GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 12, 2024

Jodie Nowak
Tranquility AFC Home LLC
11590 Lakeshore Drive
Lakeview, MI 48850

RE: License #: AM590407641
Investigation #: 2025A0577002
Tranquility AFC Home LLC

Dear Ms. Nowak:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care 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 and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (517) 284-9727.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, 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 #:	AM590407641
Investigation #:	2025A0577002
Complaint Receipt Date:	10/07/2024
Investigation Initiation Date:	10/08/2024
Report Due Date:	12/06/2024
Licensee Name:	Tranquility AFC Home LLC
Licensee Address:	11590 Lakeshore Drive Lakeview, MI 48850
Licensee Telephone #:	(989) 304-4041
Licensee Designee:	Jodie Nowak
Administrator:	Jodie Nowak
Name of Facility:	Tranquility AFC Home LLC
Facility Address:	1380 East Main Street Edmore, MI 48829
Facility Telephone #:	(989) 560-9733
Original Issuance Date:	04/12/2023
License Status:	REGULAR
Effective Date:	10/12/2023
Expiration Date:	10/11/2025
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's medications are not being administered as prescribed by a physician.	Yes
Resident A's medications are not being documented upon administration.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/07/2024	Special Investigation Intake 2025A0577002
10/08/2024	Special Investigation Initiated - Telephone
10/08/2024	Contact - Telephone call made Left Message for Complainant.
10/08/2024	Referral - Recipient Rights- Angela Loiselle, ORR-MCN reported they no longer contract with facility.
10/09/2024	Contact - Document Sent Interview with Complainant.
10/09/2024	Contact - Document Sent Email to CHHB request copy of Resident A's medical records.
10/10/2024	Contact - Document Received Resident A's Doctor Summary notes from 9/21/24, 9/23/24, and 9/30/24.
10/10/2024	Contact - Telephone call made Telephone call to Corewell Home Base Services.
10/11/2024	Contact - Telephone call received Phone call with Complainant.
10/14/2024	Inspection Completed On-site Review of resident files and medications.
10/14/2024	Contact - Telephone call made Downtown Drugs.
10/15/2024	Contact - Document Received

	Requested documents from CHBS.
10/17/2024	APS Referral
10/21/2024	Inspection Completed On-site
10/21/2024	Inspection Completed-BCAL Sub. Non-Compliance
10/21/2024	Exit Conference with licensee designee Jodie Nowak.

ALLEGATION: Resident A's medications are not being administered as prescribed by a physician.

INVESTIGATION:

On October 08, 2024, a complaint was received with concerns that Resident A's medications were not being administered as prescribed. The complaint reported Resident A's medication administration record (MAR) noted multiple discrepancies, including missing medications, extra medications and medications not currently ordered, being administered to Resident A. Complainant reported asking to review Resident A's MAR but was told by direct care staff (DCS) the electronic MAR was not working and no paper MAR was available for review.

On October 09, 2024, I interviewed Complainant who reported Resident A was admitted to the facility directly from a hospital stay on September 21, 2024. Complainant reported the overall concern being errors administering Resident A's medications. Complainant reported discovering on October 02, 2024, multiple medication discrepancies after reviewing Resident A's physician orders and then comparing those with medication label instructions and Resident A's MARs. Complainant reported reviewing with a staff member, name unknown, what medications Resident A should be taking based on the hospital *After Care Summary* orders dated September 21, 2024. Complainant reported that on September 26, 2024, Complainant verbally reviewed Resident A's medication list with licensee designee Jodie Nowak, then faxed over the current medication list to Ms. Nowak after their conversation to assure all medications were accurate on the MAR. Complainant stated Resident A's medications still were not listed accurately on Resident A's September 21- September 30, 2024 and October 1-October 2, 2024 MAR. Complainant reported finding the following medication discrepancies for Resident A:

- Medications were not available to be administered to Resident A at the facility: Mirtazapine, Macrobid, Entresto, Gabapentin.
- Resident A's Topiramate medication was available in the facility but was not administered.
- Medications were not administered per physician orders dated September 21, 2024: Baclofen was given 3x daily instead of 1x daily at bedtime per the

September 21. 2024, order, Levetiracetam given 3x daily instead of 2x daily per the September 21. 2024, order. Direct care staff used the label instructions on each medication bottle instead of administering per the updated hospital discharge summary.

