GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

Rochelle Lyons
Springvale Assisted Living
4276 Kroger Street
Swartz Creek, MI 48473

March 24, 2021

RE: License #: AH250382043
Investigation #: 2021A1011018
Springvale Assisted Living

Dear Ms. Lyons:

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 (dates) 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 licensee 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 (248) 975-5053.

Sincerely,

Andrea Krausmann, Licensing Staff
Bureau of Community and Health Systems
51111 Woodward Avenue 4th Floor, Suite 4B
Pontiac, MI 48342
(586) 256-1632

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250382043
Investigation #:	2021A1011018
Complaint Receipt Date:	02/16/2021
Investigation Initiation Date:	02/17/2021
Report Due Date:	04/18/2021
Licensee Name:	Springvale Assisted Living, LLC
Licensee Address:	3196 Kraft Se, Suite 200 Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Administrator:	Jennifer Rockafellow
Authorized Representative:	Rochelle Lyons
Name of Facility:	Springvale Assisted Living
Facility Address:	4276 Kroger Street Swartz Creek, MI 48473
Facility Telephone #:	(810) 230-6644
Original Issuance Date:	08/15/2017
License Status:	REGULAR
Effective Date:	02/15/2021
Expiration Date:	02/14/2022
Capacity:	73
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B's bed alarms were not utilized as indicated in their service plans.	No
Resident A's medications have been increased due to false documentation by staff.	No
Resident A is often restrained in her Geri chair.	No
Additional Findings	Yes

The anonymous complainant identified some concerns that were not related to licensing administrative rules and statutes for a home for the aged. Only specific items pertaining to homes for the aged provisions of care were considered for investigation.
The anonymous complainant also identified other concerns that were previously investigated in special investigation report (SIR) 2021A1027011 and will not be re-investigated here.

III. METHODOLOGY

02/16/2021	Special Investigation Intake 2021A1011018
02/16/2021	Contact - Document Received 12/18/20 incident reports for Residents A and B received from assigned licensing staff Aaron Clum via email.
02/17/2021	Special Investigation Initiated - Letter Email to complainant requesting telephone number and interview.
02/17/2021	APS Referral Emailed referral to adult protective services (APS).
02/17/2021	Contact - Document Received Confirmation email from APS intake worker Dannie Sue Balakas via email that my APS referral was received.
02/18/2021	Contact - Document Sent Second email to complainant requesting contact information for an interview.
02/19/2021	Contact - Document Received

	APS assigned worker Monica Voltz requested status of my investigation.
02/19/2021	Contact - Document Sent Informed APS worker Monica Voltz of investigation status.
03/01/2021	Inspection Completed On-site Interviews conducted, observations made, records reviewed.
03/01/2021	Contact - Document Received Documentation received via email upon request from administrator Jennifer Rockafellow.
03/01/2021	Contact – Document Received Resident A's medication administration records from complainant's email address but no contact information provided.
03/02/2021	Contact - Document Received Additional documentation received via email upon request from Ms. Rockafellow.
03/02/2021	Contact - Document Received Chart notes from Resident A's record received from complainant's email address but still not providing name or phone number.
03/03/2021	Contact - Telephone call made Interviewed Jessica Mole.
03/03/2021	Contact - Telephone call made Interviewed Crystal Smith.
03/04/2021	Contact - Document Received Documentation from Resident A's record received from C. Smith via email upon request.
03/04/2021	Contact - Telephone call made Left voice mail for hospice nurse David Beck requesting interview.
03/04/2021	Contact - Telephone call received Interviewed David Beck
03/05/2021	Contact - Document Received Upon request Ms. Rockafellow emailed Resident A's QS 106A form.
03/05/2021	Contact - Document Received

	Upon request Ms. Smith emailed Resident A's physician order for Geri-chair.
03/09/2021	Contact - Document Received Email received from the anonymous source providing update of Resident A's current condition and progress made.
03/09/2021	Contact – Document Sent Responded to anonymous email that I do not have a name/phone number to contact this individual.
03/22/2021	Contact - Telephone call made Left voice mail for licensee authorized representative Rochelle Lyons via telephone.
03/24/2021	Exit Conference – Conducted with licensee authorized representative Rochelle Lyons via telephone.

