GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 9, 2021

Connie Clauson
Pleasant Homes I L.L.C.
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390007089
Investigation #: 2021A0581053
Park Place Living Centre #A

Dear Mrs. Clauson:

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 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 (517) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390007089
Investigation #:	2021A0581053
Complaint Receipt Date:	09/14/2021
Investigation Initiation Date:	09/16/2021
Report Due Date:	11/13/2021
Licensee Name:	Pleasant Homes I L.L.C.
Licensee Address:	Suite 203 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Janet White
Licensee Designee:	Connie Clauson
Name of Facility:	Park Place Living Centre #A
Facility Address:	4214 S Westnedge Kalamazoo, MI 49008
Facility Telephone #:	(269) 388-7303
Original Issuance Date:	01/01/1989
License Status:	REGULAR
Effective Date:	07/19/2021
Expiration Date:	07/18/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was mistreated by facility staff and/or facility staff did not provide Resident A with adequate care, which contributed to his death. Facility staff failed to seek medical attention when Resident A's health declined.	No
Facility staff were using medication to immobilize Resident A.	No
Resident A's bedroom was in disarray and dirty, including blood stains on the carpet.	No
Additional Findings	Yes

III. METHODOLOGY

09/14/2021	Special Investigation Intake 2021A0581053
09/15/2021	APS Referral APS already received allegations but are not investigation due to resident being deceased.
09/16/2021	Special Investigation Initiated - Telephone Interview with Complainant.
09/17/2021	Referral - Other Attorney General's Office via email
09/17/2021	Contact - Document Received Received autopsy report, pictures, contact information and MDPOA.
09/17/2021	Contact - Document Sent Requested death certificate from Kalamazoo Co. Register.
09/17/2021	Contact - Document Received Received multiple records/documentation from Complainant.
09/21/2021	Contact - Document Received Requested death certificate from Kalamazoo County
09/21/2021	Contact - Document Sent Received Resident A's death certificate from Kalamazoo County.

10/07/2021	Inspection Completed On-site Interviewed staff and Administrator and obtained resident documentation.
10/21/2021	Contact - Telephone call made Left message with PACE, medical records\
10/26/2021	Contact - Telephone call made Left message with direct care workers, Ms. Nocera and Ms. Cummings.
10/27/2021	Contact - Telephone call received Interview with Ms. Nocera.
10/27/2021	Contact - Document Received Email from PACE medical records, Suzy Triesenberg
10/28/2021	Contact - Document Received Ms. Treisenberg indicated medical records were placed in mail.
10/29/2021	Contact - Telephone call made Left voicemail with Ms. Cummings.
11/01/2021	Contact - Telephone call made Left message with Ms. Cummings.
11/01/2021	Contact – Telephone call received Interview with Ms. Cummings.
11/01/2021	Contact – Telephone call received Interview with Mr. Shea, Attorney General's Office
11/03/2021	Contact – Document Received PACE medical records.
11/04/2021	Contact – Document Sent Requested documentation from Ms. White.
11/05/2021	Contact – Telephone call made Interviews with additional direct care staff.
11/05/2021	Contact – Document Received Documentation from Ms. White.
11/09/2021	Exit conference via telephone with licensee designee, Mrs. Clauson.

ALLEGATION:

- **Resident A was mistreated by facility staff and/or facility staff did not provide Resident A with adequate care, which contributed to his death.**

- **Facility staff failed to seek medical attention when Resident A's health declined.**

INVESTIGATION:

On 09/14/2021, this complaint was received through the Bureau of Community Health Systems (BCHS') on-line complaint system. The complaint indicated numerous concerns regarding Resident A's care while at the facility. The complaint indicated Resident A was admitted to the facility on 03/10/2021 with a diagnosis of vascular dementia with a history of dehydration. The complaint alleged there had been multiple incidences at the facility indicating Resident A was neglected by facility staff. It was alleged Resident A had been observed crawling on the facility floor, knocking over items after a potential fall, sustaining injuries to his knees and elbows, and wandering into other resident bedrooms, but the facility allowed these incidences to continue. The complaint alleged Resident A declined quickly on 04/19/2021 and 04/20/2021 and was sent to the Emergency Room (ER).