On October 09, 2024, I interviewed Guardian A1 who reported Resident A was recently admitted to Tranquility AFC Home LLC. Guardian A1 reported since Resident A was admitted, Resident A has had two emergency room visits due to falls and/or concern that Resident A's medications were not administered as ordered. Guardian A1 reported she has not reviewed Resident A's medications and MARs specifically rather these concerns were brought to her attention from another party. Guardian A1 provided the *After Visit Summary* for Resident A's hospitalization on September 21, 2024 and follow-up physician medication orders after a doctor visit on October 7, 2024. Per my review of the *After Visit Summary* from Corewell Health Structural Health and Valve Center dated October 7, 2024, the following medication changes were made effective October 7, 2024:

- Albuterol HFA 108 (90 Base) MCG/ACT inhaler, Take 2 puffs by inhalation every 6 hours as needed for Wheezing or Shortness of Breath (as needed).
- Apixaban 2.5mg tablet, take 1 tablet by mouth 2 times daily, morning and bedtime.
- Atorvastatin 40 mg tablet, Take 1 tablet by mouth nightly.
- Baclofen 5mg tablet, Take 1 tablet by mouth nightly
- Escitalopram 10 mg tablet, Take 1 tablet by mouth daily-morning.
- Gabapentin 300 mg capsule, Take 1 capsule by mouth 2 times daily, morning and evening.
- Glucose Management PO, Take 6 tablets by mouth if needed (low blood sugar).
- Imodium PO, Take 1 dose by mouth daily as needed (diarrhea).
- LevETIRAcetam 750 mg tablet, Take 1 tablet by mouth 2 times daily, morning and bedtime.
- levothyroxine 50 mcg tablet, take 1 tablet by mouth every day on an empty stomach at least 30 minutes before food in the morning.
- Melatonin 3 mg tablet, Take 3 mg by mouth nightly as needed for Sleep.
- Mirtazapine 7.5mg tablet, Take 1 tablet by mouth nightly.
- Nitrofurantoin 100mg capsule, Take 1 capsule by mouth two times daily.
- Nitroglycerin 0.4 mg sublingual tablet, Place 1 tablet under the tongue every 5 minutes, as needed for Chest pain.
- Pantoprazole 40 mg tablet, Take 1 tablet by mouth daily, morning.
- Sacubitril-valsartan 49-51 mg per tablet, Take 1 tablet by mouth two times daily, morning and evening.

- Topiramate 50 MG tablet, Take 1 tablet by mouth two times daily, morning and evening.
- Trelegy Ellipta 100-62.5-25 MCG/ACT inhaler, Take 1 puff by inhalation daily, morning. Pantoprazole medication was on EMAR but was not in the facility.

On October 14, 2024, I completed an unannounced onsite investigation where I received and reviewed a copy of Resident A's September 2024 paper MAR. I compared Resident A's September 2024 MAR starting on September 21, 2024, with the *After Visit Summary* dated September 21, 2024, and noted the following:

- Medications were prescribed on September 21, 2024, but were not added to Resident A's September 2024 MAR: Gabapentin, Pantoprazole, Sacubitril-valsartan, Nitroglycerin, Glucose Management, Trelegy Ellipta, Atorvastatin, and Apixaban.
- Medications were incorrectly administered: Baclofen 5 MG tablet, Take 1 tablet by mouth nightly but September 2024 MAR reflects to administer Baclofen as PRN, Levothyroxine 50mcg but September 2024 MAR reflects 100mcg, Tylenol Arthritis 500mg but September 2024 MAR reflects Tylenol Arthritis 100mg,
- Medications administered to Resident A but not included as medications to be administered per the *After Visit Summary* dated September 21, 2024: Diphenhydramine Injection, Hydralazine, Naloxone, Loperamide, Magnesium Hydroxide, Bisacodyl, Calcium Carbonate, Glycerin Hypromellose, Sodium Chloride Flush, and Losartan.

