GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 24, 2024

Mary North
Brookdale Grand Blanc AL
5080 Baldwin Road
Holly, MI 48442

RE: License #: AH250236939
Investigation #: 2024A1027040
Brookdale Grand Blanc AL

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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative 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 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 #:	AH250236939
Investigation #:	2024A1027040
Complaint Receipt Date:	03/19/2024
Investigation Initiation Date:	03/21/2024
Report Due Date:	05/18/2024
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	Suite 2300 6737 West Washington St. Milwaukee, WI 53214
Licensee Telephone #:	(615) 221-2250
Administrator:	Heather Vahlbusch
Authorized Representative:	Mary North
Name of Facility:	Brookdale Grand Blanc AL
Facility Address:	5080 Baldwin Road Holly, MI 48442
Facility Telephone #:	(810) 953-7111
Original Issuance Date:	10/01/1998
License Status:	REGULAR
Effective Date:	05/07/2023
Expiration Date:	05/06/2024
Capacity:	78
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's medications were not administered as prescribed.	Yes
Resident A lacked care.	Yes
The facility was understaffed.	No
Medication technicians required training.	No
Additional Findings	No

III. METHODOLOGY

03/19/2024	Special Investigation Intake 2024A1027040
03/21/2024	Special Investigation Initiated - On Site
03/29/2024	Contact - Document Received Email received from Ms. Vahlbusch with documentation requested at on-site inspection
04/01/2024	Contact - Document Sent Email sent to Heather Vahlbusch requesting medication administration history records
04/01/2024	Contact - Document Sent Email sent to Ms. Vahlbusch requesting additional documentation
04/03/2024	Contact - Document Sent Email sent to Ms. Vahlbusch requesting additional information and documentation
04/04/2024	Contact - Document Received Emails received from Ms. Vahlbusch with requested documentation
04/19/2024	Contact - Telephone call made Telephone interview conducted with Employee #2
04/19/2024	Inspection Completed-BCAL Sub. Compliance
04/24/2024	Exit Conference

	Conducted with by email with Mary North and Heather Vahlbusch

ALLEGATION:

Resident A's medications were not administered as prescribed.

INVESTIGATION:

On 3/19/2024, the Department received allegations which alleged Resident A's medications were not administered at the correct times. The allegations read Resident A was administered the wrong dose of medication and sometimes he could not receive his medications if it was after the time they were prescribed. The allegations read staff administered Resident A's medications; however, did not observe him take them. The allegations read the complainant observed pills in Resident A's bed, under the bed, and behind his dresser. The allegations specifically read:

On 2/19/2023 or 2/20/2023, Resident A was administered the wrong dose of Levodopa/Carbidopa.

On 3/8/2023, Resident A was administered his medications 90 minutes early.

In March 2023, Resident A's medications were administered six times daily and he was overdosed for three weeks by receiving his daytime Parkinson's medications around the clock.

In March 2023, Resident A's Warfarin was not administered correctly.

On 5/13/2023 and 5/14/2023, Resident A missed two doses of Warfarin because it was locked in the nurses' office and the medication technicians did not have access to it.

On 5/15/2023, the medication technician could not give Resident A his medications because it was too late.

On 7/3/2023, Resident A went to the emergency room for a fall and missed receiving all his night medications.

On 7/11/2023, Resident A's Warfarin was to be held; however, staff administered it. Also, his bedtime medications were administered at dinner and his Parkinson's medications were given 90 minutes too early.

On 7/12/2023, Resident A's Parkinson's medications were administered late.

On 7/12/2023 or 7/13/2023, Resident A was administered his medications too early and his Depakote was discontinued because staff would not cut it in half.

On 3/21/2024, I conducted an on-site inspection at the facility. I interviewed administrator Heather Vahlbusch who stated Resident A utilized an outside physician for his care.

Ms. Vahlbusch stated medications were to be administered one hour before or after the time they were prescribed by the licensed healthcare professional. Ms. Vahlbusch stated if a resident was absent from the home, the resident's family could take the medications with them to be administered. Ms. Vahlbusch stated staff were not permitted to administer medications outside the parameter of the written licensed health care professional, which was also in the facility's policy.

