GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 12, 2023

Carol Del Raso
Grandhaven Living Center LLC
Suite 200
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL330378741
Investigation #: 2023A0466032
Grandhaven Living Center (Harbor)

Dear Ms. Del Raso:

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 #:** | AL330378741 |
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| **Investigation #:** | 2023A0466032 |
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| **Complaint Receipt Date:** | 03/15/2023 |
| | |
| **Investigation Initiation Date:** | 03/20/2023 |
| | |
| **Report Due Date:** | 05/14/2023 |
| | |
| **Licensee Name:** | Grandhaven Living Center LLC |
| | |
| **Licensee Address:** | Suite 200<br>3196 Kraft Avenue SE<br>Grand Rapids, MI 49512 |
| | |
| **Licensee Telephone #:** | (517) 420-3898 |
| | |
| **Administrator:** | Brandy Shumaker |
| | |
| **Licensee Designee:** | Carol Del Raso |
| | |
| **Name of Facility:** | Grandhaven Living Center (Harbor) |
| | |
| **Facility Address:** | 3145 West Mt. Hope<br>Lansing, MI 48911 |
| | |
| **Facility Telephone #:** | (517) 485-5966 |
| | |
| **Original Issuance Date:** | 08/07/2017 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 02/07/2022 |
| | |
| **Expiration Date:** | 02/06/2024 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | AGED |

## II. ALLEGATION:

| | **Violation Established**? |
|---|---|
| On an unknown date, facility staff members failed to follow the instructions of Resident A's nurse practitioner to send Resident A to the hospital to be assessed for hypertension. | Yes |
| Resident B had a change of condition and medical care was not sought immediately. | Yes |
| Resident C's health care needs are not being met by the facility. | No |
| Resident D's personal needs are not being met. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

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| 03/15/2023 | Special Investigation Intake- 2023A0466032. |
| 03/20/2023 | Special Investigation Initiated – Telephone to DCW Celeste Weakly interviewed. |
| 03/20/2023 | Contact - Telephone call made to DCW Meeka Armstrong- message left. |
| 03/20/2023 | Contact - Telephone call made to DCW Arianna Shaw interviewed. |
| 03/20/2023 | APS Referral. |
| 03/21/2023 | Contact - Telephone call received from APS Shonna Simm-Rosa assigned. |
| 03/21/2023 | Inspection Completed On-site. |
| 03/21/2023 | Contact - Telephone call received from APS Steven Marchlewicz. |
| 03/22/2023 | Contact- Document recevied from APS Steven Marchlewicz. |
| 03/23/2023 | Contact - Telephone call received from APS Shonna Simm-Rosa. |
| 05/09/2023 | Contact - Telephone call made to Relative B1 interviewed. |

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| 05/10/2023 | Contact - Telephone call made to Bobbie Huizen, interviewed. |
| 05/10/2023 | Exit Conference with licensee designee Carol Del Raso, message left. |

**ALLEGATION: On an unknown date, facility staff members failed to follow the instructions of Resident A's nurse practitioner to send Resident A to the hospital to be assessed for hypertension.**

**INVESTIGATION:** On 03/15/2023, anonymous Complainant reported that on an unidentified date, Resident A was ordered to be sent to the hospital for high blood pressure. Complainant reported that Resident A's blood pressure was taken by direct care worker (DCW) Meeka Armstrong, who then reported to DCWs Arianna Shaw and Celeste Weakly that Resident A needed to be taken to the hospital. However, according to Complainant, Resident A remained in her room and was not sent to the hospital for hypertension (HTN), per a doctor's order. Because Complainant was anonymous, no additional information or details regarding the allegation could be gathered from Complainant.

On 03/20/2023, I interviewed both DCWs Weakley and Shaw by telephone. DCW Weakly reported that approximately two weeks ago (date unknown), she was directed to take Resident A's vitals because DCW Armstrong could not get the vitals machine to work. DCW Weakly reported wellness director Crystal Smith used the manual cuff to take Resident A's vitals but also wanted Ms. Weakly to double check them, using the vitals machine. DCW Weakly reported Resident A's pulse was strong. According to DCW Weakly, nurse practitioner (NP) Molly Bailey instructed DCW Armstrong to monitor Resident A's blood pressure and to send Resident A to the hospital if her blood pressure was high. DCW Weakly reported Resident A's blood pressure was normal when she tested it both manually and with the vitals machine. Subsequently, there was no need to send Resident A to the hospital.

