his wheelchair. Ms.

Delgado stated Resident B's vitals were taken at once the transfer was completed, which she stated were "good". Ms. Delgado stated hospice and Resident AR were both notified shortly after the incident. Ms. Delgado stated Resident B did at times "slide to the floor" from his bed. Ms. Delgado stated that prior to the incident on 8/31, she "did not feel he [Resident B] was unable to sit on his own without supervision". Ms. Delgado stated Resident B had only been at the facility for a few days before this incident and "always had family with him. When asked directly if she felt Resident B was appropriate for the facility, Ms. Delgado stated "I would agree he probably should not have been here. He came here on hospice to pass away". Ms. Delgado stated Resident B did require staff to help him with eating his meals. Ms. Delgado stated staff did take meals to him and attempt to feed him and he often did not want to eat. Ms. Delgado stated Resident B was reportedly found on his floor on a few different occasions, however he did not sustain any injuries so it is believed he lowered himself to the floor.

I reviewed Resident B's service plan, provided by Ms. Delgado. The plan includes several individual sections with a *Category* and corresponding *Services* row within each section. In a section titled *Orientation*, the *Category* row read "Resident requires frequent orientation beyond meal/activity reminders". The corresponding *Services* row read, in part, "Round on resident at least every two hours to promote resident safety". In a section titled *Wandering Behavior*, the *Category* row read "Resident does not wander". The corresponding *Services* row read "he is not able to walk but uses a wheelchair and most of the time needs someone to push him. He has been observed using his feet wheeling himself in community". In a section titled *Behaviors*, the *Category* row read, in part, Agitation: Anxious; fluctuates emotionally". The corresponding *Services* section read "Once he starts coming off the Seroquel, he becomes more confused and agitated. Tries to stand when he is not able to stand without assistance and will be found on the floor". In a section titled *Communication*, the *Category* row read "Resident can communicate independently". The corresponding *Services* row read "Able to communicate needs to staff. Has been instructed in the use of the emergency call system and has demonstrated the ability to use the system when needed". In a section titled *General Mobility*, the *Category* row read "Requires physical assistance of 1 person transferring where staff provide physical support to resident". The corresponding *Services* row read "Remind resident to wait for staff assistance to transfer. Provide transfer assistance with good technique to protect resident and care staff. Report increasing difficulty with transfers or other safety concerns. Make sure wheelchair is locked prior to standing/transferring. He uses a wheelchair to get around the community". In a section titled *Incidents*, the *Category* row read "Resident has had 1 fall within last 3 months". The corresponding *Services* row read "Resident will try to get up and walk resulting in falls as he is not able to walk. Requires at least one person with transfers". In a section titled *Dining and Diet*, the *Category* row read, in part, "Dependent on staff for consumption (requires feeding assistance or frequent prompting to consume meal or stay engaged)". The corresponding *Services* row read "He requires assistance with set up and needs to

be fed". The summary page of the plan indicated Resident B had a *Care Level* of 4 as previously indicated by Ms. Dickens.

I reviewed two *Incident Details* reports for Resident B, provided by Ms. Delgado, which Ms. Delgado explained are the facilities internal notation pertaining to notable circumstances involving residents. The first report was dated 8/31/21 and indicated the incident *Occurred Between* 3:50pm and 4:15pm. A section of this report titled *Brief Description* read "Resident had been up for several hours in wheelchair going back and forth between garden and dining room. Hospice nurse had been out to see him around lunch time and he was agitated and was given a prn Seroquel. He was found outside in garden area on the ground sitting up in front of his wheelchair going in/out. Not sure how long he had been outside as he was warm to touch. Luna ADON [assistant director of nursing] found him and got another nurse to assist getting him off the ground and into his chair. He was able to respond when shaken would open eyes and look at you but would drift back off to sleep. Took him back to his room and transferred him to the hospital bed. Removed his pants to help him cool off. Notified Hospice and Daughter. Hospice requested a blood sugar check was 354 and this information was given to hospice nurse upon her arrival. [ddickens/09-01/2021:9:48]". Page two of this report, in a section titled Current Status Update, read "Arbor Hospice was notified of fall and change of condition. Checked his blood sugar was 354 and sliding scale insulin was given per request of Dr. O'Neil. He is resting comfortable and does not exhibit pain. Provided soft foods and fluids, he is refusing to eat but is taking a few sips of water. [ddickins/09-01-2021:09:48]". The second report was dated 9/1/21 and indicated the incident *Occurred Between* 7:55pm and 8:00pm. A section titled *Brief Description* read "Arrived in Resident room and found in laying on his back in the floor by his bed. He was not in any pain or discomfort. Checked him for any bleeding none noted. James Med Tech assisted with getting resident off the floor. Sat him up first and then helped him off the floor onto the bed. [ddickens/09-01-2021:21:33]". Page two of this report, in a section titled Comments/Final Resolution, read "Hospice has ordered Ativan prn daughter is picking up from CVS and bringing to facility. Family has hired an overnight caregiver from 9p to 9a [ddickens/09-01-2021:21:33]".

