GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 17, 2022

Carl Schuler
Gladwin Adult Care, LLC
325 Commerce Court
Gladwin, MI 48624

RE: License #: AL260317409
Investigation #: 2022A0466065
The Horizon Senior Living V

Dear Mr. Schuler:

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 (517) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AL260317409 |
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| **Investigation #:** | 2022A0466065 |
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| **Complaint Receipt Date:** | 09/26/2022 |
| | |
| **Investigation Initiation Date:** | 09/27/2022 |
| | |
| **Report Due Date:** | 11/25/2022 |
| | |
| **Licensee Name:** | Gladwin Adult Care, LLC |
| | |
| **Licensee Address:** | 325 Commerce Court<br>Gladwin, MI 48624 |
| | |
| **Licensee Telephone #:** | (989) 924-6025 |
| | |
| **Administrator:** | Carl Schuler |
| | |
| **Licensee Designee:** | Carl Schuler |
| | |
| **Name of Facility:** | The Horizon Senior Living V |
| | |
| **Facility Address:** | 450 Quarter Street<br>Gladwin, MI 48624 |
| | |
| **Facility Telephone #:** | (989) 246-1000 |
| | |
| **Original Issuance Date:** | 11/01/2012 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 04/30/2021 |
| | |
| **Expiration Date:** | 04/29/2023 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | AGED |

## II. ALLEGATIONS:

| | **Violation Established**? |
|---|---|
| Resident A is often left in briefs that are saturated in urine. | No |
| A direct care worker (DCW) did not address Resident A with respect. | No |
| DCWs at the facility are not checking Resident A's blood sugar according to the physician order. | Yes |
| The facility ran out of Resident A's prescribed pain medication for four days. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 09/26/2022 | Special Investigation Intake- 2022A0466065. |
| 09/27/2022 | Special Investigation Initiated – Telephone call to Complainant, interviewed. |
| 09/27/2022 | Contact- Telephone call made to nurse Jennifer Roberts, interviewed from The Care Team Hospice. |
| 10/04/2022 | Contact- Document recevied from The Care Team Hospice. |
| 10/19/2022 | Inspection Completed On-site. |
| 10/24/2022 | APS Referral made. |
| 10/27/2022 | Contact - Telephone call received from assigned APS Ryan Christensen. |
| 11/10/2022 | Contact - Telephone call to Relative A1, interviewed. |
| 11/14/2022 | Contact - Telephone call to house manager Jammie Tate, requested Resident A's Health Care Appraisal. |
| 11/14/2022 | Exit Conference with licensee designee Carl Schuler. |

**ALLEGATION: Resident A is often left in briefs that are saturated in urine.**

**INVESTIGATION:**
On 09/26/2022, Complainant reported Resident A is frequently saturated in urine when hospice goes into this facility to see Resident A. Complainant reported Resident A can be combative and uncooperative so that is the reason direct care workers (DCW)s do not always get Resident A up to go to the bathroom or change her at night.

On 09/27/2022, I interviewed nurse Jennifer Roberts from The Care Team Hospice who reported that she and other aids from The Care Team Hospice have observed Resident A in urine saturated briefs on multiple occasions when they arrive at the facility. Nurse Roberts reported she and the other aids come to the facility at different times in the morning and sometimes in the afternoon. Nurse Roberts reported that it did not matter what time they arrived at the facility, Resident A was in a urine-soaked brief.

On 10/04/2022, I reviewed Resident A's *Hospice Visit Notes* from The Care Team Hospice which were completed by nurse Roberts:

- On 09/01/2022, "Patient laying in her bed saturated in urine. Staff reports she is often non complaint and gets combative when patient refuses care."
- On 09/02/2022, Started antibiotics today for urinary tract infection (UTI).

On 10/19/2022, I conducted an unannounced onsite investigation and I interviewed Resident A who reported she is not left in urine soaked briefs. Resident A reported when she is checked on at night, she does not always allow DCWs to change her. Resident A reported she has been working on allowing them to change her more recently. Resident A denied that she has any skin breakdown or sores on her private areas including her buttocks. Resident A reported she does not have a legal guardian but that Relative A1 is her designated representative and that she visits with her more than once a week at the facility.

