GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 24, 2021

Anna Hinton
Pioneer Resources
Suite 100
601 Terrace St.
Muskegon, MI 49440

| | |
|---|---|
| RE: License #: | AS610016252 |
| Investigation #: | 2021A0356023 |
| | Broadway Home |

Dear Ms. Hinton:

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.

If you desire technical assistance in addressing these issues, please 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

## I. IDENTIFYING INFORMATION

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| **License #:** | AS610016252 |
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| **Investigation #:** | 2021A0356023 |
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| **Complaint Receipt Date:** | 03/26/2021 |
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| **Investigation Initiation Date:** | 03/26/2021 |
| | |
| **Report Due Date:** | 05/25/2021 |
| | |
| **Licensee Name:** | Pioneer Resources |
| **Licensee Address:** | Suite 100<br>601 Terrace St.<br>Muskegon, MI 49440 |
| | |
| **Licensee Telephone #:** | (231) 773-5355 |
| | |
| **Administrator:** | Anna Hinton |
| | |
| **Licensee Designee:** | Anna Hinton |
| | |
| **Name of Facility:** | Broadway Home |
| | |
| **Facility Address:** | 2315 E. Broadway Avenue<br>Muskegon, MI 49444-2609 |
| | |
| **Facility Telephone #:** | (231) 220-2338 |
| | |
| **Original Issuance Date:** | 02/01/1995 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 07/22/2019 |
| | |
| **Expiration Date:** | 07/21/2021 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED,<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was not supervised in the facility leading to injury. | No |
| Resident A's medications are not administered as prescribed. | Yes |
| Resident A lost a considerable amount of weight at the facility. | No |
| Resident A's funds were mishandled at the facility. | No |

## III. METHODOLOGY

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| 03/26/2021 | Special Investigation Intake<br>2021A0356023 |
| 03/26/2021 | APS Referral<br>APS referred to LARA. |
| 03/26/2021 | Special Investigation Initiated - Telephone<br>Karen McGrane, APS, Muskegon Co. DHHS. |
| 03/26/2021 | Contact - Document Received<br>IR received and reviewed on 03/24/2021, filed but pulled back out due to complaint. |
| 03/29/2021 | Contact - Document Sent<br>Muskegon Healthwest Office of recipient rights, Larry Spataro, notified of complaint. |
| 03/30/2021 | Contact - Document Received<br>More complaint information received through K. McGrane; new APS referral came. |
| 03/31/2021 | Inspection Completed On-site. |
| 03/31/2021 | Contact - Face to Face<br>Home Manager, Tracy Cross interviewed at Pioneer Resources training center with Jill Bonthuis, Pioneer Resources, Karen McGrane, APS and Linda Wagner, ORR. |
| 03/31/2021 | Contact - Face to Face<br>DCW Lonnise Barnes and Tami Grasmeyer. |
| 04/01/2021 | Contact - Document Sent |

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| | Requested and received documents from Jill Bonthuis, Pioneer Resources. |
| 04/15/2021 | Contact - Telephone call made.<br>Deb Davis, legal guardian, set up meeting for 04/23/2021. |
| 04/23/2021 | Contact - Face to Face<br>APS Karen McGrane, ORR, Linda Wagner, Resident A, Deb Davis & Misty Kanaar, legal guardian, Chris Pickel, ARC advocate for Resident A. |
| 05/12/2021 | Contact-Telephone call made.<br>Anna Hinton, Licensee Designee. |
| 05/12/2021 | Contact - Document Sent<br>Requested weight records from the home for Resident A. |
| 05/13/2021 | Contact - Document Sent<br>Requested Funds II forms for Resident A. |
| 05/13/2021 | Contact - Telephone call made.<br>Chris Pickel, advocate, director of ARC. |
| 05/14/2021 | Contact-Document received.<br>Resident A's facility documents sent by Ms. Hinton. |
| 05/19/2021 | Contact-Telephone call made.<br>Chris Pickel, ARC. |
| 05/21/2021 | Contact-Telephone call made.<br>Karen Smith-HealthWest. |
| 05/24/2021 | Exit Conference-Licensee Designee, Anna Hinton. |

**ALLEGATION: Resident A was not supervised in the facility leading to injury.**

**INVESTIGATION:** On 03/26/2021, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported that on or about 03/22/2021, Resident A was in the bathroom at the facility, she let go of the rail in the bathroom while getting off the commode and fell to the floor. The complainant reported that Resident A broke her lower leg which required surgery and the AFC care plan documented that Resident A is to have 24-hour supervision including toileting. The complainant reported Resident A uses a wheelchair and there is conflicting information regarding whether or not Resident A was alone in the bathroom at the time of the fall.