ALLEGATION:

Resident A and Resident B's bed alarms were not utilized as indicated in their service plans.

INVESTIGATION:

On 2/16/21, the allegations were received from an anonymous source via the online intake unit. Therefore, I was unable to obtain additional information.

The written allegations allege that Resident A's bed alarm only blinks, it will not sound. It is also alleged that the facility's former Director of Care Crystal Smith wrote in Resident B's service plan that his bed alarm was implemented on 12/18/20 but it was not available to staff until 1/4/21 because reportedly, batteries were not available for it.

On 2/17/21, I made a referral to adult protective services centralized intake by submission of the allegations via email.

On 3/1/21, I interviewed staff Felicia Hubbard-Scott at the facility. Ms. Hubbard-Scott has been employed for a year and a half and she works directly with Resident A and Resident B. Ms. Hubbard-Scott affirmed that Resident A's bed alarm does sound and said that it is very loud. Ms. Hubbard-Scott did not know the exact date that the bed alarms were implemented but provided access to the residents' service plans.

Resident B's service plan was updated on 1/4/21 by staff Tiffany Bray and reads, "Please make sure bed alarm is in place and working during third shift hours until further notice effective 1/4/21".

On 3/1/21, I interviewed business office manager Elizabeth Cole at the facility. Ms. Cole said there are always three boxes of batteries of every size available to the staff for utilization in bed alarms and other needs.

On 3/3/21, I interviewed Memory Care Coordinator Jessica Mole by telephone. Ms. Mole also works with Resident A and Resident B directly. Ms. Mole also affirmed that the bed alarms do emit an audible alarm. Ms. Mole said there was a day that Resident A's alarm did not function. Resident A had spilled water on her bed alarm. Ms. Mole said she dried the alarm pad and replaced the batteries.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

ANALYSIS:	Documentation and interview reveal Resident A's and Resident B's bed alarms are functioning, batteries are available to staff and Resident B's service plan was updated on 1/4/21.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's medications have been increased due to false documentation by staff.

INVESTIGATION:

It was alleged that Memory Care Coordinator Jessica Mole prompted Resident A's hospice nurse David Beck to increase Resident A's morphine intake. Consequently, Resident A had experienced constipation, vomiting, a loss of appetite, weight loss, and required a change in food texture. Resident A reportedly could not speak and was catheterized instead of walking to the bathroom. Ms. Mole reportedly made up an incident about the resident's behavior. The complainant is concerned that the former Director of Care Crystal Smith, who oversees medication changes and staff's work, did not address the situation.

On 3/1/21, I interviewed the facility's administrator Jennifer Rockafellow at the facility. Ms. Rockafellow said of Jessica Mole's work "she's pretty great" and that she has no concerns with Ms. Mole's documentation. Ms. Rockafellow said Ms. Mole would relay information to hospice nurse David Beck about Resident A expressing pain and he was increasing her morphine. Mr. Beck relied on this one staff person's observations and he did not consult with Ms. Rockfellow or the facility's former Director of Care Crystal Smith. Ms. Rockafellow said Ms. Smith reviewed Resident A's prescription changes and together they called a meeting with the hospice nurse practitioner Cullen Giddings and Mr. Beck. Given Resident A's history of psychosis, it was decided to titrate her morphine and administer psychiatric medication for behavior instead. She responded favorably and now is only prescribed morphine "PRN" meaning "as needed".

Ms. Hubbard-Scott described Resident A as having verbal outbursts and explained how she can be very angry and demanding at times. Resident A will also lay on the ground repeatedly rather than stay in her recliner or her bed. Mr. Hubbard-Scott said in the past few months Resident A was screaming and complaining of pain often and her morphine was scheduled and increased at that time, however, it is now ordered PRN. Ms. Hubbard-Scott explained that Resident A complained of shoulder pain earlier this morning and she applied Biofreeze in accordance with the medication administration record (MAR) and this was sufficient. No morphine was necessary.