The complaint alleged Resident A was diagnosed with dehydration and not eating when he was admitted to the ER. The complaint indicated on 04/23/2021 Resident A was diagnosed with sepsis, dangerously low blood pressure, dehydration, pneumonia, was nonresponsive, and covered in scabs on his arms and legs when admitted to the ER. The complaint indicated Resident A was placed on hospice on 04/26/2021 and further indicated when an autopsy was completed on Resident A it was discovered Resident A had acute kidney injury when admitted to the hospital, multiple rib fractures, bronchopneumonia, scattered cutaneious healing wounds, superficial ulcers, and his blood culture was positive for a staphylococcus infection. The complaint indicated Resident A's cause of death was also related to complications from a blunt chest injury.

On 09/16/2021, I interviewed Complainant. Complainant confirmed the information provided in the complaint was correct. Complainant confirmed Adult Protective Services had been notified of the allegations; however, they denied investigating due to Resident A being deceased. Additionally, Complainant confirmed the Office of Attorney General's Office had also been notified.

Complainant indicated facility direct care staff and Senior Care Partners had been in contact while Resident A was at the facility and there had been a couple different

incidences involving Resident A displaying behaviors. Complainant indicated Resident A seemed fine until he was admitted into the ER on 04/20/2021.

Complainant did not visit with Resident A while he resided at the facility or talk to Resident A on the phone.

On 09/17/2021, Complainant provided me with multiple documents pertaining to Resident A, which included voicemails, pictures, and other documentation.

According to the voicemails provided by Complainant, the facility's associate administrator, Eric Goodlock, reported on 03/15/2021 Resident A had been observed crawling on the floor on 03/13/2021 and had knocked some things over. In another incident Resident A was observed on the floor of another resident bedroom and had observable scrapes on his knees and elbows. The other voicemail, dated 03/16/2021, was from Lisa Woodruff, a Behavioral Health Nurse, from Senior Care Partners. According to Ms. Woodruff's voicemail Resident A was displaying behaviors at the facility; therefore, she wanted to implement a medication change, which included Depakote and 3-day Ativan prescription. The third voicemail was dated 04/19/2021 and was from Kirsten [Unknown] of Senior Care Partners. The voicemail indicated Kristen [Unknown] was at the facility and Resident A was a "little dehydrated". She indicated Resident A was not himself and IV fluids were going to be administered.

I also reviewed pictures, dated 04/28/2021, provided by Complainant, which showed scabs and bruises on Resident A's arms and legs while Resident A was residing at a hospice facility. The scabs appeared in various stages of healing, but none appeared larger than a quarter. Additionally, Resident A had a baseball sized bruise on one of his knees.

I reviewed Resident A's autopsy report, dated 04/29/2021, completed by Western Michigan University's Medical Examiner, Amanda O. Fisher-Hubbard. Ms. Fisher-Hubbard's investigative findings included the following:

> "Per the investigative report, emergency medical services run sheet, and medical records, including Senior Care Partners P.A.C.E. records, [Resident A], a 74-year-old man with a history of hypertension, chronic kidney disease, vascular dementia, and atrial fibrillation, reportedly was a resident of an assisted living facility where he was moved for a higher level of supervision on 3/10/2021. Records state that he was often confused, frequently placed himself on the floor or was found on the floor, crawled around on the ground "building forts," and threw food/utensils at the facility. His oral intake had reportedly been decreasing and he had reportedly been becoming increasingly nonverbal. On the morning of

> 4/20, he was noted to have new bleeding abrasions and altered mental status after reportedly being found sleeping on the floor. He was conveyed to the hospital by emergency medical services, where he was found to have acute kidney injury. He was admitted to the hospital for further management and treatment. Of note, a computed tomography scan of the abdomen and pelvis noted a right ninth rib fracture. On the third day of his hospitalization, he became hypotensive, tachycardic, and febrile; blood cultures were positive for Staphylococcus aureus. He was ultimately transitioned to comfort care, admitted to hospice, and was pronounced dead on 4/28/2021."

