GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 07, 2024

Elyse Al-Rakabi
Bavarian Comfort Care AL & MC LLC
5366 Rolling Hills Drive
Bridgeport, MI 48722

RE: License #: AH730412299
Investigation #: 2024A1027026
Bavarian Comfort Care AL & MC LLC

Dear Licensee:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by the authorized representative and dated.

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. 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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730412299
Investigation #:	2024A1027026
Complaint Receipt Date:	01/23/2024
Investigation Initiation Date:	01/26/2024
Report Due Date:	03/22/2024
Licensee Name:	Bavarian Comfort Care AL & MC LLC
Licensee Address:	Suite B 3061 Christy Way Saginaw, MI 48603
Licensee Telephone #:	(989) 607-0001
Administrator:	Riley Moeggenberg
Authorized Representative:	Elyse Al-Rakabi
Name of Facility:	Bavarian Comfort Care AL & MC LLC
Facility Address:	5366 Rolling Hills Drive Bridgeport, MI 48722
Facility Telephone #:	(989) 777-7776
Original Issuance Date:	01/24/2023
License Status:	REGULAR
Effective Date:	07/24/2023
Expiration Date:	07/23/2024
Capacity:	65
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff did not provide care consistent with Resident A's rights.	No
Resident A did not receive his medications as ordered by the licensed health care professional.	No
Resident B lacked care.	No
The facility was short staffed.	No
Staff lacked training.	No
Food was subpar and not enough.	No
Additional Findings	Yes

III. METHODOLOGY

01/23/2024	Special Investigation Intake 2024A1027026
01/26/2024	Special Investigation Initiated - Telephone Telephone interview conducted with Complainant #1
01/29/2024	Inspection Completed On-site
01/30/2024	Contact - Document Received Email received from Ms. Moeggenberg with additional documentation
02/01/2024	Contact - Document Received Email received from Ms. Moeggenberg with additional documentation
02/02/2024	Contact - Telephone call made Telephone call conducted with Ms. Moeggenberg
02/05/2024	Contact - Document Received Email received from Ms. Moeggenberg with Resident B's incident reports and additional information
02/06/2024	Contact – Document Sent Email sent to Ms. Moeggenberg to request additional documentation

02/06/2024	Contact – Document Received Email received from Ms. Moeggenberg with additional documentation
02/06/2024	Inspection Completed-BCAL Sub. Compliance
02/07/2024	Exit Conference Conducted by email with Elyse Al-Rakabi and Riley Moeggenberg

ALLEGATION:

Staff did not provide care consistent with Resident A's rights.

INVESTIGATION:

On 1/24/2024, the Department received a complaint through the online complaint system which read in August 2023, Resident A requested an ambulance to be called; however, staff did not call immediately and argued with Resident A. The complaint read an ambulance was called and Resident A had a minor stroke.

On 1/26/2024, I conducted a telephone interview with the complainant whose statements were consistent with the complaint. The complainant stated Resident A was alert, orientated and able to inform staff of his needs.

On 1/29/2024, I conducted an on-site inspection at the facility. I interviewed administrator Riley Moeggenberg who stated she was not aware this incident happened with Resident A until last Friday when it was reported to her by Resident A's legal counsel. Ms. Moeggenberg stated staff were trained upon hire regarding residents' rights.

While on-site, I interviewed Resident A whose statements were consistent with the allegations.

I reviewed the incident report for Resident A dated 7/28/2023 at 6:00 AM completed by Employee #1 which read Resident A yelled down the hallway for staff to come quickly. The report read Resident A was in his apartment, sitting in his recliner and stated he did not feel good. The report read Resident A reported he felt like he was going to have a stroke. The report read staff assessed Resident A and obtained his vital signs, which deviated from his baseline. The report read Resident A reported he wanted to go to the hospital and the ambulance was called. The report read Resident A's family was notified on 7/28/2023 at 6:00 AM and the physician was notified on 7/28/2023 at 9:00 AM.

