GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 19, 2023

Achal Patel & Vivek Thakore
Divine Nest of Williamston INC
2045 Birch Bluff Dr
Okemos, MI 48864

RE: License #: AL330413975
Investigation #: 2024A1033008
Divine Nest Of Williamston INC

Dear Mr. Patel & Mr. Thakore:

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,

Jana Lipps, 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

License #:	AL330413975
Investigation #:	2024A1033008
Complaint Receipt Date:	10/30/2023
Investigation Initiation Date:	11/03/2023
Report Due Date:	12/29/2023
Licensee Name:	Divine Nest Of Williamston INC
Licensee Address:	2045 Birch Bluff Dr Okemos, MI 48864
Licensee Telephone #:	(517) 898-2431
Administrator:	Achal Patel
Licensee Designee:	Achal Patel & Vivek Thakore
Name of Facility:	Divine Nest of Williamston INC
Facility Address:	241 McCormick St WILLIAMSTON, MI 48895
Facility Telephone #:	(517) 655-5800
Original Issuance Date:	08/25/2023
License Status:	TEMPORARY
Effective Date:	08/25/2023
Expiration Date:	02/24/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct care staff are not properly trained to provide for Resident A's catheter care.	Yes
Direct care staff are not properly trained to provide for Resident B's ostomy care.	No
There is insufficient staffing to meet the needs of the current residents.	No
Resident B is being left in soiled undergarments which has caused skin rashes.	No
There are multiple medication errors committed by direct care staff.	Yes
Direct care staff are not properly trained to administer medications.	No

III. METHODOLOGY

10/30/2023	Special Investigation Intake 2024A1033008
11/03/2023	Special Investigation Initiated - On Site Interview with direct care staff/Community Manager, Zize Gashi, direct care staff, Shemberlee Ried & Rachel Turner, Resident B, C, D. Attempted interview with Resident A. Review of resident records initiated.
11/06/2023	Contact - Document Sent- Email correspondence sent to licensee designees, Achal Patel & Vivek Thakore.
11/27/2023	APS Referral- Current APS investigation.
11/27/2023	Contact - Telephone call made- Interview with direct care staff, Salma Sanchez, via telephone.
11/27/2023	Contact - Telephone call made- Interview with direct care staff, Natasha Westbrook, via telephone.
11/27/2023	Contact - Telephone call made- Attempt to interview direct care staff members, Karesha Pearson, Andrea Alvarez, Sacoya Dockery, Tabatha Harris, Ravin Shire, Dana Darnell, & Yvonne Murphy. Voicemail messages were left. Awaiting a response.
11/27/2023	Contact - Telephone call received- Interview with direct care staff, Dana Darnell, via telephone.

11/29/2023	Contact - Telephone call made- Follow-up interview with direct care staff/home manager, Zize Gashi.
12/13/2023	Contact – Telephone call made- Interview with Heartland Home Health nurse, Charlotte Hargrove.
12/14/2023	Exit Conference- Telephone call made to licensee designee, Achal Patal. Voicemail message left.

ALLEGATION: Direct care staff are not properly trained to provide for Resident A's catheter care.

INVESTIGATION:

On 10/30/23 I received an online complaint regarding the Divine Nest of Williamston, adult foster care facility (the facility). The complaint alleged direct care staff are not properly trained to perform intermittent or straight catheter care on Resident A. On 11/3/23 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff, Shemberlee Ried. Ms. Ried reported that Resident A's physician recently changed his catheter from an indwelling, foley catheter to a straight catheter. Ms. Ried reported that this change occurred about three weeks ago, and she feels the transition is going well. Ms. Ried reported that straight catheter care is performed multiple times per day on Resident A. She reported that the home health care nurse through Elara Home Care, Charlotte (last name unknown by Ms. Ried), came to the facility and trained approximately three direct care staff members and the manager of the facility, Zize Gashi. Ms. Ried reported that many of the direct care staff members do not like to use the straight catheter, but she was unsure the reasoning. She reported Resident A requires to be catheterized with the straight catheter every five hours and this is documented on his Medication Administration Record (MAR). Ms. Ried reported direct care staff use the straight catheter and then record on the MAR the amount of urinary output they obtain when catheterizing Resident A. Ms. Ried reported that not all the direct care staff could be present for the straight catheter training, provided by the home health nurse, so Ms. Gashi has been training the additional direct care staff to the procedure. Ms. Ried reported that she was present for the training from the home health nurse, but she has not yet provided straight catheter care to this resident.