According to this autopsy report, Dr. Fisher-Hubbard concluded Resident A died as a result of complications of blunt chest injury; hypertensive atherosclerotic cardiovascular disease, atrial fibrillation, dementia, and obesity were contributing factors. It was indicated in the autopsy report that for public health and vital statistics purposes, the manner of death is best classified as accident. There was no indication in the autopsy reporting when or how the Resident A's injuries occurred.

I also reviewed Resident A's death certificate, which was consistent with the autopsy report. The death certificate was also unable to determine the time or date of injury, but indicated the injury occurred from "unwitnessed fall/falls".

On 10/07/2021, I conducted an unannounced on-site inspection at the facility as part of my investigation. I conducted my on-site in conjunction with Attorney General Office special agent, Scott Shea. During the inspection, I requested and reviewed Resident A's resident file from the facility's Administrator, Janet White. Ms. White stated Senior Care Partners placed Resident A in the facility because he was no longer able to live alone. She stated after several days to approximately one week at the facility, he began to display behaviors like not eating, lying on the floor, and refusing medications. She stated Senior Care Partners, who is Resident A's primary care physician, were kept abreast of Resident A's health, issues, and behaviors while he resided at the facility.

While at the facility, I interviewed direct care staff, Toni Nocera, via telephone. Ms. Nocera stated she was currently on medical leave but agreed to be interviewed. Ms. Nocera confirmed she worked at the facility when Resident A resided there. She stated she primarily worked first shift (7 am – 3 pm), but also worked double shifts indicating she would have also worked 2nd shift or evening shifts at the facility.

Ms. Nocera stated Resident A's primary behavior was putting himself on the floor and then not getting back up. She stated once he was on the floor he would "scoot" himself along the floor which caused abrasions on his body, primarily his knees and elbows. She stated Resident A would get "rug burns" and would then pick at his

scabs, which caused bleeding. She stated Resident A's wounds were being addressed by Senior Care Partners as his picking at his wounds and scabs was a well-known behavior of his. Ms. Nocera stated Senior Care Partners did not seem too concerned about Resident A placing himself on the facility floor as it was indicated he had a known history of this behavior, which included making "forts" out of blankets and/or sheets. She indicated this behavior was not known when Resident A was placed at the facility but discovered after he was admitted. Ms. Nocera stated the facility did implement interventions to protect Resident A from harming himself when placing himself on the floor which included keeping his room clean of objects that could cause him injury (i.e., moved his side table away from his bed), provided him with a wheelchair when he was experiencing issues with ambulating, and put a mattress on the facility floor for him to lay on. Ms. Nocera stated she regularly kept Senior Care Partners informed of Resident A's behaviors.

Ms. Nocera denied witnessing Resident A fall or injury himself that required medical attention. She also denied mistreating Resident A or observing any other direct care staff mistreat or injure Resident A.

I also interviewed direct care staff, Tasha Cummings, at the facility. Ms. Cummings confirmed she worked at the facility when Resident A resided there. Her statement to me was consistent with Ms. Nocera's statement to me. She confirmed Resident A would not throw himself on the facility floor but would "place himself" like he would "slide off" his bed. She also denied observing him fall or hearing any incidences concerning he fell. Ms. Cummings denied mistreating Resident A or having concerns about other facility staff injuring or mistreating him while he resided at the facility.

I reviewed Resident A's assessment plan, identified as his "Resident Evaluation", dated 03/04/2021. According to this assessment plan, Resident A was independent in mobility with occasional use of a walker, had no fall history, but experienced occasional confusion and difficulty recalling details. The facility's Resident Care Guide also did not indicate Resident A requiring any assistance with mobility.

I reviewed Resident A's *Health Care Appraisal*, dated 03/04/2021, completed by Senior Care Partners, which indicated Resident A "fully ambulatory", but also "uses walker". Resident A's diagnoses included "Gout, CKD3, HTN, Hypothyroidism, OA right knee, Afib, PVD, cataracts, chronic LBP, GERD, HLD, fatty liver".

It should be noted CKD2 is chronic kidney disease, HTN is hypertension, OA right knee indicates osteoarthritis of the knee, PVD indicates peripheral artery disease, chronic LPD indicates Lewy body dementia, GERD is acid reflux, and HLD indicates hypersensitivity lung disease.

I reviewed the facility's "Observation Notes" for the entire time Resident A resided in the facility. There were no observation notes pertaining to Resident A experiencing any falls or staff suspecting Resident A falling.