On 03/26/2021, I interviewed Karen McGrane, Adult Protective Service (APS) worker, Muskegon County Department of Health and Human Services (DHHS). Ms. McGrane stated Resident A is currently in the hospital, her lower leg is broken and may have to go to rehab after the hospital stay. Ms. McGrane stated Resident A has two legal guardians, Deb Davis and Misty Kanaar who are reporting that they are getting conflicting information from the facility as to whether or not Resident A was properly supervised while in the bathroom at the facility when the fall and injury occurred.

On 03/26/2021, I reviewed an Incident Report (IR) written on 03/24/2021 by Tracy Cross, Home Supervisor and signed by Anna Hinton, Licensee Designee. The IR documents the incident occurred on 03/23/2021 at 12:00PM and the staff on duty at the facility included Tracy Cross, Lonnise Barnes and Tami Grasmeyer. The staff assigned to Resident A on this date was Ms. Barnes and the location of the incident was the West Bathroom. The IR documented the following information, '*when transferring her from toilet to wheelchair she lost control of her standing she slipped onto the floor landed on her (L) side of her knee. Called RN at Healthwest, called 911, called supports coordinator, called guardian several times, called Anna Hinton, wrote an IR. (*Resident A*) was looked over after the fall she appeared to be fine we got her into her wheelchair, looked her over again saw that her (L) knee was swollen and that's when all staff acted accordingly they were swift with their actions, looking her over, making the correct calls, and tending to her immediate needs. (*Resident A*) transported to Mercy Hospital with a broken knee, possible blot clot.'*

On 03/31/2021, I conducted a face-to-face interview with home manager, Tracy Cross at the Pioneer Resources Corporate Office with Jill Bonthuis, Director of Pioneer Resources, Ms. McGrane, APS and HealthWest, Office of Recipient Rights Officer, Linda Wagner. Ms. Cross stated she was working at the facility on the day Resident A fell in the bathroom, 03/23/2021. Ms. Cross stated she was on the opposite side of the closed bathroom door while direct care worker (DCW) Lonnise Barnes was in the bathroom assisting Resident A with toileting. Ms. Cross stated she was peeling stickers off the bathroom door when she heard a noise coming from the bathroom. Ms. Cross stated she went into the bathroom and saw Resident A on the floor on her "bum" and Ms. Barnes in the bathroom with her. Ms. Cross stated she and Ms. Barnes did a "once over" and checked Resident A out, assisted her into her wheelchair and at that point, Resident A "appeared to be fine." Ms. Cross stated they got Resident A into the living room and another staff, Tami Grasmeyer asked Ms. Cross to come and look at Resident A's knee, which was swelling up. Ms. Cross stated they immediately called the on-call RN through HealthWest, 911, Anna Hinton, Licensee Designee and Ms. Kanaar, legal guardian. Ms. Cross stated every time Resident A goes into the bathroom, staff go in with her and assist her with toileting. Ms. Cross stated Resident A is a one-person transfer, she is capable of pulling herself up on the grab bar in the bathroom, staff remove her brief, toilet her/clean her up and put a new brief on. Ms. Cross stated Resident A is never alone in the bathroom.

On 03/31/2021, Ms. McGrane, Ms. Wagner, Ms. Bonthuis, and I interviewed DCW Lonnise Barnes at the Pioneer Resources Corporate Office. Ms. Barnes stated she has worked for 2 years at this facility and prior to this facility, worked at another Pioneer Resource facility. Ms. Barnes stated she was in the bathroom with Resident A on 03/23/2021 assisting Resident A with toileting. Ms. Barnes stated Resident A was holding on to the grab bar after using the toilet and during the transfer from the toilet to the wheelchair, Resident A took her hand off the grab bar and attempted to hit Ms. Barnes and that is when she fell to the floor and landed on her left leg. Ms. Barnes stated Resident A did not give any indication that she was feeling wobbly or unsteady. Ms. Barnes stated after the fall, Ms. Cross and Ms. Grasmeyer got Resident A into her wheelchair, Resident A was quiet, she was not making any noise but appeared to be sweating with sweat on her chest and head, she looked pale and so the on-call RN was called and 911 to send Resident A out for evaluation and treatment. Ms. Barnes stated every time Resident A uses the bathroom, staff are with her, she is never left in the bathroom alone.