Ms. Hubbard-Scott said of her co-worker Jessica Mole, that she “is very hard working and the strongest employee here. She’s always here and rarely calls-in [off duty]. If [Resident A] is not having a good day, Jessica knows how to calm her down”. Ms. Hubbard-Scott said she does not know of any exaggeration or misrepresentation in Ms. Mole’s documentation.

On 3/3/21, I interviewed Memory Care Coordinator Jessica Mole by telephone. Ms. Mole said she would tell hospice nurse David Beck about her observations of Resident A that Resident A was verbally stating she was in pain and at times she seemed to be reaching out. Ms. Mole said, “All I reported is what I saw. I’m just an advocate for the residents”. Ms. Mole denied having suggested hospice increase Resident A’s medications. Ms. Mole said, “I never made up any chart notes, and I would not. Besides, that would just make more work for me.”

On 3/3/21, I interviewed the facility’s former Director of Care Crystal Smith by telephone. Ms. Smith has since been promoted and still works within the organization. Ms. Smith said Ms. Mole’s documentation was never made up. Ms. Smith explained how Ms. Mole documented events in great detail and Ms. Smith even advised Ms. Mole to be more concise with her documentation. Ms. Smith said she believes the hospice nurse was relying solely on information from Ms. Mole and he did not question or consult with any others about Resident A’s behaviors and expression of pain. He would just increase the dosages based upon one person’s observations. Ms. Smith said Ms. Mole was always working in the best interest of the residents. Ms. Mole cannot ask the doctor to prescribe medications. Hospice followed Ms. Mole’s reports of Resident A’s behavior that she observed.

Ms. Smith said in her job duties she would oversee medication changes. She noticed that hospice was substantially increasing Resident A’s prescribed scheduled morphine. On 1/8/21 Ms. Smith and administrator Ms. Rockafellow called for a medication review meeting with hospice nurse practitioner Cullen. Ms. Smith said she believed Resident A’s psychosis was getting worse. Resident A had a historical baseline of screaming, yelling out, repeatedly burping and such before she moved into the memory care unit. Ms. Smith said it seemed as though her psychiatric behavior was being exacerbated by her dementia and her increase in yelling appeared to staff as though she was expressing pain. Ms. Smith said Resident A did report pain at times but much of the reported pain was likely related to the amount of morphine medication causing constipation. Ms. Smith explained how it was decided to slowly withdraw Resident A’s morphine and introduce psychiatric medication to address her psychosis. Ms. Smith said staff were also using the “Snoozelene” room where they would take Resident A for some quiet time away from crowds and noise that could be overstimulating her. Ms. Smith said Resident A responded positively to the reduction in medication and she was titrated off the morphine to now where it is only prescribed as needed.

On 3/4/21, I interviewed hospice nurse David Beck by telephone. Mr. Beck could not identify staff Jessica Mole by name, but he did affirm regular communication

about Resident A with the staff in the memory care unit. Mr. Beck said Resident A did have an issue of screaming in pain all the time and he had observed it himself. Mr. Beck said whenever he would touch or move Resident A or try to provide any care, she would start screaming. Mr. Beck said the morphine was increased because it was believed her decline was indicating she was in a “pre-active” stage and getting close to dying. Mr. Beck explained that his approach of care is to make sure residents comfortable and he affirmed having increased Resident A’s morphine in response to the observed expression of pain. Mr. Beck said staff stories at the facility sometimes contradicted one another but he said, “I can’t get in the vibe that staff there were over-medicating her. She was on a lot of morphine, but I thought she was dying”. Of staff documentation and reports of her behavior, Mr. Beck said, “There was nothing nefarious”.

Mr. Beck also described the meeting with Ms. Rockafellow, Ms. Smith and hospice nurse practitioner and how they believed the screaming was behavioral and not necessarily pain. Mr. Beck also said they tapered off the morphine and introduced the Risperdal and said Resident A “responded great” to this change. Mr. Beck affirmed that Ms. Smith made herself available for consults and he said there was never any communication problem with Ms. Smith or anyone at the home. Mr. Beck said it was agreed that going forward, he would discuss any medication changes with Ms. Rockafellow and Ms. Smith before implementing them.

