GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 3, 2022

Lucijana Tomic
Emerald Meadows
6117 Charlevoix Woods Ct.
Grand Rapids, MI 49546-8505

RE: License #: AH410343036
Investigation #: 2022A1010025
Emerald Meadows

Dear Ms. Tomic:

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.

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
350 Ottawa, NW Unit 13, 7th Floor
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 #:	2022A1010025
Complaint Receipt Date:	02/11/2022
Investigation Initiation Date:	02/11/2022
Report Due Date:	04/13/2022
Licensee Name:	Providence Operations, LLC
Licensee Address:	18601 North Creek Drive Tinley Park, IL 60477
Licensee Telephone #:	(708) 342-8100
Authorized Representative/ Administrator:	Lucijana Tomic
Name of Facility:	Emerald Meadows
Facility Address:	6117 Charlevoix Woods Ct. Grand Rapids, MI 49546-8505
Facility Telephone #:	(616) 954-2366
Original Issuance Date:	08/26/2013
License Status:	REGULAR
Effective Date:	03/07/2021
Expiration Date:	03/06/2022
Capacity:	60
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell out of her wheelchair and broke her hip.	Yes
Resident B's medication was not administered as prescribed because it was not available. Resident C's blood sugar is not being taken.	No
Additional Findings	Yes

III. METHODOLOGY

02/11/2022	Special Investigation Intake 2022A1010025
02/11/2022	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
02/11/2022	APS Referral APS referral emailed to Centralized Intake
02/23/2022	Inspection Completed On-site
02/23/2022	Contact - Document Received Received resident MARs, service plans, and staff notes
03/01/2022	Contact - Telephone call made Message left for second complainant, a telephone call back was requested
03/02/2022	Contact – Telephone call made Interviewed the second complainant by telephone
03/07/2022	Contact – Telephone call made Interviewed Resident A's guardian by telephone
03/07/2022	Contact – Document received Received Resident C's February blood sugar results
04/13/2022	Contact – Telephone call received Message received from Hope Nework clinical manager Elena Zelinski

05/03/2022	Exit Conference Completed with licensee authorized representative Lucijana Tomic

ALLEGATION:

Resident A fell out of her wheelchair and broke her hip.

INVESTIGATION:

On 2/11/22, the Bureau received the complaint from an anonymous source, therefore I was unable to gather additional information. The complaint read, "[Resident A] fell out of her wheelchair and broke her hip." The complaint also read Resident A was also "scared for her safety" after the incident because "no one seems to know what they are doing."

On 2/11/22, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 2/23/22, I interviewed the facility's administrator Lucijana Tomic at the facility. Ms. Tomic reported she started at the facility a few weeks ago, therefore she was not present at the facility when Resident A fell and broke her hip. Ms. Tomic stated she had limited knowledge regarding the incident as a result.

Ms. Tomic provided me with a copy of Resident A's service plan for my review. The *TRANSFERRING* section of the plan read, "[Resident A] is unable to transfer herself. She requires two staff assist for repositioning every two hours." The *ASSISTIVE DEVICES* section of the plan read, "[Resident A] has a wheelchair for transportation of long distances." The *MOBILITY* section of the plan read, "Is NOT AMBULATORY." The plan also read Resident A is diagnosed with quadriplegia.

Ms. Tomic provided me with a copy of Resident A's staff notes for my review. A note dated 1/30/22 read, "[Resident A] was trying to reach for candy on the floor and was not buckled in her wheelchair. She fell out of her chair and hit her head on the edge of the door. She has a small gash behind her right ear with minimal bleeding. She also complained her left groin area hurting any time any movement was attempted. EMS was called to get her checked out due to hitting her head. EMS looked her over and recommended she get looked at however she stated she did not want to go. Due to the fact that she was able to tell EMS the day, time, who she was, and what occurred they deemed that she was able to legally make her own medical decisions. She signed AMA paperwork and EMS left.

A note dated 1/31/22 read, "I let Interim know that [Resident A] was in the hospital. I also talked to Betty and she said [Resident A] will not have anything done for her hip. But she told me she does not want [Resident A] in her electric chair at all. The

va will be coming to get her electric chair because we let her in it. I told her I will let our ed know how she feels."