During on-site investigation on 11/3/23 I interviewed direct care staff, Rachel Turner. Ms. Turner reported she is a new direct care staff and just recently completed her training. Ms. Turner reported that direct care staff Salma Sanchez trained her how to perform the straight catheter care for Resident A. Ms. Turner reported that she feels comfortable providing the straight catheter care, but also noted that she feels this should be done by someone who is professionally certified, such as a nurse. Ms. Turner reported she has previous experience performing straight catheter care while

working in another adult foster care facility. She reported Resident A requires straight catheter care every five hours and this is documented on Resident A's MAR.

During on-site investigation on 11/3/23 I interviewed Ms. Gashi. Ms. Gashi reported that Resident A's foley catheter was removed after his last hospitalization and the physician changed Resident A to a straight catheter to see if this would reduce the number of urinary tract infections Resident A was contracting. Ms. Gashi reported that there was a training provided by the Promedica Home Care nurse (name unknown by Ms. Gashi) and the direct care staff members in attendance for this training were, Ms. Gashi, Andrea Alvarez, Karesha Pearson, & Jada Moore. Ms. Gashi reported that she provided the straight catheter care training for the rest of the direct care staff who were not in attendance for the Promedica nurse's training. Ms. Gashi reported that she feels the straight catheter care for Resident A has been going well and she has not heard any complaints from direct care staff or Resident A that would indicate otherwise.

During on-site investigation on 11/3/23 I attempted to interview Resident A. Resident A had been sleeping upon my arrival and when he roused for this interview, he did not answer questions asked of him in a coherent manner. I was not able to obtain appropriate responses from this interview.

On 11/27/23 I interviewed Ms. Sanchez, via telephone. Ms. Sanchez reported that she has worked at this facility for a few months. Ms. Sanchez reported that Resident A does require the use of a straight catheter procedure every five hours. Ms. Sanchez reported that a nurse from the home health care agency came to the facility to train some of the direct care workers to the care and her manager, Ms. Gashi, was present for this training. Ms. Sanchez reported that Ms. Gashi has since trained additional direct care staff to the straight catheter procedure. Ms. Sanchez reported that she feels confident providing straight catheter care to Resident A and has trained other direct care staff members to the procedure.

On 11/27/23 I interviewed direct care staff, Natasha Westbrook, via telephone. Ms. Westbrook reported that she has recently started employment at the facility. Ms. Westbrook reported that she was trained to the straight catheter procedure for Resident A, by Ms. Sanchez. Ms. Westbrook reported that she feels her training was sufficient and she feels confident providing this care to Resident A.

On 11/27/23 I interviewed direct care staff, Dana Darnell, via telephone. Ms. Darnell reported that she is required to provide straight catheter care to Resident A, and she does not feel she has received adequate training for this procedure. Ms. Darnell reported that another direct care staff (name she could not recall) demonstrated how to perform the straight catheter care, but this individual did not appear confident in the care being demonstrated. Ms. Darnell reported that Resident A states the procedure is painful and she is aware that there are times the catheter is difficult to insert and extract from his urethra.

On 11/29/23 I conducted a second interview with Ms. Gashi, via telephone. Ms. Gashi reported that there is not a certified nurses aid or registered nurse on staff at the facility. Ms. Gashi reported she had a Medical Assistant certification, but this has lapsed. She reported the home care nurse is no longer making visits to Resident A as the episode of care has ended. Ms. Gashi reported that going forward she will be training all incoming direct care staff to the straight catheter procedure for Resident A.