During the onsite investigation, I received and reviewed a copy of Resident A's October 2024, electronic MAR (EMAR). I compared Resident A's October 2024 EMAR with Resident A's physical medications along with Resident A's *After Visit Summary* current medication list dated October 7, 2024, from and noted the following:

- Nitrofurantoin, Pantoprazole, and Mirtazapine medications were prescribed to Resident A effective October 7, 2024, but were not available in the facility to review or administer to Resident A. The October 2024 MAR documented via staff initials that these medications were administered.
- Levothyroxine 50 mcg tablet take 1 tablet by mouth every day on an empty stomach at least 30 minutes before eating. Resident A's October MAR documented Levothyroxine being administered in the evening at 8:00pm. Ms. Nowak, Administrator reported she had not realized it needed to be administered 30 minutes before food in the morning per the label instructions.
- Sacubitril-valsartan medication was not listed on Resident A's MAR despite being ordered on October 7, 2024.
- Nitroglycerin medication was not listed on the October MAR nor was this medication available to be administered in the facility.

During the onsite investigation on 10/14/24 and 10/21/24 I observed Effexor was not on the September or October MAR to be administered, but a bottle of Effexor was at the facility.

On October 10, 2024, I spoke with Laurie Howe, Nursing Director with Corewell Home Base Services and requested medical documentation pertaining to home visits with Resident A. On October 15, 2024, I received medical documentation from Corewell Home Base Services documenting the following information:

- Per CNP note dated September 26, 2024: Resident A was seen at the facility on 09/26/2024 due to recent fall. The CNP note documented that Resident A's Effexor 37.5mg medication was changed from being administered daily to every other day for 10 days starting 09/26/2024 and ending 10/06/2024. The CNP note also prescribed Resident A be weighed weekly. The CNP note documented that Resident A's Gabapentin and Entresto medications were not documented on the October 2024 MAR as being administered. These two medications were also not in the facility. Per the CNP note, an order for these medications was faxed to the AFC home.
- Per RN note dated October 02, 2024: At visit, multiple medication discrepancies were found per Resident A's ordered medications and medications available in the facility and administered by direct care staff. RN asked to review MAR, RN was told EMAR was not working and no paper MAR to review. RN reviewed medications with staff and licensee designee Jodie Nowak. "Facility is missing the following prescribed medications: Mirtazapine, Macrobid, Entresto, Gabapentin. Facility has on site but is not being given Topiramate (medication found in a basket from home). RX not administered correctly per hospital discharge-staff using instructions on home RX bottles-Baclofen was given 3x daily instead of 1x daily at bedtime per recent change and Levetiracetam given 3x daily instead of ordered 2x daily per hospital discharge."

During the onsite investigation on October 14, 2024, I interviewed licensee designee Jodie Nowak who reported she read over Resident A's *After Care Summaries* dated September 21, 2024 and October 7, 2024 but did not realize Resident A had multiple medication changes and new medications prescribed. Ms. Nowak reported some medications ordered per the *After Visit Summary* dated September 21, 2024 were not in the facility due to Ms. Nowak waiting for Resident A's family to bring the medications so she knew which medications needed to be refilled or ordered. Ms. Nowak reported there was some confusion about ordering medications due to multiple pharmacies being involved. Ms. Nowak reported she was not sure why Resident A' medications listed on October 2024 EMAR do not match what was prescribed on both *After Care Summaries*. Ms. Nowak reported she did not audit the medication labels with Resident A's EMARs and the *After Care Summaries* to ensure they all matched.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required. **(2) Medication shall be given, taken or applied pursuant to label instructions.** **(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:** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.**
ANALYSIS:	It has been found the facility is not administering Resident A's medications as prescribed by a licensed physician. During the investigation I compared Resident A's pharmacy packaged medications to Resident 's MAR and found multiple medication errors including multiple daily medications being prescribed but not listed on the MAR nor available in the facility to be administered. Medications were also being administered with no prescription or per label instructions from outdated prescription orders instead of following the current prescription orders.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident medications are not being documented upon administration.

INVESTIGATION:

The complaint received on October 08, 2024, stated direct care staff were asked to provide Resident A's MAR for review but were not able to provide this documentation because the EMAR system was not working, and direct care staff did not have a paper version of Resident A's MAR.

On October 09, 2024, Complainant reported during a visit to the facility Complainant asked to review Resident A's Medication Administration Record (MAR) but was told there was no MAR available for review due to the EMAR system not working. Complainant reported requesting to review Resident A's paper MAR and the staff member, name unknown, reported there are no paper MARs for any resident. Complainant voiced concern that direct care staff are not recording the administration of resident medications.

