GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 13, 2023

Connie Clauson
Baruch SLS, Inc.
Suite 203
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL410375721
Investigation #: 2023A0357008
Fountain View of Lowell North

Dear Mrs. Clauson:

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 contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410375721
Investigation #:	2023A0357008
Complaint Receipt Date:	11/23/2022
Investigation Initiation Date:	11/28/2022
Report Due Date:	01/22/2023
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203, 3196 Kraft Avenue SE Grand Rapids, MI 49512
License Telephone #:	(616) 285-0573
Administrator:	Betsy Nugent
Licensee Designee:	Connie Clauson
Name of Facility:	Fountain View of Lowell North
Facility Address:	11537 E. Fulton Lowell, MI 49331
Facility Telephone #:	(616) 897-8413
Original Issuance Date:	07/31/2019
License Status:	REGULAR
Effective Date:	02/01/2022
Expiration Date:	01/31/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has fallen six times within a week.	No
Resident A' teeth were not brushed for a two-week period.	No
Resident A was given medications that are not his.	No
A mouse was seen in the kitchen.	No
Additional Findings	Yes

III. METHODOLOGY

11/23/2022	Special Investigation Intake 2023A0357008
11/28/2022	Special Investigation Initiated - Telephone
01/30/2023	Contact - Telephone call made To Administrator Betsy Nugent.
01/31/2023	Inspection Completed On-site
01/31/2023	Contact - Document Received Received and reviewed Resident A's file with Betsy Nugent, Administrator.
02/01/2023	Contact - Face to Face Interview with Direct Care Staff, Caitlynn Woodward, Bobbie Sedelmaier, and Charity Dominquez.
02/01/2023	Contact - Document Received Reviewed Resident A's medication sheets.
02/06/2023	Contact – Documents emailed from Betsy Nugent Resident A's assessment plan.
02/08/2023	Contact – Telephone call made To Betsy Nugent.
02/08/2023	Contact -Documents received By email from Betsy Nutgen
02/10/2023	Telephone Exit Conference with the Licensee Designee, Connie Clawson.

ALLEGATION: Resident A has fallen six times within a week.

INVESTIGATION: On 11/23/2023 I received an anonymous complaint alleging that Resident A has fallen six times. There were no dates provided.

On 11/27/2022, I telephoned the facility and asked to speak to Betsy Nugent, the Administrator. The staff (name unknown) said since the call came to the phone on the unit it probable meant that Ms. Nugent had left for the day.

On 01/30/2022, I spoke by telephone with Ms. Nugent. I explained that we had a complaint related to the care needs of Resident A. She explained that Resident A contracted COVID-19 on 12/25/2022, and he went to the hospital around the first of the year. She explained that he will not return to their facility. I explained the documents I would need to review, and she said she would get them around for me.

On 01/31/2023, I conducted an announced inspection at the facility. I met with Betsy Nugent, Administrator. She stated that they document each fall of any resident, on the state form, Incident / Accident Report, (IR's).

On 02/06/2023, Ms. Nugent sent me Incident reports (IRs) pertaining to falls that Resident A had at the facility. The first IR documented that on 11/08/2022, Resident A was found on the floor of his bathroom. There were no visible injuries and the staff turned on his bed alarm. The second IR documented that on 11/10/2022 Resident A fell next to his bed getting up to go to use the bathroom. There were no injuries found. The third IR documented that on 11/16/2022 Resident A fell out of his recliner and there were no injuries noted. The plan was to put his walker right next to his bed. A fourth IR was completed on 11/22/2022 and reported that staff found Resident A on his bedroom floor and there were no injuries noted. This documentation was for four falls from 11/08/202 through 11/22/2022 and there was no additional documentation indicating any other falls for six falls within a one-week period. Ms. Nugent reported that Resident A had a bed alarm and a chair alarm so when he got up the staff would be alerted and would go to him. She said he was unstable at times and that Resident A was usually up all night and he walked freely around the unit. She said staff are not permitted to "hold him down or try to keep him in his bed".

