GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 23, 2023

Marcia Curtiss
MCAP Fennville Opco LLC
Ste 115
21800 Haggerty Road
Northville, MI 48167

RE: License #: AL030404608
Investigation #: 2023A0581028
Golden Orchards II

Dear Mrs. Curtiss:

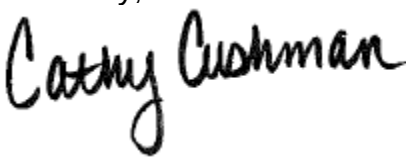
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9730.

Sincerely,



Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL030404608
Investigation #:	2023A0581028
Complaint Receipt Date:	03/28/2023
Investigation Initiation Date:	03/28/2023
Report Due Date:	05/27/2023
Licensee Name:	MCAP Fennville Opco LLC
Licensee Address:	Ste 115 21800 Haggerty Road Northville, MI 48167
Licensee Telephone #:	(269) 561-4663
Administrator:	Natalie Bustillos
Licensee Designee:	Marcia Curtiss
Name of Facility:	Golden Orchards I
Facility Address:	2464 55th Street Fennville, MI 49408
Facility Telephone #:	(269) 561-4663
Original Issuance Date:	01/15/2021
License Status:	REGULAR
Effective Date:	07/15/2021
Expiration Date:	07/14/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff did not seek medical attention upon a change in Resident A's health status.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/28/2023	Special Investigation Intake 2023A0581028
03/28/2023	Special Investigation Initiated - Letter Requested death certificate from Ottawa Co. Clerk's office
03/29/2023	APS Referral APS will not investigate a deceased resident; therefore, no referral is necessary.
03/29/2023	Contact - Document Sent Email to licensee designee requesting resident documentation.
03/31/2023	Contact - Document Received Resident A's AFC documentation received.
04/04/2023	Inspection Completed On-site Interviewed direct care staff and obtained documentation.
04/04/2023	Contact - Telephone call made Left voicemail with Complainant.
04/04/2023	Contact - Telephone call received Interview with Complainant.
04/04/2023	Contact - Telephone call made Voicemail left with Guardian A1.
04/04/2023	Contact - Telephone call received Interview with Guardian A1
04/04/2023	Contact – Document Received Email from Guardian A1.
04/05/2023	Contact - Telephone call made Interview with direct care staff, Moses Gonzalez.

04/05/2023	Contact - Telephone call made Voicemail left with direct care staff, Abbigail Cripps.
04/05/2023	Contact - Telephone call made Allegan Co. Central Dispatch
04/05/2023	Contact - Document Sent Email to licensee designee, Marcia Cross, requesting additional information.
04/05/2023	Contact - Telephone call made Contacted ambulance company, American Medical Response (AMR), requested ambulance records.
04/05/2023	Contact - Document Sent Requested additional information from licensee designee via email.
04/06/2023	Contact - Telephone call received Interview with AMR ambulance personnel, Kyle Schumacher
04/06/2023	Contact - Document Received Received documentation from licensee designee via email.
04/17/2023	Contact - Telephone call made Contacted AMR again to request ambulance records.
04/18/2023	Contact - Document Sent Requested ambulance records.
05/05/2023	Contact - Telephone call received Requested AMR ambulance records.
05/12/2023	Contact - Telephone call made Interview with direct care staff, Abbigail Cripps.
05/12/2023	Contact - Telephone call made Interview with direct care staff, Ellie Garcia Morales
05/12/2023	Contact - Document Sent Email to licensee designee, Marcia Curtiss.
05/12/2023	Contact - Telephone call made Left voicemail with direct care staff, Roseanne Chatterson.

05/13/2023	Contact - Telephone call received Received voicemail from Ms. Chatterson.
05/15/2023	Contact - Telephone call made Interview with Ms. Chatterson.
05/15/2023	Contact – Document Sent Email to Administrator, Ms. Bustillos.
05/16/2023	Exit conference with licensee designee, Marcia Curtiss, via telephone.

ALLEGATION:

Direct care staff did not seek medical attention upon a change in Resident A's health status.