On 12/13/23 I interviewed Charlotte Hargrove with Heartland Home Health services. Ms. Hargrove reported that she was the registered nurse who made visits to Resident A to provide education to direct care staff on the straight catheter procedure. Ms. Hargrove reported that she was no longer working with Resident A as the episode of care has ended due to completing the teaching for the direct care staff at the facility. Ms. Hargrove reported that Resident A previously had a foley catheter and she would visit him at least monthly to monitor this catheter. She reported that Resident A's sister, wanted to have the foley catheter discontinued and try a straight catheter procedure as Resident A was having multiple urinary tract infections, and she felt this change would benefit Resident A with hopes of reducing these infections. Ms. Hargrove reported that she was skeptical about this change in catheterization for Resident A as this would mean direct care staff would be required to perform straight catheter care multiple times per day and she was aware they were not trained to provide this care. Ms. Hargrove reported that ultimately Resident A's physician made this change to Resident A's plan of care and she taught the direct care staff how to perform straight catheter care. Ms. Hargrove reported that she first trained Resident A's sister to the care, then Ms. Gashi, and about four of the direct care staff members at the facility. Ms. Hargrove reported that it was known to her that Ms. Gashi's plan for training all direct care staff was that Ms. Gashi would be providing the ongoing training. Ms. Hargrove reported that she felt Ms. Gashi was skilled with the procedure, but she was worried about direct care staff turnover and how the direct care staff would keep up with competencies for this procedure. Ms. Hargrove reported that ideally each direct care staff should be trained by a registered nurse for their initial training and competency.

On 11/2723 I received an email correspondence from The Divine Living Centers, Director of Human Resources, Kerri Wheeler. This email contained the direct care staff training records for all direct care staff working at the facility. I reviewed these training records. There was no record of straight catheter training being provided to the direct care staff on these forms. It was noted that direct care staff were trained to foley/indwelling catheter care.

On 12/7/23 I received an email correspondence from Ms. Gashi. Ms. Gashi had supplied a training sign in sheet which lists the direct care staff who have been trained to the straight catheter care and dates of their training. The list reports the following information:

- Zize Gashi – October 2023
- Raven Shire – Nov 29

- Dana Darnell – Nov 29
- Karesha Pearson – Dec 4th
- Natasha Westbrook – Dec 4th
- Sacoya Dockery – Dec 5th
- Andrea Alvarez – Dec 5th
- Salma Sanchez – Dec 6th
- Tabatha Harris – Dec 6th
- Yvonne Murphy – Dec 6th

During on-site investigation on 11/3/23 I reviewed Resident A's MAR for the month of October 2023. On this MAR is listed "Straight Catheter" with the following instructions, "Clean the head of the penis with iodine. Take one small pack of lubricate gel apply it to the catheter and insert the catheter into the penis, make sure you have a urinal at the other end of the catheter so it does not spill the urine and it will measure of how much output he is having. If he has more than 400cc Please let me know." This procedure is documented on the MAR as being administered four times per day at the following times, 2:30am, 7:30am, 3:30pm, and 8:30pm. The following direct care staff have initialed that they performed this procedure for Resident A during the month of October 2023:

- Dana Darnell
- Andrea Alvarez
- Alhousseyni Sako
- Selma Sanchez-Williams
- Raven Shire
- Zize Gashi
- DeAndrea Edmonds
- Jada Moore
- Tesia Wilson
- KaResha Pearson
- Sacoya Dockery
- Yvonne Murphy
- Rachel Turner
- Hayli Binns

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(d) Personal care, supervision, and protection.**