I interviewed Crystal Hoard, nurse aid with The Care Team Hospice who reported she just assisted Resident A with a shower. Ms. Hoard reported that The Care Team Hospice provides Resident A with showers twice a week. Ms. Hoard reported that although this was the first time that she has helped Resident A shower, she reported she did not observe Resident A with any sores or skin breakdown. Ms. Hoard reported she was told Resident A did wake up wet this morning. Ms. Hoard reported she talked with Resident A about allowing DCWs to change her throughout the night as that is a known concern.

I interviewed DCW Naomi Sickles who reported she is the first shift supervisor. DCW Sickles reported Resident A does frequently wake up wet and needs to be showered in the morning. DCW Sickles reported Resident A is diagnosed with dementia and needs help remembering to allow DCWs to change her. DCW Sickles reported Resident A is toileted throughout the day and she will let DCWs know when

she needs to use the bathroom. DCW Sickles reported nighttime can be challenging as Resident A does not always allow the DCW on duty to change her. DCW Sickles reported Resident A does not like to get up at night to use the bathroom. DCW Sickles reported Resident A does urinate a large amount when she urinates, so it often saturates an adult brief. DCW Sickles reported Resident A does not have any skin breakdown or sores on her bottom.

I interviewed DCW Natasha Celestino who reported she has worked at the facility for a month. DCW Celestino reported Resident A wears an adult brief all day, but she also does toilet throughout the day. DCW Celestino reported that during the day Resident A will tell DCWs when she needs assistance to use the toilet. DCW Celestino reported Resident A is often wet in the morning upon awakening. DCW Celestino reported night shift direct care staff report trying to get Resident A up to change her throughout the night, but she refuses. DCW Celestino reported Resident A does not like to be bothered throughout the night. DCW Celestino reported Resident A does not have any skin breakdown or sores on her bottom.

I observed Resident A's bedroom to be clean with clean, dry bedding and free from any foul odor. I observed Resident A to be in clean, dry clothing and free of any foul odor.

I reviewed Resident A's record which contained a written *Assessment Plan for Adult Foster Care (AFC) Residents* that was dated 10/15/20 and signed by Relative A1. In the "toileting" section of the report it stated, "1 to 2 person assist."

On 10/27/2022, I interviewed adult protective services (APS) worker Ryan Christianson who reported he was at the facility and found that Resident A was receiving excellent care. APS Christianson reported Resident A refuses to be changed at night and therefore wakes up wet. APS Christianson reported he interviewed Relative A1 who was happy with the care Resident A receives. APS Christianson reported he did not have any concerns. APS Christianson reported his investigation has been concluded without substations.

On 11/10/2022, I interviewed Relative A1 who reported she is happy with the care Resident A is receiving from both facility direct care workers and hospice caregivers. Relative A1 reported there are times Resident A wakes up wet because Resident A has not allowed DCWs to change her throughout the night. Relative A1 reported the hospice team and facility direct care workers have been working together to help Resident A understand why they need to change her throughout the night. Relative A1 reported she visits Resident A two to three times per week and does not have any concerns about the care Resident A is receiving. Relative A1 reported Resident A does not have any skin breakdown or sores on her bottom.

| APPLICABLE RULE | |
|---|---|
| **R 400.15301** | **Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.** |
| | **(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions:**<br>**(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** |
| **ANALYSIS:** | Complainant reported Resident A is often left in briefs that are soaked in urine. Resident A denied that she is left in urine soaked briefs. Ms. Hoard, DCW Sickles, DCW Celestino and Relative A1 all reported Resident A regularly refuses to allow DCWs to change her at night and therefore she wakes up with a wet adult brief. Resident A, Ms. Hoard, DCW Sickles, DCW Celestino and Relative A1 all reported Resident A does not have any skin breakdown or sores on her bottom despite her refusal. Resident A, Ms. Hoard, DCW Sickles, DCW Celestino and Relative A1 all reported that The Care Team Hospice and direct care workers are all working together with Resident A, so she understands the importance of being changed throughout the night. Resident A's record contained a written *Assessment Plan for Adult Foster Care (AFC) Residents* that stated in the "toileting" section of the report, "1 to 2 person assist." There is not enough evidence to support that the amount of personal care, supervision, and protection Resident A requires is not available in the home. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION: A direct care worker (DCW) did not address Resident A with respect.**