I interviewed Employee #1 who stated Resident A's spouse maintained the machine to check Resident A's INR [international ratio] in which was needed to dose his Warfarin Sodium. Employee #1 stated Resident A's spouse would call the result to Resident A's licensed health care professional then provide a verbal order from the physician; however, Employee #1 stated the facility required a written prescription or the licensed healthcare professional would need to call the order directly into the pharmacy. Employee #1 stated if medication orders were sent to their pharmacy before 2:00 PM, they would be delivered that night.

On 4/19/2024, I conducted a telephone interview with Employee #2 whose statements were consistent with previous staff interviews. Employee #2 stated she observed Resident A take his medications and was not aware of any medications on his floor or in his bed. Employee #2 stated Relative A1 would sometimes offer to provide Resident A his medications once they were removed from the medication cart and ready to be administered.

I reviewed Resident A's service plan dated 2/17/2023 which read in part facility staff were to order and coordinate medications between family, health care providers and pharmacy, as well as aid with administration of medications. The service plan updated on 6/23/2023 read in part the resident/designee would order and coordinate his medications between the health care providers and pharmacy. The plan read in part Resident A's spouse ordered and obtained his prescriptions from the retail pharmacy.

I reviewed Resident A's February, March, May and July 2023 medication administration records (MARs).

The February 2023 MAR read in part:

Carbidopa-Levodopa ER oral tablet extended release 50-200 mg, give 2 tablets by mouth at bedtime at 9:00 PM. The MAR read the order started on 2/17/2023 and discontinued on 2/20/2023.

Carbidopa-Levodopa ER oral tablet extended release 50-200 mg, give 2 tablets by mouth at bedtime at 11:00 PM. The MAR read the order started on 2/20/2023 and discontinued on 6/15/2023.

Carbidopa-Levodopa ER oral tablet extended release 25-100 mg, give 3 tablets by mouth every 2.5 hours at 3:00 AM, 5:30 AM, 8:00 AM, 10:30 AM, 1:00 PM, 3:30 PM, 6:00 PM and 8:30 PM. The MAR read the order was started on 2/17/2023 and discontinued on 3/15/2023.

The March 2023 MAR read in part:

The Carbidopa-Levodopa ER 50-200 mg order read consistent with the February 2023 MAR and was documented by staff as administered.

Carbidopa-Levodopa ER oral tablet extended release 25-100 mg, give 3 tablets by mouth every 2.5 hours at 3:00 AM, 5:30 AM, 8:00 AM, 10:30 AM, 1:00 PM, 3:30 PM, 6:00 PM and 8:30 PM was stopped on 3/15/2023. The MAR read the medication was administered as prescribed except on 3/1/2023 in which the 1:00 PM dose was left blank.

Carbidopa-Levodopa ER oral tablet extended release 25-100 mg, give 3 tablets by mouth six times a day at 8:00 AM, 10:30 AM, 1:00 PM, 3:30 PM, 6:00 PM and 8:30 PM was started on 3/15/2023 and discontinued on 6/15/2023. The MAR read the medication was administered by staff as prescribed or staff documented a reason why it was not administered, such as "*absent from home*."

Additionally, the March 2023 MAR read Resident A was prescribed Warfarin Sodium to be administered at 6:00 PM in which various doses were prescribed as written below. The MAR read the medication was administered by staff as prescribed or staff documented a reason why it was not administered.

Warfarin 6 mg – 1 tablet which started on 2/24/2023 and discontinued on 3/3/2023.

Warfarin 5 mg – 1 tablet which started on 2/21/2023, held from 2/24/2023 to 3/3/2023 and discontinued on 3/24/2023.

Warfarin 4 mg – ½ tablet which started on 3/7/2023 and discontinued on 3/15/2023.

Warfarin 2 mg – 1 tablet which started on 3/15/2023 and discontinued on 3/16/2023.

Warfarin 2 mg – 1 tablet which started on 3/16/2023 and discontinued on 3/24/2023.