I reviewed documentation from Resident A’s record on 3/1/21 at the facility, and as received via email upon request from Ms. Rockafellow and Ms. Smith on 3/2, 3/4, and 3/5/21. Staff regularly documented Resident A’s behavior several times a shift on *Chart Notes*. *Chart Notes* from 12/1/20 thru 3/1/21 revealed that in addition to Ms. Mole, 18 other staff documented Resident A’s challenging behaviors, including when PRN medication was administered to call her down and/or address her pain. Many entries include Resident A yelling and calling out “Help me!” which might have interpreted as pain. Other entries specifically state Resident A was in pain. These entries were documented by Ms. Mole, Shannon Sagamang, Hollie Bailey, Emily Swann, April Bolin, Tiffany Bray, Deneshi Smith and Karri Robertson.

In addition to staff’s observations of pain, staff Sydney Johnson wrote on 12/20/20 that Resident A’s son came to visit but did not stay long. He felt he was upsetting Resident A and said he would be contacting the doctor to see if they can give her stronger medications.

On 2/28/21, Karrie Robertson wrote Resident A’s son came to visit and was upset that her Morphine had been changed to PRN status and not on a scheduled basis. “He demanded that staff give Resident a dose of Morphine as Resident was in pain. …Staff explained to [son[that resident had no been complaining of this afternoon as staff had just been in resident’s room administering afternoon meds and taking vital. [Son] stated, ‘Well she is now.’ Staff administered all meds, cleaned up after resident at dinner, got resident ready for bed”.

APPLICABLE RULE	
R 325.1942	**Resident records.**
	(2) A home shall assure that a current resident record is maintained and that all entries are dated and signed.
ANALYSIS:	Based on interviews and documentation review, there is no evidence to indicate Ms. Mole fabricated documentation about Resident A's behavior and pain. Eighteen other staff documented on Resident A's various behaviors and seven of them specifically noted that she complained of pain. Resident A's son also reportedly observed Resident A in pain. Mr. Beck increased Resident A's medications based on staff reports and his own observation of Resident A's behavior.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is often restrained in her Geri chair.

INVESTIGATION:

Resident A has a physician order from hospice that reads, "12/20/20 DME- Order Geri Chair through Cardiac DME for decline in patient's safety. To be delivered on 12/21/20".

Resident A has another order for a "Hospice wheelchair reclining back" and "Hospice Lap Buddy" from a medical equipment company that indicates the equipment was delivered on 12/21/20.

The facility's policy reads, Physical restraints will not be allowed for resident use. Physical restraint shall be defined as a device used to restrain a resident's movement for staff convenience or to restrict a resident's movement if injury is not a concern. Assistive devices shall be used under the following conditions:

a. Enhances mobility/independence
b. Provides physical comfort
c. Promotes well-being and safety

Assistive devices shall be mutually agreed upon by the resident/designated responsible party, the resident's physician and community management. The resident's physician shall authorized in writing the type of assistive device, reason for use, and term of authorization. May utilize QS 106 A. The resident and/or

responsible party shall be educated to the type of assistive device, reason for use, risks for [illegible] term of use. Documentation shall be placed in the resident's chart. May utilize form QS 106A. Assistive devices shall be specified in the resident's guide/service plan (See QS 202) For AFC residents and [illegible] devices shall also be specified in the resident's written assessment plan form OCAL-3265 (see QS213).

There was no indication that the resident and her authorized representative were educated to the type of device, the reason for use and the risks involved.

Resident A's QS 106A *Leisure Living Management Assistive Device Designation Form* was signed by her physician and by Crystal Smith on 2/4/21, six weeks after the equipment was received. It indicates Resident A has a lap belt for wheelchair, a lap tray for wheelchair or Geri-chair, and a Geri-chair. On the Lap Tray line it is written "during meal times (8-9:30a), (12-1pm), (5-6pm) and activities when table surface is needed".