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference:	**Definitions**

R 325.1901	
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	The complaint alleged multiple issue related to inadequate care and supervision of Resident B who lived at the facility from 8/24/21 until 9/4/21. Review of Resident B's service plan and interviews with staff indicated Resident B was a person who required staff assistance with transfers, extensive assistance from staff with activities of daily living including being fed by staff, would fall when attempting to walk and that he would attempt to walk, especially when agitated, without staff assistance having also been discovered on the floor in his room on several occasions without a known cause. Despite this, Resident B was left unsupervised for extended periods of time leaving him vulnerable to an increased risk of harm including once when Ms. Delgado admitted to having left him unattended in a condition that can be described as agitated in which Resident B somehow made his way on to an elevator and up the second floor, and once in the courtyard at which time he became lethargic and difficult to arouse. Ms. Delgado also reported her thought that Resident B may not have been appropriate for the facility. Additionally, while Resident B reportedly verbalized a desire to attempt suicide, and attempted to act on this desire, his service plan was not reasonably developed so that staff could adequately meet his needs related to his mental health and protect him from harm. Given these issues, it is reasonable to determine that Resident B did not have adequate supervision either in practice or according to his service plan as, notably, his service plan indicated staff were to conduct "2-hour checks" for Resident B which, given his condition and behavior, is not reasonably sufficient. Based on the findings, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was improperly transferred

INVESTIGATION:

According to the complaint, during an attempted transfer on 8/31/21, Resident A was set up on a sit to stand by an agency staff care associate. Resident A notified the associate that her foot and leg were not properly aligned for the transfer but was told it would be ok and lifted anyway causing Resident A to cry out in pain. The associate set Resident A down and attempted the transfer again.

Review of the facility licensing file revealed a timely incident report was submitted to the department regarding Resident A being transferred improperly. According to the report, the incident happened on 8/30/21 at 9:26am with an agency staff person named Andoria.

On 9/8/21, I interviewed Resident A t the facility. Resident A stated that on the morning of 8/31/21, she was hurt during an improper transfer performed by an associate who's name she said should could not recall but that it was "something like Andoria". Resident A state the associate was an "agency" staff person who she had not seen prior and has not seen since. Resident A stated staff use a sit to stand or a Hoyer device to transfer her from her bed to her wheelchair and that she prefers to use the sit to stand. Resident A stated there are usually two associates conducting the transfer but that this associate was the only one present that morning. Resident A stated that in order to use the sit to stand, she has to be sitting on the side of the bed with her feet on the platform. She stated once she is in this sitting position, a support rap is placed behind her back and each side is attached to a handle about her head on the lift. Resident A stated that once she is in the sit to stand correctly, a remote control is used to lift her up in order to get her into her wheelchair. Resident A stated that during this lift, her right foot was not aligned correctly as it was "4 to 6 inches" in front of her knee and should be lined up directly parallel with her knee. Resident A stated she informed the associate of this who she stated told her "It's ok". Resident A stated that once the associate used the remote to start lifting her to stand her up, she felt her knee pop back and hyperextend and which time she stated she screamed "Stop!". Resident A stated the associate told her "It will only be a minute" and that she told the associate to put her down. Resident A stated the associate started to lower her down and then all of a sudden started to lift her again at which time Resident A stated her knee started to hyperextend again at which time she stated she called out in pain again. Resident A stated the associate told her "Hold on, it will just take a minute to get you to your chair". Resident A stated she did end up in her chair, however she did not recall the associate taking the sit to stand device off of her or the actual point which she got into her chair as she was in so much pain. Resident A stated the associate had left

at that point. Resident A stated the pain stopped for approximately 5 to 10 minutes at which time she went to the cafeteria to get breakfast.