I reviewed Employee #1's file which read in part she signed and dated a caregiver job description on 2/23/2021 and 6/29/2022. The job description read in part she

would uphold and practice resident's rights. Employee #1's file read in part she signed and dated a supervisor job description on 2/23/2021 and 6/29/2022 which read in part in part she must know and understand the policy and procedure book, as well as be prepared to handle a crisis.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(j) A patient or resident is entitled to know who is responsible for and who is providing his or her direct care, is entitled to receive information concerning his or her continuing health needs and alternatives for meeting those needs, and to be involved in his or her discharge planning, if appropriate.**
ANALYSIS:	Interview with Ms. Moeggenberg revealed she was not apprised of staff denying Resident A the right seek emergency medical care. Review of facility's incident report for Resident A revealed he was transferred to the hospital after reporting his symptoms to Employee #1. Review of Employee #1's file revealed she signed a job description which read she would uphold residents' rights. Thus, there was insufficient evidence to substantiate this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A did not receive his medications as ordered by the licensed health care professional.

INVESTIGATION:

On 1/24/2024, the Department received a complaint through the online complaint system which Resident A's thyroid medication was administered after his meals.

On 1/26/2024, I conducted a telephone interview with the complainant who stated Resident A was supposed to receive his thyroid medication before breakfast. The complainant stated Resident A was evaluated by his physician on 1/18/2024 who planned to provide the facility with orders to ensure he received his thyroid medication prior to breakfast.

On 1/29/2024, I conducted an on-site inspection at the facility. I interviewed Ms. Moeggenberg who stated staff were to administer residents' medications one hour before or after the time it was prescribed.

While on-site, I interviewed Resident A who stated sometimes he received his thyroid medication at or after breakfast in which he was supposed to take it on an empty stomach. Resident A stated he received his thyroid medication at breakfast today.

I reviewed Resident A's physician orders from August 1, 2023, through January 29, 2024. The physician orders read Levothyroxine 50 mcg, take one tablet by mouth once daily at 7:00 AM.

I reviewed Resident A's November and December 2023 medication administration records (MARs) which read consistent with the physician orders. The MARs read staff initialed Levothyroxine as administered.

I reviewed Resident A's January 2024 MARs which read consistent with the November and December 2023 MARs and staff initialed Levothyroxine as administered. The MAR read on 1/15/2024 Resident A was out of the facility, so he did not receive his prescribed Levothyroxine.

I reviewed Resident A's medication administration history report dated 10/31/2023 to 1/29/2024 which read Levothyroxine was administered within the timeframe it was prescribed by the licensed healthcare professional. Additionally, the report read Resident A was administered Levothyroxine at 7:00 AM on 1/29/2024 which was the time it was prescribed.

On 2/2/2024, I conducted a telephone call with Ms. Moeggenberg who stated she would have staff reach out to Resident A's physician for a clarification order for Levothyroxine to be administered at 6:00 AM and prior to breakfast.

On 2/5/2024, I received email correspondence from Ms. Moeggenberg who stated Resident A's Levothyroxine administration time was changed to 6:00 AM.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Review of Resident A's physician orders and MARs revealed he was prescribed Levothyroxine daily at 7:00 AM in which staff initialed it as administered. Review of the administration history report read consistent with the time the Levothyroxine was prescribed. Ms. Moeggenberg obtained clarification orders for the Levothyroxine to be administered at 6:00 AM. Nonetheless, staff administered the medication consistent with the licensed health care professional's order therefore this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B lacked care.

INVESTIGATION:

On 1/24/2024, the Department received a complaint through the online complaint system which read the Resident B had a wet urinated mattress. The complaint read Resident B was a high fall risk and alarms were not on her bed/chair. Additionally, the complaint alleged Resident B's earrings were stolen.

On 1/26/2024, I conducted a telephone interview with the complainant who stated Resident B's mattress was replaced in Fall 2023 due to being in poor condition from urine. The complainant stated Resident B had alarms on her both her bed and chair. The complainant stated the alarm was not on and Resident B had fallen. Additionally, the complainant stated Resident B's earrings were stolen during the night.

