GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

Amanda Germain
First & Main of Commerce Township
2500 Martin Parkway
Commerce Township, MI 48390

September 9, 2019

RE: License #: AH630370124
Investigation #: 2019A1022006
First & Main of Commerce Township

Dear Ms. Germain:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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) 356-0183.

Sincerely,

Barbara Zabitz, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(313) 296-5731

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630370124
Investigation #:	2019A1022006
Complaint Receipt Date:	06/19/2019
Investigation Initiation Date:	06/25/2019
Report Due Date:	08/19/2019
Licensee Name:	F&M Commerce Township OPCO, LLC
Licensee Address:	Suite 2200 2221 Health Drive, SW Wyoming, MI 49519
Licensee Telephone #:	(616) 248-3566
Administrator/Authorized Representative:	Amanda Germain
Name of Facility:	First & Main of Commerce Township
Facility Address:	2500 Martin Parkway Commerce Township, MI 48390
Facility Telephone #:	(248) 387-2961
Original Issuance Date:	02/02/2018
License Status:	REGULAR
Effective Date:	08/02/2018
Expiration Date:	08/01/2019
Capacity:	157
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was abused by a caregiver.	No
Resident E's safety was not ensured.	Yes
Staff are not providing all that is required when reporting an incident.	Yes
Resident F was not being turned or fed according to the instructions in his service plan. Resident A was not provided services to prevent falls.	Yes
There was not enough staff to meet resident needs.	Yes
Medications orders are falsified.	Yes
Medication errors are not reported to the residents licensed health care professional.	Yes
Resident records are incomplete.	No
Additional Findings	Yes

III. METHODOLOGY

06/19/2019	Special Investigation Intake 2019A1022006
06/19/2019	Contact - Telephone call made Phone call to APS worker Pam Safronoff
06/25/2019	Special Investigation Initiated - On Site
06/27/2019	Inspection Completed On-site
07/01/2019	Contact - Telephone call made Phone calls made to various staff members
07/01/2019	Contact – Document sent Received documents from C. Parrish regional health and wellness

09/09/2019	Recommend Emergency/Correction Order (AH ONLY)

ALLEGATION:

Resident A was abused by a caregiver.

INVESTIGATION:

On 6/21/19, the facility submitted an *Incident / Accident* report that described an incident that occurred on 6/19/19, in which a contracted hospice nurse overheard a caregiver "yelling at the resident." According to an attachment to the *Incident / Accident* report, signed by health and wellness director Jasmine Jones, "one of our caregivers was overheard being verbally abusive to [Resident A] in room [Resident A's room]. Also, that resident's wrist band was around her neck along with neck necklace with on call pendent."

On 6/25/19, I interviewed both Ms. Jones and administrator/authorized representative Colleen Higgins at the facility. Ms. Higgins explained that the hospice nurse was standing in the hallway in front of Resident A's room when she heard "yelling" and "commands" from within but was not able to enter because she did not have a facility key fob. The hospice nurse left the hallway and went to the nursing office, where she found the medical director, who did have a key fob. When the hospice nurse and the medical director entered Resident A's room, they found Resident A alone, in bed. Resident A had both her expandable key fob wristlet and her call pendant necklace around her neck. The pendant was draped down the resident's back, so that Resident A was on top of it.

Ms. Higgins went on to explain that immediately after the hospice nurse reported the situation to facility staff members, the assigned caregiver was suspended and interviewed by Ms. Jones. Ms. Jones stated that while at first, they had thought that Resident A had been subjected to verbal and possible physical abuse, after interviewing the caregiver and examining the wristlet, they came to a different conclusion. According to Ms. Jones, while the caregiver spoke to Resident A in a very loud voice, it was only to give instructions to the resident. Ms. Jones stated that she thought the hospice nurse had interpreted the caregiver's tone of voice as "scolding" the resident. Regarding the wristlet being around Resident A's neck, Ms. Jones stated that she had determined that Resident A had the ability to expand the wristlet and place it over her head on her own.