When interviewed, Ms. Dickens stated she had been made aware of the improper transfer of Resident A by Ms. Delgado. Ms. Dickens stated she did not recall the details of the incident except that it involved an agency staff person who's name she could not recall. Ms. Dickens stated that her understanding from Ms. Delgado was that the incident had happened a day prior to when Ms. Delgado reported it to her. Ms. Dickens stated Resident A requires a mechanical lift for transfers with two staff.

When interviewed Ms. Delgado provided statements similar to Ms. Dickens regarding Resident A's transfer needs. Ms. Delgado confirmed the agency staff member's name was Andoria, last name unknown, and that according to the schedule, Andoria worked on the evening of 8/30/21 from 3pm to 11pm and not in the morning of 8/31.

I reviewed Resident A's service plan which was consistent with statements provided by Ms. Dickens and Ms. Delgado pertaining to Resident A's transfer needs.

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.
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.

ANALYSIS:	The complaint alleged Resident A suffered an injury to her knee related to an improper transfer conducted by an agency staff person. Interviews with staff and Resident A, as well as review of Resident A's service plan, support the allegation. Based on the findings the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility did not seek adequate medical attention for Resident A

INVESTIGATION:

According to the complaint, Resident A was in severe pain after the attempted transfer. Facility staff did not seek medical attention and Resident A called her doctor on her own. Resident A had a family member come to the facility and take her to be evaluated. The doctor who conducted the evaluation believes Resident A suffered from a torn ligament.

Under a section titled Action taken by Staff/Treatment Given, the incident report submitted by the facility read "Lunda ADON was notified by resident the next day after lunch of the incident due to pain [Resident A] was having in her right knee. Luna contacted Agency and notified of incident and that the caregiver was not eligible to return to the building. Tele Health Visit scheduled with PCP.

When interviewed, Resident A stated that after the transfer incident, she went downstairs to breakfast. Resident A stated that after breakfast she notified Ms. Delgado of the transfer incident and reported she had pain in her knee. Resident A stated Ms. Delgado gave her a pain pill. Resident A stated that evening the pain came back again and so she asked, and received, another pain pill. Resident A stated the next day, the pain her knee became increasingly worse. Resident A stated she met with her physician at this point for a virtual appointment at which time she was prescribed pain medication and told to go to urgent care if the pain increased. Resident A stated the pain increased so she contacted her dad who her took her to the hospital. Resident A stated x-rays were taken of her knee and no breaks or fractures were found; however, she was told she may have damaged a ligament due to her leg being hyperextended.

When interviewed, Ms. Dickens stated she did not receive the initial reporting from Resident A, but that it was reported to her that Resident A initiate a tele-health visit with her physician after initially indicating she did not feel the need to Ms. Delgado.

When interviewed, Ms. Delgado stated she had not been aware of the improper transfer until Resident A notified her on 8/31/21 which she stated was a day after the

incident reportedly happened. Ms. Delgado stated that based on Resident A's reporting to her, the incident happened on the evening of 8/30/21. Ms. Delgado stated Resident A did initially indicate the morning of 8/31 as the incident date, but then stated it had happened the previous evening. Ms. Delgado stated she asked Resident A how she was feeling Resident A reported having some pain in her knee, but that she was ok. Ms. Delgado stated she gave Resident A an "as needed" [prn] Tylenol and suggested she should have her knee checked out by a doctor to which she stated Resident A declined at the time. Ms. Delgado stated Resident A did ultimately have a tele-health appointment with her physician who prescribed her pain medication. Ms. Delgado stated that the day after that, 9/1/21, Resident A contacted her father and had him take her to the hospital to have her knee check out. Ms. Delgado stated she is not aware of Resident A notifying staff that she needed to go to the hospital due to increased pain.