On 1/29/2024, I conducted an on-site inspection at the facility. I interviewed Ms. Moeggenberg who Resident B resided in the facility's memory care in which her

spouse, Resident A, was her responsible party and resided in the assisted living. Ms. Moeggenberg stated Resident B's daughter assisted her every morning and evening. Ms. Moeggenberg stated Resident A visited with Resident B every day and stayed with her most of each afternoon. Ms. Moeggenberg stated Resident A ate lunch and dinner with Resident B every day. Ms. Moeggenberg stated Resident B's family requested she was out of her bed for meals; however, sometimes she refused. Ms. Moeggenberg stated Resident B required checks every two hours in which at night, staff would assist her to bathroom or change her in bed if she declined to get up. Ms. Moeggenberg stated Resident B received a new mattress.

Ms. Moeggenberg stated Resident B's bed alarm was on the outside of her door so staff could hear it. Ms. Moeggenberg stated Resident B's daughter posted signs to ensure the alarms were turned on.

Ms. Moeggenberg stated Resident B's earrings were reported as missing, so she investigated and observed the cameras, as well as posted pictures of them at the nurses' station, in which she was unable to locate them.

While on-site, I interviewed Resident A who stated he sat with his spouse, Resident B, most of the day. Resident A stated he would assist Resident B with her meals and toileting, if needed. Resident A stated staff showered Resident B this morning and she was in her wheelchair. Resident A stated he thought third shift staff did not always get Resident A up during the during the night and her bed would get "soaking wet," but had recently seen improvement in her care on that shift. Resident A stated he thought Resident B's bed and chair alarms were on most of the time.

While on-site, I observed Resident B's bed alarm was located on the outside of her apartment door and tested it in which it alarmed and worked appropriately. I observed Resident B's chair alarm was located on her recliner chair and tested it in which it alarmed and worked appropriately.

I observed Resident B who was in her wheelchair visiting with her family and appeared well groomed.

I observed Resident B's bed which was made and appeared to have clean sheets.

I reviewed Resident B's face sheet which read consistent with Ms. Moeggenberg's interview. The face sheet read in part she moved into the facility on 2/7/2022.

I reviewed Resident B's admission contact which read in part:

> "*The Company makes no representations or guarantees that the Company is secure from theft or any other criminal act perpetrated by any other Resident or person; therefore, the Company recommends that valuables, including but not limited to, jewelry and large amounts of money, not be brought into the Facility. If the Resident chooses to bring in such valuables or large amounts of money, the*

Resident is doing so at their own risk and the Company will not be responsible for any theft or loss of these items."

I reviewed Resident B's service plan updated on 5/30/2023 which read in part she was one person assist with personal care, grooming, bathing, ambulation, and transferring.

The plan read in part Resident B was totally dependent on staff for assistance to transfer in case of a fall and staff were to the follow the fall prevention program. The plan read in part Resident B had a history of falls and had a bed alarm. The plan read in part staff were to ensure the bed alarm was on and functioning every time she was placed in bed. The plan read in part staff were to conduct every two-hour checks at night in which they must wake Resident B up and take her to the bathroom to help treat symptoms of overactive bladder which could be causing increased falls. The plan read in part Resident B moved well if she used her walker, but often forgot to use it and was very unsteady on her feet without an assistive device. The plan read in part Resident B had neck mobility issues when turning her walker causing falls.

I reviewed Resident B's chart notes dated 8/3/2023 to 1/28/2024.

Note dated 8/17/2023 read in part Resident B was observed on the floor on her stomach in which she had a rug burn above her eye. The note read in part her physician, waiver program and daughter were notified.

Note dated 8/21/2023 read Resident B received a new mattress from covenant over the weekend.

Note dated 8/27/2023 read in part Resident B lost her balance trying to use the bathroom on her own in which she did not have an injury.