**INVESTIGATION**:
On 09/26/2022, Complainant reported she has heard staff call patient "Bro." Complainant reported for example, a DCW was passing meds and said, "I got your meds bro, open your mouth bro." Complainant reported that this slang is disrespectful.

On 09/27/2022, Complainant did not know the name of the DCW that was overheard addressing Resident A by "Bro."

On 10/19/2022, I conducted an unannounced onsite investigation and I interviewed Resident A who denied that any of the DCWs were disrespectful to her. Additionally, Resident A denied that anyone called her “Bro.” Resident A reported she did not recall a time when she was being administered medications when a DCW stated to her, “I got your meds bro, open your mouth bro.”

I interviewed Ms. Hoard, DCW Sickles, DCW Celestino and none of them reported ever hearing any DCW use the word “Bro” while addressing Resident A or any other resident. Additionally, Ms. Hoard, DCW Sickles and DCW Celestino reported that Resident A did not report to any of them that any DCW disrespected her nor did she report that any DCW used the word “Bro” to address her.

On 11/10/2022, I interviewed Relative A1 who reported she is at the facility two to three times per week and that she has never heard any DCW address Resident A or any other resident as “Bro.” Relative A1 reported she has never witnessed any DCW disrespect Resident A or any other resident. Relative A1 reported Resident A has not reported to her that any DCW disrespected her or did they use the word “Bro” to address her.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15304** | **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:**<br>**(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**<br>**(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.** |

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|---|---|
| **ANALYSIS:** | Complainant reported that a DCW addressed Resident A as "Bro" which Complainant reported was disrespectful. Resident A denied any DCW has ever addressed her as "bro" or had been disrespectful toward her in any way. Ms. Hoard, DCW Sickles, DCW Celestino and Relative A1 all reported that they have never heard any DCW use the word "Bro" while addressing Resident A or any other resident. Additionally, Ms. Hoard, DCW Sickles, DCW Celestino and Relative A1 all reported Resident A did not report to any of them that any DCW disrespected her, nor did Resident A report that any DCW used the word "Bro" to address her. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION: DCWs at the facility are not checking Resident A's blood sugar according to the physician order.**

**INVESTIGATION:**
On 09/26/2022, Complainant reported Resident A is a diabetic and is supposed to have her sugar checked two times a day. Complainant reported that frequently DCWs check Resident A's blood sugar after she has eaten. Complainant reported DCWs have been told multiple times by the hospice nurse that blood sugars need to be obtained before meals to be accurate. Complainant reported this has been brought this to the attention of the manager, however this problem persists and is still not resolved.

On 09/27/2022, I interviewed nurse Roberts who reported blood sugars must be taken on an empty stomach to be accurate. Nurse Roberts reported this issue had been addressed several times on different days with both the DCWs and the facility manager, yet this concern is still not rectified. Nurse Roberts reported facility direct care workers are provided with *Hospice Visit Notes* that document what occurred while she was at the facility and instructions for Resident A's care.

On 10/04/2022, I reviewed Resident A's *Hospice Visit Notes* from The Care Team which were completed by nurse Roberts:

- On 09/02/2022, "Spoke with Alexis at facility at 3:48. She stated blood sugars were obtained after breakfast and after lunch. Instructed that blood sugars need to be fasting to be more accurate and should be obtained just before she eats. She stated that they go by the times that are scheduled in the computer and sometimes it's before meals and other times its after. Alexis verbalized understanding of instructions. Will notify facility manager to change instructions in computer for staff."
- On 09/02/2022, "Spoke with facility manager Jamie and discussed concerns regarding earlier phone conversation with facility staff member. Offered some education regarding general hospice information/philosophy/cares etc.