An observation note, dated 03/15/2021, indicated an incident where Resident A was very confused throughout the night and went into another resident's room. The note also indicated Resident A raised his fist at a staff and tore a pillow apart in his bedroom. There was an additional note, dated 03/15/2021, which indicated Mr. Goodlock contacted Senior Care Partners informing them of the incident and reporting how Resident A was repeatedly placing himself on the facility floor. A note, dated 04/14/2021, indicated staff contacted Senior Care Partners about Resident A putting himself on the floor. According to the note, Senior Care Partners, Lisa Woodruff, indicated to staff Resident A experienced these behaviors at his home, as well. It was indicated in the note "it was ok to make a pallet on the floor and keep the area around him safe". An additional note, dated 04/19/2021, indicated Senior Care Partners were again contacted due to Resident A refusing to eat, but the note indicated he was drinking. The note indicated Senior Care Partners came out to do an assessment on him and provided an IV of fluids. The note also indicated Resident A had "many scrapes" from "rolling around on the floor" and maintenance was contacted to clean the carpets. There were additional notes on 04/20/2021 indicating Resident A was again on the facility with blood from new cuts, scrapes, abrasions, and bruising. It was indicated in the notes on 04/19/2021 and 04/20/2021 that facility direct care staff had been in contact with Senior Care Partners and Senior Care Partners came out to assess him.

I also reviewed the facility's *Incident/Accident Reports* (IR) pertaining to Resident A, which consisted of the following four reports:

- 03/12/2021 – Staff went to check on Resident A in his bedroom and discovered him on the floor with a blanket on top of him. The IR indicated staff asked Resident A how he fell, but Resident A stated he placed himself on the floor to crawl to the bathroom. The IR indicated Resident A had no visible marks or bruises. The IR further indicated Senior Care Partners was notified of the incident.
- 03/15/2021 – Resident A was on the floor of another resident's room. The IR indicted staff placed him in his broda chair and contacted Senior Care Partners. Additionally, the IR indicated they would "check on him a little more" and to "make sure he is sitting in his chair or recliner".
- 04/19/2021 – Resident A "laid on the floor and was responding not to his normal baseline". The IR indicated Senior Care Partners were contacted and came to do an assessment and administered an IV.
- 04/20/2021 – Resident A was observed at approximately 8 am "bleeding from somewhere as it was on the carpet". It was noted on the IR, Resident A had "scraped scabs from his old abrasions, new abrasions, bruising, cuts and carpet marks observed". The IR indicated Senior Care Partners assessed him and requested he be sent to the ER for evaluation.

On 11/04/2021, I reviewed Senior Care Partners' medical information and case notes pertaining to Resident A's care from January 2021 through April 2021 focusing on his time while at the facility, which was from 03/10/2021 through 04/20/2021.

According to this documentation, Senior Care Partners staff either talked to facility staff or visited with Resident A at the facility multiple times per week. Their case notes indicate Senior Care Partners staff addressed concerns with Resident A pertaining to his skin issues, not eating, placing self on the floor, combative type behaviors, and weight loss/gains.

Senior Care Partners completed a progress note on 04/14/2021 indicating they received return call from Ms. Nocera from the facility. Ms. Nocera indicated to Senior Care Partners Resident A wouldn't need his medications crushed or sprinkled as staff's medication administration technique mattered more. Ms. Nocera indicated to Senior Care Partners she found it helpful knowing Resident A was having these behaviors at home so she can address them differently. Ms. Nocera indicated she would contact Senior Care Partners if she felt this or other interventions were helpful.

Senior Care Partners then completed a Covid Screen of Resident A on 04/15/2021 and emailed Ms. Nocera on 04/16/2021 to ascertain the best staff to work with Resident A on his behaviors at the facility and to determine if Senior Care Partners was providing the facility staff with appropriate support.

In my review of Senior Care Partners' notes, there were no additional contact between Senior Care Partners and facility staff until Ms. Nocera contacted them the morning of 04/19/2021.