I reviewed Resident B's incident reports dated 8/17/2023 and 8/27/2023 which read consistent with her chart notes. Report dated 8/17/2023 read in part Resident B's alarms were in place and staff responded to the alarm sounding. Report dated 8/27/2023 read in part Resident B's bed alarms were on and staff responded it sounded.

I reviewed Resident B's Activities of Daily Living (ADL) logs dated December 2023 and January 2024. The logs read in part staff were to initial two-hour safety and alarm checks, as well as toileting every two hours from 1:00 AM to 11:00 PM daily, which staff initialed as completed. The logs read in part Resident B was to receive showers twice weekly in which staff initialed were completed. The December 2023 log read in part staff initialed that Resident B received four as needed showers.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Review of Resident B's medical records revealed she required staff assistance with her activities of daily living. Review of Resident B's service plan read consistent with her activities of daily logs in which staff documented her care was completed. Review of the facility's incident reports for Resident B revealed her alarms were on and staff responded accordingly. Review of Resident B's admission contract revealed they were not liable for her jewelry. Therefore, the allegations could not be substantiated based upon this evidence.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility was short staffed.

INVESTIGATION:

On 1/24/2024, the Department received a complaint through the online complaint system which read there was not enough help.

On 1/29/2024, I conducted an on-site inspection at the facility. I interviewed Ms. Moeggenberg who stated that she has terminated several staff who were not meeting the facility's expectations; however, has been hiring staff consistently to ensure residents received care consistent with their service plans.

Ms. Moeggenberg stated there were currently 25 assisted living residents and 12 memory care residents. Ms. Moeggenberg stated there were two assisted living residents who required a Hoyer lift for transfers which also required two-person assistance, along with one resident who required a sit to stand for transfers. Ms. Moeggenberg stated there were two memory care residents who required a Hoyer lift for transfers and one resident who required two-person assistance.

Ms. Moeggenberg stated there were three shifts in which there was a 15-minute overlap for staff to conduct narcotic counts and change of shift reports. Ms. Moeggenberg stated on the day and afternoon shifts, there were two staff members assigned to the assisted living and two staff members assigned to the memory care. Ms. Moeggenberg stated there three staff members on night shift in which two staff members were assigned to assisted living and one staff member assigned to memory care. Ms. Moeggenberg stated one staff member in the assisted living floated to the memory care to assist when needed. Ms. Moeggenberg stated the staff schedule identified which staff were on-call that day if staff called off their shift as well as the staff that were scheduled to be mandated to work additional hours if needed.

While on-site, I observed the staff assigned to the assisted living and memory care units which was consistent with statements from Ms. Moeggenberg.

I reviewed the facility's January 2024 staff schedule from 1/1/2024 through 1/29/2024 which read consistent with statements from Ms. Moeggenberg.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Staff attestations were consistent with January 2024 staff schedule; therefore, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff lacked training.

INVESTIGATION:

On 1/24/2024, the Department received a complaint through the online complaint system which read staff were not trained.

On 1/29/2024, I conducted an on-site inspection at the facility. I interviewed Ms. Moeggenberg who stated all staff completed two hours of orientation training and a checklist which including review of the facility's policies and procedures. Ms. Moeggenberg stated staff were educated on the facility's policies and procedures

utilizing PowerPoint presentations. Ms. Moeggenberg stated each staff also reviewed and signed their job descriptions.

Ms. Moeggenberg stated newly hired caregiver would first follow and observe a staff member on duty, then would have three to four days of training on the floor with the caregiver. Ms. Moeggenberg stated night shift caregivers were trained on day shift first, so they could be introduced to the residents and their care. Additionally, Ms. Moeggenberg stated medication technicians were trained as caregivers first.

Ms. Moeggenberg stated medication technicians completed a medication administration course training, then would have three to four days of training on the floor with another medication technician. Ms. Moeggenberg stated the medication technician completed a competency checklist and was observed by another trained medication technician.

Ms. Moeggenberg stated an additional training and checklist were completed when as staff member became a supervisor.