Warfarin 4 mg – 1 tablet which started on 3/24/2023 and discontinued on 4/14/2023.

The March 2023 MARs read consistent with the medication administration audit report.

On 3/8/2023, the MARs read some of Resident A's medications were prescribed to be administered at 9:00 AM, 6:00 PM and 11:00 PM and staff documented them as administered at 08:03 AM, 6:51 PM and 11:21 PM consecutively. Specifically, on 3/8/2023, Carbidopa-Levodopa was prescribed to be administered at the following times and was documented as administered per the chart below.

Medication/dose	**Scheduled Time**	**Administration Time by Staff**
Carbidopa-Levodopa 25-100 mg	3:00 AM	2:40 AM
Carbidopa-Levodopa 25-100 mg	5:30 AM	5:02 AM
Carbidopa-Levodopa 25-100 mg	8:00 AM	7:57 AM
Carbidopa-Levodopa 25-100 mg	10:30 AM	10:40 AM
Carbidopa-Levodopa 25-100 mg	1:00 PM	1:54 PM
Carbidopa-Levodopa 25-100 mg	3:30 PM	4:38 PM
Carbidopa-Levodopa 25-100 mg	6:00 PM	6:51 PM
Carbidopa-Levodopa 50-200 mg	11:00 PM	11:21 PM

The May 2023 MAR read in part:

Warfarin Sodium was documented as administered on 5/13/2023. Warfarin Sodium was documented as not administered on 5/14/2023 for reason "*pharmacy action required*."

On 5/15/2023 Resident A's 6:00 PM medications were documented as not administered for reason "*absent from home*;" however, his 11:00 PM medications were documented as administered.

The July 2023 MAR read in part:

On 7/3/2023, the MAR read staff documented Resident A received his medications as prescribed including his night medications. However, Resident A was prescribed Midodrine, take one tablet by mouth three times a day for

hypotension and hold if systolic blood pressure was greater than 130 in which staff initialed the medication as administered on 7/3/2023 at 8:00 AM for blood pressure of 143/95, on 7/13/2023 at 5:00 PM for a blood pressure of 168/82, and on 7/24/2023 at 5:00 PM for a blood pressure of 174/113.

On 7/11/2023, Warfarin Sodium 5 mg was documented as held; however, there was another order for Warfarin Sodium 5 mg, give ½ tablet by mouth at 5:00 PM in which staff initialed the medication as administered. The medication administration audit report read to hold Warfarin Sodium on 7/11/2023 at 10:54 AM to 7/12/2023 at 10:54 AM; however, both orders were on the order summary report.

Also, specifically, on 7/11/2023, Carbidopa-Levodopa was prescribed to be administered at the following times and was documented as administered per the chart below.

Medication/dose	**Scheduled Time**	**Administration Time by Staff**
Carbidopa-Levodopa 25-100 mg	7:00 AM	7:32 AM
Carbidopa-Levodopa 25-100 mg	9:30 AM	10:04 AM
Carbidopa-Levodopa 25-100 mg	12:00 PM	12:38 PM
Carbidopa-Levodopa 25-100 mg	2:30 PM	2:19 PM
Carbidopa-Levodopa 25-100 mg	5:00 PM	4:53 PM
Carbidopa-Levodopa 25-100 mg	7:30 PM	7:39 PM
Carbidopa-Levodopa 50-200 mg	9:30 PM	9:01 PM

On 7/12/2023, Carbidopa-Levodopa was prescribed to be administered at the following times and was documented as administered per the chart below.

Medication/dose	**Scheduled Time**	**Administration Time by Staff**
Carbidopa-Levodopa 25-100 mg	7:00 AM	7:12 AM
Carbidopa-Levodopa 25-100 mg	9:30 AM	9:30 AM
Carbidopa-Levodopa 25-100 mg	12:00 PM	12:42 PM
Carbidopa-Levodopa 25-100 mg	2:30 PM	2:35 PM

Carbidopa-Levodopa 25-100 mg	5:00 PM	5:48 PM
Carbidopa-Levodopa 25-100 mg	7:30 PM	7:29 PM
Carbidopa-Levodopa 50-200 mg	9:30 PM	8:55 PM

On 7/13/2023, Carbidopa-Levodopa was prescribed to be administered at the following times and was documented as administered per the chart below.