On 6/27/19, I interviewed Resident A at the facility. She denied that anyone mistreated her.

On 6/27/19, I interviewed hospice nurse Kim McKenzie by phone. Ms. McKenzie stated that on 6/19/19, she had come to the facility to check up on a medication

order for Resident A that had not yet been filled by the pharmacy. As Ms. McKenzie approached Resident A's room, she heard yelling with what she described as "a demeaning tone," but nothing that she could describe as abuse. Ms. McKenzie went on to say that the medical director let her into Resident A's room with his key fob and they found the resident alone, lying in bed on top of the call pendant, with her wristlet and pendant necklace around her neck. Ms. McKenzie stated that she believed that Resident A had the ability to put the wristlet over her head on her own and that the staff member did not do anything to injure Resident A.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 333.20201	**(2) (l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**

ANALYSIS:	Although a caregiver was overheard to give instructions to Resident A in a loud, demanding voice, there was no evidence that the resident had been either verbally or physically abused.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident E's safety was not ensured.

INVESTIGATION:

On 6/19/19, Adult Protective Services (APS) submitted an allegation that Resident E was displaying problematic behaviors that were not addressed and could pose a threat to his safety and to others. Resident E had "broke a third story window out and then attacked staff who were stopping him from jumping out the window. That resident was allowed back into the facility the following day."

On 6/25/19, I received a phone call from APS worker Pamela Safronoff to inform me that during the evening hours of 6/24/19, Resident E had climbed out of a third story window and fell to the ground below.

On 6/25/19, I interviewed both director of health and wellness Jasmine Jones and Ms. Higgins at the facility. Ms. Higgins confirmed that on the previous evening, Resident E had opened a window on the third floor and jumped out. Resident E, who lived in the facility's locked memory care unit located on the third floor of the building had a diagnosis of dementia and was known to have problematic behaviors. I advise Ms. Higgins and Ms. Jones to submit an incident report to their assigned licensing staff member although I would investigate the incident.

Although neither Ms. Higgins nor Ms. Jones had information about Resident E's current condition, he was alive when paramedics arrived at the facility and he had been admitted to a local hospital.

On 6/25/19, I interviewed caregiver Tyneshia Nelson at the facility. Ms. Nelson had been the assigned caregiver for Resident E on the previous evening. According to Ms. Nelson, at about 7:00 pm on the previous evening, she was in the third-floor common area when she noticed that Resident E was pacing the hallways of the third floor. Ms. Nelson went on to say that not long after that, she got a call on her two-way radio saying that Resident E "was in the garden." Ms. Nelson stated that when she heard that, she got up and searched the third-floor hallways until she noticed an opened window. When she looked out of the window, she saw Resident E lying on the ground below.

Ms. Nelson then explained that when she compared the opened window to other windows on the third floor, she noticed a striking difference. According to Ms. Nelson, all the other windows had a plastic brace that had been placed onto the window track to prevent the window from opening completely, but the window that Resident E had jumped out of was missing this brace.

On 6/25/19, I was taken to the third floor by Ms. Jones and regional health and wellness director Crystal Parrish to view the window that Resident E opened and jumped out of. Ms. Jones confirmed Ms. Nelson's observation that this window had lacked the brace that had been applied to all the other windows. When I asked Ms. Jones and Ms. Parrish if the facility had ever done an audit of the braces on their windows or if they had any window maintenance records, they indicated that they did not have any such records.

On 7/17/19, I received notification that Resident E had expired.

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.**
Definitions: **R 325.1901**	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.

ANALYSIS:	The third floor, a memory care unit, was not a safe place for a resident with cognitive impairments to live, as one of the windows lacked the safety brace designed to prevent the window from completely opening. As a result, Resident E attempted to leave via the third-floor window and fell to the ground.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** Licensing study report (LSR) dated 8/6/19 Corrective Action Plan (CAP) dated 8/21/19, Special Investigation Report (SIR) #2019A1019026 dated 3/27/19 CAP dated 4/16/19

ALLEGATION:

Staff are not providing all that is required when reporting an incident.