Requested Jamie to change blood sugar checks in computer to read before breakfast and before lunch."

- On 09/06/2022 that "[Resident A] had eaten breakfast and blood sugars had not been taken prior to eating. Instructed again that blood sugars need to be obtained when patient has been fasting prior to meals/drinks."
- On 09/15/2022, "Staff member reports blood sugar today after lunch was 385. Sugars not obtained before meal as instructed. Provided more education to get accurate sugar readings before meals. Also spoke with facility manager again regarding issue. Spoke with pharmacy last week to change times and instruction on MAR but apparently that was not changed. Manager typing up a note to post in the kitchen not to serve meals until blood sugar is checked."

On 10/19/2022, I conducted an unannounced onsite investigation and I interviewed Resident A who reported that the facility takes her blood sugar. Resident A could not remember if it is taken before or after meals.

I interviewed DCW Sickles who reported that blood sugars were being taken after Resident A ate and when the readings were high, they would call the hospice nurse for direction. DCW Sickles reported that now the facility is taking Resident A's blood sugar before she gets out of bed so the cooks do not serve her breakfast/ give her coffee before her blood sugar can be taken. DCW Sickles reported that they are getting more accurate blood sugar readings now that they are taking them prior to her eating.

DCW Celestino reported she has worked at the facility a month and reported she was trained to take blood sugars before meals.

I reviewed Resident A's record which contained a written *Assessment Plan for Adult Foster Care (AFC) Residents* that was dated 10/15/20 and signed by Relative A1. Nowhere in Resident A's written assessment plan does it document that Resident A is supposed to have her blood sugar taken nor does it document any instruction as how to take the blood sugar.

I reviewed Resident A's medication administration records (MAR)s for September 2022. According to the September MAR, Resident A was prescribed "Embrace Talk Test Strips, check blood sugar twice at 8am and 12pm." The MAR documented that Resident A's blood sugar was taken at 11am and 4pm 09/01/2022-09/16/2022. The MAR documented that Resident A's blood sugar was taken at 7:30am and 4:30pm 09/17/2022-09/30/2022. Resident A's October 2022 MAR documented that she was prescribed "Embrace Talk Test Strips, check blood sugar twice at 8am and 12pm." The MAR documented Resident A's blood sugar was taken at 7:30am and 4:30pm 10/01/2022-10/18/2022. The September 2022 MAR and the October 2022 MAR did not document how Resident A's blood sugar was supposed to be taken.

On 10/27/2022, I interviewed APS Christianson who reported that there was a miscommunication with the cooks regarding Resident A. APS Christianson reported that the cooks were not aware Resident A needed her blood sugar checked therefore they would provide her a meal when she came into the dining room. APS Christianson reported that this has been addressed and resolved and that the cooks are not serving Resident A until they know her blood sugar has been taken.

On 11/10/2022, I interviewed Relative A1 who reported that there had been some confusion with facility DCWs taking Resident A's blood sugar after meals. Relative A1 reported that this issue has been addressed and that all DCWs have been trained to take Resident A's blood sugar twice daily before meals. Relative A1 believes that they are properly taking Resident A's blood sugar.

On 11/14/2022, I reviewed Resident A's *Health Care Appraisal* dated 11/20/2021. The *Health Care Appraisal* did not document that blood sugars needed to be taken or how to take them.

On 11/14/2022, house manager Jamie Tate provided Resident A's prescription for Embrace talk test strips which stated, "check blood sugar twice daily at 8am and 12pm."

| **APPLICABLE RULE** | |
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| **R 400.15310** | **Resident health care.** |
| | **(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following:**<br>**(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.** |

