GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 2, 2022

Danielle Gill
Christian Care Assisted Living
1530 McLaughlin Avenue
Muskegon, MI 49442-4191

| | |
|---|---|
| RE: License #: | AH610236765 |
| Investigation #: | 2022A1021022 |
| | Christian Care Assisted Living |

Dear Ms. Gill:

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 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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

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 #:** | AH610236765 |
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| **Investigation #:** | 2022A1021022 |
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| **Complaint Receipt Date:** | 01/10/2022 |
| | |
| **Investigation Initiation Date:** | 01/10/2022 |
| | |
| **Report Due Date:** | 03/09/2022 |
| | |
| **Licensee Name:** | Christian Care Inc. |
| | |
| **Licensee Address:** | 1530 McLaughlin Ave.<br>Muskegon, MI 49442 |
| | |
| **Licensee Telephone #:** | (231) 722-7165 |
| | |
| **Administrator/ Authorized Representative:** | Danielle Gill |
| | |
| **Name of Facility:** | Christian Care Assisted Living |
| | |
| **Facility Address:** | 1530 McLaughlin Avenue<br>Muskegon, MI 49442-4191 |
| | |
| **Facility Telephone #:** | (231) 777-3494 |
| | |
| **Original Issuance Date:** | 01/01/2000 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 07/07/2021 |
| | |
| **Expiration Date:** | 07/06/2022 |
| | |
| **Capacity:** | 105 |
| | |
| **Program Type:** | AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| The facility is not following Covid-19 guidelines. | No |
| Resident A was not provided medical attention. | No |
| Resident B was not checked on. | No |
| Medication technicians are not trained. | No |
| Resident C was not provided medication on leave of absence. | No |
| Facility does not follow diabetic diets. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

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| 01/10/2022 | Special Investigation Intake<br>2022A1021022 |
| 01/10/2022 | Special Investigation Initiated - Letter<br>referral sent to centralized intake at APS |
| 01/12/2022 | Contact - Telephone call made<br>interviewed complainant |
| 01/21/2022 | Inspection Completed On-site |
| 01/24/2022 | Contact-Letter sent<br>Contacted Gordon Food Services Cycle Menu Management |
| 01/27/2022 | Contact-Telephone call made<br>Interviewed caregiver Sierra Lucas |
| 01/27/2022 | Contact-Telephone call made<br>Interviewed medication technician Rhonda Sullivan |
| 01/27/2022 | Contact- Telephone call made<br>Interviewed caregiver Tanya Bosse |
| 01/28/2022 | Contact-Telephone call made<br>Interviewed caregiver Alex Ross |

| | |
|---|---|
| 01/28/2022 | Contact-Telephone call made<br>Interviewed caregiver Jarrod Jones |
| 02/02/2022 | Exit Conference<br>Exit Conference with authorized representative Danielle Gill |

**ALLEGATION:**

**The facility is not following Covid-19 guidelines.**

**INVESTIGATION:**

On 1/10/22, the licensing department received a complaint with allegations staff members at the facility have tested positive for Covid-19 and no changes to their hours have been made. In addition, the complainant alleged the facility is not notifying staff members when a resident or staff member tests positive.

On 1/10/22, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 1/12/22, I interviewed the complainant by telephone. The complainant alleged Staff Person 1 (SP1) worked first shift but was not tested and taken off the schedule until near the end of the shift.

On 1/21/22, I interviewed administrator Danielle Gill at the facility. Ms. Gill reported all caregivers are to complete a caregiver screening for Covid-19 symptoms prior to working their shift. Ms. Gill reported if a caregiver does not pass the screening, they are removed from the schedule. Ms. Gill reported the facility tests non-vaccinated employees once a week. Ms. Gill reported caregivers that are vaccinated are also able to be tested, if requested. Ms. Gill reported if during a shift, a caregiver begins to show symptoms of Covid-19 then they are to be tested immediately. Ms. Gill reported caregivers are encouraged to use their own face covering but the facility does have N95 masks available for use. Ms. Gill reported when there is a Covid-19 positive case in the facility, there is an automatic message that is sent to staff members and authorized representatives. Ms. Gill reported the facility posts a notice near the elevator that states the number of positive cases. Ms. Gill reported the activity director also goes room to room to tell the resident when there is a positive case and provides a copy of the printed notice.

On 1/21/22, I interviewed human resources director Danielle DeTorres at the facility. Ms. DeTorres reported unvaccinated caregivers are tested every Wednesday and Thursday. Ms. DeTorres reported if a caregiver has symptoms of Covid-19 then they are tested immediately. Ms. DeTorres reported once a caregiver has Covid-19, they are taken off the schedule. Ms. DeTorres reported the caregiver can return to work

after five days if the caregiver has no symptoms. Ms. DeTorres reported SP1 started exhibiting symptoms of Covid-19 in the middle of the shift. Ms. DeTorres reported the shift supervisor tested SP1 and the test was positive. Ms. DeTorres reported SP1 was then removed from the schedule and returned five days later per the recent CDC guidelines.