On October 14, 2024, during the onsite investigation I received and reviewed a copy of Resident A's September 2024 paper MAR which consisted of a list of medications not prescribed to Resident A per the After Care Summary dated 09/21/24 and medication bottles I observed in the facility. The MAR did not document the correct medications, dosage, label instructions for use, time to be administered and did not have the initials of the person who administers the medication. I interviewed licensee designee Jodie Nowak who reported the facility switched pharmacies in September 2024 so she no longer has access to previous EMARs. Ms. Nowak reported she did not print off copies of the EMAR for each resident from the previously used system. Ms. Nowak reported she knows Resident A received her medications but does not have any documentation to confirm this. Ms. Nowak reported she was not sure where Resident A's September 2024 paper MAR came from, Ms. Nowak stated, "the handwriting looks like my sons who administers medications." I reviewed and received copies of Resident A's MAR for October 2024. Per Resident A's EMAR, the following reflects the number of days with no initials from a staff member administering the medication as prescribed:

- Atorvastatin-11 days; Baclofen-11 days; Eliquis: AM -1 days, PM-11 days; Entresto: AM-5days, PM-10days; Escitalopram-11days; Gabapentin: AM-5 days, PM-10 days; Levetiracetam: AM-11days, PM-10 days; Levothyroxin-10 days; Mirtazapine-10 days; Nitrofuran: AM-5 days, PM-12 days; Pantoprazole-10 days; Topiramate: AM-12 days, PM-11 days; Trelegy-11 days.

On October 21, 2024, licensee designee Jodie Nowak reported she was not sure why the October 01-October 11 are greyed out and stated, "maybe we did not have the new system up and running by then." Ms. Nowak reported she knows Resident A received her medications as prescribed but could not provide any way to verify the administration of Resident A's medication because direct care staff members did not initial after administering the medications. Ms. Nowak reported there are no paper MARs for October 1- October 11, 2024. Ms. Nowak stated direct care staff started using the EMAR on October 12, 2024. Ms. Nowak reported all direct care staff who administer medications use Ms. Nowak's log-in information for the EMAR system because she does not know how at add additional users. Consequently, all medication

administrations reflect Ms. Nowak as administering the medications even though she did not administer all the medications.

APPLICABLE RULE	
R 400.14312	**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: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Per my review of Resident A's September 2024 medication administration record, there was no record to verify Resident A received any prescribed medications from 09/21/24-09/30/2024. Resident A's September MAR did not have direct care staff initials documenting Resident A's medications had been passed per the prescription label instructions as required. I also reviewed Resident A's October 2024 which had no record to verify Resident A received any prescribed medications from 10/01/24-10/21/24. Resident A's October EMAR did not have direct care staff initials documenting Resident A's medications had been passed per the prescription label instructions as required. Licensee designee Jodie Nowak stated direct care staff are not using their initials when administering resident medications on the EMAR due to Ms. Nowak's lack of understanding on how to add additional users to the system. Medications administrations are not being initialed by the direct care staff member who is administering the medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite investigation on October 14, 2024, I reviewed Tranquility AFC Home LLC *Resident Register* which documented three residents were admitted to the facility. Ms. Nowak reported four residents currently reside in the facility, but the *Resident Register* has not been updated to reflect Resident C's admission into the facility. Ms. Nowak reported Resident C moved in a "few days ago" but could not provide an exact date of admission.

On October 21, 2024, I completed a second onsite investigation and Jodie Nowak, LD reported she has had three admissions since 10/14/2024. I reviewed the *Resident Register* which had not been updated to reflect the names of the three new admissions. Ms. Nowak stated, "I have been so busy I forgot to update the *Resident Register* with the new admissions."