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|---|---|
| **ANALYSIS:** | Based on Resident A's September 2022 and October 2022 Medication Administration Record (MAR) and Resident A's physician written prescription for Embrace talk test strips Resident A's blood sugar was required to be checked at 8am and 12pm daily. Resident A's September 2022 MAR documented that Resident A's blood sugar was taken at 11am and 4pm on 09/01/2022-09/16/2022. Resident A's September 2022 MAR documented that Resident A's blood sugar was taken at 7:30am and 4:30pm from 09/17/2022-09/30/2022. Resident A's October 2022 MAR documented that Resident A's blood sugar was taken at 7:30am and 4:30am on 10/01/2022-10/18/2022. The written physician directions for Resident A's blood sugar checks were not followed as prescribed and therefore a violation has been established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION: The facility ran out of Resident A's prescribed pain medication for four days.**

**INVESTIGATION:**
On 09/26/2022, Complainant reported Resident A is on a pain pill, Hydroco/Apap (Norco) scheduled three times a day, but Resident A ran out of that prescription for four consecutive days and it was not refilled timely. Complainant reported the hospice nurse was in the facility on 09/01/2022, the day before Resident A ran out of medication, but no one reported Resident A needed any medication. Complainant reported that the nurse was on the phone with DCW Alexis Ferguson on 09/02/2022 but again nothing was mentioned about Resident A being without medication. Complainant reported that later on 09/02/2022, the on-call hospice staff was at the facility and again, nothing was mentioned regarding Resident A needing/being without medication. Complainant reported the hospice nurse was not aware until the next schedule meeting with Resident A on 09/06/2022 that Resident A was out of Hydroco/Apap (Norco) and had been for four days. Complainant reported DCW Ferguson reported she thought her manager was going to get Resident A's medication over the weekend. Complainant reported that on 09/06/2022, hospice nurse Roberts contacted DCW/manager Jamie Tate and DCW Tate reported she tried to put the Hydroco/Apap (Norco)through the pharmacy, but it did not go through.

On 10/04/2022, I reviewed Resident A's *Hospice Visit Note* which was completed by nurse Roberts on 09/06/2022 and documented that "staff reports that [Resident A] has been out of Norco since Friday night, 4 days. This writer had asked on admission last week if there were any refills needed and it was reported no. Instructed staff that when they noticed that she ran out of medication, they needed to inform hospice. They thought it was ordered from their manager in on its way over the weekend. Spoke with manager and there was a misunderstanding. She did not

realize that hospice needed to send a script for the medication to be sent over. Educated manager and medication ordering process. Plan to coordinate next Thursday to come in and educate staff/manager regarding General Hospital information and patient."

On 10/19/2022, I conducted an unannounced investigation and I interviewed Resident A who reported that she recalled running out of medication, but she could not remember which one the facility ran out of or for how long.

I interviewed DCW Sickles who reported that she is trained to administer resident medication. DCW Sickles reported that the facility did run out of Resident A's Hydroco/Apap (Norco) but that it was not for long. DCW Sickles could not remember any other information about this incident.

I interviewed DCW Celestino who reported that she is trained to administer resident medication. DCW Celestino reported that she was not aware of Resident A running out of Hydroco/Apap (Norco).

I reviewed Resident A's medication administration records (MAR)s for September 2022. According to the September MAR, Resident A was prescribed "Hydroco/Apap (Norco)Tab 7.5-325, take 1 tablet by mouth three times a day for pain." In the "exceptions" portion of the MAR it documented:

- 09/02/2022, 3:39pm, "out of inventory"
- 09/02/2022, 7:19pm, "out of inventory"
- 09/03/2022, 10:05am, "out of inventory"
- 09/03/2022, 1:58pm, "out of inventory"
- 09/03/2022, 9:40pm, "resident refused"
- 09/04/2022, 8:59am, "out of inventory"
- 09/04/2022, 12:49pm, "out of inventory"
- 09/04/2022, 11:17pm, "out of inventory"
- 09/05/2022, 10:51am, "out of inventory"
- 09/05/2022, 1:09pm, "out of inventory"
- 09/05/2022, 7:35pm, "out of inventory"
- 09/06/2022, 10:01am, "out of inventory"
- 09/06/2022, 1:01pm, "out of inventory"
- 09/06/2022, 7:59pm, "out of inventory"

After 09/06/2022, Resident A's September 2022 MAR documented that Resident A was administered the medication as prescribed. In the "exceptions" portion of the MAR there were no additional notations for "out of inventory" for any prescribed medication.