DCW Shaw stated that on either 3/12/2023 or 3/13/2023, DCW Armstrong asked her if she could get a manual blood pressure on Resident A, as DCW Armstrong could not get the cuff to work. DCW Shaw reported that Resident A's pulse was strong, would fade, and then come back strong again, which was inconsistent with DCW Weakly's statements. DCW Shaw reported taking Resident A's pulse twice and then sending a message to NP Bailey. DCW Shaw reported that "hours" went by before they received a response from NP Bailey, directing them to send Resident A to the hospital. DCW Shaw reported that it was DCW Armstrong's responsibility to send Resident A to the hospital, but she never did. DCW Shaw reported that DCW Armstrong thought NP Bailey was making the arrangements for Resident A to be transported to the hospital, which did not occur. According to DCW Shaw, DCW Armstrong reported not knowing how to send a resident to the hospital, even though she was a seasoned DCW who had done it several times before.

I reviewed Resident A's March 2023 medication administration record (MAR) which documented that full vitals are to be taken for Resident A from 6am to 9am daily.

Documentation on the MAR read:

*"*Reminder - Sanitize equipment before use* Recheck any vital sign outside parameter listed below, if still outside parameter report to PCP: Temperature above 100 degrees F or 2 readings above 99 degrees F in a 24hr period or a reading of 2 degrees above the resident's normal reading. Pulse below 60 or above 100 beats per minute. Respirations below 8 or above 28 per minute. Systolic BP below 90 or above 180. Diastolic BP above 90. Pulse OX below 90%."*

Resident A's *March 2023 MAR* documented that Resident A's Systolic blood pressure (BP) was over 180 on 03/07/2023, 03/08/2023, 03/09/2023. Resident A's Diastolic BP was above 90 on 03/07/2023 and 03/09/2023.

On 05/10/203, I interviewed operations specialist Bobbie Huizen, via telephone, who reported that according to DCW Armstrong, on an unknown date, DCW Shaw informed DCW Armstrong Resident A was ordered by NP Bailey to be sent to the hospital to be assessed for HTN. Operations specialist Huizen reported DCW Armstrong thought DCW Shaw sent Resident A to the hospital and vice versa. According to operations specialist Huizen, the next morning it was discovered Resident A had not been sent to the hospital, per NP Bailey's order. Subsequently, operations specialist Huizen contacted NP Bailey. However, since Resident A was now stable, NP Baily informed her there was no need to send her to the hospital at that time. Operations specialist Huizen reported that as a result of the incident, DCW Armstrong was reeducated on how to send a resident to the hospital. According to operations specialist Huizen, DCW Armstrong was also informed that if she receives an order from a physician to send a resident to the hospital, that it is her responsibility to follow that order. Operations specialist Huizen reported that Resident A was newly admitted into the facility at the time of this incident. Subsequently her baseline vitals had not been established. Ms. Huizen reported that there were no adverse consequences as a result of Resident A not being assessed at the hospital, per NP Baily's order and that Resident A has not had any medical issues since.

| **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** |

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| | **and recommendations shall be recorded in the resident's record.** |
| **ANALYSIS:** | It has been determined Resident A was ordered by NP Bailey to be taken to the hospital to be assess for HTN. It has been established that there was a breakdown in communication when DCW Armstrong thought NP Bailey was making arrangements for Resident A to be admitted to the hospital. Subsequently, DCW Shaw thought DCW Armstrong was making arrangements to send Resident A to the hospital. As a result, Resident A was never transported to the hospital as ordered. Based upon my investigation, there is enough evidence to substantiate the allegation that on an unidentified date, facility staff members failed to follow NP Baily's instructions to send Resident A to the hospital to be assessed for HTN. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION: Resident B had a change of condition and medical care was not sought immediately.**

**INVESTIGATION:** On 03/15/2023, anonymous Complainant also reported Resident B was in her room for a number of unspecified days with broken ribs due to a fall. The written complaint did not indicate who the fall was not reported to. According to the written complaint, Resident B was not sent to the hospital for a medical evaluation following her fall. Complainant reported that following the fall, Resident B was reporting pain and had a decline in condition. However, neither her doctor nor her designated representative, Relative B1, were notified. Because Complainant was anonymous, no additional information or details regarding the allegation could be gathered from Complainant.