Medication/dose	**Scheduled Time**	**Administration Time by Staff**
Carbidopa-Levodopa 25-100 mg	7:00 AM	6:58 AM
Carbidopa-Levodopa 25-100 mg	9:30 AM	9:24 AM
Carbidopa-Levodopa 25-100 mg	12:00 PM	12:00 PM
Carbidopa-Levodopa 25-100 mg	2:30 PM	2:19 PM
Carbidopa-Levodopa 25-100 mg	5:00 PM	4:53 PM
Carbidopa-Levodopa 25-100 mg	7:30 PM	6:48 PM
Carbidopa-Levodopa 50-200 mg	9:30 PM	9:09 PM

The MAR read Resident A's Divalproex Sodium was discontinued on 7/19/2023. The MAR read give one tablet by mouth at bedtime for seizures, and lacked specific instructions for administration, such as to cut it in half. I reviewed the order summary report which lacked a reason why the medication was discontinued.

Additionally, the order summary report read in part staff may crush appropriate medications/open capsules if not contraindicated. The report read Resident A may go out on "LOA" [leave of absence] with medications unless otherwise contraindicated.

I reviewed Resident A's progress notes dated 2/16/2023 to 7/31/2023 which read in part:

"*Effective Date: 03/01/2023 14:04 [2:04 PM] Type: *General Progress Note* Note Text: [Relative A1] called and stated INR was 3.6 and PCP is keeping Warfarin at 6 mg daily. Faxed to pharmacy*."

"*Effective Date: 03/16/2023 16:44 [4:44 PM] Type: *General Progress Note**

[Relative A1] in and stated resients [sp] INR is 1.5 and his PCP wants him on the Warfarin Coumadin 7 mg daily until next reading. Orders faxed."

"*Effective Date: 03/24/2023 18:34 [6:34 PM] Type: *General Progress Note* Resident INR too High new order from PCP to decrease to 4mg daily.*"

"*Effective Date: 04/13/2023 14:38 [2:38 PM] Type: *General Progress Note* Resident's PT/INR is 1.8. [Relative A1] called in to Dr. Sherman the results if they want to change the dosage of the Coumadin*."

"*Effective Date: 04/14/2023 11:34 [11:34 AM] Type: *General Progress Note* New orders to d/c warfarin 4 mg daily and change to 5 mg daily*."

"*Effective Date: 04/28/2023 18:29 [6:29 PM] Type: *General Progress Note" [Relative A1], checked PT/INR and it was 3.8. She put a call in to his doctor. No new orders at this time*."

"*Effective Date: 05/12/2023 13:26 [1:26 PM] Type: *General Progress Note* New orders to hold coumadin x 1 day from Dr. Sherman due to PT/INR value at 4.9*."

"*Effective Date: 06/23/2023 13:49 [1:49 PM] Type: *General Progress Note* Resident back from LOA. Medications reviewed with [Relative A1]. Vitals taken and medications received and verified. Faxed list to pharmacy - MSO. New pendant supplied with resident*."

"*Effective Date: 06/29/2023 15:32 [3:32 PM] Type: *General Progress Note* [Relative A1] here. She checked [Resident A's] INR and it is 2.8. His MD is aware and no new Coumadin orders at this time*."

"*Effective Date: 07/19/2023 13:54 [1:54 PM] Type: *General Progress Note* New orders from Dr. Spears to discontinue Depakote ER. Noted and entered in PCC."*

"*Effective Date: 07/21/2023 10:02 [10:02 AM] Type: *General Progress Note* INR 1.5. Doctor increased coumadin to 6 mg a day. [Relative A1] will bring in new prescription*."

I reviewed the facility's medication administration policy which read consistent with staff interviews. The policy read in part tablets should not be cut or divided unless scored. The policy read in part pharmacy should be contacted to provide tablets that do not need to be cut or the ordering physician notified for alternate dosages if possible. The policy read in part medications should be administered within the parameters of the physician orders.