On 03/31/2021, Ms. McGrane, Ms. Wagner, Ms. Bonthuis, and I interviewed DCW Tami Grasmeyer at the Pioneer Resources Corporate Office. Ms. Grasmeyer stated Ms. Barnes was assigned to Resident A on 03/23/2021 but for the past couple of months, Resident A has exhibited some behaviors so “to be on the safe side” we (Ms. Barnes and Ms. Grasmeyer) assist Resident A together as much as possible with toileting and getting Resident A dressed. Ms. Grasmeyer stated Resident A was on the toilet, Ms. Barnes was in the bathroom with her and so she (Ms. Grasmeyer) ran out to her car to get a toy and when she came back in, Resident A was sitting on her butt on the floor in the bathroom. Ms. Grasmeyer stated Resident A said her leg hurt, so she (Ms. Grasmeyer) assisted in getting Resident A into her wheelchair. Ms. Grasmeyer stated that is when she noticed Resident A was sweating profusely, she was quiet and her leg “didn’t look right.” Ms. Grasmeyer stated they called the on-call RN at HealthWest and sent Resident A to the hospital immediately for evaluation and treatment.

On 04/23/2021, Ms. McGrane, Ms. Wagner and I conducted a face-to-face interview with legal guardian, Deb Davis at Ms. Davis’ house. Also present at this interview was Chris Pickel, Executive Director of ARC, as an advocate for Resident A. Ms. Davis stated Ms. Cross told two stories about how Resident A’s injury occurred which raised suspicion about what actually happened to Resident A. Ms. Davis stated, the first story was that Resident A fell, landed on her side and then staff sat her up on her butt and the next story was that Resident A fell off the toilet and landed on her butt. Ms. Davis stated the surgeon at the hospital told her Resident A’s break did not look right and that the break was suspicious, but she does not know if the surgeon reported this to anyone else for investigation. At this point, Ms. McGrane, Ms. Wagner, and myself had Ms. Davis call Ms. Kanaar so she could be present via telephone in the interview, so we had all sides of the information and story. Ms. Kanaar reported she went to the hospital and Ms. Cross was there and told Ms. Kanaar that Resident A was on the toilet, staff was transferring Resident A from the toilet to her wheelchair when Resident A let go of the grab bar and fell on

her butt. Ms. Kanaar stated she then asked Ms. Cross if Resident A fell on her butt, how did her shin break and Ms. Cross seemed to be confused or unaware that Resident A's shin was broken and how could Resident A sustain a break to the front of her leg if she fell on her butt. Ms. Kanaar and Ms. Davis stated that was suspicious to them. Ms. McGrane, Ms. Wagner, and I informed Ms. Davis and Ms. Kanaar that Ms. Cross was not the DCW that was in the bathroom with Resident A when the fall occurred. Ms. Kanaar and Ms. Davis stated Resident A's fall in the bathroom at the facility was due to neglect on the part of staff at the facility.

On 04/23/2021, Resident A was present at Ms. Davis' house (she has been living with Ms. Davis since her release from the hospital) for the interviews but not able to provide information that supported or refuted the allegations made in this complaint due to cognitive impairment.

On 04/23/2021, I received and reviewed the Assessment Plan for Resident A, dated 06/23/2019 and signed by Ms. Kanaar, former home manager, Cindy Morden and HealthWest supports coordinator, Nicole Skodack. The assessment plan documents Resident A as requiring assistance with toileting described as *'needs help with wiping thoroughly, staff must assist her in the bathroom per health care plan for seizure activity. Has a weak bladder-uses toilet more frequently than most.'* The assessment plan did not document that Resident A had a history of falls or the need for Resident A to have more than one staff to assist with transfers.