INVESTIGATION:

On 6/19/19, APS submitted allegations that falls, medication errors and other incidents were not properly documented or reported.

On 6/27/19, I reviewed all incident reports completed by the facility since 5/1/19 with regional health and wellness director Crystal Parrish and could find no evidence to suggest that incidents were not reported. However, closer inspection of those incident reports revealed that the facility was not using the incident report process to formulate "corrective measures taken to prevent future incidents/accidents from occurring."

On 6/27/19, the facility submitted an *Incident / Accident* report that referred all information required by R 325.1924(1) to an attached narrative. The attached narrative described how health and wellness director Jasmine Jones had been terminated after it was determined that Ms. Jones, a licensed practical nurse, had written a "verbal order" for gabapentin for anxiety/agitation to be administered to Resident A without actually receiving a verbal order from a physician or other qualified health care professional. While the narrative did include individuals involved, dates and time, the effect of the incident upon the resident, documentation of who was informed, it did not specify any corrective measures that would be taken to prevent a reoccurrence.

On 5/30/19, the facility submitted an *Incident / Accident* report describing the incident that occurred on 5/29/19, when Resident E he put his fist through a window in the third-floor common area and tried to climb through the opening. In the spot designated for "Corrective Measures Taken to Remedy and/or Prevent Reoccurrence," the report only indicates that Resident E was taken for treatment to a local hospital and the facility's intention to have Resident E seen by their

psychiatric service, but did not indicate what actions would be taken to prevent reoccurrence. On 6/24/19, Resident E managed to open a third-floor window and jump out.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**
ANALYSIS:	While there was no evidence that falls or other incidents were not reported, the facility did not attempt to formulate any corrective actions to prevent reoccurrence of the incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident F was not turned or fed according to the instructions in his service plan. Resident A was not provided services to prevent falls.

INVESTIGATION:

On 6/19/19, APS submitted allegations that neither Resident A nor Resident F were provided appropriate services. According to the APS allegation, Resident A had sustained a broken bone as the result of a fall and subsequently was not provided appropriate services to address further injury.

According to the APS allegation, staff had been directed to reposition Resident F every hour and to feed him all his meals, because he could no longer feed himself. According to the allegation, staff member did not provide him with either of these services. The APS allegation noted that Resident F had died on a prior date.

Ms. Jones reported that Resident F was admitted to the facility on 5/16/19, after requiring hospitalization for medical issues and a subsequent stay in a rehabilitation facility. When Resident F was admitted, he had “a pressure sore” and was receiving hospice benefits. Ms. Jones went on to say that Resident F was attended by a hospice nurse three days weekly that increased to five days weekly on 6/4/19 to provide care for the pressure sore. In addition, Resident F was attended by a hospice aide who provided care twice weekly, usually at lunch time to help with bathing, turning and feeding. Resident F also was attended by a private caregiver, who was with him during the morning five days weekly.

On 6/27/19, I reviewed Resident F’s service plan with Ms. Parrish. The service plan indicated that Resident F needed to be fed and that he was to be repositioned on a frequency of one to two hours.

On 6/25/19, I interviewed medication technician Precious Jackson at the facility. Ms. Jackson stated that she fed Resident F, but that he was a very light eater. She also stated that he was turned at least every two hours and usually more often.

On 7/1/19, I interviewed caregiver Culeia Clemmons by phone. Ms. Clemmons also stated that if his caregiver was not there, she would feed Resident F his meals and that he was turned every hour.

On 6/27/19, I interviewed Resident A in her room. She was seated in a reclining (Brouda brand) chair and was unable to safely stand up by herself. Her call pendant was tied to her bed and was at least three feet beyond her reach. When I brought this to the attention of Ms. Parrish, Ms. Parrish stated that this situation was not appropriate. When I reviewed Resident A’s service plan, it indicated that Resident A was to be reminded to use the call device (pendant) for assistance as needed. The service plan also indicated that she was to be provided with physical assistance for all personal care.