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 medical records revealed from February to June 2023 staff were responsible for coordinating Resident A's medications with his licensed healthcare professional and the pharmacy, as well as administration. Staff attestations and review of the facility medication administration policy revealed staff were to observe residents take their medications in which there was lack of evidence to support these actions were not taken, as well as observation of medications on the floor. Review of the MARs on 2/19/2023 and 2/20/2023 revealed there was a change to the administration times of the Carbidopa-Levodopa which read consistent with order summary report and the physician's orders, so it could not be substantiated that Resident A was administered the wrong dose. Review of the medications administered on 3/8/2023 revealed there was lack of evidence demonstrating Resident A's medications were administered 90 minutes early. Review of the March 2023 MAR revealed Resident A's Carbidopa-Levodopa 25-100 mg medication was administered every 2.5 hours, except on 3/1/2023 at 1:00 PM which was left blank. The MAR read Carbidopa-Levodopa 50-200 mg medication was administered at 11:00 PM. Both Carbidopa-Levodopa orders on the MAR read consistent with order summary report and the physician orders. Additionally, review of the March 2023 MAR read Resident A's Warfarin was prescribed and held for various doses in which there was insufficient evidence to support it was not administered correctly. Review of the May 2023 MARs revealed staff documented Resident A's Warfarin Sodium as administered on 5/13/2023. The MAR read on 5/14/2023 staff documented the medication required pharmacy action in which there was insufficient evidence to support this allegation. The MAR read on 5/15/2023 Resident A was absent from the home for some of his medications in which read consistent with the facility's policy. On 7/3/2023, the MAR read staff documented Resident A received his medications as prescribed including his night medications. On 7/11/2023, the medication administration report revealed Warfarin Sodium was to be held and read consistent on the

	MAR; however, a single dose was placed on the MAR that same day and read consistent with order summary report. It could not be confirmed if Resident A should have received a dose of Warfarin Sodium or not since the both orders were on the physician orders. Also, review of the facility's medication administration audit report for Resident A revealed his medications prescribed to be administered at 5:00 PM were documented by staff as administered within the permitted timeframe and his bedtime medications were also documented as administered within the permitted timeframe. Additionally, the records read Resident A's Carbidopa-Levodopa was administered per the licensed health care provider's orders. On 7/12/2023, review of the facility's medication administration audit report for Resident A revealed his Carbidopa-Levodopa Parkinson's medications were administered within the timeframe they were prescribed by the licensed healthcare provider. On 7/12/2023 and 7/13/2023, review of the facility's medication administration audit report for Resident A revealed his medications were administered within the timeframe per the licensed healthcare provider's orders. Review of Resident A's physician's orders lacked a reason why his prescribed Divalproex Sodium was discontinued. Review of Resident A's Midodrine revealed it was not always administered within the perimeters ordered by the licensed health care professional. In conclusion, review of the medication records revealed his medications, specifically Midodrine and Carbidopa-Levodopa, were not always administered as prescribed by the licensed healthcare professional; therefore, a violation was established for this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A lacked care.

INVESTIGATION:

On 3/19/2024, the Department received allegations which alleged Resident A had falls with injuries in which the complainant was required to bandage herself.

The complaint alleged Resident A required to be fed in which was not completed. The complaint alleged Resident A lost more than 20 pounds since admission to the facility. The complaint alleged Resident A was given broccoli three times the first week of being at the facility in which was on his dislike food list.

The complaint alleged Resident A had a heart monitor in which staff did not maintain the recording device needed for it.

The complaint specifically read:

> On 3/31/2023, Resident A fell, and skin peeled back four inches on his arm and his spouse had to bandage his arm.
>
> On 4/30/2023, Resident A fell and was sent to the emergency room in which he stayed in the hospital until 5/4/2023 because his blood levels were too high.
>
> On 5/16/2023, Resident A fell and was hospitalized until 6/4/2023 then went to rehabilitation until 6/23/2023.
>
> On 7/3/2023, Resident A fell, hit his head and staff left him on the couch bleeding. The complaint alleged Resident A's spouse had to bandage his head, then he went to the emergency room.
>
> On 7/13/2023, Resident A was left in the recliner to sleep until after 12:21 PM.
>
> On 7/14/2023, Resident A was not put in bed until after 10:00 PM.

