RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

May 25, 2017

Shawn Phillips
Emerald Meadows
6117 Charlevoix Woods Ct.
Grand Rapids, MI 49546-8505

RE: License #: AH410343036
Investigation #: **2017A1010041**
Emerald Meadows

Dear Mr. Phillips:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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 (616) 356-0100.

Sincerely,

Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License#:	AH410343036
Investigation #:	2017A1010041
Complaint Receipt Date:	04/28/2017
Investigation Initiation Date:	04/28/2017
Report Due Date:	06/28/2017
Licensee Name:	Providence Operations, LLC
Licensee Address:	18601 North Creek Drive Tinley Park, IL 60477
Licensee Telephone #:	(708) 342-8100
Administrator:	Shawn Phillips
Authorized Representative:	Shawn Phillips
Name of Facility:	Emerald Meadows
Facility Address:	6117 Charlevoix Woods Ct. Grand Rapids, MI 49546-8505
Facility Telephone #:	(616) 954-2366
Original Issuance Date:	08/26/2013
License Status:	REGULAR
Effective Date:	03/07/2017
Expiration Date:	03/06/2018
Capacity:	60
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There are no activities on the dementia unit. There are very limited activities for residents in the general assisted living area.	No
• Resident Oxygen tubing is brown. In addition, Resident A's Continuous positive airway pressure therapy (CPAP) machine is not cleaned by staff. • Resident A is supposed to have her weight and blood sugars taken daily, however this is not getting done. • Staff have not been putting Resident A's compression socks on her.	Yes
Staff are not administering Resident A's short acting insulin at the correct time.	Yes
There are no snacks available for residents after dinner. Residents with diabetes are only offered "diabetic bars."	Yes

III. METHODOLOGY

04/28/2017	Special Investigation Intake 2017A1010041
04/28/2017	Special Investigation Initiated - Telephone APS referral
04/28/2017	APS Referral
05/02/2017	Inspection Completed On-site
05/02/2017	Contact - Document Received Resident A weight log, blood sugar log, and Resident B incident report
05/02/2017	Contact - Telephone call made Interviewed Relative A1 by telephone
05/25/2017	Exit Conference

ALLEGATION:

There are no activities on the dementia unit. There are very limited activities for residents in the general assisted living area.

INVESTIGATION:

On 4/28/17, the bureau received the allegations from the online complaint system.

On 5/2/17, I interviewed the life enrichment director Jackie Hall at the facility. Ms. Hall showed me the activity calendar for the dementia unit and the general assisted living area. I observed where the activity calendar was posted in the dementia unit and general assisted living area. I observed a range of activities on the calendars for residents to participate in. Ms. Hall reported there is a bus outing residents can participate in twice a month.

On 5/2/17, Resident A reported there are several activities she participates in at the facility. Resident A stated she can assist with the game bingo. Resident A explained she enjoys living at the facility.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(1) Personal care and services that are provided to a resident by the home shall be designed to encourage residents to function physically and intellectually with independence at the highest practical level.
ANALYSIS:	Interviews with Ms. Hall, Resident A, and review of May's activity calendar reveal there are various activities for residents to participate in.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Resident Oxygen tubing is brown. In addition, Resident A's Continuous positive airway pressure therapy (CPAP) machine is not cleaned by staff.**

- **Resident A is supposed to have her weight and blood sugars taken daily, however this is not getting done.**

- **Staff have not been putting Resident A's compression socks on her.**

INVESTIGATION:

On 5/2/17, I interviewed the facility's administrator Shawn Phillips at the facility. Mr. Phillips reported Resident A's oxygen tubing is provided by Carelink. Mr. Phillips stated medication technicians (med techs) are responsible for changing resident oxygen tubing as needed. Mr. Phillips stated the facility does not maintain a schedule of when residents who are on oxygen need replacement tubing. Mr. Phillips reported there are four residents at the facility who are currently prescribed oxygen.

Mr. Phillips stated staff are not responsible for cleaning resident CPAP machines. Mr. Phillips reported staff change the water in resident CPAP machines in the morning. Mr. Phillips explained resident family members are responsible for cleaning and providing replacement parts for CPAP machines. Mr. Phillips stated a resident family member recently brought in materials used to clean CPAP machines. Mr. Phillips reported staff cleaned the CPAP machines for residents after the materials were received.