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.
Definitions: **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:	There was no evidence that Resident F was not provided most of the services indicated on her service plan; however, direct observation revealed that caregivers did not provide Resident A with a method to summon help when needed consistent with her plan.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** SIR #2019A10113014 dated 1/3/19 CAP dated 1/18/19, SIR # 2018A1013051 dated 10/22/18 CAP dated 12/4/18, LSR dated 8/6/19 CAP dated 8/21/19

ALLEGATION:

There was not enough staff to meet resident needs.

INVESTIGATION:

On 6/19/19, APS submitted an allegation that the facility was not sufficiently staffed and that residents had long waits for help.

Ms. Jones stated that the facility had three eight-hour shifts daily and that they had one caregiver on the first floor, two caregivers on the second floor and one caregiver on the third floor. Additionally, whenever possible, the facility scheduled a caregiver to “float” between floors and to help the other caregivers as needed. The facility made an effort to schedule a licensed nurse for all shifts, who was designated as shift supervisor and at least one medication technician for medication administration. If no nurse was scheduled, the two medication technicians were scheduled. When Ms. Jones was asked about the ways that residents requested help from staff members, Ms. Jones stated that residents who had the ability to activate a pendant as a call device were issued a pendant that was worn as a necklace around their neck. Not all residents who resided in the memory care unit had the ability to activate a pendant and so staff used hourly check-ins to meet their needs. When Ms.

Jones was asked who was responsible to respond to activated pendants, she stated that it depended upon who was available.

On 6/25/19, I interviewed Relative C at the facility. Relative C stated that Resident C often had to wait long periods of time for help. Relative C stated that the caregivers seemed to congregate in one area and were not always responsive when the pendant was activated.

According to Resident C's service plan, she had a history of falls and required maximum assistance to ambulate when she was not using a wheelchair.

Review of Resident C's *Resident Event Report* for call response for the time period 5/1/19 through 6/25/19 revealed multiple occasions where Resident C waited more than one hour for assistance, including an 82-minute wait on 6/4/19, 7:01 am until 8:24 am. On that day, at 7:00 am, Resident C fell in her apartment and was taken to the hospital.

Resident A's *Resident Event Report* for call response for the time period 5/1/19 through 6/25/19 also documented multiple occasions when Resident A waited long periods of time for assistance. According to Resident A's service plan, Resident A was to be reminded to use the call device (pendant) for assistance as needed. The service plan also indicated that she was to be provided with physical assistance for all personal care.

Resident A was deemed to be at risk for falling when on 5/25/19, she complained of pain and assessment determined that her right wrist was broken. According to the internal incident report, "Upon starting shift, writer was notified from ED that resident stated she fell yesterday." For the previous day, 5/24/19, the *Resident Event Report* for call response documented that Resident A waited for 46 minutes from 7:20 am to 8:06 am and for 131 minutes at 11:23 am to 1:35 pm. According to an internal incident report dated 6/15/19, Resident A was on the floor of her room when the medication technician arrived at 7:45 am. Resident A's *Resident Event Report* for call response for 6/15/19 documented that Resident A waited for help 63 minutes, from 6:24 am until 7:27 am. This incident was reported to the facility's assigned licensing staff member on 7/25/19, but it did not include Resident A's statement that she had fallen on the previous day.

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:	The staffing pattern being used by the facility was insufficient to provide assistance to residents, causing residents to engage in unsafe behaviors when staff did not respond to their calls for help.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** SIR #2018A1013043 dated 8/8/18 CAP dated 8/25/18

ALLEGATION:

Medication orders are falsified.

INVESTIGATION:

On 6/19/19, Adult Protective Services (APS) submitted an allegation that verbal orders for medication orders were taken without a signature from a qualified prescriber.