Regarding Resident A's decline between 04/19/2021 and 04/20/2021, Senior Care Partners' documentation indicated, facility staff, Ms. Nocera, contacted Senior Care Partners on 04/19/2021 stating Resident A was not drinking or eating consistently and seemed to be dehydrated. Ms. Nocera reported to Senior Care Partners Resident A was "on the floor a lot" and was sleeping there. Senior Care Partners indicated Ms. Nocera was concerned Resident A was on the floor because staff was unable to get him up and he "bats" at staff when they attempt to assist or feed him. Ms. Nocera also reported to Senior Care Partners Resident A was more confused than usual and he was "off". Senior Care Partners documentation indicated Senior Care Partners staff came to the facility that day to assess Resident A and provided him with an IV for fluid. Their documentation indicated Resident A had a lot bruising but he didn't indicate pain. Areas of bruising were located on Resident A's "left hip and lower lateral ribs with hematoma. Rugburn appearance on upper and lower back". Instruction indicated to facility staff by Senior Care Partners was "Staff updated and reminded to call with further needs or concerns and they verbalize understanding".

According to their notes, Senior Care Partners determined later in the day the facility was unable to care for Resident A and were going to request he be moved to a different facility. Additionally, Senior Care Partners indicated in their note Resident A needed "more direct supervision and now assistance with mobility" and it was being discussed he would "do better with male care givers as well". The only instruction

indicated to facility staff by Senior Care Partners at approximately 2 pm was “Staff encouraged to encourage oral fluids (reported he drank 3 16oz glasses of water prior to our arrival)”.

Senior Care Partners contacted the facility at 8 pm on 04/19/2021, per their progress note. They indicated the following:

> “Call to PP and spoke with Katheryn/staff. Staff reports ppt is not eating or drinking fluids. COVID screen negative. Staff reports minimal verbal contact from ppt, with the exception of occasional groan or grunt. Staff states ppt does not leave his room.
>
> Assessment/Plan: Instructed the staff to call the center with any changes and someone from his team will contact them tomorrow.”

Per their note from 04/20/2021, Senior Care Partners indicated the following:

> “Check in visit made to facility following nursing visit yesterday. Participant found on the floor in his room laying on his right side, his head on a pillow, wearing a brief and covered with a blanket. 3ft area of blood noted on carpet between the bed and participant that has dried into carpeting. Increased abrasions and bruising noted on participant extremities and back since yesterday. Participant is moaning and shivering but unable to verbalize source of the pain. Participant asking for help on occasion and is attempting to reposition self but cries out in pain. Attempts to help participant reposition elicit similar response. Carpet under participant is damp. Vital signs WNL. Participant eyes remain closed majority of the visit. Participant unable to follow one step commands such as "squeeze my hand" which he could do yesterday. Facility staff Tony reports participant was noted to have "put himself on the floor around 5:00am" by night staff. Tony came in at 8:00am "and found him like this with the blood on the floor. I cleaned him up and covered him up". Tony attempts to give morning medications but participant is unable to sit up to do so. Tony reports participant refused medications last night as well as dinner, breakfast, and fluids. Sarah NP updated and arrives to facility along with Dr. Smith. EMS called and arrives with stretcher. Participant transferred via hoyer onto stretcher and taken to hospital ER. [DPOA] updated and is agreeable to hospital transfer.”

An additional Senior Care Partner note indicated the following:

> "Problem Hx: [Resident A] is seen in his room at Park Place with Kristen RN and Dr Smith. Kristen went out to do a check in visit and found [Resident A] on the floor bleeding from his abrasions. He was moaning and repeatedly asking for help. He was unable to provide answers as to what hurt. He had additional abrasions since our visit yesterday. He received a liter of IVF yesterday. Tony reports he refused dinner last night and breakfast and had not been drinking since yesterday afternoon.
>
> Findings: See RN note for vitals. [Resident A] is on the floor, cool to touch, moaning and asking for help. He has additional abrasions since yesterday. He is bleeding from knee abrasions where scabs have rubbed off, there was blood on carpeting in room. His mucous membranes were dry.
>
> Assessment/Plan: Dehydration-refusing to eat or drink. At this time I am going to send him to the ER for evaluation. He is unable to be appropriately cared for at Park Place and appears dehydrated despite receiving IVF yesterday. Call placed to Life for transport and Bronson First to provide history and DNR status. 1:45pm Call placed to Bronson ER for update, spoke with Steve NP who reports they are waiting for imaging but [Resident A] will be admitted for AKI and hypokalemia. 3pm Call placed to Summer WMed FM resident at her request to provide history."