ANALYSIS:	Based upon interviews with Ms. Gashi, Ms. Ried, Ms. Turner, Ms. Sanchez, Ms. Westbrook, Ms. Darnell & Ms. Hargrove, as well as review of the direct care staff training records sent by Ms. Wheeler, and the Straight Catheter care training log sent by Ms. Gashi, it can be determined that not all direct care staff were trained & competent to provide straight catheter care to Resident A, prior to administering this care to Resident A. Resident A's for medication administration record the month of October 2023, indicates that fourteen direct care staff members provided straight catheter care to Resident A in the month of October. The straight catheter care training log provided by Ms. Gashi indicates that only ten direct care staff members had straight catheter care training completed and only one of the ten direct care staff were trained to provide the straight catheter care in the month of October 2023. Furthermore, the following direct care staff, Ms. Sako, Ms. Edmonds, Ms. Moore, Ms. Wilson, Ms. Turner, & Ms. Binns, are documented as having administered the straight catheter procedure to Resident A in the month of October 2023, but have no documentation of completion of the straight catheter care training. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff are not properly trained to provide for Resident B's ostomy care.

INVESTIGATION:

On 10/30/23 I received an on-line complaint regarding the facility. The complaint alleged direct care staff are not properly trained to provide care for Resident B's ostomy. On 11/3/23 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Ried. Ms. Ried reported that Resident B does have an ostomy that direct care staff provide care for. Ms. Ried reported that she had prior knowledge and training, through Henry Ford Home Care, in providing ostomy care for a family member. She reported direct care staff also received training at the facility.

On 11/3/23 I interviewed Ms. Turner. Ms. Turner reported that she was trained to Resident B's ostomy care needs by Ms. Sanchez. Ms. Turner reported that she feels the training has been adequate and she has no issues with providing for Resident B's ostomy care.

On 11/3/23, during on-site investigation, I interviewed Ms. Gashi. Ms. Gashi reported that Resident B was admitted to the facility when it was previously owned in January 2023. Ms. Gashi reported Resident B has had the ostomy in place since her original

admission when the building was owned by another adult foster care licensee designee. The facility was issued its current license on 8/25/23. Ms. Gashi reported direct care staff are currently being trained to the ostomy care for Resident B by existing direct care staff members. Ms. Gashi reported current direct care staff members are competent in providing this care. Ms. Gashi reported that Resident B is currently connected with a home health agency and has a nurse coming on a regular basis to manage the ostomy care.

During on-site investigation on 11/3/23 I interviewed Resident B. Resident B reported that she does have an ostomy that requires care from direct care staff members. Resident B reported that there has been one occasion where the ostomy bag leaked, and she had a direct care staff member who did not know how to correct the issue. She reported that on this occasion a direct care staff member was located in the facility to assist with this need. Resident B reported no current concerns at this time.

On 11/27/23 I interviewed Ms. Sanchez, via telephone. Ms. Sanchez reported that she has been trained to provide ostomy care to Resident B. Ms. Sanchez reported that she had previous experience with providing ostomy care through a previous employer. Ms. Sanchez further reported that the home care nurse for Resident B came to the facility a week prior and did another demonstration on correct ostomy care for the direct care staff. She reported that about three direct care staff were present for this demonstration and a video was made to further educate the direct care staff members who could not be in attendance. Ms. Sanchez reported that she was trained to the ostomy care for Resident B, by Ms. Gashi.

On 11/27/23 I interviewed Ms. Westbrook, via telephone. Ms. Westbrook reported that she was recently trained to provide for Resident B's ostomy care by Resident B's home health nurse the week of 11/20/23. Ms. Westbrook reported that prior to this most recent training, she had experience providing for ostomy care through a previous employer and through training she received at the facility through other direct care staff members.

On 11/27/23 I interviewed Ms. Darnell, via telephone. Ms. Darnell reported that she has been provided ostomy care training by Ms. Gashi. She reported that she has not felt completely confident with this care until recently as she had some issues with the ostomy leaking.

On 11/29/23 I conducted a second interview with Ms. Gashi. Ms. Gashi reported that the direct care staff had a recent training from the home health nurse for Resident B as to trouble shooting and changing the ostomy bag. Ms. Gashi reported that this training was recorded and made available to all direct care staff to demonstrate proper changing of the ostomy bag and skin care for Resident B. She reported that this video will be used to assist with training any incoming direct care staff members during their orientation period.