Ms. Moeggenberg stated she recently implemented that the wellness coordinator would train all medication technicians. Ms. Moeggenberg stated the wellness coordinator would provide the new medication technicians written instructions, as well as observe and follow them on the floor. Ms. Moeggenberg stated the wellness coordinator re-evaluated all medication technicians by observing and testing them annually.

Ms. Moeggenberg stated she would also be providing all newly trained staff members a trainer evaluation form which could be submitted anonymously with to provide her feedback of the employees who trained other staff.

While on-site, I reviewed Employees #1, #2, #3 and #4's files. Employees #1, #2 and #3 were medication technicians and supervisors, and Employee #4 was a resident caregiver. Employees #2, #3 and #4's files read in part each had signed that they completed training titled "*Caregiver Training Checklist and Observation*;" however Employee #1's file lacked this training record. The "*Caregiver Training Checklist and Observation*" checklist read in part following policies and procedures were reviewed:

-Disaster preparedness and location of disaster book/review of content/shut-off's
-Resident Rights and Abuse/Procedure/Responsibilities
-Infection Control (standard precautions, prevention, containment of communicable disease
-Reporting requirement
-Service plan/purpose/location

Additionally, the "*Caregiver Training Checklist and Observation*" read in part staff were provided a clinical explanation/demonstration on the following: hand hygiene, post mortem care, repositioning, vital signs and reporting abnormal vital signs,

weight scale and reporting abnormal weights, perineal care, colostomy care, catheter care, ted hose application, feed a resident/special diet review, oral and denture care, dressing a resident, bathing/showering/bed bathing a resident, review of recognition of decubitus ulcers (bed sores)/skin checks, oxygen tank storage location/how to transfer oxygen tanks/valve assembly/transfer of and usage, basic wound care and skin assessments on shower days/completing the paperwork/reporting.

Employees #1, #2, and #4 files included training titled "*Medication Administration Competency Checklist and Observation*" as well as a "*Supervisor Job Description*" and "*Supervisor Training Checklist*" which were signed by the employees that they were completed. The Supervisor Training Checklist included training on but was not limited to disaster plan training for fires, gas, water, generator, emergency supplies, the disaster book, electrical outage, tornado, active shooter, evaluation protocol, completing incident reports, ADL completion, and conducting rounds.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	Although review of Employee #1's file revealed it lacked the initial caregiver training and checklist, other training records within her file demonstrated training on all areas consistent with this rule. Review of the other randomly selected Employees #2, #3 and #4 files revealed they were trained consistent with this rule; therefore, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Food was subpar and not enough.

INVESTIGATION:

On 1/24/2024, the Department received a complaint through the online complaint system which read the food was subpar and not enough.

On 1/26/2024, I conducted a telephone interview with the complainant who stated residents were served what appeared to be lunch meat with gravy over it for meal.

On 1/29/2024, I conducted an on-site inspection at the facility. I interviewed Ms. Moeggenberg who stated although she had received complaints recently regarding the food; she had received complaints regarding the amount of food served. Ms. Moeggenberg stated residents complained about the lack of variety. Ms. Moeggenberg stated residents were served hotdogs on Christmas day in which was not proper. Ms. Moeggenberg stated the chief operating officer and regional director met with the chef on 1/25/2024. Ms. Moeggenberg stated hotdogs were removed from the menu starting 1/28/2024. Ms. Moeggenberg stated residents could request second servings of anything on the menu if they required more food as well as order from the alternate menu.

Ms. Moeggenberg stated the facility contracted with Gordon's Food Service to deliver food to the facility.

Ms. Moeggenberg stated the facility's menus were not reviewed by a dietician; however, they were reviewed by the regional director of operations.

I reviewed the menus for November 2023, December 2023, and January 2024, in which each weekly menu had a soup of the day, as well as each meal contained a meat. The menus read the lunch and dinner meals contained a meat and vegetable, as well was a dessert. The bottom of the menus read how the meals would be modified if a resident was prescribed a special or therapeutic diet such as renal, dysphagia, gluten-free, or lactose-free. The menus read there some handwritten changes on various dates if the meal was changed.