On 6/27/19, I interviewed hospice nurse Kim McKenzie by phone. She stated that on 6/19/19, she had received a request from health and wellness director Jasmine Jones to "push through" a medication for Resident A that had not yet been filled by the pharmacy. The medication order was for gabapentin, a medication used for nerve pain or seizures, but had been classified as a controlled substance by the state of Michigan due to its synergistic effects when used in combination with opioids. While Resident A had an existing medication order for gabapentin, this was an additional order being prescribed "for anxiety/agitation." Ms. McKenzie reported that when she checked with the pharmacy, she was informed that they did not consider "anxiety" or "agitation" as being appropriate indications and that was the reason the order had not been filled.

Ms. McKenzie went on to explain that she had never worked with Resident A previously, and she only responded because she was the "on-call" nurse that day. Ms. McKenzie then explained that when she asked Ms. Jones if this gabapentin order had been discussed with Resident A's assigned hospice nurse, Ms. Jones "blew up" at her, making Ms. McKenzie suspicious that something was wrong with the order. Ms. McKenzie went on to say that she asked both Resident E's physician and the hospice physician if they had been the prescriber of the second gabapentin order and both physicians denied being the prescriber. Ms. McKenzie then stated that she took no further action regarding this medication order.

On 6/27/19, I interviewed Ms.Higgins and regional health and Ms. Parrish at the facility. Both informed me that Ms. Jones had been terminated on the previous day because they determined that Ms. Jones had been the source of an unauthorized medication order for Resident A, gabapentin for anxiety/agitation. Prior to her termination, Ms. Jones had claimed she received a verbal order to begin the

additional gabapentin from an “on-call” physician; however, Ms. Higgins was not able to verify that this “on-call” physician even existed.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	The licensed practical nurse who served as the facility’s director of health and wellness attempted to initiate a medication order for Resident A by misrepresenting it as a “verbal order” from a physician without that physicians’ knowledge.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** LSR dated 8/6/19 CAP dated 8/21/19

ALLEGATION:

Medication errors are not reported to the residents licensed health care professional.

INVESTIGATION:

On 6/19/19, APS submitted an allegation that errors in medication administration were not being reported. On 6/27/19, I received a phone call from Ms. Safronoff, who communicated an update to the allegation from an anonymous reporting source that clarified when staff did not administer all Resident D’s prescribed medications, it was not reported as a medication error. Ms. Safronoff was able to report that Resident D had been recently admitted to the facility but was not able to provide additional information.

On 6/25/19, I interviewed Ms. Jones at the facility. Ms. Jones stated all medication errors were to be documented on the facility’s *Incident Report* record and reported to the prescriber.

On 6/27/19, I reviewed Resident D’s *Medication Administration Record (MAR)* with Ms. Parrish. Resident D had a medication order for a blood thinner, Xarelto, 15 milligrams administered one time daily. According to the *MAR*, Resident D was present in the facility on 6/19/19, but was not administered the Xarelto. Staff documented on the *MAR* that Xarelto was administered on 6/20/19, but on 6/21/19, the medication was “not available.” When Resident D’s medical record was reviewed, there was a medication administration note for 6/21/19 indicating that the medication was not on the cart. There was no explanation for the lack of medication

administration for 6/19/19 in the medical record. Neither episode had an accompanying *Incident Report* record, although Ms. Parrish indicated that an *Incident Report* record was an expectation if a medication was not administered for any reason.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(g) Upon discovery, contact the resident's licensed health care professional if a medication error occurs. A medication error occurs when a medication has not been given as prescribed.**
ANALYSIS:	Resident D missed doses of a blood thinner, but this was never reported to her physician or other health care professional responsible tor prescribing medications to her.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** LSR dated 8/6/19 CAP dated 8/21/19

ALLEGATION:

Resident records are incomplete.

INVESTIGATION:

On 6/19/19, Adult Protective Services (APS) submitted an allegation that medical records were missing vital information.

On 6/27/19, I reviewed the medical records for six residents for completeness with Ms. Parrish. All records complied with the requirements enumerated in R 325.1942(3).