On 3/21/2024, I conducted an on-site inspection at the facility and interviewed Ms. Vahlbusch who stated she had several communications and care conferences with Relative A1 during his stay at the facility regarding his plan of care. Ms. Vahlbusch stated staff were required to contact emergency medical services if Resident A hit his head during a fall.

I interviewed Employee #1 who stated Resident A was a fall risk and his family placed a camera in his room. Employee #1 stated staff assisted with Resident A with his meals.

On 4/19/2024, I conducted a telephone interview with Employee #2 who stated residents were assisted with their meals. Employee #2 stated when Resident A had finger foods, staff encouraged to try to do feed himself; however, staff would assist him and other residents in the dining area.

Employee #2 stated Resident A had a heart monitor. Employee #2 stated monitoring device had to be unplugged and was placed in his wheelchair, so it was always within 10-15 feet of him. Employee #2 stated staff also changed the battery on the monitoring device. Employee #2 stated there were instructions in Resident A's nightstand or staff would educate each other.

Employee #2 stated Resident A had a history of falls and did not recall injuries except for when he hit his head and was sent to the hospital. Employee #2 stated Resident A had fragile skin and bruising. Employee #2 stated an incident report should be completed for every fall or suspected fall.

Employee #2 stated although they encouraged all residents to get into bed to sleep for the night, they could not force them. Employee #2 stated Resident A would sometimes be "*reluctant*" to get into bed. Employee #2 stated she would inform third shift of the reason why a resident was not in bed yet so they could check on the resident again and assist them to bed if they were ready.

I reviewed Resident A's face sheet which read in part he admitted to the facility on 2/16/2023 and discharged on 7/31/2023. The face sheet read in part his primary physician was in Flint. The face sheet read in part Relative A1 was his responsible party.

I reviewed Resident A's service plans.

Service plan dated 2/17/2023 read in part Resident A was on a regular diet with thin liquids, was not a picky eater and had no food allergies. The plan read in part Resident A was independent with showering, bathing, dressing, grooming, and utilized the bathroom independently; however, wore briefs for episodes of urinary incontinence. The plan read in part Resident A used a four wheeled walker and had fallen in the last twelve months, so he was a fall risk. The plan read in part Resident A had some short-term memory loss. The plan read in part Resident A had no wounds but had bruising on his wrists and lower arms.

Service plan updated on 3/19/2023 read consistent with the plan dated 2/17/2023. The plan read in part for Resident A's skin care, staff were to notify nurse of redness or open areas.

Service plan updated on 6/23/2023 read in part Resident A required one person assistance with eating. The plan read in part he could not fed himself and was unable to hold and use a fork or a spoon. The plan read part, finger foods were ordered; however, he would still require assistance with eating. The plan read in part Resident A required one person assistance with dressing, grooming, transfers, and care. The plan read in part Relative A1 would shower him and assist with daily bathing. The plan read in part Resident A could verbally communicate the need to use the restroom, but would require assistance with

cleaning his peri area, changing briefs and soiled clothing as needed. The plan read in part Resident A was fall risk. The plan read in part Resident A utilized a manual wheelchair and propelled himself without difficulty.

I reviewed an incident report for Resident A dated 5/16/2023 at 6:00 PM which read in part that he fell out of his wheelchair on the front porch and staff immediately called 911. The report read in part corrective measures were to follow all discharge orders and instructions, have Resident A seen by primary care practitioner for a follow up exam and medication review, therapy to evaluate and treat as ordered, encourage resident to increase his fluid intake, and ensure he washed his hands before and after using the bathroom. The report read in part Relative A1, and his physician were notified.