On 11/05/2021, Ms. White sent via email copies of the staff schedule for the last week Resident A had resided at the facility.

Based on my review of the facility's staff schedule, I interviewed direct care staff, Allison Hill, Keya Clark, and Juanita Parker, via telephone, as they had worked with Resident A while he resided at the facility. All of the staff indicated they no longer worked at the facility but recalled working with Resident A. Ms. Hill and Ms. Clark both indicated they primarily worked overnight shifts, while Ms. Parker worked 1st and 2nd shifts. All of the staff indicated Resident A had a lot of behaviors, which were consistent with what was documented in the observation notes and with what was indicated by Ms. Nocera and Ms. Cummings. None of the staff indicated they had

seen Resident A fall or indicated he was injured by any direct care staff. They all, except Ms. Parker, stated they recalled mats being placed on Resident A's floor to prevent injuries if he fell or they recalled hearing about them. None of the staff recalled any issues with Resident A consistently not eating. They all stated if a resident was not eating or drinking, they would document it using the observation notes or inform management. They all also reported they would document a fall if one had been observed. Neither Ms. Hill, Ms. Clark nor Ms. Parker recalled why Resident A left the facility. None of the staff could recall any concerns they had pertaining to Resident A's care while he resided at the facility.

On 11/09/2021, I re-interviewed Ms. Nocera via telephone. Ms. Nocera indicated it was protocol to contact a resident's primary care physician if a resident was no longer baseline or "normal" but wasn't requiring emergency medical assistance. She stated 911 would be contacted immediately if a resident was displaying chest pain, uncontrolled bleeding, or displaying symptoms of a stroke. She stated Resident A wasn't displaying any of these symptoms on 04/19/2021, which is why she contacted Senior Care Partners, his primary care for medical services. She stated Senior Care Partners came out to assess him on 04/19/2021 and determined he was dehydrated and provided care to him at that time. She did not indicate any additional instructions by Senior Care Partners but noted the returned on 04/20/2021 when the made the decision to send him to the ER.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(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:	Based on my investigation, which included a review of Resident A's resident file, Senior Care Partners' documentation, and interviews with multiple direct care staff, there is no evidence Resident A did not receive adequate supervision, protection, or personal care while he resided at the facility. Facility staff kept in regular and consistent contact with Senior Care Partners staff to inform them of Resident A's behaviors, which was also being addressed and monitored by Senior Care Partners when they visited with Resident A multiple times per week.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on my investigation, there is no evidence indicating any direct care staff at the facility mistreated Resident A or exposed him to serious risk while he resided at the facility. Though Resident A's autopsy report indicated Resident A suffered from blunt chest injury, there is no evidence to indicate staff were aware of any incident occurring where Resident A suffered such an injury.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Based on my investigation, which included a review of documentation provided by Senior Care Partners and the facility, and interviews with multiple direct care staff, Resident A declined rapidly between 04/19/2021 and 04/20/2021. According to the facility's documentation from 04/19/2021 and 04/20/2021, Resident A was discovered on the facility floor and was not his normal self as indicated by facility observation notes. Additional documentation from Senior Care Partners from these two dates indicated Resident A had significant bruising and hematomas on his hip and abdomen. Senior Care Partners staff assessed Resident A on 04/19/2021 for dehydration and informed facility staff to keep them updated on changes with Resident A. A follow up phone call from Senior Care Partners to the facility at 8 pm indicated facility staff reported Resident A was not drinking or eating, leaving his room, wasn't verbal, but was moaning and groaning. The only instruction provided to facility was to contact Senior Care Partners with changes; otherwise, Senior Care Partners would come to the facility in the morning. Based on Senior Care Partners' 04/20/2021 progress notes, their staff did come back to the facility in the morning and determined that based on his condition, Resident A needed to be sent to the ER for medical attention. When Resident A's physical condition decline, facility staff did seek medical attention by contacting his primary care physician (i.e., Senior Care Partners), as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility staff were using medication to immobilize Resident A.