On 01/31/2023, I reviewed Resident A's assessment plan, which was completed by Cathy Seese, Resident Care Manager for second shift. date on the form was 10/19/2022 and her "Finalized date" was recorded as 11/09/2022. The plan did not indicate Resident A had previous falls. The plan stated that he requires physical assistance with grooming and dressing, and he used a walker. The assessment plan did not however mention Resident A's falls and made no mention of a need for any form of enhanced supervision or monitoring. Resident A had been diagnosed with Dementia/Alzheimer's and had great difficulty with speaking and making his needs known.

On 01/31/2023, I conducted interviews with direct care staff, Alyssa Knowlton and Cathy Seese. Both are Resident Care Managers. They both confirmed that Resident A had fallen a few times at the facility because he is “on the go” all the time. Both Ms. Knowlton and Ms. Seese stated Resident A walks all around the facility, especially at night, as a result of having “Sundowners”. They said it is very difficult to keep him still and they cannot physically stop him from getting up and walking.

On 02/01/2023, I conducted interviews with direct care staff Catilynn Woodeward, Bobbie Sedelmaier, and Charrty Dominguez and they all stated that Resident A is “frequently on the move,” walking around. He has a walker, but he does not always remember to use it and staff have to remind him to use it. They also have use of a wheelchair, but he does not seem to like to use it.

On 02/10/2023, I conducted a telephone Exit Conference with the Licensee Designee, Connie Clawson and she agreed with my findings.

R. 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection , and personal care as defined in the act and as specified in the resident’s written assessment plan. I can’t remove the line.
ANALYSIS:	It was alleged that Resident A had six falls within a week. A review of Incident Reports concerning Resident A revealed that he actually had four falls between 11/08/2022 and 11/22/2023. None of these falls reportedly resulted in any injury and medical attention was not sought or required. Resident A’s Assessment Plan did not include any reference to Resident A experiencing frequent falls or requiring any form of enhanced supervision or monitoring. During this investigation there was no evidence found that Resident A had fallen six times within a week.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A’s teeth were not brushed for a two-week period.

INVESTIGATION: On 01/31/2023, I conducted interviews with Alyssa Knowlton and Cathy Seese. Both are Resident Care Managers. Ms. Knowlton is for first sfhift and Ms. sese is for second shift. Both stated that they had brushed Resident A’s teeth each time they cared for him. Both are full time staff. On 02/09/2023 I followed up

with Ms. Seese regarding Resident A's assessment plan and she explained that when she included his need for help with oral care, she meant it to have his teeth brushed two times daily, when he gets up and when he goes to bed. She acknowledged she did not write those times in the plan. She expected staff to know the times because they brush resident's teeth two times daily. She stated that on 2nd shift she brushed his teeth at bedtime.

On 02/01/2023, I conducted interviews with direct care staff Catilynn Woodeward, Bobbie Sedelmaier, and Charity Dominguez. Ms. Woodeard and Ms. Sedelmaier both stated that they when they have cared for Resident A, they brushed his teeth. Ms. Sedelmaier stated that Resident A did not like to have his teeth brushed and he resisted but she was still able to brush his teeth. She acknowledged that on 2nd shrift she brushes his teeth at bedtime between 7:00 and 8:00 PM. Ms. Sedelmaier reported she is a full-time staff. Ms. Dominguez stated that she usually passed the residents' medications and therefore she did not provide personal care for Resident A. When asked when she would brush his teeth, she stated on 2nd shift it would have been at bedtime.. She stated that she works full time. Ms. Woodward stated she works full time on 1st. shift and she indicated she brushed his teeth when she got him up in the morning.

On 02/06/2023, Ms. Nugent sent me Resident A's assessment plan, which I reviewed. The plan read that Resident A requires physical assistance with teeth brushing. The plan also stated that he requires physical assistance with grooming and dressing.