On 04/23/2021, I reviewed Consumer Progress Notes written by staff each day documenting Resident A's activities each day. On 03/23/2021, Ms. Barnes documented the following, *'(Resident A) had all meds, did not get to eat do to her falling to the floor on her left side of the knee, had to get rushed to the ER.'*

On 04/23/2021, I reviewed the Mercy Health ER notes dated 03/23/2021 by Dr. Brian Smith, MD. Dr. Smith documented Resident A's fall, with a diagnosis of *'Acute impacted and minimally angulated fracture of the proximal tibia diametaphysis, an acute comminuted fracture of the fibular head.'* Dr. Smith and Dr. Angelic D. Dye DO document on 03/23/2021, *'I independently gathered a history and performed a physical examination of the patient. Critical elements including vital signs, physical examination, as well as any laboratory and imaging data were discussed and agreed upon as documented by the resident.'* The ER notes did not include any information stating that Resident A's injury was "suspicious".

On 05/24/2021, Exit Conference conducted with Licensee Designee, Anna Hinton via telephone. Ms. Hinton stated she agreed with the information, analysis, and conclusion of this applicable rule.

| **APPLICABLE RULE** | |
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| **R 400.14303** | **Resident care; licensee responsibilities.** |

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| | (2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan. |
| **ANALYSIS:** | The complainant reported Resident A fell in the bathroom at the facility and sustained a fracture to her leg. The complainant reported Resident A is supposed to be supervised while in the bathroom at all times and Resident A did not have supervision by staff while toileting.<br><br>Ms. Cross, Ms. Grasmeyer and Ms. Barnes all stated Ms. Barnes was in the bathroom with Resident A when she fell during a transfer and injured her leg.<br><br>Resident A's assessment plan documents that Resident A required staff assistance with toileting.<br><br>Ms. Davis and Ms. Kanaar stated Ms. Cross' report of how Resident A fell was not consistent which created suspicion about how Resident A fell.<br><br>There is no documentation in medical notes reviewed that Dr. Smith and/or Dr. Dye suspected Resident A's fall or injury stemmed from neglect at the facility per information provided by Ms. Davis.<br><br>A preponderance of evidence is not established to show that staff failed to properly supervise Resident A per her assessed needs when she fell in the bathroom on 03/24/2021. Based on the investigative findings, staff were in the bathroom with Resident A at the time of her fall. Therefore, a violation of this applicable rule is not established. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ALLEGATION: Resident A's medications are not administered as prescribed.**

**INVESTIGATION:** On 03/30/2021, I received additional complaint information from Ms. McGrane that came through APS Centralized Intake. The complainant reported on 03/26/2021, Resident A was discharged from the hospital after a leg fracture sustained at the facility. Resident A's guardian took her home from the hospital with no plan to return Resident A to the facility because of the guardian's concern that she was neglected in the facility. The complainant reported the facility provided Resident A's medications but no documentation or listing of all of Resident A's medications, including a blood pressure medication. The complainant reported all of Resident A's medications, including the blood pressure medication was filled by the

pharmacy on 02/22/2021 and there were still 15 days left of her medication on 03/26/2021. The complainant reported on 03/23/2021, Resident A's blood pressure was only 50/30 when the ambulance picked her up from the facility which is another indicator that Resident A was not getting her medication as prescribed at the facility. The complainant reported Resident A can no longer demonstrate how to use her nebulizer, which she has been using her whole life and it is unknown if she has been using the nebulizer at the facility as prescribed or if staff have even assisted Resident A in using the nebulizer while at the facility. The complainant reported Resident A was not getting her prescribed medications at the facility.

On 03/31/2021, Ms. McGrane, Ms. Wagner, Ms. Bonthuis, and I interviewed Ms. Cross at the Pioneer Corporate office. Ms. Cross stated Resident A has a PRN (as needed) nebulizer that she has not used over the past year because Resident A has not needed it. Ms. Cross stated Resident A's blood pressure was extremely low on 03/23/2021 when EMS took her to the hospital, it was 50/30 which Ms. Cross said was surprising because she has never known Resident A's blood pressure to be that low. Ms. Cross stated staff administer Resident A's medications as prescribed by her physician.

On 03/31/2021, Ms. McGrane, Ms. Wagner, Ms. Bonthuis, and I interviewed Ms. Barnes at the Pioneer Resources Corporate Office. Ms. Barnes stated, at times, Resident A refused to take her medications, but staff tried again later and Resident A would take them. Ms. Barnes stated Resident A used her nebulizer as she needed it and staff always helped her. Ms. Barnes stated staff passed all of Resident A's medications as prescribed.