INVESTIGATION:

The complaint alleged Senior Care Partners placed Resident A on a 3-day Ativan cycle and Depakote medication to address Resident A's unmanageable behaviors, which were being reported by facility staff. The complaint alleged facility staff deemed Resident A's behaviors as "risky"; however, the complaint alleged the medication was being used to sedate and immobilize Resident A; despite Senior Care Partners staff indicating the medication was temporary and only for a certain quantity to prevent staff from using it as a crutch. The complaint indicated Resident A's responsible person was in agreement with the medication to be administered.

On 09/17/2021, I listened to two voicemails left for Complainant on 03/15/2021 and 03/16/2021 from Eric Goodlock, the facility's associate administrator, and Lisa Woodruff, Senior Care Partners Behavioral Health Nurse. The voicemail from Mr. Goodlock was notifying Complainant of some incidences involving Resident A. The incidences that occurred were Resident A had been observed on 03/13/2021 crawling on the floor and had seemingly knocked some items over and another incident Resident A had been observed on the floor of another resident bedroom and was observed with scrapes on his knees and elbows. The voicemail from Ms. Woodruff indicated Senior Care Partners wanted to implement two different medications to address Resident A's recent behaviors, including Depakote and a 3-day Ativan prescription.

Direct care staff, Ms. Nocera, stated she could not recall if Resident A was provided with a PRN to control his behaviors, but indicated he was on numerous psychiatric medications. She stated Resident A's behaviors consisted of picking at his scabs on his body, putting himself on the floor and not getting back up, and towards the end of his stay he would not eat. Ms. Nocera stated Resident A's behaviors were communicated to Senior Care Partners on a regular and consistent basis.

Ms. Cummings' statement to me was consistent with Ms. Nocera's statement to me.

During the on-site inspection, Ms. White provided me with Resident A's March and April 2021 *Medication Administration Record* (MAR). According to these MARs, Resident A was prescribed a scheduled 125 mg Depakote tablet twice daily starting 03/27/2021 until 04/14/2021. Upon review of the March 2021 MAR, Resident A received this medication, as prescribed. Upon review of the April 2021 MAR, Resident A received his Depakote prescription at 8 am, as prescribed; however, on 04/08/2021, 04/09/2021, 04/12/2021 and 04/13/2021, the MAR indicated Resident A refused his 8 pm Depakote tablet. A refill prescription for 125 mg of Depakote was ordered on 04/14/2021 through 04/19/2021. The Depakote prescription was then increased on 04/19/2021 to 250 mg twice daily.

I did not observe on either of the MAR's a prescription for a 3-day Ativan cycle.

I reviewed Resident A's Observation Notes from the facility, as well. There was no indication in the observation notes Resident A was prescribed medication to address behaviors. On 03/15/2021, former Associate Administrator, Eric Goodlock, indicated in an observation note he contacted Senior Care Partners to inform staff of Resident A's behaviors, which consisted of "balling his fist toward staff overnight, getting up and putting himself on the floor repeatedly during the day, hyper verbal (talking a lot, not having a filter when speaking) and nonsensical". There were additional observation notes indicating Resident A was demonstrating behaviors tearing up his bedroom, throwing items, refusing to eat, picking at scabs, and putting himself on the floor and refusing to get up. There were notes indicating direct care staff contacted Senior Care Partners to inform them of these behaviors.

An observation note, dated 04/19/2021, indicated Resident A was seen by Senior Care Partners and was increasing his Depakote medication.

In my review of Resident A's resident file, I did observe a Home Town Pharmacy "Controlled Substance Proof of Use Form", which indicated Resident A had been prescribed three tablets of Lorazepam, which could be administered "1 Tab by mouth daily as needed for anxiety". The form indicated two pills had been administered to Resident A on 03/22/20321 and 04/21/2021 with the final pill being destructed on 04/29/2021.

In my review of Senior Care Partners' documentation for Resident A, I confirmed on 03/16/2021 Senior Care Partners prescribed Resident A a 3-day supply of .5 mg Ativan tablets (generic name: Lorazepam), which was to be used, as needed, for anxiety.