During my interview with DCW Weakly on 03/20/2023, she reported that on an unknown date, while working at the facility, she was informed Resident B was in a lot of pain. DCW Weakly reported Relative B1 requested Resident B be administered Tylenol. However, Resident B did not have a prescription for that. DCW Weakly reported that wellness director Crystal Smith gave Relative B1 500mg of Tylenol to administered to Resident B. DCW Weakly reported Relative B1 informed her that Resident B was in pain because she had recently fallen at the facility. DCW Weakly reported that according to Relative B1, Resident B now needed assistance ambulating from the bathroom to the dining room, which was not required before her fall. DCW Weakly reported DCWs checked on Resident B periodically and confirmed she is in a lot of pain and displaying behavior that is not her typical "baseline" behavior. DCW Weakly confirmed Resident B had never needed assistance with ambulation until recently. According to DCW Weakly, while she wasn't sure exactly when Resident B fell, she believed Resident B was in pain for approximately one week before outside medical attention was sought. DCW Weakly reported she felt Resident B should have been sent out to the hospital immediately

following her fall. According to DCW Weakly, the decision to send residents to the hospital is made by the facility's wellness director. According to DCW Weakly, this vacant position is currently being filled by operations specialist Bobbie Huizen, wellness director Crystal Smith and a facility employee named "Helen" (last name unknown).

During my interview with DCW Shaw on 03/20/2023, she reported Resident B fell sometime in the beginning of March 2023. DCW Shaw was unsure if the fall was witnessed but confirmed Resident B was not sent out to the hospital after her fall for a medical assessment. DCW Shaw stated that on an unknown date, DCW Weakly came to Resident B's room to assist her with various activities of daily living that she was previously able to do independently, prior to her fall. According to DCW Shaw, acting wellness director Smith instructed DCWs to administer Tylenol to Resident B for a "couple of days" to see how she felt. DCW Shaw reported that it wasn't until DCW Croom saw the condition Resident B was in that Resident B was sent to the hospital, where she was diagnosed with broken ribs. DCW Shaw reported that Resident B was in pain for "a while" and had verbalized her pain to facility staff members.

On 03/21/2023, I conducted an unannounced investigation with assigned Adult Protective Services Specialist (APS) Shonna Simms-Rosa and together we interviewed Resident B, who was laying in her bed. We observed that Resident B appeared "disoriented", as evidenced by her inability to answer questions and provide information about her fall and the care that she received at the facility. Resident B reported she was not in pain and fell asleep before we left.

APS Specialist Simms-Rosa and I interviewed DCW Takeria Taylor, who reported that Resident B fell a "couple of weeks ago". According to DCW Taylor, she was not sure of the exact date. DCW Taylor stated that when Resident B would move her left arm, she would report being stiff and in pain. DCW Taylor's statements regarding Resident B's pain and condition following her fall was consistent with the statements DCWs Weakly and Shaw provided. DCW Taylor also confirmed that following Resident B's fall, she was administered Tylenol for her pain. DCW Taylor confirmed DCW Croom eventually gave DCWs the directive to send Resident B to the hospital where she was admitted, kept overnight, and diagnosed with broken ribs. DCW Taylor also confirmed Resident B required outside medical attention much sooner than it was provided.

APS Specialist Simms-Rosa and I interviewed licensee designee Carol Del Raso who confirmed that on 02/28/2023, Resident B fell coming out of the bathroom. Licensee designee Del Raso reported that on 03/01/2023, NP Bailey assessed Resident B in the facility and prescribed Tylenol for pain. Licensee designee Del Raso reported that on 3/04/2023, Resident B was sent to the hospital, and diagnosed with broken ribs. During our unannounced investigation, licensee designee Del Raso could not locate an *AFC Licensing Division- Incident/Accident Report* (IR) regarding the details of Resident B's fall on 02/28/2023.