On 11/2723 I received an email correspondence from Ms. Wheeler. This email contained the direct care staff training records for all direct care staff working at the facility. On these training records is a section noting, “CG education on Ostomy care will be provided as required”. On each training log reviewed this area was marked with a check mark and initialed by the direct care staff member.

On 12/7/23 I received an email correspondence from Ms. Gashi. Ms. Gashi had supplied a training sign in sheet which lists the direct care staff who have been recently, retrained, to the ostomy care requirements for Resident B. The following direct care staff were noted as having completed the most recent ostomy care training:

- Zize Gashi
- Sacoya Dockery
- Karesha Pearson
- Alhousseyni Sako
- Yvonne Murphy
- Salma Sanchez
- Shemberlee Ried
- Ravin Shire
- Dana Darnell
- (Two unidentifiable signatures)

On 12/13/23 I received a video recording from Ms. Gashi of the demonstration Resident B’s home health nurse had provided for the direct care staff the week of 11/20/23. This educational video appeared informative and demonstrated proper changing of the ostomy bag and skin care around the ostomy site.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(d) Personal care, supervision, and protection.**

ANALYSIS:	Based upon interviews with Ms. Gashi, Ms. Ried, Ms. Turner, Ms. Sanchez, Ms. Westbrook, & Ms. Darnell, as well as review of the direct care staff training records sent by Ms. Wheeler, and the Ostomy care training log sent by Ms. Gashi, it can be determined that the direct care staff have been provided training regarding the care of Resident B's ostomy. It is documented that the direct care staff received training upon being hired at the facility and a further training was recently provided by a home health nurse, which was video recorded to further support and demonstrate proper ostomy care to the direct care staff for a refresher. Therefore, no violation is cited at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: There is insufficient staffing to meet the needs of the current residents.

INVESTIGATION:

On 10/30/23 I received an online complaint regarding the facility. The complaint alleged that there is not adequate staffing to meet the needs of the current residents. On 11/3/23 I conducted an unannounced, on-site investigation. I interviewed Ms. Ried during this investigation. Ms. Ried reported that to her knowledge the facility is currently caring for 3 residents who require a two-person direct care staff member assistance with mobility, transfers, and personal care. Ms. Ried reported that the facility staffs at least four direct care staff during the days and evenings. She reported that their job duties are as follows:

- Two direct care staff who act as medication technicians/personal care providers.
- One direct care staff who assists with personal care.
- One direct care staff who prepares meals and assists with personal care needs between mealtimes.

Ms. Ried reported that she feels the staffing is adequate to meet the needs of the current residents and further reported that during the day shift, they also have access to Ms. Gashi for additional assistance. Ms. Ried reported that the overnight shift is always staffed with two direct care staff members.

On 11/3/23, during on-site investigation I interviewed Ms. Turner. Ms. Turner reported that to her knowledge there are four residents who require two person direct care staff member assistance with mobility/transfers/personal care. Ms. Turner reported that during the day and evening shifts there are always four direct care staff scheduled. Ms. Turner reported the same information that Ms. Ried provided regarding two direct care staff utilized as medication technician/personal care providers, one direct care staff assisting with personal care, and a direct care staff member preparing meals. Ms. Turner reported that there are usually three direct care staff scheduled for the overnight shifts.

During on-site investigation on 11/3/23 I interviewed Ms. Gashi. Ms. Gashi reported that there are currently five residents who require a two person direct care staff member assistance with mobility/transfers/personal care needs. Ms. Gashi reported that on the day shift (6am – 10pm) there are four direct care staff scheduled to provide for resident care needs. She reported that there are two direct care staff who work as medication technicians/personal care providers, one direct care staff who provides personal care, and one direct care staff who prepares meals. Ms. Gashi reported that from 10pm to 6am there are two direct care staff members scheduled to provide for the care of the current residents. Ms. Gashi reported that she has not received any complaints from direct care staff or residents about the current staffing levels. Ms. Gashi reported that she feels the staffing levels are adequate to manage the care of the current residents.