INVESTIGATION:

On 03/28/2023, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on or around 07/26/2022, Resident A was taken to the hospital because he "wasn't acting normal" per facility direct care staff. The complaint alleged Resident A finished breakfast, was joking with staff, and then "seemed to be in a stare not responding"; however, his vitals were reported as normal. The complaint further alleged when Resident A was admitted to the hospital, he arrived with a fever, vitals were unstable, and he was unresponsive.

The complaint alleged Resident A had a diagnosis of sepsis from infection and alleged he could have been sick from infection for hours before facility direct care staff requested assistance. The complaint alleged Resident A's change in condition should have been identified prior to 07/26/2022 so he would not have passed away from hypoxic respiratory failure and aspiration pneumonitis.

On 03/29/2023, I received Resident A's death certificate from Ottawa County Clerk's office. According to the death certificate, Resident A was pronounced dead on 07/26/2022 at approximately 9:47 pm. His manner of death was determined to be "natural" due to "hypoxic respiratory failure" and "aspiration pneumonitis." The death certificate stated other significant conditions contributing to Resident A's death but not resulting in the underlying cause were "shock, acute kidney injury, uremia." The death certificate indicated the approximate interval between onset and death for the hypoxic respiratory and aspiration pneumonitis was 4 and 6 hours, respectively.

On 03/29/2023, I sent email correspondence to the facility's licensee designee, Marcia Curtiss, requesting the *AFC Licensing Accident / Incident Report* (IR) when Resident A was sent to the Emergency Room (ER) on or around 07/26/2022. I also requested any other IRs relating to him for July 2022, his last *Assessment Plan for AFC Residents* (assessment plan) and/or other additional care plans completed by the licensee, last *Health Care Appraisal* (HCA), *Resident Care Agreement* (RCA), and any notes completed by direct care staff for July 2022

On 03/31/2023, Ms. Curtiss emailed me eight IRs for Resident A, dated 07/08, 07/09, two for 07/16, two for 07/17, 07/21, and 07/26, his assessment plan, dated 06/28/2022, HCA, dated 06/28/2022, Activities of Daily Living (ADL) log for June and July 2022, and RCA, dated 06/28/2022. She also provided me with medical discharge paperwork, dated 07/06/2022, 07/17/2022, and 07/18/2022, and a typed and signed statement from the facility's Administrator, Natalie Bustillos, dated 07/18/2022.

The IR's indicated the following:

- On 07/08/2022, at approximately 5 pm, direct care staff, Roseann Chatterson, indicated Resident A was found outside sitting on the ground stating he was looking for his Power of Attorney (POA). Ms. Chatterson indicated in the IR she asked if Resident A was hurt, which he replied he had just put sunscreen on. The IR stated Resident A's vitals were taken and he was looked over and brought back into the facility. The IR identified corrective measures to be taken were "15 min checks" and a message was left with Resident A's legal guardian due to Guardian A1 not answering.

- On 07/09/2022, at approximately 6:05 pm, direct care staff, Kathryn Tregoning, stated she heard a door alarm going off by the facility's time clock. She wrote in the IR when she got to the door alarm, she observed Resident A "standing in the doorway with the door open." She wrote she was able to successfully redirect Resident A back to his room without incident. She indicated Resident A did not obtain any injuries.

- On 07/16/2022, at approximately 2:30 pm, direct care staff, Abbigail Cripps, wrote in the IR Resident A was "walking to bathroom in hallway and fell. Both knees scrapped, and forhead[*sic*]." The IR indicated she helped Resident A to a chair, checked vitals, and called his family. No additional information was included in the IR other than the corrective measures taken to remedy and/or prevent recurrence was to "assist the daily needs of the resident."

- On 07/16/2022, at approximately 10:26 pm, direct care staff, Roseann Chatterson, wrote Resident A "came out of his room, to go looking for his room. Lost his balance and fell." The IR indicated Resident A was assessed for injuries, vitals were taken, and Resident A was taken back to his room.

The IR indicated Ms. Chatterson completed 15 minute “watches” on Resident A to prevent recurrence.