Mr. Beck said hospice ordered the chair, commonly referred to as a "Geri Chair", because Resident A kept putting herself on the floor. Mr. Beck said it has a reclining back that she would not be able to put her legs down and get out. Mr. Beck also said the chair was for staff to "Take her to the common area and she would not be able to get out. The tray was for eating and safety. It was not meant for restraint." Mr. Beck said he was not told that staff were not over-using the Geri Chair and she was not in it every time he would visit. Mr. Beck said it was, "To prevent her from throwing herself on the floor and to get her out of her room safely so she could have conversations with others."

Ms. Hubbard-Scott said she believed Resident A was complaining about her wheelchair and that the Geri-chair was ordered for her comfort. Ms. Hubbard-Scott said Resident A uses the lap tray for meals and for table-top activities. She affirmed that Resident A could not remove the lap tray when she is seated in the chair. Ms. Hubbard-Scott explained how difficult it is to remove it just by standing in front of the chair and having to adjust the handles underneath the tray to remove it. Ms. Hubbard-Scott said Resident A has tried to "wiggle out of it but if you recline the chair she just wiggles herself out more". Ms. Hubbard Scott said Resident A is not left in the chair for the entire shift. Ms. Hubbard-Scott said when Resident A says wants to get out of the chair, staff will take her to her bed or her recliner per her request. Ms. Hubbard-Scott said Resident A is repositioned at least every two hours whether she is in the Geri-chair or elsewhere. Although she is capable of ambulating with a walker and she takes herself to the bathroom.

Ms. Mole's responses to the use of the Geri-chair concurred with those statements made by Ms. Hubbard-Scott's. Ms. Mole said she will also push Resident A around the facility in the Geri-chair and show her different things as a means to calm her down when she is agitated. Ms. Mole said the tray is on Resident A's chair approximately 50% of the time she is in the chair and that she is usually in it for an

hour then she wants to go to her bed for a nap. Ms. Mole said Resident A is repositioned approximately every 30 minutes to an hour but there are no specific instructions on that.

In regard to ambulation, laying on the floor, and the use of a Geri-chair, Resident A's service plan reads, Report any concern with change in wandering behavior. Redirect as needed; Assist resident to bathroom and ensure privacy; Resident will ambulate without assistance or throw herself on the floor saying God told her to. Use low bed and keep at lowest position while in bed. Keep low level light on at all times. Report increasing signs of unsteadiness or falls; Ambulates with support of one person or one person to push wheelchair. One person to push wheelchair. Use foot pedals. Resident also has Geri-chair; Requires reminders for repositioning. Remind resident to reposition. Encourage physical activity. Use pressure relief cushions; Assistive Devices Standard Walker Remind resident to use devices. Report any forgetfulness with device use. Use for short distances only. Manual Wheelchair use foot pedals. Report any safety concerns with use and/or forgetfulness, use for long distances. Geri chair use tray table for meals and activity as needed.

Specifically, in regard to the use of the Geri chair, Resident A's *Chart Notes* included the following:

12/24/29 Shannon Sagamang 9 pm Res[ident] was sitting in chair when staff did hourly check. Staff left Res in chair for the day and Res enjoyed it Res was in good spirits today…Res asked staff to help her get out of this place so Staff took Res for a walk around MC [memory care unit] common area. Res was happy to go on the walk and let staff know when she was ready to go back to her apt and get into bed. After assisting Res into bed she went to sleep.

1/14/21 Jessica Mole 9:26 am Res cried and seemed agitated all morning but staff tried to redirect her. Staff left res in her geri chair for most of the shift besides toileting her. Res seemed to do much better in the geri chair as she didn't throw herself out of it and relaxed.

1/18/21 Karri Robertson 6:39 pm Resident was very emotional this afternoon stating that she was homeless and had nowhere to live. Resident ate dinner in dining room of MC, she became upset and began pounding on the tray of her wheelchair.

1/18/21 Brooke Baley 8:34 pm Staff found resident on the floor next to her bed at 4:45p. Res stated "I was trying to get up". Res did not complain of any pain and had no new visible wounds. Assisted Res into Ger chair, ensured the tray was on and brought re into common area.