During on-site investigation on 11/3/23, I interviewed Resident B. Resident B reported that she has no issues with the current staffing levels and feels her care needs are being attended to.

During on-site investigation on 11/3/23 I interviewed Resident C. Resident C reported that she feels the current direct care staff schedule is not adequate to meet the needs of the current residents. Resident C reported that sometimes she must wait a long period of time to receive assistance from direct care staff. She reported that wait times are anywhere from 5 minutes to one hour. Resident C reported that it is usually five minutes but the other day she waited an hour and had to report this to Ms. Gashi. Resident C reported that she receives two showers per week and the direct care staff can accommodate this. She reported that she has participated in fire drills and feels that the direct care staff were able to evacuate everyone in a realistic amount of time.

During on-site investigation on 11/3/23 I interviewed Resident D. Resident D reported she had no concerns about current staffing levels at the facility. She reported that the direct care staff are attentive to her needs, and she feels they are skilled.

On 11/27/23 I interviewed Ms. Sanchez. Ms. Sanchez reported that the facility has been staffed with at least four direct care staff members during the days and evenings and two direct care staff members for overnight shifts. Ms. Sanchez reported that the four direct care staff members for days and evenings consists of two medication technicians/personal care staff, one direct care staff providing personal care, and one direct care staff member preparing meals. Ms. Sanchez reported no current concerns about the direct care staffing levels at the facility.

On 11/27/23 I interviewed Ms. Westbrook via telephone. Ms. Westbrook reported that each day shift and evening shift are staffed with at least four direct care staff members. Ms. Westbrook reported that two direct care staff work as medication technicians/personal care providers, one direct care staff member works as a

personal care provider, and the other direct care staff prepares resident meals. Ms. Westbrook reported that on the overnight shift there are always two direct care staff members scheduled. Ms. Westbrook reported that she feels the current staffing levels are adequate to meet the care needs of the current residents.

On 11/27/23 I interviewed Ms. Darnell, via telephone. Ms. Darnell reported that she feels the current staffing levels are adequate to provide for the current resident care needs. Ms. Darnell reported the same staffing levels reported by Ms. Gashi, Ms. Ried, Ms. Westbrook, Ms. Turner, and Ms. Sanchez. Ms. Darnell reported that she is not confident that the midnight staff could evacuate all residents in a safe amount of time due to so many residents requiring a two person assist. Ms. Darnell reported that she has not participated in midnight shift fire drills since the current license was issued on 8/25/23. Ms. Darnell did report that she primarily works the midnight shift.

During on-site investigation on 11/3/23 I reviewed the document, *Resident Care Plan*, for all residents. It was noted that the following residents require a two person assist with mobility/transfers/personal care:

- Resident A
- Resident C
- Resident E
- Resident F
- Resident G

On 11/22/23 Ms. Wheeler sent an email correspondence containing documentation of fire drill records for the facility. I reviewed the document, *Fire Drills – One Shift Per Month Total of 3 Drills Per Quarter*. This document had recorded fire drills on 8/31/23 at 6:04pm, taking 6.34 mins to complete, and 11/7/23 at 1:51pm, taking 8 minutes to complete.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based upon interviews with Ms. Gashi, Ms. Ried, Ms. Darnell, Ms. Sanchez, Ms. Westbrook, Ms. Turner, Resident B, C, & D, as well as review of the *Resident Care Plan* documents for all residents, and current fire drill records, it can be concluded that there is not adequate evidence to suggest that the current staffing levels are not sufficient to provide for the care needs of the current residents at the facility. Despite having five residents who are identified as a two person assist with mobility/transfers/personal care, the facility is staffed with separate meal preparation staff members, who are also dual trained to perform direct care tasks as needed. The facility is documenting conducting regular fire drills and the residents interviewed state feeling the current staffing levels are sufficient to meet their needs. Therefore, a violation cannot be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident B is being left in soiled undergarments which has caused skin rashes.