On 2/23/22, I interviewed administrator in training Katie Kirchner at the facility. Ms. Kirchner's statements were consistent with Ms. Tomic. Ms. Kirchner reported Resident A experienced multiple falls at her previous facility and received rehabilitation services at a long-term care facility. Ms. Kirchner said Resident A used a "power chair" because she is non-ambulatory. Ms. Kirchner stated Resident A fell out of her "power chair" at the facility, however she did not have any additional information regarding the incident.

On 2/23/22, I interviewed medication technician (med tech) Ariana Cole at the facility. Ms. Cole reported Resident A fell out of her wheelchair approximately four weeks ago. Ms. Cole's statements were consistent with the staff note regarding Resident A that was dated 1/30/22. Ms. Cole reported Resident A was supposed to be buckled into her "power chair" to prevent her from falling out. Ms. Cole said Resident A was not buckled in and fell out of it as a result.

On 2/23/22, I interviewed med tech Princess Leon at the facility. Ms. Leon's statements were consistent with the staff note regarding Resident A that was dated 1/30/22. Ms. Leon reported Resident A had a history of unbuckling herself from her "power chair." Ms. Leon stated she did not know whether Resident A unbuckled herself or if staff did not buckle her into her power chair when she fell on 1/30/22. Ms. Leon explained Resident A also has a "grabber" she is supposed to use to pick things up off the floor. Ms. Leon stated Resident A had a history of not using this device to pick things up off the floor.

On 2/23/22, I interviewed Resident A at the facility. Resident A said she did fall out of her "power chair" and broke her hip. Resident A reported she did not know there was a buckle in her chair or that she was supposed to be buckled in. Resident A stated she broke her hip, received rehabilitation treatment, and is now bed bound. Resident A said staff no longer put her in her "power chair" or get her out of bed. Resident A reported her power chair is kept in her bathroom. I observed the "power chair" in Resident A's bathroom. I observed the buckle in the "power chair" that was supposed to be used to keep Resident A from falling out of it.

On 3/7/22, I interviewed Resident A's guardian Betty Hadley by telephone. Ms. Hadley explained Resident A has a history of alcohol abuse and would sneak out of the facility and her previous placements in her "power chair" to get alcohol to consume. Ms. Hadley reported Resident A also had a history of falling out of her "power chair" when she got intoxicated. Ms. Hadley said to her knowledge, Resident A was intoxicated when she fell out of her "power chair" on 1/30/22.

Ms. Hadley reported there was a guardianship hearing on 2/1/22 and the judge ordered Resident A's "power chair" could be removed from the facility due to her poor judgement and frequent falls out of it that resulted in injury. Ms. Hadley had no

concerns regarding care staff at the facility and the care they provide to Resident A. Ms. Hadley said care staff at the facility are not to blame for Resident A's poor judgement while she was in her "power chair."

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 interviews with Ms. Cole and Ms. Leon, along with review of Resident A's staff notes revealed she fell out of her powered wheelchair on 1/30/22. Ms. Cole and Ms. Leon reported Resident A was supposed to be buckled into the chair to prevent her from falling out. Review of Resident A's service plan revealed the use of Resident A's powered wheelchair and instruction for staff to buckle her into it were not outlined. Resident A's service plan did not accurately describe her safety needs and how staff were to ensure her safety while she was in her powered wheelchair prior to 1/30/22. The interview with Ms. Hadley revealed Resident A had a guardianship hearing on 2/1/22 in which the judge ordered the powered wheelchair to be removed from the facility. Resident A's plan was not updated to reflect this order and her powered wheelchair was still at the facility as of 2/23/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B's medication was not administered as prescribed because it was not available. Resident C's blood sugar is not being taken.

INVESTIGATION:

On 2/11/2022, the complaint read, "[Resident C] isn't having her sugar monitored like it should be." The complaint also read there were "issues" with Resident C's blood sugar testing supplies.

On 2/18/2022, the Bureau received allegations regarding Resident B's medications not being administered as prescribed. The complaint read Resident B "has been told her meds are not available to be given to her resulting in her being unable to take

them as prescribed, they have also tried to give her too many doses of a med today."

On 2/23/22, Ms. Tomic reported she had limited knowledge regarding Resident B and Resident C's medications. Ms. Tomic stated to her knowledge Resident B and Resident C's medications were administered as prescribed. Ms. Tomic said medication technicians (med techs) at the facility were trained to administer resident medications as they are prescribed.