Senior Care Partners documentation also indicated on a 03/16/2021 progress note that facility staff were concerned about Resident A's behaviors, which included "wandering into other resident's room, attempting to get into bed and broad chair with other residents. Hyper-vocal, talking nonstop and saying things that are hurtful and insensitive to other residents without realizing it".

The documentation also indicated Resident A's "Interactions with staff include comments/movements that they consider threatening. Team agreed that [Resident A] will say or do things that he considers being in a joking manner, but this could easily be misinterpreted by staff that does not know him well". The progress note indicated Senior Care Partners would prescribe a "mood stabilizer, as well as a short script of PRN medication for staff to use until this takes effect (3 days)".

My interviews with direct care staff with Ms. Nocera, Ms. Cummings, Ms. Hill, Ms. Clark, and Ms. Parker indicated Resident A has numerous behaviors, but there was no indication he was overly medicated to sedate or immobilize him.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**

ANALYSIS:	Based on my review of Resident A's March and April 2021 *Medication Administration Records,* Resident A's resident file, Senior Care Partners' documentation and my interviews with direct care staff, there is no indication Resident A was being administered any PRN medication in an attempt to sedate or immobilize him. I confirmed Senior Care Partners did prescribe Resident A a 3-day Ativan prescription; however, this medication wasn't even fully administered to him. Additionally, Resident A was prescribed Depakote, which is a mood stabilizer; however, this was a scheduled medication, which was given as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's bedroom was in disarray and dirty, including blood stains on the carpet.

INVESTIGATION:

The complaint alleged Resident A's bedroom was in dirty with floor covered in blood stains.

I reviewed multiple pictures provided by Complainant, which indicated they were taken on 04/26/2021. The pictures showed a multi gray carpet with stains near a side table and hospital type bed. Additional pictures were taken close up of the carpet, which showed stains or marks that were various shades of red. None of the stains appeared wet or fresh in nature to indicate they had just been made.

On 10/07/2021, Ms. White took me to Resident A's former bedroom. I did not observe this bedroom to have any carpeting and instead had linoleum flooring. Ms. White stated the carpeting was removed and replaced with a flooring more easily cleanable. I observed the bedroom to be comfortable, clean, and orderly. The bedroom also had an en-suite bathroom, which presented in similar fashion as the bedroom. I did not observe any concerns with the cleanliness or presentation of either the bedroom or bathroom.

My interviews with Ms. Nocera, Ms. Cummings, Ms. Hill, Ms. Clark, and Ms. Parker indicated Resident A could make his room messy by throwing his sheets on the floor or the facility's furniture. They also indicated Resident A would urinate on the floor and would bleed from his skin abrasions/scabs; however, all the direct care staff I interviewed stated staff would clean the floor if a mess was observed. The staff indicated if Resident A's bedroom or bathroom was observed unclean or needed to be addressed then direct care staff would clean it for him. They also indicated the

facility has a housekeeper come in once a week to complete a more thorough cleaning.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based on my review of the pictures submitted by Complainant, Resident A's bedroom floor was observed to have stains on it; however, at the time of my on-site inspection on 10/07/2021 the facility addressed the stained flooring by renovating the bedroom. The facility changed the carpet to linoleum flooring making the flooring more easily cleanable; therefore, there were no issues with the cleanliness or appearance of the bedroom or bathroom.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

I reviewed Resident A's March 2021 and April 2021 MAR for his 3 day Ativan (generic: Lorazepam) prescription that was prescribed by Senior Care Partners for Resident A's behaviors; however, this medication was not listed on either MAR. Though the facility had a controlled substance proof of use form available for review, which did document the Lorazepam prescription, it did not indicate the dosage of the medication.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.**

	(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	The facility did not have Resident A's 3 day supply of Ativan (generic: Lorazepam) listed on his monthly March 2021 or April 2021 MARs. While a controlled substance proof of use form was provided by the facility from the pharmacy, this documentation did not indicate the dosage of the medication, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/09/2021, I conducted my exit conference via telephone with the licensee designee, Connie Clauson. I explained my findings with Ms. Clauson, which she agreed with.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Cathy Cushman

11/09/2021

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Cathy Cushman Date

Licensing Consultant

Approved By:

11/09/2021

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Dawn N. Timm Date
Area Manager