I reviewed Resident B's *March 2023 MAR*. Documentation on the MAR confirmed that on 3/1/2023, NP Bailey prescribed Resident B Acetaminophen (Tylenol) TAB 500 MG, to be administered by mouth three times, daily. Documentation on Resident A's MAR indicated Resident B was not administered any Acetaminophen on 03/01/2023 and began taking the medication on 03/02/2024. Documentation on Resident B's MAR confirmed Resident B was hospitalized on 03/04/2023 and 03/05/2023.

I reviewed a facility document titled *Resident Evaluation* which was completed for Resident B and signed by Relative B1 on 10/26/2021.

Documentation in the "toilet" section of the evaluation read;

*"Assist resident to bathroom and ensure privacy. Assist resident with removing clothing and/or incontinence products. Offer time for toileting. Assist resident with peri care and re-dress with fresh incontinence product and clothing. Dispose of soiled incontinence products and remove from room. Place any soiled clothing in laundry hamper and launder as needed. Assist resident with hand hygiene afterwards."*

Documentation in the "assistive devices" section of the evaluation read;

*"Walker and manual wheelchair available for long distances."*

In the "pain" section of the evaluation it read;

*"MAPAP 325 MG TAB (Tylenol): Take 2 tablets (650 MG) by mouth every 6 hours as needed for pain not to exceed 3GM (3000 MG)/24 hours from all Tylenol sources."*

I reviewed Resident B's *Assessment Plan for Adult Foster Care (AFC) Residents* (assessment plan). Both the toileting and walking/mobility sections of Resident B's assessment plan were blank.

I reviewed an IR, dated 3/4/2023, four days after Resident B's fall. Documentation on the IR indicated "*Staff observed resident in apartment, sitting in her chair, expressing she was in pain. Complaint of pain was side pain. Vitals were obtained. BP 144/80, P:79, R:17, Temp: 96.6, Pain: 10/10. Staff notified DPOA who came and picked resident up and took her to the ER. Resident given Tylenol per her physician order before leaving for the ER."*

At the time of my unannounced investigation (3/21/2023), while there was evidence NP Bailey prescribed Resident B Tylenol on 03/01/2023, there was no documentation in Resident B's record indicating she was physically assessed by NP Bailey at the facility on 03/01/2023 nor was there any documentation of medical treatment/hospitalization about a fall/broken ribs.

On 03/23/2023, APS Specialist Simms-Rosa informed me, via telephone, she interviewed Relative B1, who reported denying taking Resident B to the hospital on 03/04/2023. Relative B1 reported that Resident B was in so much pain that he requested an ambulance be called to transport her to the hospital. APS Specialist Simms-Rosa reported Relative B1 confirmed that someone at the facility did provide him with Tylenol to administer to Resident B when she was in pain.

On 05/09/2023, I interviewed Relative B1 by telephone, who reported that he received a call (date unknown) from a DCW (name unknown), who reported finding Resident B on the floor in her apartment, as a result of a fall. Relative B1 reported that he went to the facility the following day and was informed that Resident B was complaining of elbow pain. Relative B1 confirmed requesting Tylenol to give to Resident B. Relative B1 reported that at this time, he did not want to take Resident B to the hospital. Relative B1 was not aware that Resident B was assessed by NP Baily after the fall, as no one reported that to him. Relative B1 reported that by Saturday, three days after the fall, Resident B was not doing well. Subsequently, a facility staff member contacted him. Relative B1 reported that when he arrived at the facility, he requested that they call an ambulance, as he wanted Resident B1 to receive outside medication attention at the emergency room (ER). Relative B1 confirmed Resident B was diagnosed with broken ribs while in the ER.