I reviewed Resident A's April and May 2023 Medication Administration Records (MARs) which read consistent with the allegations and documented he was hospitalized from 4/30/2023 to 5/5/2023, and from 5/16/2023 to 6/23/2023.

I reviewed Resident A's weight summary which read:
2/20/2023: 161.8 lbs.
3/8/2023: 163.8 lbs.
3/17/2023: 163.8 lbs.
4/10/2023: 164 lbs.
4/17/2023: 160 lbs.
5/9/2023: 149 lbs.
6/23/2023: 136 lbs.
7/17/2023: 134.2 lbs.

I reviewed Resident A's progress notes.

Note dated 06/28/2023 read:
LATE ENTRY
Note Text : "*Care giver observed resident laying on floor in the hallway. He was on the floor outside of his room. He was laying on his left side with his left arm under his head and his legs extended out. He stated someone was attacking him. There was not anyone else in the hallway. Resident was wearing socks and shoes. He stated no pain and that he was "fine". No signs of injury and vitals signs WNL. Advised resident to use call pendant for all transfers. Showed him his pendant and how to use it. He returned demonstrated how to use the pendant. [Relative A1] aware and will come up later to see him.*"

Note dated: 06/30/2023 read:
"*Resident observed sitting on floor in front of his TV. He stated he hit his head on the TV stand. Small laceration on left eye brow. No complaints of pain. Vitals WNL. Called [Relative A1] and she stated she would take him to ED for evaluation and treatment since he hit his head. Dr. Gach was notified by [Relative A1*]."

Note dated 7/6/2023 read:
"*WEIGHT WARNING:*
Value: 136.0
Vital Date: 2023-06-23 13:55:00.0
-7.5% change [17.1% , 28.0]
-10.0% change [15.9% , 25.8]PCP aware of residents wt loss. Resident having increase in Parkinson's symptoms. Staff to assist feeding resident. No new orders at this time. Continue to monitor as ordered."

Note dated 7/31/2023 read:
"*WEIGHT WARNING:*
Value: 134.2
Vital Date: 2023-07-17 10:21:54.0
-7.5% change [9.9% , 14.8]
-10.0% change [17.1% , 27.6] PCP aware of wt loss. Resident returned to community from rehab with wt loss. Staff to feed resident every meal."

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: **R 325.1901**	**Definitions.** **Rule 1. As used in these rules:**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
For Reference: **R 325.1924**	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as

	soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	Review of Resident A's weight records revealed he had lost weight from 2/20/2023 to 5/9/2023. Resident A was out of the facility from 4/30/2023 to 5/4/2023, and again from 5/16/2023 to 6/23/2023; therefore, the accumulation of weight loss could not be solely attributed to his time within the facility. There was lack of evidence Resident A received broccoli three times since it could not be confirmed if it was served to Resident A due to maintenance of meal records being for three months. Staff attestations were consistent with the complaint which read Resident A had a heart monitor requiring specific care and maintenance; however Resident A's service plan and records lacked instructions for staff on the heart monitor's care and maintenance. Review of Resident A records revealed he had history of falls in which read consistent with some chart notes and one incident report. Resident A's MARs revealed he was hospitalized from 4/30/2023 to 5/5/2023 and review of his chart notes revealed he had a fall on 6/30/2023, thus, indicating there were other incidents that had occurred without record and consistent with the facility's policy. There was insufficient evidence regarding injuries requiring bandages for Resident A or that he was not assisted to bed. Nonetheless, the facility lacked an organized program to ensure Resident A's service plan reflected specific care and maintenance for his heart monitor as well as record of falls. Therefore, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility was understaffed.

INVESTIGATION:

On 3/19/2024, the Department received allegations which alleged the facility was understaffed.

On 3/21/2024, I conducted an on-site inspection at the facility. I interviewed Ms. Vahlbusch who stated the facility was staffed according to acuity of residents' needs. Ms. Vahlbusch stated there were three shifts: 6:00 AM to 2:00 PM, 2:00 PM to 10:00 PM, and 10:00 PM to 6:00 AM. Ms. Vahlbusch stated the facility could accommodate a resident required who required two-person assistance or a Hoyer lift depending on if the current level of staffing could adequately manage the resident. Ms. Vahlbusch stated medication technicians were also caregivers and were also sometimes assigned to care for a few residents.