I reviewed Resident A's MARs for October 2022. According to Resident A's October 2022 MAR, Resident A was prescribed "Hydroco/Apap (Norco)Tab 7.5-325, take 1 tablet by mouth three times a day for pain." The MAR documented that Resident A

was administered the medication as prescribed. In the “exceptions” portion of the MAR there were no notations for “out of inventory” for any prescribed medication.

On 10/27/2022, I interviewed APS Christianson who reported he was told that Resident A’s pain medication, Hydroco/Apap (Norco), ran low but that they did not run out of pain medication.

On 11/10/2022, I interviewed Relative A1 who reported she was not aware that Resident A ran out of Hydroco/Apap (Noro). Relative A1 reported she visits with Resident A two to three times per week and that Resident A never complained to her about missing medication nor that she was in pain.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.** |
| **ANALYSIS:** | Resident A’s medication administration records (MAR)s for September 2022 documented that Resident A was prescribed “Hydroco/Apap (Norco)Tab 7.5-325, take 1 tablet by mouth three times a day for pain. Resident A was not administered this medication as prescribed on 09/02/2022, 09/03/2022, 09/04/2022, 09/05/2022 and 09/06/2022. Resident A’s *Hospice Visit Note* which was completed by nurse Roberts on 09/06/2022, documented that “staff reports that [Resident A] has been out of Norco since Friday night, 4 days.” DCW Sickles reported that the facility did run out of Resident A’s Hydroco/Apap (Norco) but that it wasn’t for long. A violation has been established as the facility did not have Resident A's prescribed medication available to administer to her. The facility was unable to obtain a refill and the facility did not contact the prescribing physician/hospice to obtain the Hydroco/Apap (Norco). Resident A’s Hydroco/Apap (Norco) was refilled when nurse Roberts was at the faiclity on 09/06/2022 and noticed that Resident A was not being administered her prescribed Hydroco/Apap (Norco) three times a day. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**
On 10/19/2022, I conducted an unannounced investigation and I reviewed Resident A’s record which contained a written *Assessment Plan for AFC Residents* that was dated 10/15/20 and signed by Relative A1. At the time of the unannounced

investigation Resident A's record did not contain any updated written *Assessment Plan for AFC Residents* dated 2021 or 2022 nor did Resident A's record contain any documentation that Resident A and/or her designated representative participated in the completion of an updated written Assessment Plan for AFC Residents during any of those years either. Additionally, Resident A's written *Assessment Plan for AFC Residents* documented in the "toileting" section of the report it stated, "1 to 2 person assist." Although Resident A, Ms. Hoard, DCW Sickles, DCW Celestino and Relative A1 all reported Resident A wore briefs and was combative and refused to let the DCWs change her throughout the night, Resident A's written *Assessment Plan* was not updated with that information.

On 10/19/2022, I interviewed house manager Jamie Tate who reported that the resident records are electronic and that she could provide me with any documents that I requested. DCW Tate reported that she provided me with copies of the most up to date documents available for Resident A.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15301** | **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 licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.** |
| **ANALYSIS:** | Resident A's record contained a written *Assessment Plan for AFC Residents* that was dated 10/15/2020 that was signed by Relative A1 and licensee designee Carl Schuler. At the time of the unannounced investigation Resident A's record did not contain any updated written *Assessment Plan for AFC Residents* for 2021 and 2022. Resident A's record did not contain documentation that Resident A and/or her designated representative participated in updating the written assessment plan. Although Resident A, Ms. Hoard, DCW Sickles, DCW Celestino and Relative A1 all reported that Resident A wore briefs and was combative and refused to let the DCWs change her throughout the night, Resident A's written *Assessment Plan* was not updated with that information therefore a violation has been established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in license is recommended.

11/14/2022

_____

Julie Elkins Date
Licensing Consultant

Approved By:

11/17/2022

_____

Dawn N. Timm Date
Area Manager