Ms. Tomic provided me with a copy of Resident B's February medication administration record (MAR) for my review. The MAR read Resident B is prescribed "QUETIAPINE 200MG TAB TAKE 1 TABLET BY MOUTH AT BEDTIME. TAKE WITH 400MG TO EQUAL 600MG AT HS, QUETIAPINE 400MG TAB TAKE 1 TABLET BY MOUTH AT BEDTIME, QUETIAPINE XR 50 MG TAB TAKE 1 TABLET BY MOUTH ONCE DAILY, BENZTROPINE 2MG TAB TAKE 1 TABLET BY MOUTH TWICE DAILY, LITHIUM CARB 150MG CAP TAKE 1 CAPSULE BY MOUTH TWICE DAILY, and OXCARBAZEPINE 600MG TAB TAKE 1 TABLET BY MOUTH TWICE DAILY" to treat Bi-polar Disorder.

The MAR read Resident B was "Absent from home" without her prescribed "BENZTROPINE 2 MG TAB" on 2/12/22, 2/14/22, 2/15/22, 2/16/22, and 2/18/22. The MAR read Resident B was "Absent from home" without her prescribed "LITHIUM CARB 150MG CAP" ON 2/3/22, 2/5/22, 2/8/22, 2/9/22, 2/10/22, 2/11/22, 2/12/22, 2/15/22, 2/17/22, and 2/20/22. The MAR read Resident B was "Absent from home" without her prescribed "OXCARBAZEPINE 600MG TAB" on 2/12/22, 2/14/22, 2/15/22, 2/16/22, and 2/18/22.

Ms. Tomic provided me with a copy of Resident C's February MAR for my review. The MAR read, "LANCETS THIN USE AS DIRECTED 4 TIMES A DAY (indications for Use: Medical Supplies), and ALCOHOL PREP PAD 100/BX USE AS DIRECTED (indications for Use: Medical supplies)." The MAR read Resident C was prescribed HUMALOG 1000UNITS/ML KWIKPEN USE PER SLIDING SCALE FOUR TIMES DAILY, ULTRACARE PEN NEEDLE 6MM 31G Inject 1 unit subcutaneously before meals and at bedtime." The MAR read Resident C's insulin and her blood sugar testing supplies were administered and used as prescribed.

Ms. Tomic provided me with a copy of Resident C's service plan for my review. The *MEDICATIONS* section of the plan read, "[Resident C] does not know name, reason, or time of medication. Needs medication pre-poured or requires insulin syringes to be pre-filled. Requires assistance with ordering meds. Requires daily supervision of medication. Unable to self-inject or self-administer pre-poured medications."

Ms. Tomic provided me with a copy of Resident B's February staff notes for my review. A note dated 2/11/22 read, "Left message at Hope Network to try and get a new script of Hydralazine 50mg, Quetiapine 50 mg, Quetiapine 400mg, and Quetiapine 200mg." A note dated 2/14/22 read, "Staff placed call to DR. Kauffmens

[sic] office requesting a refill for Lithium carb 150 mg cap. Will call back to follow up." A note dated 2/17/22 read, "Late entry. Called hope net work last week about her meds they will send her refills over after she see them. they only do 1 refill because of her coming in to make sure meds are still at the amount she needs.."

Ms. Tomic provided me with a copy of Resident B's service plan for my review. The *MEDICATIONS* section of the plan read, "[Resident B] has insulin that she takes daily and weekly. Staff to assist with preparation and injection. [Resident B] understands her medications, their purposes and doses, ad takes them as prescribed. Staff is needed to dispense medications and supervise medications daily." The *BEHAVIORS* section of the plan read, "[Resident B] receives mental health services through: Hope Network. Report changes from baseline behaviors to Nurse."

On 2/23/2022, Ms. Kirchner stated Resident B may have had some medications not available because she missed an appointment with her psychiatrist recently. Ms. Kirchner reported Resident B is aware if she missed any of her psychiatric appointments, she would be unable to get her medications to treat her Bi-polar Disorder. Ms. Kirchner said one of the medications Resident B was prescribed is Lithium, however she was unable to recall the names of all Resident B's medications prescribed to treat Bi-polar Disorder. Ms. Kirchner was unable to recall the date of Resident B's missed psychiatric appointment. Ms. Kirchner explained Resident B can sign herself in and out of the facility, has her own car, and drives herself to her psychiatric appointments.

Ms. Kirchner denied knowledge regarding staff attempting to administer too many doses of one of Resident B's medications. Ms. Kirchner reported she did not receive any complaints from Resident B regarding her medications.

Ms. Kirchner denied knowledge regarding staff not taking Resident C's blood sugar and issues regarding her blood sugar testing supplies.