On 03/31/2021, Ms. McGrane, Ms. Wagner, Ms. Bonthuis, and I interviewed DCW Tami Grasmeyer at the Pioneer Resources Corporate Office. Ms. Grasmeyer stated she has never used the PRN nebulizer with Resident A because she has never seen her in respiratory distress where she needed the nebulizer. Ms. Grasmeyer stated Resident A has blood clots, and that is what caused her low blood pressure. Ms. Grasmeyer stated Resident A's medications are not all delivered on the same day of the month, controlled substances come on a different cycle as routine medications so there will be more or less of some medications than other medications at any given time. Ms. Grasmeyer stated every medication delivered has a packing slip, it is all tracked, and staff administer Resident A's medications as prescribed.

On 04/23/2021, Ms. McGrane, Ms. Wagner and I conducted a face-to-face interview with Ms. Davis, in attendance is Ms. Pickel and on the phone is co-guardian Ms. Kanaar. Ms. Davis stated when Resident A's medications were picked up at the facility, it was March 2021, and the facility was still working on February 2021's medications.

On 04/23/2021, Resident A was present for the interviews at Ms. Davis' house, but was not able to provide information that supported or refuted the allegations made in this complaint due to cognitive impairment.

On 04/23/2021, I reviewed Resident A's MARs (medication administration records) for the months of January, February, and March 2021. I specifically reviewed the following medications:

- Albuterol Neb 0.083% sub for: Accuneb-0.083%, inhale 1 vial nebulizer four times daily as needed (PRN-as needed).
- Flovent HFA AER 110MCG, inhale 2 puffs twice daily (asthma, breathing).
- Theophylline Tab 300MG ER, take one tab by mouth once daily (asthma, COPD, bronchitis, emphysema).
- Amlodipine Tab 10MG, take one tablet by mouth once daily (hypertension, high blood pressure).
- Lisinopril tab 10MG sub for Zestril, take one tablet by mouth once daily (blood pressure).
- For the months of January, February and March 2021, Albuterol Nebulizer PRN (as needed) is not documented as being administered. Albuterol is documented as an '*as needed*' medication and staff reported Resident A did not need this treatment to be administered.

The MARs dated January, February and March 2021 reflected no signatures by staff as administering these medications for the following dates/times.

- Flovent HFA AER was not marked on the MARs as administered on 01/08/2021 AM, 01/16/2021 PM and 03/19/2021 PM.
- Theophylline Tab was not marked on the MARs as administered on 01/08/2021.
- Amlodipine Tab was not marked on the MARs as administered on 01/08/2021, 03/15/2021 and 03/27/2021.
- Lisinopril tab was not marked on the MARs as administered on 01/08/2021 PM and 01/15/2021 PM.

On 05/24/2021, Exit Conference conducted with Licensee Designee, Anna Hinton via telephone. Ms. Hinton stated she will submit an acceptable corrective action plan.

| **APPLICABLE RULE** | |
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| **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 §333.1101 et seq. of the Michigan Compiled Laws, kept with |

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| | the equipment to administer it in a locked cabinet or drawer, and refrigerated if required. |
| **ANALYSIS:** | Based on my investigative findings, there is a preponderance of evidence to show that on several dates during the months of January, February and March 2021, Resident A's medications are not documented by staff as administered per doctor's orders. Therefore, a violation of this rule is established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION: Resident A lost a considerable amount of weight at the facility.**

**INVESTIGATION:** On 04/23/2021, Ms. McGrane, Ms. Wagner and I conducted a face-to-face interview with Ms. Davis, in attendance is Ms. Pickel and on the phone is co-guardian Ms. Kanaar. Ms. Davis stated another concern of hers is that Resident A lost a considerable amount of weight when she left the Pioneer Resources Riverwood facility and went to this facility. Ms. Kanaar expressed the same concerns as did Ms. Pickel.

On 04/23/2021, Resident A was present for the interviews, at Ms. Davis' house, but was not able to provide information that supported or refuted the allegations made in this complaint due to cognitive impairment.