APPLICABLE RULE	
R 325.1942	**Resident records.**
	(3) The resident record shall include at least all of the following: **(a) Identifying information, including name, marital status, date of birth, and gender.**

	(b) Name, address, and telephone number of next of kin or authorized representative, if any. **(c) Name, address, and telephone number of person or agency responsible for the resident's maintenance and care in the home.** **(d) Date of admission.** **(e) Date of discharge, reason for discharge, and place to which resident was discharged, if known.** **(f) Health information, as required by MCL 333.20175(1), and other health information needed to meet the resident's service plan.** **(g) Name, address, and telephone number of resident's licensed health care professional.** **(h) The resident's service plan.**
ANALYSIS:	There was no evidence of incomplete medical records.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 6/25/19, Ms. Higgins stated that on the previous evening of 6/24/19, Resident E, who was residing the facility's locked memory care unit located on the third floor of the building, had opened a window on the third floor and jumped out. Ms. Higgins stated that he was alive when paramedics arrived at the facility and he was taken to a local hospital.

Both Ms. Higgins and Ms. Jones indicated that Resident E presented challenges to the staff due to problematic behavior, including a previous attempt to exit the building by a window. The both agreed that on 5/29/19, Resident E put his fist through a window in the third-floor common area and tried to climb through the opening. However, on that occasion, staff were able to stop him and prevent further injury.

When I asked Ms. Jones what actions had been put into place to address his challenging behaviors, she stated that after the incident on 5/29/19, he had been evaluated by their psychiatric service and had been given clearance to return to the facility and was then provided "one-on-one" supervision for the next three to four days. Ms. Jones went on to say that Resident E's medication had been adjusted and caregivers were provided with additional education regarding actions to take if a resident were to become agitated, or combative and how to recognize and deal with

“sun-downing.” According to Ms. Jones, Resident E’s behavior consistently worsened around 7:00 pm each day.

On 6/25/19, I interviewed caregiver Tyneshia Nelson at the facility. Ms. Nelson had been the assigned caregiver for Resident E on the previous evening. Ms. Nelson reported that Resident E had been agitated most of the shift. She reported that at 5:00 pm, she noticed that he was placing his belongings into a bag, saying that his wife was coming to take him home. Ms. Nelson went on to say that although Resident E had an “as needed” order for an anti-anxiety medication (a gel to be applied to the inside of his wrist) neither the nurse on duty nor the medication technician were able to apply it because Resident E was uncooperative.

When Ms. Nelson was asked if she had attempted to engage Resident E in any way, she stated that she felt she needed to be careful with her actions because Resident E could be threatening to staff. Ms. Nelson stated that for part of the afternoon, Resident E had been carrying a wooden plaque that was in the shape of a Teddy Bear, that he would hold by its end and try to use it as a paddle to swing at staff members and so she kept her distance. When Ms. Nelson was asked if she was able to use any of the additional training provided to caregivers regarding agitated, combative residents, Ms. Nelson stated that she had not been given any such education.

Ms. Nelson went on to describe how at about 7:00 pm she was in the third-floor common area with a second caregiver discussing schedules for showers to be given during the shift when she noticed that Resident E was pacing the hallways of the third floor. According to Ms. Nelson, it was not too long after that when she got a call on her two-way radio saying that Resident E “was in the garden.”

On 6/27/19, I reviewed Resident E’s service plan with Ms. Parrish. There were no new interventions entered on Resident E’s service plan after the incident on 5/29/19, the first time he attempted to exit the building through a window. There were additional interventions dated 6/25/19, one day after he was able to open a third-floor window and jump out; however, none of the interventions gave staff members any directions on what to do when Resident E became combative or wanted to leave the building.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
Definitions: **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:	On 5/29/19, Resident E exhibited signs of a significant change in his care needs that required an update to his service plan. No changes were made until after he was successful in his efforts to leave the building via a third-floor window.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** SIR #2019A10113014 dated 1/3/19 CAP dated 1/18/19

IV. RECOMMENDATION

I recommend issuance of a Corrective Notice Order.

9/9/19

Barbara Zabitz — Date
Licensing Staff

Approved By:

9/9/19

Russell B. Misiak — Date
Area Manager