On 5/2/17, I interviewed med tech Janet Goff at the facility. Ms. Goff reported med techs change resident oxygen tubing once every two weeks. Ms. Goff stated med techs can change resident oxygen tubing as needed as well, such as when it gets damaged. Ms. Goff reported she is able to identify when resident oxygen tubing needs to be changed by looking at it.

On 5/2/17, I interviewed med tech Elisa Bailey at the facility. Ms. Bailey reported residents on oxygen get their tubing changed every two weeks. Ms. Bailey's statements regarding resident oxygen tubing were consistent with Ms. Goff.

Ms. Bailey stated staff changed the water in resident's CPAP machines every morning. Ms. Bailey was not aware of any additional methods used to clean CPAP machines.

On 5/2/17, I observed the residents who are prescribed oxygen. I observed the oxygen tubing was clean.

On 5/2/17, I interviewed Resident A at the facility. Resident A reported she cleans her CPAP machine by emptying out the old water and refilling it with fresh water every morning. I observed Resident A's Resmed S9 CPAP machine that was on her night stand. The outside of the machine was clean.

On 5/2/17, I interviewed Relative A1 by telephone. Relative A1 reported Resident A's CPAP machine was dirty on the inside and outside. Relative A1 stated she thoroughly cleaned Resident A's CPAP machine because staff at the facility did not.

Relative A1 reported Resident A had a physician order for her weight to be taken daily, however staff did not follow this order.

Relative A1 stated staff have not been putting Resident A's compression socks on her daily as ordered.

On 5/5/17, I received pictures of the inside and outside of Resident A's CPAP machine. There was an unknown substance on the outside of the machine and a white calcified residue on the inside of the machine.

On 5/18/17, I received an email from Mr. Phillips stating there was not a physician order for Resident A's weight to be taken every day.

On 5/19/17, I reviewed Resident A's service plan. The *Medication Administration* section of the plan read, "staff to check on every two hours at night to ensure that CPAP is on. Oxygen at 2L with CPAP when sleeping." The plan does not address the CPAP machine and oxygen's maintenance requirements.

I also reviewed Resident A's electronic medication administration record (EMAR) for the month of April. The EMAR read, "vital signs check BP, pulse, and weight weekly." Resident A's weight was taken by staff on 4/2, 4/9, and 4/23. Resident A's weight was taken by "outside services" on 4/30.

The *Ted Hose/Compression stockings* portion of the EMAR read, "apply compression stockings every am and remove every hs." The EMAR read this task was not completed the evening of 5/12 and the morning of 5/16. Resident A's service plan did not address Resident A's use of compression socks.

The *Blood Glucose* portion of the EMAR read, "check blood glucose three times daily before meals." The plan read Resident A's blood glucose was to be taken at 6:00a, 11:00a, and 4:00p. Resident A's blood glucose was not taken on 4/6 at 11:00a.

The *medication administration blood sugar checks* portion of Resident A's service plan read, "staff to check blood sugars before every meal. Remind resident that she needs to be checked before she starts eating."

On 5/23/17, I reviewed the instruction manual for Resmed S9 CPAP machine. The *Daily Cleaning and Maintenance* section of the document read, "Remove the air tubing by pulling on the finger grips on the cuff. Hang it in a clean, dry place until next use. Notes Do not hang the air tubing in direct sunlight as it may harden over time and eventually crack. Do not wash the air tubing in a washing machine or dishwasher." The *Weekly* section of the document read, "Remove air tubing from S9 device and the mask, wash the air tubing in warn water using mild detergent, rinse thoroughly, hang, and allow to dry. Before next use, reconnect the air tubing to the air outlet and mask. The *Monthly* section of the document read, "Wipe the exterior of the S9 with a damp cloth and mild detergent, check the air filter for holes and blockage by dirt or dust. Replace the air filter if necessary."