- On 07/17/2022, at approximately 1:30 pm, direct care staff, Abbigail Cripps, wrote Resident A was “walking to closet, fell while trying to get hangers. No known injuries.” She wrote she “helped [Resident A] to chair. Checked vitals. Called his Doctor, and family”. No additional information was included in the IR other than the corrective measures taken to remedy and/or prevent recurrence was to “assist the daily needs of the resident.”

- On 07/17/2022, at approximately 1:35 pm, direct care staff, Abbigail Cripps, wrote Resident A was “trying to move from in front of door so we could get in his room to assist him. He fell on to floor again. No known injuries.” It was also written in the IR Ms. Cripps told Resident A to “roll instead of trying to stand. When we got into his room we helped him to the chair, checked for injuries – none – checked vitals.” Additionally, no additional information was included in the IR other than the corrective measures taken to remedy and/or prevent recurrence was to “assist the daily needs of the resident.”

- On 07/21/2022, at approximately 6:15 am, direct care staff, Moses Gonzalez, wrote in an IR “while getting residents dressed breakfast and bringing them to the dining room [Resident A] was on the floor. We didn’t here[*sic*] a fall. Unwitnessed fall.” The IR indicated Resident A was looked over and no injuries were observed.

- On 07/26/2022, at approximately 1 pm, direct care staff Jessica Wells stated Resident A “woke to have blood in his mouth, very pale and shaking not responding to questions only making noises / moaning”. The IR indicated direct care staff attempted to take Resident A’s vitals but were unable to. The IR indicated Resident A’s Power of Attorney (POA) was called who told direct care staff to send Resident A to the hospital. The IR stated 911 was called and Resident A was transported to the local hospital and admitted to the Intensive Care Unit (ICU). The IR stated that “per POA, resident passed away last night at the hospital.”

It should be noted the facility, Golden Orchards II, is the facility in which this special investigation originated; however, the facility is attached to another licensed AFC, which is separated by fire doors. The attached licensed AFC is where Resident A was originally admitted to and the facility in which his AFC paperwork (e.g., RCA, assessment plan) references. Despite Resident A being admitted to Golden Orchards II, an entirely new facility, the licensee did not complete a new assessment plan. Therefore, the only assessment plan I was able to review was for his original admittance in the attached facility.

According to this assessment plan, Resident A required assistance from direct care staff with his activities of daily living like eating/feeding, toileting, bathing, dressing,

and personal hygiene. The assessment plan indicated Resident A required the use of one direct care staff to assist him with bathing, dressing and personal hygiene. The assessment plan identified Resident A as not requiring assistance with walking or mobility, being alert to his surroundings, but being unable to communicate his needs.

Resident A's HCA identified Resident A as "fully ambulatory." The HCA identified Resident A's diagnoses as "Hypertriglyceridemia, Depression with anxiety, Essential hypertension, Proteinuria unspecified, Type 2 diabetes mellitus with diabetic chronic kidney disease, Diabetes mellitus with renal complications, diabetic peripheral neuropathy, Alzheimer's disease with early onset, Dementia in other diseases classified elsewhere without behavioral disturbance, Hypertension renal disease stage 1-4 or unspecified chronic kidney disease, Familial hyperlipidemia, Stage 3a chronic kidney disease".

Resident A's ADL logs, which included the percentage of food accepted and/or eaten by him, included the following information:

- 07/08
    - Breakfast – 100%
    - Lunch – 100%
    - Dinner – 75%
- 07/09
    - Breakfast – 100%
    - Lunch – 100%
    - Dinner – 100%
- 07/10
    - Breakfast – 100%
    - Lunch – 100%
    - Dinner – 100%
- 07/11
    - Breakfast – 100%
    - Lunch – Resident refused
    - Dinner – 100%
- 07/12
    - Breakfast – 100%
    - Lunch – 100%
    - Dinner – 100%
- 07/13
    - Breakfast – 100%
    - Lunch – 100%
    - Dinner – 100%
- 07/14
    - Breakfast – 100%
    - Lunch – 100%
    - Dinner – 100%