1/20/21 Shannon Sagamang 9:42 pm Res sat in her chair in MC common area most of day/evening. She was calm … After having her snack Res started screaming at staff every 10/15 minutes that she wanted to go to bed or that she needed to go to the bathroom. Staff took Res to the bathroom 3x within a 2 hour period before dinner

and Res did urinate and have a BM Assisted with ADLs checked on throughout shift, administered medications, checked vitals, room tidy, per-care “I just want to lay down and die”.

1/20/21 Jessica Mole 7:31 am Staff was assisting res getting up off the toilet and res then started hitting staff. Staff tried to calm res with talking to her and getting her in her Geri-chair so she could get warm. Res then kicked staff while staff was adjusting her Geri-chair. Staff took res into the care station and started talking about the wedding that the res was planning…That seemed to calm res down a bit…When staff tried to leave her…res started screaming. Staff took res for a walk and put on some Jesus music and took res wherever I went. That seemed to calm res down and she wasn’t screaming so loud. Eventually re fell asleep to the soft music and being pushed around the unit at 7:40 am. Res ate all of breakfast and seemed to be much more calmer. Resident in her Geri-chair with staff.

1/29/21Shannon Sagamang 9:19 pm Res would get herself up to go to the bathroom and sit in her Geri-chair for awhile because laying down was hurting her butt she stated.

On 3/1/21, I interviewed Resident A at the facility. She was seated in a recliner chair in her room, appearing relaxed. Resident A said of the staff at the facility, “They treat me very well” and later said she receives “Beautiful treatment from staff”. Resident A said the staff “come pretty quick” in response to her pushing her call-alert pendant. Resident A said she did not know anything about receiving hospice care. Resident A said she is able to walk with a walker, and later I did observe her doing this will staff providing stand-by assistance. I asked Resident A about the Geri-chair next to her and she denied having ever sat in that chair. Resident A said, “It looks uncomfortable”.

Staff documentation in Resident A’s February 2021 medication administration record (MAR) includes treatment provided. Staff initials confirm that she was repositioned minimally every two hours and supervised monitoring occurred hourly. Toileting is documented at 12 am, 2 am and 4 am daily.

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… 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:	Resident A's physician order of the Geri-chair for "decline in patient's safety" is unclear. *Leisure Living Management Assistive Device Designation Form* indicates the lap tray is to be used "during meal times (8-9:30a), (12-1pm), (5-6pm) and activities when table surface is needed". However, the use of a lap tray that Resident A cannot remove when she is in the Ger-chair, limits the resident's freedom of movement. In addition, Mr. Beck said he ordered the chair so she would not be able to put her legs down and get out. For these reasons the Geri-chair and lap tray appear to be ordered to implement as a restraint. However, documentation in Resident A's *Chart Notes* is not definitive as to whether staff applied Resident A's lap tray for extended periods of time she was in the Geri-chair, nor whether she remained in the chair against her will. Interviews and other related documentation were unclear whether Resident A was actually restrained or allowed to exit the chair upon request. Therefore, violation of this statute cannot be confirmed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A's physician order indicates the Geri-chair is for decline in patient's safety. Resident A's QS 106A *Leisure Living Management Assistive Device Designation Form* was indicates the lap tray is to be used "during meal times (8-9:30a), (12-

1pm), (5-6pm) and activities when table surface is needed". However, the use of a lap tray that Resident A cannot remove, when she is in the Ger-chair, limits the resident's freedom of movement. In addition, Mr. Beck said he ordered the chair so she would not be able to put her legs down and get out. For these reasons the Geri-chair and lap tray appear to be ordered to implement a restraint. However,

Resident A's service plan was not updated to specify the circumstances in which Resident A was to use the Geri-chair, the lap tray and/or the lap belt. The service plan did not specify whether the lap belt was applied to the Geri-chair, to the wheelchair or used at all. The service plan did not address using the lap tray only during meal times and for table-top activities in accordance with the QS 106A form. The service plan did not specify how long Resident A was to remain in the chair nor the how she was to be supervised while in the chair, nor under what circumstances she was to be assisted out of the chair. include clear and specific instructions as to the circumstances in which Resident A is to use the Geri-chair, the lap tray, and the lap belt, if any, as identified on the *Leisure Living Management Assistive Device Designation Form* that was signed by the physician and Ms. Smith. The form indicates the tray is to only be used for meals and table-top activities. However, the service plan also does not specify this, nor how long Resident A is to remain in the chair, how she is to be monitored while in the chair, nor