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.
For Reference: R 325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each 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.
ANALYSIS:	Interviews with Mr. Phillips and Relative A1 reveal staff did not clean Resident A's CPAP machine. Mr. Phillips stated resident family members are responsible for cleaning resident CPAP machines, however this was not noted on Resident A's service plan. The maintenance and cleaning of Resident A's CPAP machine was not addressed. Review of Resident A's service plan and April EMAR read staff were to put her compression stockings on every morning and take them off at night. The EMAR documented this task was not completed the evening of 5/12 and the morning of 5/16. Resident A's service plan did not address Resident A's use of compression socks. Review of Resident A's service plan and April EMAR reveal she was supposed to have her blood sugar tested before meals. Resident A's blood sugar was not taken on 4/6 before lunch.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation Report (SIR) 2016A0001013 Corrective Action Plan (CAP) dated 7/8/16**

ALLEGATION:

Staff are not administering Resident A's insulin a half hour before meals as ordered.

INVESTIGATION:

Ms. Goff stated she administers all Resident A's medication as prescribed. Ms. Goff reported Resident A has insulin that is administered before meals. Ms. Goff explained the times the insulin is to be administered is on Resident A's EMAR. Ms. Goff specifically said she administers Resident A's insulin as prescribed.

Ms. Bailey's statements regarding Resident A's medications were consistent with Ms. Goff.

Resident A reported she has not had any concerns or issues regarding her medications. Resident A stated staff administer her insulin on time before meals.

On 5/19/17, Resident A is prescribed "Novolog INJ flexpen." Resident A's EMAR read, "inject 3 units subcutaneously three times daily with meals." The administration times were 8:00a, 12:00p, and 5:00p. Resident A's Novolog was not administered on 4/12 at 8:00a and 12:00p because the medication was not available. Information regarding why the medication was not available was not documented on the EMAR.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or signed orders by the prescribing licensed health care professional.
ANALYSIS:	Review of Resident A's EMAR reveal her prescribed Novolog insulin was not administered on 4/12 at 8:00a and 12:00p because the medication was not available.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There are no snacks available for residents after dinner. Residents with diabetes are only offered "diabetic bars."

INVESTIGATION:

Mr. Phillips stated the only snacks available to residents after dinner are high protein and low carbohydrate cookies for residents with diabetes. Mr. Phillips reported these are kept in the medication rooms at the facility. Mr. Phillips stated the kitchen is closed after dinner to maintain cleanliness and infection control.

Resident A reported snacks are not offered to residents after dinner. Resident A stated she gets an ensure shake with her 8:00 pm medications because she is diabetic. Resident A explained residents without diabetes are not offered snacks after dinner.

On 5/2/17, I interviewed resident care aide Alicia Davis at the facility. Ms. Davis reported the kitchen is locked after dinner. Ms. Davis stated several residents keep food in their rooms that they can eat if they want a snack after meals.

On 5/2/17, I interviewed Resident B at the facility. Resident B reported she keeps food in her room that she is able to access when she gets hungry. Resident B stated the facility does not offer snacks to residents after dinner is served, therefore she can eat whatever she has in her room.

I observed resident rooms in the general assisted living area are equipped with mini refrigerators.

On 5/23/17, I interviewed kitchen manager Phil Friesbie by telephone. Mr. Friesbie reported the kitchen is locked after dinner and the only snacks that were available to residents were protein bars for residents with diabetes. Mr. Friesbie reported he was recently informed of the licensing rule regarding snacks being made available to residents. Mr. Friesbie stated as a result, the facility filled a cupboard in the memory care area with snacks two weeks ago.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.

ANALYSIS:	Interviews with Mr. Phillips, Mr. Friesbie, and Ms. Davis reveal the kitchen at the facility was locked after dinner is served. Mr. Phillips and Mr. Friesbie stated the only snacks made available to residents were diabetic cookies that are stored in the medication room. Interviews with Residents A and B revealed residents are not offered or given snacks after dinner. It appears that the locking of the kitchen at night prevents staff from accessing and making snacks available to residents if they should want any. This limiting access does not seem consistent with the intent of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Shawn Phillips by telephone on 5/25. Mr. Phillips stated the facility identified employees who were not completing their job duties. Mr. Phillips reported these individuals resigned before the facility could terminate them. Mr. Phillips stated a snack cupboard and documentation system has been established for residents.

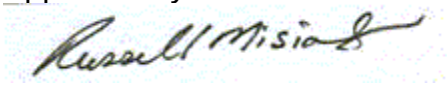
IV. RECOMMENDATION

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

5/22/17

Lauren Wohlfert — Date
Licensing Staff

Approved By:



5/23/17

Russell B. Misiak — Date
Area Manager