On 02/08/2023, Ms. Nugent sent me sheets that included Resident A's name, the name of the month and the days of the month. She reported they call these sheets "Resident Log Sheets." She sent me Resident's Log sheets for Resident A for the months of October, November and December. Each section contained the staffs' initials for the shift they worked and their initials indicated they had completed Resident A's care needs including mouth care. All the sections contained staff's initials for each day of each month. This demonstrated that direct care staff had provided personal care including brushing his teeth two times per day for three months.

On 02/10/2023, I conducted a telephone Exit Conference with the Licensee Designee, Connie Clawson and she agreed with my findings.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	It was alleged that Resident A did not have his teeth brushed for a two week period. Resident A's assessment plan documents that he requires assistance with teeth brushing. Alyssa Knowlton and Cathy Seese both stated they have brushed Resident A's teeth. Direct care staff Catilynn Woodeward and Bobbie Sedelmaier, both stated they brushed Resident A's teeth when they worked. On 02/08/2023, Ms. Nugent sent me Resident A's sheets for October, November and December. Each section of the sheets had staffs' initials recorded for the three months. This was evidence that staff had provided personal care including teeth brushing. Evidence was not discovered through this investigation to support the allegation that Resident A's teeth were not brushed twice daily for a two-week period.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: **Resident A was given medications that are not his.**

INVESTIGATION: On 01/30/2023, I was at the facility, and I spoke with Betsy Nugent, Administrator. She stated that no one has ever alleged that Resident A had received any medications other than his own. She stated that Resident A was only on one medication and originally it was once a day and then it changed to every other day, (no date provided.) She reported that it was his prescribed water pill and he received it in the AM.

On 01/31/2023, I conducted interviews with Resident Care Managers Alyssa Knowlton and Cathy Seese. Both reported they administer resident medications. They also stated that they never gave Resident A any medications other than what was prescribed to him, and they never saw anyone else administer any medications to Resident A that were not his.

On 02/01/2023, I interviewed direct care staff Charrty Dominguez. Ms. Dominguez stated she has passed Resident A's medication. She said she never gave him any other resident's medications.

On 02/01/2023, Ms. Nugent provided me with Resident A's Medication Record's from his admission of 10/18/2022 through his discharge on 01/02/2023. She

explained that the residents' medications come from Hometown Pharmacy LTC in Rockford and that they have electronic medications for staff to administer residents' medications. She reported the they can pull up their own Medication Administration Records, MAR's. I reviewed Resident A's MAR's for the months Resident A resided in the facility and each MAR included only one medication. In addition, this was the only medication that has been documented by staff as being administered to Resident A since his admission.

On 02/01/2023, I reviewed Resident A's "Progress Notes." The first note is dated 10/18/2022 which read: "*Res got here 3pm. 1 person assist, he walks with a walker. His daughter will be gives his shower and will do his laundry*." I reviewed Resident A's October 2022, MAR which had the medication "Metolazone 2.5mg., Take one tablet by mouth once daily." I reviewed Resident A's MAR's for November 2022, December 2022 and January 2023. The same medication was on all of the MAR's.

On 02/10/23, I conducted a telephone Exit Conference with the Licensee Designee, Connie Clawson and she agreed with my findings.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	It was alleged that Resident A was given medications that are not his. Ms. Nugent stated that Resident A only received one medication, described as a water pill, while he was a resident of the facility and this was the only medication he received. Resident A's October, November, December 2022 and January of 2023 MARs only list Metolazone 2.5mg., which was the ony medication documented as administered. Resident Care Managers Alyssa Knowlton and Cathy Seese both denied administering any other medications to Resident A other than his one prescribed pill. Direct care staff Charity

	Dominguez also denied administrating any medications to Resident A other than his prescribed medication. During this investigation there was no evidence found that Resident A received any medications other than what was prescribed for him.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: A mouse was seen in the kitchen.