On 04/23/2021, I reviewed Resident A's Assessment Plan for AFC residents. The assessment plan documents that Resident A requires a special diet, *'1500 calorie diet, chopped food, no spicy due to stomach troubles. She doesn't like milk on cereal, rice, oatmeal, bananas, bagels, butterscotch puddings.'* The assessment plan documents Resident A requires assistance with eating/feeding and describes, *'needs reminders that she doesn't have to eat all food if she is full or don't like it or she might gag. Chopped food (1/2") to make it easier for her to chew and swallow.'*

On 04/23/2021, I reviewed Resident A's health care appraisal signed by Dr. Kevin Kiley, MD on 07/11/2019. Dr. Kiley documented Resident A's diagnosis as mental retardation, seizure, severe kyphoscoliosis, and reflux. Dr. Kiley documents Resident A as requiring a special diet, *'1500 calorie diet, chopped food ½" pieces, no spicy, reminders to slow down when eating to reduce potential choking'* with no other special instructions. Dr. Kiley documented Resident A's blood pressure as 106/66 and ideal weight as 110-115 lbs.

On 04/23/2021, I reviewed Resident A's HealthWest treatment plan written by Laura Ritchie with Resident A, facility staff, Ms. Davis, and James Robinson SC (HealthWest supports coordinator) in attendance on 09/30/2020. The treatment plan documents that Resident A accepts assistance from staff at the facility 100% of the time with eating/feeding. The treatment plan specifies that staff monitor Resident A's special dietary needs, *'1500 calories with meals cut up ½ inch or smaller' and staff*

*monitors Resident A's 'eating due to a history of gagging.'* The plan does not document any issues with Resident A's appetite or concerns of weight loss due to not eating.

On 05/12/2021, I interviewed Anna Hinton via telephone. Ms. Hinton stated Resident A moved from another Pioneer facility to this facility because of her declining health. Ms. Hinton stated Resident A was weighed every month and did not lose considerable amounts of weight while at this facility.

On 05/14/2021, I received and reviewed Resident A's weight chart covering 01/20/2019 to 02/2021 when Resident A left the facility. Resident A's weight fluctuated between 112 lbs. to 100 lbs. over the two years she was in the facility. The weight chart showed the last weight taken was on 02/27/2021 and Resident A weighed 106 lbs.

On 05/24/2021, Exit Conference conducted with Licensee Designee, Anna Hinton via telephone. Ms. Hinton stated she agreed with the information, analysis, and conclusion of this applicable rule.

| **APPLICABLE RULE** | |
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| **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:** | Ms. Davis, Ms. Kanaar and Ms. Pickel expressed concern about the amount of weight Resident A lost while at this facility.<br><br>Ms. Hinton stated Resident A's weight loss from the previous facility to now, which has been more than two years, is due to the decline in Resident A's health.<br><br>A review of Resident A's assessment plan, health care appraisal and HealthWest treatment plan all address Resident A's special dietary needs and staff's assistance with Resident A's eating/feeding needs. The HCA documents Resident A's ideal weight as 110-115 lbs.<br><br>Based on my investigative findings, Resident A's weight from January 2019 until she left the facility in March 2021 fluctuated between 100 lbs. and 112lbs. At the time Resident A left the facility in March 2021, Resident A weighed 106 lbs. There is not a preponderance of evidence to show that Resident A lost a significant amount of weight from 2019 to 2021 while in this |

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| | facility. Therefore, a violation of this applicable rule is not established. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ALLEGATION: Resident A's funds were mishandled at the facility.**

**INVESTIGATION:** On 04/23/2021, Ms. McGrane, Ms. Wagner and I conducted a face-to-face interview with Ms. Davis in her home, in attendance is Ms. Pickel and on the phone is co-guardian Ms. Kanaar. Ms. Davis stated Resident A's funds always increased while living in this facility when the previous home manager ran the facility, but since Ms. Cross has been the home manager, Resident A's funds have not increased nor has Ms. Davis or Ms. Kanaar been updated on the status of Resident A's funds. Ms. Davis stated an iPad was purchased for Resident A with Resident A's funds and she has never seen Resident A with the iPad, Resident A typically has a lot of gift cards she (Ms. Davis and Ms. Kanaar) question if the gift cards are being used for Resident A.

On 04/23/2021, Resident A was present for the interview but not able to provide information that supported or refuted the allegations made in this complaint due to cognitive impairment.