On 2/23/22, Ms. Cole denied knowledge regarding Resident B's medications being unavailable to administer. Ms. Cole reported there were several incidents when Resident B was not at the facility when Resident B's medications were due to be administered to her. Ms. Cole explained when Resident B returned to the facility, she would ask for her medications, however staff were unable to administer them because it was outside the timeframe they could be administered. Ms. Cole stated Resident B did not understand why staff were unable to administer them several hours after they were prescribed to be given. Ms. Cole reported Resident B's medications were administered as prescribed.

Ms. Cole stated to her knowledge, Resident C's blood sugar was taken by staff. Ms. Cole reported there have been issues in the past when Resident C's pharmacy was late in delivering her lancets and test strips. Ms. Cole explained when this occurred, lancets and test strips from the facility's supply were used.

On 2/23/22, Ms. Leon's statements regarding resident B's medications were consistent with Ms. Cole.

Ms. Leon denied knowledge regarding Resident C's blood sugar and blood sugar testing supplies.

On 2/23/22, I interviewed the facility's secured memory care unit assistant manager Carol Scott at the facility. Ms. Scott denied knowledge regarding Resident B.

Ms. Scott reported Resident C's blood sugar was taken and her insulin was administered as prescribed. Ms. Scott denied knowledge regarding issues with Resident C's blood sugar testing supplies. I observed the medication cart in the secured memory care unit. I observed Resident C's blood sugar testing supplies. I observed Resident C had a sufficient supply of lancets, test strips, and alcohol pads. I also observed Resident C's glucometer.

On 2/23/22, I interviewed Resident B at the facility. Resident B reported there were instances when staff told her that her medications could not be administered because they were not available." Resident B stated she did not know why they were not available. Resident B was unable to recall the exact dates this occurred. Resident B said to her knowledge she was at the facility during her medication administration times.

On 2/23/22, I attempted to interview Resident C at the facility. I was unable to engage Resident C in meaningful conversation. Resident C resides in the secured memory care unit in the facility.

On 3/2/22, I interviewed the second complainant by telephone. The second complainant reported she received a telephone call from Resident B a couple of weeks ago and she stated some of her psychiatric medications were not available at the facility. The second complainant reported staff did not answer the telephone when she attempted to call to inquire about Resident B's medications. The second complainant said Resident B also reported staff tried to give her too many doses of her prescribed Trulicity, however she corrected them. The second complainant stated Resident B's medications that were not available arrived at the facility shortly after Resident B said they were not available.

On 3/7/22, I interviewed shift manager Jelaine Naffziger at the facility. Ms. Naffziger's statements regarding Resident B's missed psychiatric appointment and psychiatric medications were consistent with Ms. Kirchner. Ms. Naffziger reported Resident B's medications were administered as prescribed.

On 3/7/22, I received a copy of Resident C's blood sugar results from February 2022 for my review. The document read Resident C's blood sugar was documented three to four times a day in February 2022.

On 4/13/2022, I received a voicemail from Hope Network outpatient clinical manager Elena Zelinksi. After several attempts to reach Hope Network staff, Ms. Zelinski was the only one to return my telephone calls. Ms. Zelinski reported Resident B had not missed any of her psychiatric appointments. Ms. Zelinski said Resident B's last appointment was on 3/10/22 and she was present. Ms. Zelinski stated Resident B's next appointment is on 4/14/22.

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.
ANALYSIS:	The interviews with staff, along with review of Resident B and Resident C's MARS, revealed their medications were administered as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 3/3/22, I reviewed the facility file. There was no incident report regarding Resident A's fall on 1/30/22.

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.
ANALYSIS:	Review of the facility file revealed an incident report regarding Resident A's fall that resulted in her fractured hip on 1/30/22 was not submitted to licensing in accordance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 2/23/22, Review of Resident B's service plan revealed her ability to sign herself in and out of the facility and use her personal vehicle were not outlined in her service plan. Resident B's responsibility to sign herself in and out and to transport herself to her medical and psychiatric appointments was also not outlined.

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:	Review of Resident B's service plan revealed her ability to sign herself in and out of the facility and transport herself to her medical and psychiatric appointments was not outlined.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Lucijana tomic by telephone on 5/3/22. Review of resident service plans was discussed.

IV. RECOMMENDATION

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

3/7/22

Lauren Wohlfert Date
Licensing Staff

Approved By:

05/02/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section