INVESTIGATION: On 01/31/2023, I met with Ms. Nugent, and she explained that they have a contract with Griffin Pest Control Company, and they come to the facility two times a month and check the facility for any pests. She stated at no time has the staff of Griffin reported seeing a mouse in the facility. She also stated that she has never personally seen a mouse and she has asked the kitchen staff as well as other staff and no one has reported seeing a mouse in the facility.

On 01/31/2023, I conducted interviews with direct care staff Alyssa Knowlton and Cathy Seese. Both stated that they have never seen a mouse in the facility and to their knowledge, no other staff had reported seeing a mouse.

On 02/01/2023, I conducted interviews with direct care staff Catilynn Woodeward, Bobbie Sedelmaier and Charity Dominguez. All three stated that they have never seen a mouse in the facility.

On 02/10/2023 I conducted an exit conference with the Licensee Designee, Connie Clawson and she agreed with my findings.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	It was alleged that a mouse seen in the kitchen. Ms. Nugent reported that they have a contract with Griffin Pest Control, and they come twice a month to inspect. They have never reported finding a mouse in the facility. Resident Care Manager, Alyssa Knowlton and Cathy Seese both stated that they have never seen a mouse in the facility and no other staff had reported seeing a mouse.

	Direct care staff Catilynn Woodeward, Bobbie Sedelmaier and Charity Dominguez all stated that they have never seen a mouse in the facility. During this investigation there was no evidence found that there has been a mouse seen in the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: On 01/31/2023, I interviewed Ms. Nugent at the facility. I asked her about Resident A's medications. She explained that all the residents of the facility eventually had COVID. She explained the staff administered a COVID-19 test to Resident A on 12/25/2022 and he tested positive. She stated that their physician, Dr. Amelia Albachten, had prescribed medications for Resident A to treat the COVID. Ms. Nugent provided documentation. This included: "*Careline Physician Services, Diagnoses: Weakness and COVID-19. Services Ordered: molnupiravir 200mg capsules. Instructions: Take 4 capsules by mouth every 12 hours for 5 days."* Ms. Nugent provided a document of "*New Rx, Electronically Transmitted Prescription, Prescriber: Amelia Albachten and Electronically Signed, Date written 12/27/2022, Effective Date: 12/27/12:00 AM.* Ms. Nugent acknowledged that this new medication was not recorded on Resident A's MAR's for December 2022 and for January 2023. Therefore, the medication was not administered as prescribed.

On 01/31/2023, Ms. Alyssa Knowton, stated that she was aware that their physician, Dr. Albachten had prescribed a medication for Resident A to treat his COVID-19. She thought the medication came to the facility from Hometown Pharmacy LTC on 12/27/2022. She was not certain of the arrival time of the medication. She acknowledged that the medication was not on Resident A's MAR for December 2022 or January 2023.

On 02/01/2023, Ms. Nugent provided me with Resident A's Medication Administration Records from his admission of 10/18/2022 through his discharge on 01/02/2023. She explained that the residents' medications came from Hometown Pharmacy LTC in Rockford and that they have electronic medications for staff to administer resident's medications. She reported the pharmacy provides their Medication Administration Records, MAR's. She also provided me with Resident A's progress notes.

On 02/01/2023, I reviewed Resident A's "Progress Notes." The first note is dated 10/18/2022 read: "*Res got here 3pm. 1 person assist, he walks with a walker. His daughter will be gives his shower and will do his laundry*." I reviewed Resident A's, October 2022, MAR. Medication "*Metolazone 2.5mg. Take one tablet by mouth once daily."* There were no staff's initials found on 10/19/2022 when he should have been administered his Metolazone 2.5mg at 8:00AM. There were no staff's initials for administration on 10/27/2022, 10/28/2022 or on 10/31/2022 for his prescribed

medication of Metolazone. There was no explanation on the MAR as to why it was not documented that he received his prescribed medication on these days.