I reviewed an *Incident Details* report for Resident A dated 8/31/21 provided by Ms. Delgado. Within a section titled *Current Status Update* the report read, in part, "After Tele Health she was put on Tylenol/Ibuprofen every six hours as needed.
Later on 9/1/21 she had her dad come pick her up and take her to ER due to pain in her right knee. The ER did not have a confirmed diagnosis but believed it was a pulled muscle [ddickens/09-03-2021:15:42]".

I reviewed the *AFTER VISIT SUMMARY* relative to Resident A's ER visit, dated 9/1/21, provided by Ms. Delgado. The summary provided no specific diagnosis but did include a *Knee Pain or Injury: Care* Instructions page which detailed how to treat knee injuries.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	The complaint alleged that after suffering an injury related to an improper transfer, the facility did not adequately seek medical attention for Resident A. While the investigation did reveal Resident A suffered an injury, the evidence was insufficient to indicate the facilities actions were inadequate.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was not treated with dignity

INVESTIGATION:

According to the complaint Resident A has reported that on multiple occasions nurse Luna Delgado has made comments to her feel like she is “crazy”.

When interviewed, Resident A stated Ms. Delgado has made several comments to her that seem to imply she is not of sound mind. Resident A stated it’s not always “what is said” but how it is said. Resident A stated that she had recently reported to her case worker that she did not receive several medications on more than one occasion. Resident A stated her case worker met with Ms. Delgado to discuss the medication issue and that after that meeting, Ms. Delgado came to her room and said “you know you received your medications”. Resident A stated that she had also recently reported continued pain in her knee to Ms. Delgado to which stated Ms. Delgado tried to convince her that her knee is not going to get better because she lets her let hang off of her wheelchair without using the support step. Resident A could not recall other specific statements Ms. Delgado has said to her.

When interviewed Ms. Delgado stated she recalled speaking to Resident A’s case worker about issues with Resident A’s medications not being administered. Ms. Delgado denied every making comments to Resident A regarding the medications being received. Ms. Delgado stated she did suggest to Resident A that she should not allow her leg to hang from her wheelchair. Ms. Delgado stated she suggested this because she has seen Resident A’s leg hit the edge of doors due to her let not being in the stirrup which could be causing more pain in her knee. Ms. Delgado stated she believes there must be some mis understanding between her and Resident A as her intentions with anything she says to her are never to make her feel crazy.

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:	The complaint alleged Ms. Delgado has made multiple comments to Resident A in an effort to make her feel crazy. There is insufficient evidence to support a finding.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A and B did not receive their medications

INVESTIGATION:

According to the complaint, On the evening of 9/1/21 and 9/2/21, Resident A did not receive several of her medications and was told by staff that the facility only had 3 or her 7 prescribed medications. This has happened on other occasions. Resident B was not having his blood sugar tested. Ms. Delgado stated the facility did not have orders to manage Resident B's diabetes, however hospice staff for Arbor Hospice, working with Resident B, reported the orders were hand delivered to Ms. Delgado and Ms. Dickens on 8/24/21. On the evening of 8/31/21, when Resident B was left outside, hospice ordered as PRN Seroquel and Ativan for Resident B. The medications were not administered to Resident B and it was reported it was because Resident B already had an order for scheduled Seroquel.

When interviewed, Ms. Dickens stated Resident A did miss the administration of sever of her medications on 9/1/21 and 9/2/21. Ms. Dickens stated this was due to several of the medications not having been delivered by the pharmacy. Ms. Dickens stated some medications are ordered through the facilities electronic medication administration [EMAR] system by staff when meds get low or, if they are psychotropic medications, they are auto filled by the pharmacy. Ms. Dickens stated all the medications not sent by the pharmacy had pre-existing orders. Ms. Dickens stated the EMAR system does not have a mechanism to notify staff when medications are low and does not have a specific policy regarding contact with the pharmacy to ensure medications are ordered and received on time. As it pertains to Resident B, Ms. Dickens stated the facility did follow physicians orders for his blood sugar and his Seroquel and Ativan. Ms. Dickens stated the facility did not receive an order to track Resident B's blood sugar readings until 8/31/21. Ms. Dickens stated that until then, Resident A was getting his blood sugar tested since that is a part of the process of administering insulin. Ms. Dickens stated Resident B did have a scheduled prescription for Seroquel and a prescription for PRN Seroquel, but that hospice discontinued the PRN Seroquel on 8/31/21 at the same time they prescribed Ativan which she stated was not available until the next day, 9/1/21.