INVESTIGATION:

On 10/30/23 I received an online complaint regarding the facility. The complaint alleged that direct care staff members are leaving Resident B in soiled undergarments which has led to skin rashes and irritation for Resident B. On 11/3/23 I conducted an unannounced on-site investigation at the facility. I interviewed Ms. Ried at this time. Ms. Ried reported that Resident B has an ostomy bag that requires regular care and attention. Ms. Ried reported that the ostomy bag does not like to stay on Resident B's skin, around her stoma, and this will lead to her skin becoming red and irritated. Ms. Ried reported direct care staff are managing this ostomy bag and one issue concerning Resident B's hygiene is the fact that she regularly refuses personal care. Ms. Ried reported that Resident B tries to refuse showers and the direct care staff will need to make a telephone call to her son and have him assist in encouraging her to allow the direct care staff to provide the shower.

During on-site investigation on 11/3/23 I interviewed Ms. Turner. Ms. Turner reported that she feels Resident B is offered and provided personal care on a regular basis. She reported she has not ever found Resident B sitting in her own urine or feces for prolonged periods of time. Ms. Turner reported no unusual skin rashes on Resident B.

During on-site investigation on 11/3/23 I interviewed Ms. Gashi. Ms. Gashi reported that Resident B does have some issues with red and irritated skin around her stoma where the ostomy bag attaches to her skin. Ms. Gashi reported that Resident B has a history of refusing personal care from direct care staff which leads to further issues

with skin irritation. Ms. Gashi reported that the direct care staff have involved Resident B's son in her care plan as he is able to provide encouragement to Resident B to allow personal care.

During on-site investigation on 11/3/23, I interviewed Resident B. Resident B reported that the direct care staff are offering and providing her personal care but admitted that she tends to refuse the care they are offering. Resident B reported that she does not currently have any issues with skin irritation and feels the direct care staff are providing adequate care.

On 11/27/23 I interviewed Ms. Sanchez, via telephone. Ms. Sanchez reported that Resident B can be difficult to provide care to as she tends to scream out and refuse care. Ms. Sanchez reported that the direct care staff are providing for her care needs, however sometimes it is a struggle. Ms. Sanchez reported that the direct care staff are working with Resident B's son on motivating Resident B to be more accepting of showers/personal care.

On 11/27/23 I interviewed Ms. Westbrook via telephone. Ms. Westbrook reported that Resident B is offered and provided regular personal care by direct care staff. Ms. Westbrook reported that Resident B tends to refuse personal care. She reported that there are times when Resident B does have skin redness and irritation around her stoma. She reported that the direct care staff are working with Resident B's son on encouraging Resident B to accept personal care each time it is offered.

On 11/27/23 I interviewed Ms. Darnell, via telephone. Ms. Darnell reported that she feels the direct care staff are providing for Resident B's care needs. She reported that Resident B has never refused care that she has offered. Ms. Darnell reported that occasionally there is skin redness and irritation around Resident B's stoma due to her ostomy bag leaking.

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:	Based upon interviews with Ms. Ried, Ms. Turner, Ms. Gashi, Ms. Westbrook, Ms. Darnell, Ms. Sanchez, & Resident B, it can be determined that there is not adequate evidence direct care staff are not providing for Resident B's personal care needs. However, skin redness and irritation around Resident B's stoma/ostomy bag were mentioned by several direct care staff interviewed, this does not demonstrate that the direct care staff are not providing for her personal care needs. It was also noted that Resident B tends to refuse personal care, which was noted as being addressed with Resident B by collaborating with her son to encourage her to be more accepting of personal care offered. The direct care staff appear to be aware of Resident B's care needs and are working on solutions to assist with her continued personal care and skin integrity.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: There are multiple medication errors committed by direct care staff.

INVESTIGATION:

On 10/30/23 I received an online complaint regarding the facility. The complaint alleged that there have been multiple medication errors committed by direct care staff members at the facility. On 11/3/23 I conducted an unannounced on-site investigation. I interviewed Ms. Ried at this time. Ms. Ried reported that she is unaware of any medication administration errors occurring at the facility.