APPLICABLE RULE	
R 400.14210	**Resident register.**
	A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(a) Date of admission.** **(b) Date of discharge.** **(c) Place and address to which the resident moved, if known.**
ANALYSIS:	Since September 21, 2024, per licensee designee Jodie Nowak, the facility has had four residents admitted to the facility however the *Resident Register* has not been updated to reflect these admissions as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On October 14, 2024, during the onsite investigation, Jodie Nowak reported Resident C moved into the facility around 10/11/24. Upon review of Resident C's resident file, I determined there was no completed *Health Care Appraisal* for Resident C. Ms. Nowak reported she thought the *Health Care Appraisal* was completed and kept returning to the completed *Assessment Plan for AFC Residents* thinking this was the *Health Care Appraisal*. I showed Ms. Nowak a blank copy of the resident *Health Care Appraisal*, to which Ms. Nowak reported this was not completed for Resident C because it was difficult to find a doctor.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Upon admission, on 10/11/24, Resident C did not have a completed *Health Care Appraisal* in her resident file.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On October 10, 2024, Laurie Howe, Nursing Director with Corewell Home Base Services, reported Resident A was prescribed weekly weights on September 26, 2024, and an order for this was faxed to the facility on the same date. On October 15, 2024, I received medical documentation CNP note dated September 26, 2024 which confirmed the physician's order for weekly weights for Resident A starting September 26, 2024, and verified this order was faxed to the facility on the same date. During the onsite investigation on October 14, 2024, I reviewed and received a copy of Resident A's *Resident Weight Record* which documented Resident A was first weighed on September 27, 2024, which was one day past his date of admission. Resident A's *Resident Weight Record* documented other weights were taken but no dates were assigned to these weights to verify weekly weights. The final weight for Resident A was taken on 10/13/2024. During the onsite investigation on October 21, 2024, I interviewed licensee designee Jodie Nowak who reported her fax machine has not been working properly so she did not receive the faxed prescription order for Resident A to be weighed weekly and was not aware of weekly weights being prescribed.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Based on the evidence found during the investigation, Resident A was not weighed upon admission nor weighed according to the physician's order for weekly weights. On 09/26/24 Resident A was prescribed to be weighed weekly and per Resident A's Resident *Weight Record* weights were documented, but no dates were included to ensure weekly weights were completed as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite investigation on October 21, 2024, while in the medication room with licensee designee Jodie Nowak I observed a cup of resident medications pre-set on the counter. Ms. Nowak denied knowing to whom the medications belonged and stated, "I did not do that."

According to SIR#2024A0622009 dated February 9, 2024, the facility was in violation of rule 400.14312 due to a resident's medications missing from the facility.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	On October 21, 2024, I observed a cup of resident medications pre-set on the counter in the medication room. Licensee designee did not know to whom the medications belonged but stated she had not pre-set the medication. Precautions by the licensee designee and direct care staff were not taken to ensure that prescription medications are not being used by another resident after pre-setting medications and leaving them on the counter in the medication room.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR 2024A0622009 dated 02/09/2024, CAP 03/01/2024.]**

INVESTIGATION:

Upon review of the resident medications during my onsite investigation on October 14, 2024, I discovered Resident B's medications remained in the facility despite Resident B's death on 08/02/24 per the *Resident Register.* Licensee designee Jodie Nowak reported she had not disposed of the medications in case the family wanted Resident B's personal belongings including his medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	Resident B's medications remained in the facility despite his death in August 2024. No effort had been made to dispose of the medications as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Per Resident A's *After Visit Summary* from Corewell Health Hospital dated 09/21/24, Resident A was prescribed a "high protein-high calorie meal, eat small meals, 5-8 times a day, increase high calorie and protein." During the onsite investigation on October 14, 2024, I interviewed licensee designee Jodie Nowak who reported she was not aware of the ordered high protein-high calorie diet for Resident A. Ms. Nowak reported she read the *After Visit Summary* but did not recall this being ordered. Ms. Nowak reported Resident A has not had much of an appetite since being admitted and they have not been documenting what Resident A has been eating. I reviewed the facility menus for the past past 30 days and none of the menus documented Resident A's prescribed diet of high protein-high calorie meals.

On October 21, 2024, I interviewed licensee designee Jodie Nowak who reported Resident A is starting to eat more but is still losing weight. Ms. Nowak reported the facility has not been documenting what Resident A has been offered to eat, how much and when.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet. **(5) Records of menus, including special diets, as served shall be provided upon request by the department.**

ANALYSIS:	Upon admission to the facility, Resident A was prescribed a special diet of high calorie-high protein diet. Per the facility menus, resident record, and interview with licensee designee Jodie Nowak, Resident A has not been provided the prescribed special diet high calorie-high protein diet. The facility also has not been developed menus to reflect the special diet prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Due to the quality of care violations cited in this report, I recommend the issuance of a six-month provisional license.

Bridget Vermeesch
11/12/2024

_____

Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 11/12/2024

_____

Dawn N. Timm Date
Area Manager