On 02/01/2022, I reviewed Resident A's MAR for November 2022. The order remained the same for Metolzone 2.5m. Take by mouth once daily. According to Resident A's MAR this medication was administered every other day during the month of November 2022. The order on the MAR had not changed. Therefore, he received the medication every other day instead of as the order read on the MAR, as every day. On 11/11/2022 the entry listed was "Other," which meant Resident A did not receive his prescribed medication for that day.

On 02/01/2022, I reviewed Resident A's MAR for December 2022. The same order remained on Resident A's MAR, Metolazone 2.5mg to be administered daily (oral) by mouth. Again, the MAR demonstrated that the staff's initials were on every other day on Resident A's MAR, instead of administering it daily as the order read on the MAR. In addition, on 12/01/2022 the note for the medication was "Ref" and the following was documented on the MAR, "Refused by Resident." On 12/23/2022, and 12/25/2022, the notation was "Other." There was no further explanation as to why Resident A did not receive his prescribed medications on these days. On 12/31/2022, the note was "Refused by Resident."

On 02/01/2022, I reviewed Resident A's MAR for January 2023. The same order was written, *Metolazone 2.5mg. Take one tablet by mouth daily*. There were no staff's initials for any administration of any medications. According to the January MAR, Resident A would have received his medication on 01/01/2023 and 01/02/2023, as prescribed, for the orders to be administered at 8:00AM daily Ms. Nugent reported that Resident A was taken by ambulance to the hospital on 01/02/2023, in the afternoon.

On 02/08/2023, I called Hometown Pharmacy LTC and spoke with Jason Hendges, Pharmacy Manager. He reported that they had not provided any medication to the facility for Resident A. He said they received their first prescription for Resident A on 12/27/2022. He reported they delivered the medication to the facility that same day. He reported the medication was Metolazone/Lagevrio 200 mg for 4 capsules orally for two times daily. He stated Resident A's medication was delivered to the facility on 12/27/2022, but he was unable to provide the time of the delivery to the facility. He reported that the medication was to treat Resident A for COVID-19.

On 02/08/2023, I learned that Resident A had been prescribed the medication Metolazone/Lagevrio 200 mg for 4 capsules orally for two times daily on 12/27/202. This prescribed medication was not on Resident A's MAR for December 2022 or on January's 2023 MAR. Therefore, Resident A had not received his prescribed medication of two doses on 12/27,28, 29, 30, 31/2022. Nor had he received the medication on 01/01/2023. He would have received the full five days with the prescribed doses by 01/01/2023 depending on the start of the administration on 12/27/2022. Other wise it would have been completed on 12/31/2022.

On 02/10/2023, I conducted a telephone Exit Conference with the Licensee Designee, Connie Clawson and she agreed with my findings.

APPLICABLE RULE	
R. 400.15312	**Resident medications.**
	(2) Medications shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Ms. Nugent reported that resident's medications came from Hometown Pharmacy LTC and that through the computers Resident A's MAR sheets were produced and provided. Jason Hendges, Pharmacy Manager from Hometown Pharmacy reported that they did not provide Resident A's MAR's because they had not received any prescriptions for Resident A until 12/27/2022. On this date they received a prescription for the medication Metolazone/Lagevrio 200 mg for 4 capsules orally for two times daily, every 12 hours for five days. He stated it was delivered to the facility on 12/27/2022. Resident A's MAR for December and January did not include the medication Metolazone/Lageviro. Both Ms. Nugent and Ms. Knowton acknowledged that Resident A did not receive his prescribed medications for the full five days because it was not on the MAR's. According to Resident A's Progress note on 10/18/2022, he was admitted to the facility at 3:00 PM. His October MAR 2022 contained a written order for the medication, "*Metolazone 2.5mg. Take one tablet by mouth once daily."* There were no staff initials found on 10/19/2022 when he should have been administered his Metolazone 2.5mg at 8:00AM. There were also no staff initials for administration on 10/27/2022, 10/28/2022, or on 10/31/2022 for his prescribed medication of Metolazone. Resident A's MAR's for November, December and January all contained the same order for Metolazone 2.5 mg once daily. The MAR's demonstrated that the same medication was administered every other day. There was no change on the scheduled medication for administration to every other day on the MAR. Resident A's MAR for December indicated that Resident A refused his medication on 12/01/2022 and on 12/31/2022. On 12/23/202 and on 12/25/2022 the note "other" was indicated. On Resident A's MAR for January there was no