| **APPLICABLE RULE** | |
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| **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 upon my investigation, it is believed Resident B fell in the facility on 2/28/2023. According to Licensee Designee Del Raso's statements, as well as documentation on Resident B's March MAR, the following day (03/01/2023) NP Baily wrote Resident B a prescription for Tylenol to address the pain she was experiencing after her fall. While conducting interviews with multiple DCWs, neither of them were able to provide any details regarding Resident B's fall at the time it occurred, or immediately following. There was also no IR documenting Resident B's fall on 2/28/2023, her condition immediately following her fall, or what steps had been taken to address her medical needs at that time, if necessary. Based upon interviews with multiple facility staff members, APS Specialist Simms-Rosa, and Relative B1, there is enough evidence to substantiate the allegation that B had a change in her condition and continued to report she was in pain. Resident B wasn't transported to the hospital until 03/04/2023, where it was determined that as a result of her fall, she had broken ribs. |

| CONCLUSION: | VIOLATION ESTABLISHED |
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**ALLEGATION: Resident C's health care needs are not being met by the facility.**

**INVESTIGATION:** On 03/15/2023, anonymous Complainant also reported that due to a decline in Resident C's condition, on an unidentified date, her physician ordered a urinalysis (UA) for a possible urinary tract infection (UTI). Complainant reported that the urine was collected by DCW Armstrong and the facility's care coordinator was notified that they needed to fill out a requisition form and call Sparrow laboratory for pick up. However, Complainant reported that three days after collecting the sample, the urine was still in the refrigerator and never sent to the laboratory for evaluation. Complainant reported that in the meantime, Resident C was getting worse, and now exhibiting "exit seeking" behaviors. Because Complainant was anonymous, no additional information or details regarding the allegation could be gathered from Complainant.

During my interview with DCW Weakly on 03/20/2023, she reported that the day Resident C's physician ordered the UA, the facility was unable to get a urine sample from Resident C, as she could not provide any urine. DCW Weakly reported that she left instructions for DCWs to get a sample from Resident C. DCW Weakly reported that "days later", DCW Armstrong reported that the urine sample was still in the refrigerator. DCW Weakly reported that she told DCW Armstrong to send the urine sample out to the laboratory and confirmed it was sent out late.

During my interview with DCW Shaw 03/20/2023, she reported she was informed by DCW Armstrong on 03/12/2023 that the UA for Resident C had not been picked up by the laboratory. DCW Shaw reported there was a confirmation number that confirmed the laboratory had been notified of the need for a "pickup" but did not pick the sample up. According to DCW Shaw, the urine sample was eventually picked up by the laboratory, although she is not sure who followed up on this matter.

On 03/21/2023, I conducted an unannounced investigation and was informed Resident C was not home. Therefore, I was not able to interview her.

During my interview with licensee designee Del Raso on 03/21/2023, she reported that the UA for Resident C was ordered on 3/14/2023. She confirmed there was an issue catching Resident C's urine. Subsequently, her physician ended up ordering blood work instead of a UA. Licensee designee Del Raso reported that the blood was negative for a UTI. Therefore, the UA was unnecessary.

During my investigation on 03/21/2023, I reviewed Resident C's record, which contained a document titled, *Sparrow Laboratories Report* for Resident C. Documentation on this report confirmed that on 03/13/2023, NP Bailey ordered blood work to be completed on Resident C.

On 03/23/2023, APS Specialist Steve Marchlewicz informed me he also interviewed licensee designee Del Raso, who provided him with the same statements she provided to me.

| **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.** |
| **ANALYSIS:** | It has been established that per an order by NP Baily, Resident C had bloodwork done on 03/13/2023 to ensure that her medical needs were met. Resident C's bloodwork indicated she was negative for a UTI. Therefore, a UA was no longer necessary. Based upon my investigation, there is not enough evidence to substantiate the allegation Resident C's health care needs are not being met by the facility. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION: Resident D's personal needs are not being met.**

**INVESTIGATION:** On 03/15/2023, Anonymous Complainant also reported that on an unidentified date, Resident D's physician ordered facility staff members to conduct two-hour checks on Resident D. However, they are not being completed. Complainant reported that Resident D's adult brief is not being changed every two hours, nor is he/she receiving showers. Complainant reported that DCWs refuse to get Resident D out of bed and Resident D is fearful of retaliation when she pushes her "pendant" for help because DCWs are mean to her. Because Complainant was anonymous, no additional information or details regarding the allegation could be gathered from Complainant.