On 05/12/2021, I interviewed Ms. Hinton via telephone. Ms. Hinton stated all of Resident A's expenditures have been documented on the appropriate forms and all funds including gift cards have been turned over to HealthWest since Resident A is no longer a resident in the facility. Ms. Hinton explained that months ago, Resident A's guardians asked about the iPad Resident A had, Ms. Hinton stated the guardians were referring to an iPad Resident A used while living at the Riverwood AFC home, this iPad was not Resident A's. Ms. Hinton stated Resident A owned a kindle, and when Ms. Hinton looked, there was no documentation or history of a purchase made of an iPad for Resident A. Ms. Hinton stated at one of Resident A's PCP (person centered planning) meetings it was decided that Resident A would purchase an iPad for herself. Ms. Hinton stated this was done and to her knowledge, the new iPad went with Resident A when she was moved out of this facility.

On 05/14/2021, I received Resident A's Resident Funds II documents from Ms. Hinton. Ms. Hinton submitted copies of both cash and checking ledgers with specific information about Resident A's checking, cash account and gift cards. In addition, Ms. Hinton provided a copy of a check made out in Resident A's name for the balance of funds that were maintained in the home. Ms. Hinton documented that she submitted these documents with receipts and gift cards to HealthWest staff (Joanna Gottberg) on 04/15/2021.

On 15/14/2021, I reviewed the Resident Funds II document submitted by Ms. Hinton. Resident A's Funds II form for cash dates back to 08/14/2019 and the checking account to 11/12/2019. The forms have documentation showing they were audited

by HealthWest on 09/21/2020 for the cash and on 03/11/2020 for the checking. The forms are complete, and the expenditures documented on the forms appear to be appropriate. The forms reflect the purchase of an iPad for Resident A.

On 05/19/2021, I interviewed Ms. Pickel via telephone. Ms. Pickel reported Resident A's funds at the facility used to always be at the top of what they could have on hand at the facility and often Resident A's funds needed to be spent down for Medicaid qualification purposes. Ms. Pickel stated this has not occurred over the past year. Ms. Pickel stated an iPad was purchased by staff for Resident A with her funds in January 2021 but according to Ms. Kanaar and Ms. Davis, Resident A never was able to use it. Ms. Pickel stated Ms. Kanaar and Ms. Davis are concerned about the handling of Resident A's funds while at this facility.

On 05/21/2021, I interviewed Kathy Smith, accountant for HealthWest. Ms. Smith stated HealthWest is the representative payee for Resident A and they conducted an audit today, 05/21/2021 on the cash and check ledgers received from Ms. Hinton. Ms. Smith stated all cash and check expenditures are acceptable and all the ledgers are complete and match the supporting documentation provided by the facility. Ms. Smith stated Resident A's gift cards were returned by the facility and the cards will be verified as to the amounts on the cards and any expenditures made on them. Ms. Smith stated there are no concerns regarding Resident A's funds.

On 05/24/2021, Exit Conference conducted with Licensee Designee, Anna Hinton via telephone. Ms. Hinton stated she agreed with the information, analysis, and conclusion of this applicable rule.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14315** | **Handling of resident funds and valuables.** |
| | (1) Upon a request from a resident or the resident's designated representative, a licensee may accept a resident's funds and valuables to be held in trust with the licensee. |
| **ANALYSIS:** | Ms. Davis and Ms. Kanaar reported concerns about the facility's handling of Resident A's funds.<br><br>Upon review of the Resident Funds II forms for both cash and checks, there is no indication that Resident A's funds were mishandled at the facility.<br><br>Ms. Smith completed an audit on the documents provided to HealthWest by Ms. Hinton in regard to Resident A's funds and reported no adverse findings.<br><br>Based on my investigative findings, there is not a preponderance of evidence to show that staff at the facility |

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| | mishandled Resident A's funds. Therefore, a violation of this rule is not established. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

## IV. RECOMMENDATION

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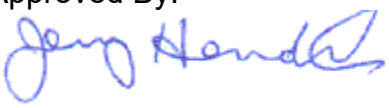
| Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged. |

05/24/2021

Elizabeth Elliott Date
Licensing Consultant

Approved By:



05/24/2021

Jerry Hendrick Date
Area Manager