- 07/15
  - Breakfast – 100%
  - Lunch – 100%
  - Dinner – 25%
- 07/16
  - Breakfast – 100%
  - Lunch – 100%
  - Dinner – 100%
- 07/17
  - Breakfast – 100%
  - Lunch – 100%
  - Dinner – 100%
- 07/18
  - Breakfast – Resident refused
  - Lunch – Resident refused
  - Dinner – Resident was out of facility
- 07/19
  - Breakfast – 100%
  - Lunch – Resident refused
  - Dinner – 100%
- 07/20
  - Breakfast – 100%
  - Lunch – 100%
  - Dinner – 100%
- 07/21
  - Breakfast – 50%
  - Lunch – 25%
  - Dinner – 50%
- 07/22
  - Breakfast – 50%
  - Lunch – 0%
  - Dinner – 25%
- 07/23
  - Breakfast – 0%
  - Lunch – 50%
  - Dinner – Resident refused
- 07/24
  - Breakfast – Resident refused
  - Lunch – Resident refused
  - Dinner – Resident refused
- 07/25
  - Breakfast – Resident refused
  - Lunch – 25%
  - Dinner – Resident refused
- 07/26
  - Breakfast – Resident refused

- Lunch – Resident refused

Documentation from the licensee designee, Ms. Curtiss, indicated direct care staff, Jessica Wells, who is also identified as the facility's "Clinical Manager", contacted Resident A's physician on 07/11/2023 to report Resident A's increased confusion and exit seeking behavior. Ms. Wells reported to Resident A's physician he was moved to the licensee's "memory care" facility. The note indicated Resident A's guardian would be contacting the physician that week to request an evaluation for Resident A's "change in mentation." The documentation indicated Resident A's physician ordered Resident A to start taking the medication Seroquel, tablet 25 mg, with the instruction of take "1 tablet at bedtime, once a day."

My review of Ms. Bustillos' typed statement indicated she requested Resident A be moved "due to cognitive and elopement concerns." The statement identified the IR incidences from 07/16 and 07/17, as well as other issues such as exit seeking behavior, elevated blood pressure, unsteady gait, and confusion. The statement indicated an "on call doctor" requested Resident A to go to the hospital after Resident A experienced two falls on 07/17; however, Ms. Bustillos statement indicated Resident A's POA stated to "just watch him closely" rather than send him to the hospital. The statement indicated after Resident A fell the third time the on-call doctor instructed for the facility staff to send Resident A to the hospital. Ms. Bustillos' statement indicated Resident A was sent back to the facility after four hours with no changes. Ms. Bustillos' statement reiterated Resident A was appropriate for the facility's Memory Care Unit, but she requested a medication adjustment to help Resident A with his falls, anxiety, and confusion.

I also reviewed Resident A's after visit summary from a medical appointment with his physician on 07/18/2023, which instructed Resident A to stop taking Melatonin, 10 mg at bedtime, to increase Seroquel to 50 mg at bedtime, to continue taking Hydroxyzine HCL 25 mg every 8 hours as needed, and to continue taking Memantine 10 mg twice daily. The after-visit summary indicated Resident A's falls were addressed in the appointment as a "Fall Risk – Assessment" was noted as being completed; however, the documentation indicated no falls had been reported in the past year. The documentation indicated Resident A did not have another appointment scheduled with his physician until October 2023.

On 04/04/2023, I conducted an unannounced inspection at the facility. I interviewed administrator Natalie Bustillos. Ms. Bustillos confirmed Resident A was initially admitted to Golden Orchards I, which Ms. Bustillos identified as the "assisted living side". Ms. Bustillos stated Resident A's guardian, Guardian A1 indicated to her upon Resident A's admission that Resident A was independent; however, she stated Resident A didn't acclimate to the facility as he continued to be "very confused." She stated he would go into other resident bedrooms, didn't know where he was, and would forget he had a bird, which was with him in the facility. She stated he was also falling, exit seeking, talking about the past and making "off the wall" comments. Ms. Bustillos stated she had a conversation with Guardian A1 about needing to

place Resident A in the memory care facility or Resident A would need to leave as he was not a good fit for the facility. Ms. Bustillos stated Guardian A1 was in agreement with Resident A moving to the new facility.