During my interview with DCW Weakly on 03/20/2023, she reported DCWs are aware they are required to check on Resident D every two hours. DCW Weakly reported that Resident D was having seizures while in the shower, so they are now providing her with bed baths, as she does not want to take showers anymore. DCW Weakly denied the allegations DCWs refuse to get Resident D out of bed and that Resident D is fearful of retaliation when she pushes her pendant for help because DCWs are mean to her. DCW Weakly reported she has never observed any DCWs

be mean to Resident D nor has Resident D reported to her that any DCWs were mean to her.

During my interview with DCW Shaw on 03/20/2023, she reported DCW Weakly follows the two-hour checks for Resident D but she is not sure that all DCWs do. DCW Shaw reported that some DCWs at the facility have a poor work ethic and she believes that a lot of DCWs do not follow this requirement. DCW Shaw denied the allegations DCWs refuse to get Resident D out of bed and that Resident D is fearful of retaliation when she pushes her pendant for help because DCWs are mean to her. DCW Shaw also reported she had never observed any DCWs be mean to Resident D nor has Resident D reported to her that any DCWs were mean to her.

During my unannounced investigation on 03/21/2023, I reviewed Resident D's *Resident Evaluation*, dated 6/20/2022. Documentation on this evaluation confirmed Resident D requires assistance with toileting and bathing, as well as assistance from both DCWs and mechanical lifts with transferring.

During my unannounced investigation on 03/21/2023, I interviewed Resident D who reported DCWs check on her every two hours. Resident D confirmed she does not want a shower anymore because she has been having seizers in the shower and she would pass out. Resident D reported DCWs are providing her with bed baths twice a week. Resident D stated that during the day she feels like the DCWs check on her more, but she is not sure how often she is checked on in the evening, because she is asleep at night. Resident D did report that she does use her pendant when she needs assistance and that is takes DCWs "about 5 minutes" to attend to her. Resident D did report that sometimes when she pushes her pendant, a DCW does not come to her room at all. Resident D reported being bed bound and cannot transfer without assistance. However, DCWs help her transfer to a wheelchair or recliner if she wants to move. Resident D denied the allegations DCWs refuse to get her out of bed and also denied the allegation she is fearful of retaliation when she pushes her pendant for help because DCWs are mean to her. Resident D reported that she is happy with the care that is being provided to her.

During my interview with licensee designee Del Raso on 3/21/2023, she confirmed Resident D does not have a written physician order for two-hour checks. However, per facility protocol, DCWs conduct checks on all residents, including Resident D, at least every two hours.

I reviewed Resident D's record, which contained a facility document titled, *Incontinent Care Log.* Documentation on this log from 2/19/2023 through 3/20/2023, confirmed Resident D was checked on and her adult brief was changed every two hours. There were 13 times noted when the time in between checks on Resident D was more than two hours.

| APPLICABLE RULE | |
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| **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:** | Based upon my investigation, which consisted of interviews with multiple facility staff members and Resident D, as well as a review of pertinent documentation relevant to this allegation, there is not enough evidence to substantiate the allegation Resident D's personal needs are not being met. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:** During my investigation on 03/21/2023, I reviewed Resident A, B, and C's record. Resident A's record did not contain a *Health Care Appraisal*.

Resident B and D's records contained expired *Health Care Appraisal*s.

Resident B's *Resident Evaluation* had expired. Resident B's record also contained an assessment plan that was missing page four. Subsequently, I was unable to determine when Resident B's assessment pan was completed.

| 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.**<br>**(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department** |

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| **ANALYSIS:** | It has been established Resident A's record did not contain a *Heath Care Appraisal*. Resident B and Resident D's records contained *Health Care Appraisal*s that were expired. It has also been established Resident B's *Resident Evaluation* had expired and her assessment plan was missing page four. Subsequently, I was unable to determine when Resident B's assessment pan was completed. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan I recommend no change in license status.

05/12/2023

Julie Elkins — Date
Licensing Consultant

Approved By:

05/12/2023

Michele Streeter — Date
Section Manager