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.
For reference: R325.1901	**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:	Resident A's service plan was not updated to identify specific care and services in regard to the use of a Geri-chair, lap tray and lap belt, appropriate for the resident's physical, social and behavioral needs and well-being and the methods of providing that care and services while taking into account the resident's preferences and competency.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

In regard to medications, Resident A's service plan read staff to assist with all medication administration; that she takes 10 more medications/supplements daily; that requires assistance; she requires topical meds or treatments more than once daily and that she uses as needed medications frequently.

Resident A's February 2021 medication administration record (MAR) revealed she is prescribed Haldol as needed for "agitation", and Lorazepam "as needed". Staff documentation revealed they are administering the Lorazepam for "anxiety". However, Resident A's service plan does not address these prescribed medications needed for agitation nor anxiety. The service plan does not identify how Resident A demonstrates this agitation or anxiety behavior for staff to be able to identify it as such; nor does it specify care services to be provided to address these specific behaviors including the method of using medication.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	Resident A's service plan does not address giving prescription medication for behaviors of agitation nor anxiety. The service plan does not identify how Resident A demonstrates these behaviors nor the specific services including the use of medications to address these behaviors.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

The home has not always recorded instructions for “PRN” or “as needed” medications.

For example: The home maintains and administers medications to Resident A. According to the February 2021 medication administration record (MAR), Resident A has an order for Lorazepam every 6 hours “as needed”; Morphine Sulfate .25ml/5mg every 4 hours “as needed”; and polyethylene glycol powder once daily “as needed”. There are no instructions as to the circumstances or parameters to alert and inform staff when any of these medications would be “needed”.

Other medications prescribed “PRN” or “as needed” lack sufficient instructions to ensure the medications are administered as ordered. For instance, a resident is prescribed various medications for the same purpose; or various methods of one medication are ordered “as needed” without sufficient instructions clarifying situations and/or parameters as to when to administer one medication or the other; or one method or the other.

For example: According to the MAR, Resident A has an order for Acetamin suppository as needed for pain/discomfort/fever above 100.4º; and an order for MAPAP 2 tablets every 4 hours as needed for pain/discomfort/fever above 100.4º. There are no instructions clarifying when to give the suppository or the tablets, whether they are to be given together, separately, in tandem, etc.

Resident A also has an order for Biofreeze Gel 4% apply to any external part of body that is causing pain once daily. There are no instructions clarifying if/when Resident A would be administered the Biofreeze Gel versus the Acetamin or MAPAP for pain; whether the medications are prescribed for different pains or different levels of pain; whether three orders of medications for “pain” are to be administered together, separately, in tandem, etc. In addition, should Resident A’s order for Morphine be adjusted with instructions to give as needed for pain, instructions would also need to be clarified if/when Biofreeze Gel, Acetamin suppository, MAPAP tablets, and Morphine would be administered for different pains or different levels of pain, whether the four medications would be administered together, separately, in tandem, etc.

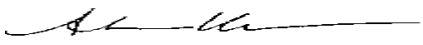
APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
As a result of facility’s omission of and/or lack of sufficient written instructions from the prescribing licensed health care professional to administer medications ordered “PRN” or “as needed”, it cannot be determined that these medications were safely administered as intended by the prescriber, or by what the staff	

member “thought” was right at the time. This lack of instruction does not reasonably comply with this rule.
VIOLATION ESTABLISHED

On 3/24/21, I reviewed the findings of this report with licensee authorized representative Rochelle Lyons via telephone.

IV. RECOMMENDATION

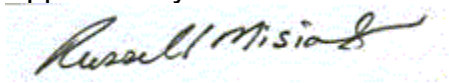
Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.



3/5/21

Andrea Krausmann Date
Licensing Staff

Approved By:



3/18/21

Russell B. Misiak Date
Area Manager