	entries for any administration of Metolazone 2.5mg on 01/01/2023 or 01/02/2023 at 8:00 AM. Upon investigation there was evidence that Resident A's prescribed Metolazone 2.5mg once daily at 8:00 am was administered every other day in November and December 2022. Other dates were entered as "other" or "refused." On 12/27/2022 Resident A's physician, Amelia Allbachten had prescribed Molnupiravir/Lageviro 200mg capsules. Ms. Nugent acknowledged that this new medication was not put on Resident A's MAR for December or January's MAR and therefore the staff did not administer the medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: On 02/08/2023, I spoke by telephone with Ms. Nugent. I explained that on Resident A's MAR for December 2022, there were two refusals by Resident A of Metolazone 2.5mgm once daily at 8:00 AM. These refusals were dated 12/01/202 and on 12/31/2022. I explained that I could not find on the MAR that they had called an appropriate health care professional and recorded the instructions. I asked her if her staff had telephoned an appropriate health care professional when Resident A or any other resident had refused a medication. She stated that she was not aware of a rule requiring them to call an appropriate health care professional upon any refusals. She stated that they were trained to offer it to Resident A or any resident several times and if they still refused, they would record it as a 'Refusal.' She acknowledged that their staff had not been calling anyone if a resident refused any of their prescribed medications because they were not trained about the rule.

On 02/10/2023, I conducted a telephone Exit Conference with the Licensee Designee, Connie Clawson and she agreed with my findings.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medications or procedures and follow and record the instructions given.
ANALYSIS:	Upon review of Resident A's MAR for 12/2022, it was noted that Resident A had refused his prescribed Metolazone 2.5mg daily at 8:00 AM on 12/01/2022 and on 12/31/2022. Ms. Nugent reported she was unaware of the rule, and they had not been trained to contact an appropriate health care

	professions if a resident had refused their prescribed medications. Evidence found that the staff did not call an appropriate health care professional when Resident A refused his prescribed medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: On 01/31/2023, I requested to review Resident A's Incident/Accident Reports.

On 02/01/2023, Ms. Nugent provided me with Resident A's "Progress Notes," dated 10/18/2022 through 12/03/2023, which I reviewed.

On 02/06/2023, Ms. Nugent sent Resident A's five Incident/Accident (IR's) to me by email, which I reviewed:

Incident/Accident Reported:
On 11/08/2022, at 1:00 AM. Staff wrote the following: *'I was doing my rounds and I checked on (Resident A). I found him in his bathroom on the floor. No visible injuries. (Resident A) stated he was ok. No bruises/No marks on him from the fall.'* Under the section of action taken by Staff/Treatment the following was written: *'Jocelynn May and Charity got (Resident A) off the floor and cleaned him up/dressed and back into bed. Checked for visible injuries and none were noted.'* Under the section of the report, Corrective measures Taken to Remedy or Prevent Recurrence the following was written: *'N/A turned on resident's bed alarm.'* This report was written and signed by staff Jocelynn May on 11/08/2022 and signed by Betsy Nugent on the same day. I reviewed Resident A's 'Progress Notes.' An entry on 11/08 at 6am read as follows: *'(Resident A) fell @ 1:00 AM. We found him in the bathroom naked /and on the floor. He had fell in his own urine.'* This information was not included in the IR.