Ms. Bustillos stated Resident A was seen by his primary care physician the week prior to him passing away. She stated she had made the appointment since she was concerned about his behaviors; however, she stated the physician stated Resident A's behavior was "normal" and only increased his Seroquel medication. Ms. Bustillos stated she and facility direct care staff were in contact with Resident A's physician "almost every day" about his behaviors and their concerns; however, she didn't have documentation to support this statement.

Ms. Bustillos confirmed Resident A did not eat or refused to eat the last several days prior to him being sent to the ER. I requested any physician contacts made by direct care staff from 07/23 – 07/26 regarding Resident A refusing to eat or not eating; however, Ms. Bustillos stated there was no documentation of any physician contacts. Ms. Bustillos stated the day prior to Resident A being sent to the ER she attempted to get him to eat breakfast and lunch; however, she indicated he had said "no" when prompted to eat or drink. She stated he hadn't been talking much either. She stated the day prior to him being sent out he was breathing fine, everything seemed normal although he seemed more tired or "blah." She stated she was able to get Resident A to drink cranberry juice the night before he went to the ER. She stated he "burped", which she attributed to drinking too fast. She stated there was no indication he had choked on the juice.

I interviewed the facility's Clinical Manager, Jessica Wells. Ms. Wells stated on the day Resident A was sent to the ER, she came into the facility at approximately 7:30-7:45 am. Ms. Wells stated she did not recall seeing Resident A that morning. She stated she went into see him after lunch. She stated he was lying in bed, unresponsive. She stated his eyes were "fluttering" and he couldn't keep them opened. She stated it appeared he was struggling to breathe as well. She stated she and staff observed "blood on his lips and between his gums and teeth." Ms. Wells stated she attempted to have Resident A talk to Guardian A1; however, he would not respond to Guardian A1 either so Guardian A1 requested Resident A be sent to the ER. She stated only approximately 20 minutes lapsed from the time she observed Resident A in an unresponsive state to when the ambulance arrived at the facility.

Ms. Wells stated direct care staff had been trying to feed him that morning and for lunch; however, he did not want anything. She stated she was not aware of staff putting food or drink in Resident A's mouth, which could have caused him to choke or have difficulty breathing. She stated direct care staff tried getting Resident A to drink by placing a cup with a straw near his mouth, but he would not take it.

I also interviewed direct care staff, Veronica Mars. Ms. Mars confirmed working on 07/26/2022. She said that while she was working in the facility's kitchen that day she also likes to visit with residents, including Resident A. Ms. Mars stated Resident A

did not eat breakfast that morning and indicated it was abnormal behavior for him. She stated when she checked on him around lunch she determined he was not doing well. She stated he was not breathing well as his breathing had increased and he also had dried blood in his mouth. He stated he was also “very pale.” She stated he could not speak, but he had grabbed at her hand. Ms. Mars stated she then contacted another direct care staff and Ms. Wells for assistance.

Ms. Mars stated she worked the evening of 07/25/2022 and indicated Resident A had eaten dinner. She stated he seemed “fine and normal.”

I interviewed direct care staff, Hailey Maccaig, as the facility’s business office manager was able to reach her via telephone. Ms. Maccaig’s statement to me about finding Resident A unresponsive and with blood in his mouth around lunch time was consistent with Ms. Wells’ and Ms. Mars’ statements to me. She stated Resident A was also making “raspy” type noises. Ms. Maccaig also stated an overnight staff informed her Resident A appeared weak during the overnight shift and would not get up. She indicated this type of behavior was abnormal for Resident A as he was usually up, walking around, and would eat most of his food.

On 04/04/2023, I Interviewed Resident A’s guardian, Guardian A1. Guardian A1 stated when Resident A was admitted to the original facility, Golden Orchards I, despite having a dementia diagnosis, Resident A was able to get up without any support, did not have a history of falls, could eat by himself, and did not require much assistance from anyone with his ADLs. Guardian A1 stated that approximately two weeks after Resident A was in the facility, direct care staff were reporting Resident A was not eating much food. Guardian A1 said this was abnormal due to Resident A having a history of a “big appetite.”