On 11/3/23, during on-site investigation, I interviewed Ms. Turner. Ms. Turner reported that she is unaware of any medication administration errors occurring at the facility.

On 11/3/23, during on-site investigation, I interviewed Ms. Gashi. Ms. Gashi reported that she is unaware of any medication administration errors occurring at the facility.

On 11/27/23 I interviewed Ms. Sanchez via telephone. Ms. Sanchez reported that she is unaware of any medication administration errors occurring at the facility.

On 11/27/23 I interviewed Ms. Westbrook via telephone. Ms. Westbrook reported that she is unaware of any medication administration errors occurring at the facility.

On 11/27/23 I interviewed Ms. Darnell via telephone. Ms. Darnell reported that she is unaware of any medication administration errors occurring at the facility.

During on-site investigation on 11/3/23 I reviewed MARs for Resident A, B, G, I, J, K, L, & M, for October 2023. I observed the following findings:

- Resident M is ordered, Metoprol SUC Tab 50MG ER, with the instructions, "Take 1 tablet by mouth daily *hold for B/P <150 & Heart Rate <100*". The MAR indicates that the Metroprol medication was administered on the following dates, 10/1/23 – 10/6/23, 10/8/23 – 10/15/23, 10/20/23 – 10/31/23, despite having documentation that Resident M's blood pressure was <150 and his heart rate was <100 on each of these dates.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon interviews with Ms. Ried, Ms. Turner, Ms. Gashi, Ms. Sanchez, Ms. Westbrook, & Ms. Darnell, as well as review of the Medication Administration Records for Residents A, B, G, I, J, K, L, & M, for the month of October, it can be determined that Resident M's Metoprol medication has not been administered as prescribed by his physician. Resident M's Metoprol medication has written instructions to hold the medication when his blood pressure is <150 and his pulse rate is <100. The MAR documents that he was administered the Metoprol on 10/1/23 – 10/6/23, 10/8/23 – 10/15/23, and 10/20/23 – 10/31/23, despite having documentation that Resident M's blood pressure was <150 and his heart rate was <100 on each of these dates. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff are not properly trained to administer medications.

INVESTIGATION:

On 10/30/23 I received an online complaint regarding the facility. This complaint alleged that the direct care staff members have not been properly trained to administer medications. On 11/3/23 I conducted an unannounced on-site investigation. I interviewed Ms. Ried at this time. Ms. Ried reported that she has been trained as a direct care staff who can administer resident medications and she feels she is competent in this area.

During on-site investigation on 11/3/23 I interviewed Ms. Turner. Ms. Turner reported that she has been trained to administer medications at the facility. She reported feeling competent with this task.

During on-site investigation on 11/3/23 I interviewed Ms. Gashi. Ms. Gashi reported that all direct care staff who administer medications are trained to medication administration prior to being assigned this responsibility.

On 11/27/23 I interviewed Ms. Sanchez via telephone. Ms. Sanchez reported that she administers medications at the facility and was trained to do so during her orientation. Ms. Sanchez reported that she feels this training was adequate.

On 11/27/23 I interviewed Ms. Westbrook via telephone. Ms. Westbrook reported that she has been trained to administer medications. She reported that she feels this training was adequate.

On 11/27/23 I interviewed Ms. Darnell via telephone. Ms. Darnell reported that she has been trained to administer medications. She reported she feels this training was adequate.

On 11/2723 I received an email correspondence from Ms. Wheeler. This email contained the direct care staff training records for all direct care staff working at the facility. There was documentation of extensive medication administration training in these direct care staff training records provided by Ms. Wheeler.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4)When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (a) Be trained in the proper handling and administration of medication.
ANALYSIS:	Based upon interviews with multiple direct care staff members and review of the direct care staff training records provided by Ms. Wheeler, it can be determined direct care staff, who are administering medications have been adequately trained to administer resident medications.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

12/18/23

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Jana Lipps Date
Licensing Consultant

Approved By:

12/19/2023

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Dawn N. Timm Date
Area Manager