When interviewed, Ms. Delgado provided statements consistent with those of Ms. Dickens. Ms. Delgado stated that if Resident B was prescribed a medication, it would have been available to him as prescribed.

I reviewed Resident A's medication administration record (MAR) for 9/1/21 and 9/2/21 with the corresponding *Medication Administration History* records, provided by Ms. Delgado. The reports are consistent with Ms. Dickens statements reflecting several medications noted as "Note Administered: Drug/Item Unavailable".

I reviewed Resident B's *Physician Order Report* dated between 8/24/21 and 9/8/21. The report indicated a *General* order was started on 9/1/21 to "Check blood sugars before meals and at bedtime. Record results and give sliding scale as needed". The report indicated Resident B was prescribed Lorazepam [generic for

Ativan] starting on 9/1/21. The report indicated Resident B had three separate prescriptions for Quetiapine [generic for Seroquel]. Two of the quetiapine prescriptions indicate a start date of 8/25/21and an end date of 9/2/21 with one prescribed “Twice Daily” and one prescribed “Twice Daily As Needed”. The third prescription indicated a start date of 9/2/21 with instruction to administer “Three times daily for agitation. Review of Resident B’s MAR indicated that at least one of the PRN medications were not administered to Resident B on 8/31/21

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
For Reference: R 325.1901	**Definitions**
	(14) "Medication management" means assistance with the administration of a resident's medication as prescribed by a licensed health care professional.
ANALYSIS:	The complaint alleged Resident A and B did not receive medications as prescribed. Interviews with staff and review of physician's orders and MARs for Residents A and B support the allegation. Based on the findings the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

When interviewed, Ms. Dickens stated staff who are hired out from an agency are expected to have been trained on all aspects of care required by residents of the facility including transfers. Ms. Dickens stated the facility does not train agency staff when they work a shift on specific skills but provides an “overview” of the care required for the residents they are working with during their shift.

Ms. Delgado provided statements consistent with Ms. Dickens as it pertains to agency staff training.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	The facility allowed agency staff to work with residents having not been provided any specific facility training, other than an "overview" on the first day they are appointed or confirming specific training was provided to the agency staff prior to working at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of the facility licensing file revealed no incident reports were submitted to the department regarding Resident B's courtyard incident, or related change in condition, on 8/31 or reporting regarding medication errors related to Resident A.

Within a section titled *Follow-up Actions* of the 8/31/21 dated *Incident Details* report for Resident B, there was a sub section titled *State Reported* which indicated "no" regarding the incident involving Resident B being discovered in the courtyard with a change in condition.

APPLICABLE RULE	
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.
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.
ANALYSIS:	Resident B displayed a change in condition as discovered when he was found outside on 8/31/21, however this was not reported by the facility. Additionally, medications errors related to Resident A were also not reported to the facility. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Delgado was unable to provide any training documentation for Andoria.

APPLICABLE RULE	
R 325.1944	**Employee records and work schedules.**
	(1) A home shall maintain a record for each employee which shall include all of the following: **(d) Summary of experience, education, and training.**
ANALYSIS:	The facility was unable to demonstrate verification of agency staff training as Ms. Dickens and Ms. Delgado reported they did not have any such documentation on file and were unable to even provide a last name of the agency staff who performed the improper transfer. Based on the findings the facility is not in compliance with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/4/21, I discussed the findings of the investigation with authorized representative Rhonda Hendrickson, administrator Kelly Hardy and regional nurse specialist Dana Dickens.

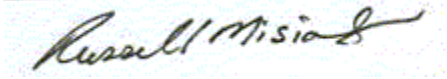
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

10/28/21

Aaron Clum — Date
Licensing Staff

Approved By:



11/3/21

Russell B. Misiak — Date
Area Manager