Guardian A1 stated he was contacted by facility staff about Resident A being found unresponsive at the facility. He stated he instructed them to contact an ambulance. Guardian A1 stated he got to the hospital sometime between 1:30-2 pm. He stated Resident A passed at approximately 6:30 pm.

On 04/04/2023, I received an email from Guardian A1 containing Resident A’s Emergency Documentation while in the ER. According to my review of this documentation, the paramedics reported to the attending physician Resident A experienced “gradual decreasing level of interaction over the past few days”. The report indicated Resident A answered some questions in the morning prior to becoming unresponsive by the afternoon. The report also indicated the attending physician reviewed Resident A’s “medication reconciliation report” which showed he had been refusing medication over the past few days. Additionally, the documentation showed Resident A was hypothermic with an initial temperature of 31.9 degrees Celsius. The documentation further indicated Resident A had “refractory shock”, had “declining respiratory status and was suctioned.” The documentation stated Resident A vomited a “large amount of black-colored vomit.” Consequently, the documentation stated Resident A experienced a “multisystem

organ dysfunction with refractory shock, respiratory failure, renal failure, severe electrolyte abnormalities and acidosis." The documentation indicated when Resident A was transitioned to comfort care he declined rapidly and passed away.

On 04/05/2023, I interviewed direct care staff, Moses Gonzalez, via telephone. Mr. Gonzalez stated he only works the overnight shift at the facility, which is 7 pm until 7 am. Mr. Gonzalez stated he was only aware of Resident A falling "maybe once" while he was working. He stated he did not have any concerns with Resident A not taking his medications or not eating; however, he stated he was not working when dinner or breakfast were served to residents. Mr. Gonzalez was unable to recall the state of Resident A the days prior to him passing away. Consequently, he was unable to recall if Resident A had been eating and drinking regularly; however, he stated Resident A was a "big man." He indicated he was not thin and stated that due to this he believed Resident A was eating regularly. Mr. Moses could not recall much information the night before Resident A passed away. Mr. Moses also could not recall if Resident A was notably tired or weak the nights prior to him passing.

On 04/06/2023, I interviewed American Medical Response (AMR) paramedic, Kyle Schumacher. Mr. Schumacher stated he responded to the call regarding Resident A being found unresponsive. He stated he observed Resident A "pale and with an altered level of consciousness." Mr. Schumacher stated he had been informed by facility staff Resident A had "a decreasing mental status the last few days."

On 04/06/2023, the licensee designee, Mrs. Curtiss, emailed me Resident A's July Medication Administration Record (MAR), which indicated he only refused his morning medications on 07/23/2022 while it was documented he received his medications on 07/24, 07/25, and the morning of 07/26.

On 05/02/2023, I received and reviewed AMR patient care report for Resident A, dated 07/26/2022. According to this report, AMR received a call from the facility at 1:16 pm after finding Resident A "unresponsive" in his bed. When AMR paramedics arrived at the facility, they determined the following:

> "PT LAYING IN BED, SKIN PALE, BREATHING WITH SOME ACCESSORY MUSCLE USE TO ABD, PT AWAKE HOWEVER NOT ANSWERING QUESTIONS AND NOT ACTING HIS NORMAL PER STAFF ON SCENE. PT COMBATIVE AT TIMES, GARBLED SPEECH. PT STAFF ON SCENE THEY HAVE NOTICED PT HAS HAD A DECREASE IN MENTAL STATUS AND INCREASED WEAKNESS OVER THE LAST DAYS. PT HAS HAD NO KNOWN ILLNESS PER STAFF. NO RECENT FALL OR TRAUMA. NO MEDICATION CHANGES. BLOOD GLUCLOSE CHECK BY FD NORMAL."

According to the patient report, Resident A was taken to the hospital by 2:16 pm.