While on-site, I observed the weekly menu was posted and read consistent with the lunch meal served. I observed the lunch meal was ham and cheese pizza, side salad and fruit Jello cup. I observed residents were served two slices of personal sized pizza. I observed some residents were served meals from the alternate menu, such as a cheeseburger. I observed some residents were served a modified meal.

While on-site, I observed the "Always Available/Alternative Menu" in which read in part and was not limited to options such as chicken salad, egg salad, tuna salad, chicken salad wrap, grilled cheese, hamburger/cheeseburger, hotdog, seasoned chicken breast, soup, house salad, and cottage cheese.

While on-site, Ms. Moeggenberg asked an assisted living resident how her lunch was in which she responded "*good*." I observed both assisted living and memory care residents enjoying their meals.

While on-site, I interviewed Resident A who stated, "*something is missing with favoring*." Resident A stated the facility had a good breakfast in which you could have anything you wanted. Resident A stated most of the meals "*aren't too bad*" however they served a lot of pasta and rice and there was not a lot of variety.

I reviewed Resident A's monthly weights from August 2023 to February 2024 which read he weighed 155 pounds on 8/15/2023 and 149 pounds on 2/1/2024.

I reviewed Resident B's monthly weights from August 2023 to February 2024 which read she weighed 153.5 pounds on 9/4/2023 and 159 pounds on 2/1/2024.

APPLICABLE RULE	
R 325.1951	**Nutritional need of residents.**
	A home shall meet the food and nutritional needs of a resident in accordance with the recommended daily dietary allowances of the food and nutrition board of the national research council of the national academy of sciences, adjusted for age, gender, and activity, or other national authority acceptable to the department, except as ordered by a licensed health care professional.

ANALYSIS:	Review of the weekly menus revealed residents were served three meals daily, in which most meals contained a source of protein. Staff attestations revealed residents could request additional servings of food or order from the alternate menu. Ms. Moeggenberg statements revealed complaints regarding the food were addressed with the chef. Review of Resident A and B's weights revealed Resident A lost weight while Resident B gained weight. Interview with Resident A revealed he walked every day so it could not be determined the cause of his weight loss. Therefore, the aforementioned evidence revealed that it could not support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of the December 2023 menu and meal census revealed on 12/25/2023 residents were served tomato basil chicken over egg noodles and German chocolate cake for dinner in which was inconsistent with statements from Ms. Moeggenberg; therefore, the menu and meal census were not updated to reflect the food that was actually served.

Review of the January 2024 meal census revealed it was not always completed with the food temperatures or the number of residents served. For example, on the following dates one or more meals were lacked a food temperature or the number the residents served: 1/3/2024, 1/4/2024, 1/14/2024 through 1/20/2024, 1/28/2024, and 1/29/2024. Additionally, the food served on the meal census did not always read consistent with the menu. For example, on 1/21/2024 the menu read lunch meal was garlic parmesan chicken tenders, macaroni and cheese and watermelon cup and the dinner meal was sweet and sour meatballs over white rice, mixed vegetables, apple pie, while the meal census read lunch meal was broccoli and cheese soup, grilled cheese sandwich, fruit cup and the dinner meal was barbeque pork sandwich, macaroni and cheese and a sugar cookie.

APPLICABLE RULE	
R 325.1954	**Meal and food records.**
	The home shall maintain a record of the meal census, to include residents, personnel, and visitors, and a record of the kind and amount of food used for the preceding 3-month period.
ANALYSIS:	Review of the December 2023 menu and meal census revealed it was not corrected to read hotdogs were served on 12/25/2023. Review of the January 2024 meal census revealed for various dates and meals, it read inconsistent with the menu and was not always completed; therefore, a violation was substantiated for these reasons.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

02/06/2024

_____

Jessica Rogers Date
Licensing Staff

Approved By:

02/07/2024

_____

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section