On 4/4/2024, email correspondence with Ms. Vahlbusch read in part the total number of residents at the first of each month was:

February 2023: 62 residents
March 2023: 55 residents
April 2023: 63 residents
May 2023: 61 residents
June 2023: 61 residents
July 2023: 59 residents

Additionally, the email correspondence read in part the facility utilized a system that pulled the acuity numbers for staffing and what was current within the system on that day, due to the adjustments within the needs of our residents. The correspondence read in part on average there were six staff on duty for first and second shifts, and three staff on third shift.

On 4/19/2024, I conducted a telephone interview with Employee #2 whose statements were consistent with Ms. Vahlbusch.

I reviewed the staffing schedules for two-week periods in February, March, April, May, June, and July 2023 which read consistent statements from Ms. Vahlbusch and her email correspondence. The schedules read in part there were five or six staff members on duty for both first and second shifts, and three or four staff members on duty for third shift. The schedule read in part some staff members worked 12-hour shifts, partial shifts, or double shifts.

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:	Review of staffing schedules revealed there was lack of evidence to support the facility understaffed; therefore, a violation was not substantiated for this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medication technicians required training.

INVESTIGATION:

On 3/19/2024, the Department received allegations which alleged the medication technicians needed training.

On 3/21/2024, I conducted an on-site inspection at the facility. I interviewed Ms. Vahlbusch who stated staff were trained to administer medications by completed "*LMS course*" modules, then completion of two full days of in-class training. Ms. Vahlbusch stated after completion of the modules and in-class training, the staff person would shadow another trained staff member on the medication cart for minimally three days. Ms. Vahlbusch stated a nurse observed the staff member administer medications and signed off that the person completed medication administration per the facility's guidelines. Ms. Vahlbusch stated once the staff member was signed off by the nurse, the staff member could independently administer medications.

I interviewed Employee #1 who stated staff documented administration of medications in the computer system. Employee #1 stated the staff member would compare the medication card to the medication order on the computer to ensure that they read the same. Employee #1 stated the staff member would pop the medication out of the card, click yes on the computer, then give the medication to the resident. Employee #1 stated the staff member would observe the resident swallow the medication, then return to the computer to save that the medications were administered. Employee #1 stated the staff member would document at that time if the resident did not take the medications in which they document a reason for not administering the medications as prescribed.

On 4/19/2024, I conducted a telephone interview with Employee #2 who statements were consistent with previous staff interviews. Employee #2 stated the facility had previous residents who required medications every two hours, like Resident A, so she was knowledgeable of the required timing of the medications.

Review of Resident A's MARs read in part Employee #2 administered his medications from February through July 2023, therefore I reviewed Employee #2's medication administration training records.

On 4/4/2024, email correspondence with Ms. Vahlbusch read in part Employee #2's date of hire was 10/13/2021.

I reviewed Employee #2's training records which read in part she attended training with Employee #1 on 2/18/2022 and 2/19/2022. The records read part Employee #2 shadowed another staff member on 2/23/2022, 2/26/2022, 2/28/2022 and 3/2/2022. The records read in part Employee #2 had final supervision by a nurse and was deemed competent to pass medications on 3/5/2022 from Employee #1. The records read in part Employee #2 was observed and passed her competency skills evaluation on 3/5/2022 for the following: pulse oximetry, rectal/vaginal medication, respiration rate, oral temperature, transdermal patch medication, blood glucose testing/monitoring, blood pressure and orthostatic blood pressure, disposing of medications including controlled substances and discontinued medications, eye drops/ointment, handwashing/hygiene skills, use of insulin pens, and use of nebulizer treatments.

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:	Staff attestations, and review of the facility's training program revealed Employee #2's training records were consistent with the facility's medication administration training program; therefore, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

04/19/2024

Jessica Rogers Date
Licensing Staff

Approved By:

04/23/2024

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