On 05/12/2023, I interviewed direct care staff, Ellie Garcia Morales, via telephone. Ms. Morales stated that while she was not working the day Resident A was sent to the ER, she had worked with him in the days leading up to being sent out. Ms. Morales stated during that time, Resident A stayed in bed and "kind of talked to himself." She stated this behavior was "kind of normal." She stated he also stopped talking to his pet bird. She stated he only ate "like a quarter" of food at each meal the several days prior to his passing, whereas before that he was eating his entire meals. Ms. Morales stated she could not recall if his change in appetite had been brought up to any other facility staff or the Administrator.

On 05/12/2023, I also interviewed direct care staff, Abbigail Cripps. Ms. Cripps stated she has not been employed at the facility since approximately April 2023, but she stated she was working at the facility when Resident A was sent to the ER. Ms. Cripps' statement to me was consistent with Ms. Maccaig's and Ms. Mars' statements to me. She stated when she checked on Resident A the morning prior to him being sent to the ER he stated he wasn't talking and would only "moan". She stated she attributed his moaning to Resident A potentially being in pain from his number of falls the week before.

On 05/15/2023, I interviewed direct care staff, Roseanna Chatterson, via telephone. Ms. Chatterson was unable to recall much information regarding Resident A, including the days leading up to him being sent to the ER. Ms. Chatterson stated she only recalled Resident A being moved to the facility from the neighboring facility because his "health deteriorated."

On 05/15/2023, Mrs. Curtiss emailed me observation notes for Resident A while he was in the facility. There were only two notes created by direct care staff, dated 07/15 and 07/17, which addressed exit seeking behaviors and a PRN being ineffective, respectively.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Based on my investigation, Resident A experienced a change in his physical condition over the course of several days prior to being admitted to the ER on 07/26/2022, but care was not obtained immediately. Despite reports from multiple direct care staff, of Resident A not getting out of bed, refusing to eat and drink and appearing more tired than usual, none of the facility's direct care staff nor the facility's Administrator, contacted Resident A's physician or obtained medical attention for him. Though there were reports contacts had been made with Resident A's physician or medical provider, there was no documentation to confirm such contacts. Subsequently, it was not until direct care staff noticed blood on or around Resident A's lips and mouth was emergency services contacted as facility staff had determined Resident A was unresponsive. Consequently, Resident A passed away while in the hospital due to a multisystem organ dysfunction with refractory shock, respiratory failure, renal failure, severe electrolyte abnormalities and acidosis.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

Resident A was initially admitted to the Golden Orchards I on 07/01/2023. He was then admitted to the attached memory care facility, Golden Orchards II, on 07/12/2023; however, a new *Assessment Plan for AFC Residents* was neither created, completed, nor signed by Resident A or Resident A's designated representative, the responsible agency, if applicable, or the licensee.

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 the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall

	maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Despite Resident A being admitted to a neighboring facility under the licensee, the licensee did not obtain a new *Assessment Plan for AFC Residents* upon admission to Golden Orchards II, which is an entirely different AFC license number.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident A was initially admitted to the Golden Orchards I on 07/01/2023. He was then admitted to the attached memory care facility, Golden Orchards II, on 07/12/2023; however, a new *Resident Care Agreement* was neither created, completed, nor signed by Resident A or Resident A's designated representative, the responsible agency, if applicable, or the licensee.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.** **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee,**

	including health-related information at the time of admission. **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R400.15315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.**
ANALYSIS:	Despite Resident A being admitted to a neighboring facility under the licensee, the licensee failed to obtain a new *Resident Care Agreement* upon admission to Golden Orchards II, which is an entirely different AFC license number.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/16/2023, I conducted an exit conference with the licensee designee, Marcia Curtiss, via telephone. She acknowledged my findings. She stated she would review the report and provide an acceptable plan of correction.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

05/16/2023

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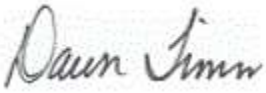
Cathy Cushman Date
Licensing Consultant

Approved By:



05/23/2023

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Dawn N. Timm Date
Area Manager