On 02/08/2023, I telephoned Ms. Nugent and asked her about the corrective measures taken after his incident. She reported that they had put an alarm on Resident A's bed and his chair and this would alert staff that Resident A is on the move. She acknowledged that this was not the corrective measures to prevent Resident A from falling again. She thought that the staff were turning on the bed alarm when Resident A went to bed which if it was on, she expected staff would be alerted and would go to check on him immediately.

Incident/Accident Report:
On 11/10/2022, no time noted, and the following was written: *'(Resident A) fell when getting up to use the restroom. Staff found him on the floor next to his bed. (Resident A) said he was not hurt.'* Action taken by staff: *'Vitals were taken and recorded. Skin assessment done.'* Corrective Measures taken: *'Monitor resident for safety.'*

This document was signed by Jocelynn May on 11/10/2022 and by Betsy Nugent on 11/11/2022. I reviewed Resident A's Progress Notes and they read on; *'11/11/22, Res fell @ 11PM. Incident report done. No injuries. There were 2 scratches on leg/back.'* On 11/12/2022, the Progress notes at 9p, for Resident A read, *'When Rcg was due ADl's he notice two skin tears on back of L (left) hand.'*

Incident/Accident Report:
11/12/2022 at 8:30pm. The following was written: *'Observed skin tear on L (Left) hand.'* Action taken by staff: '*Cleaned wounds. Put triple antibiotic on them.'* Corrective measures section was left blank. This was signed by Bobbi Sedelmaier on 11/12/2022 and by Ms. Nugent on 11/14/2022. *'Daughter was notified*.' Progress Notes for Resident A read: *'11/13/22 6am. Rebandaged res L hand, Hand was bleeding through old bandages.'*

Incident/Accident Report:
On 11/16/2022, at 4:11 AM. *'(Resident A) had fallen out of his recliner. When doing rounds, I found (Resident A) on the ground. Vitals were taken and skin assessment. No new injuries. (Resident A) started they did not get hurt.'* Action taken by staff: *'I got Resident Safely back in bed and made sure his walker was by him.'* Corrective measures read: *'N/A.'* This was signed by Jocelynn May on 11/16/22 and by Ms. Nugent on the same date.

Incident/Accident Report:
On 11/22/2022, at 1:09am and it read: *'While doing rounds Charity found (Resident A) on his bedroom floor and he was naked. We assisted him up. Vitals are good. No visible injuries. Back in bed.'* Action taken by staff: *'Bed alarm is still on*.' Corrective measures was left blank. On the side of his IR the following was written with an arrow pointing to the section of the bed alarm still being on. *'If it was on how did it not alert you before he fell? It takes him quite a while to take all of his clothes off. I moved the alarm to the nurse's station. Linda'*

On 02/28/2022, I reviewed the IR's including the corrective measures to prevent falls for Resident A in the future with Ms. Nugent. She acknowledged that they had not written adequate corrective measures that would prevent Resident A from falling.

On 02/10/2023, I conducted a telephone Exit Conference with the Licensee Designee, Connie Clawson and she agreed with my findings.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) (f) The corrective measures that were taken to prevent the accident or incident from happening again.

ANALYSIS:	Upon review of five of Resident A's, Incident/Accident reports it was found that Resident A had fallen on 11/08/22 in the bathroom, two days later on 11/10/22 next to his bed, again on 11/16/22 out of his recliner, and again on 11/22/22 on the bathroom. Ms. Nugent acknowledged that they had not provided adequate solutions to prevent Resident A from falling. During this investigation evidence was found that the Incident/Accident reports had not recorded the required preventive measures taken to prevent Resident A from falling.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that the licensee provide an acceptable plan of correction and the license remain unchanged

Arlene B. Smith 02/13/2023

Arlene B. Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 02/13/2023

Jerry Hendrick Date
Area Manager