On 1/21/22, I interviewed shift supervisor Kyeann Voice at the facility. Ms. Voice reported she was the on-call supervisor when SP1 tested positive for Covid-19. Ms. Voice reported she completed the Covid-19 test on SP1 and it was positive. Ms. Voice reported SP1 was removed from the schedule and able to return five days later.

On 1/21/22, I interviewed neighborhood director Carena Levelston at the facility. Ms. Levelston reported she was the medication technician and neighborhood director that worked the day SP1 tested positive for Covid-19. Ms. Levelston reported in the middle of the shift, SP1 reported she had a cough. Ms. Levelston reported she advised SP1 to be tested for Covid-19. Ms. Levelston reported she is trained in administering Covid-19 tests, but the tests were locked in an office that day. Ms. Levelston reported she contacted Ms. Voice and Ms. Voice came to the facility within the hour to complete the Covid-19 test for SP1.

On 1/27/22, I interviewed SP1 by telephone. SP1 reported she worked first shift and had a dry cough. SP1 reported the shift supervisor heard her cough and recommend her to get Covid-19 tested. SP1 reported she did not believe she had Covid-19 because she had Covid-19 a year prior and these symptoms were very different. SP1 reported she agreed to get tested and it was a faint positive. SP1 reported she immediately left and did not return to work for six days. SP1 reported at the beginning of each shift each caregiver must complete the Covid19 screening, take their temperature, and can receive a new mask, if needed. SP1 reported she passed the screening because she was not coughing at that time. SP1 reported she is vaccinated and therefore does not require weekly Covid-19 testing.

I reviewed Covid-19 notice that the facility provides to the residents. The notice read,

> *“Update 01/24/2022:*
> *Current positive cases in the building: 12*
> *All meals in rooms until further notice*
> *When leaving your room you must wear a mask.”*

I reviewed two messages that have been sent to staff members and authorized representatives. The messages read,

> *“Additional COVID-19 cases, 1 additional resident and 2 staff as of today. All residents will remain in the facility at this time due to the lack of COVID Recovery Centers, staff are removed from the schedule per CDC guidelines.*

*"Two additional residents tested positive for COVID-19 on 1/21/22. Most common sign, runny nose. Isolation is in place and transfer to another facility being implemented until the virus is not active. If positive DPOA will be notified. All residents are stable."*

I reviewed *Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.* The guidelines read,

"*work restrictions for health care personnel with Covid-19 infection, contingency, 5 days with/without negative test, if asymptomatic or mild to moderate illness (with improving symptoms)."*

I reviewed Center for Medicare and Medicaid Services QSO-20-38-NH. The order read,

*"Vaccinated staff do not need to be routinely tested."*

I reviewed Michigan Department of Health and Human Services Requirements for Residential Care Facilities order. The order read,

*"Inform employees and residents of the presence of a confirmed COVID-19 positive employee or resident as soon as reasonably possible, but no later than 12 hours after identification."*

| **APPLICABLE RULE** | |
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| **R 325.1917** | **Compliance with other laws, codes, and ordinances.** |
| | **(1) A home shall comply with all applicable laws and shall furnish such evidence as the director shall require to show compliance with all local laws, codes, and ordinances.** |
| **ANALYSIS:** | Interviews with management and document review revealed the facility is appropriately following Covid-19 protocols by testing caregivers, removing caregivers from work schedule, and notifying all appropriate parties when there are positive Covid-19 cases within the facility. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Resident A was not provided medical attention.**

**INVESTIGATION:**

The complainant alleged that Resident A fell and received no medical attention. The complainant alleged after the fall, Resident A was bed bound and eventually passed away.

Ms. Gill reported Resident A was active with Hospice of Michigan. Ms. Gill reported Resident A had a fall at the facility and hospice was contacted. Ms. Gill reported Hospice of Michigan recommended to keep Resident A in bed and would complete an x-ray. Ms. Gill reported the facility administered pain medication to Resident A to keep her comfortable. Ms. Gill reported because Resident A was on hospice, the resident was not transferred to the hospital. Ms. Gill reported the facility worked closely with Hospice of Michigan to provide the appropriate medical care to Resident A.

On 1/27/22, I interviewed caregiver Sierra Lucas by telephone. Ms. Lucas reported she was working when Resident A fell. Ms. Lucas reported Resident A had eaten dinner and returned to her room. Ms. Lucas reported she observed Resident A one hour prior to the fall. Ms. Lucas reported she went to check on Resident A and Resident A was on the ground sitting by her bed. Ms. Lucas reported Resident A reported she was trying to open the blinds. Ms. Lucas reported after Resident A fell, caregivers made her comfortable and got her off the floor. Ms. Lucas reported the hospice company was contacted and a mobile x-ray was ordered. Ms. Lucas reported because Resident A was on hospice services, Resident A was not sent to the hospital. Ms. Lucas reported the hospice company did send a worker to evaluate Resident A.

I reviewed observation notes for Resident A. The notes read,

> *"11/24/21: Resident had a fall tonight at 8:01. Hospice was notified and they are scheduling mobile x to come out to give resident x-ray. On call doctor was notified POA was notified Supervisor was notified.*
> *11/24/21: Hospice did put the order for the X-ray in. Still awaiting x-ray arrival as of 11pm. Told 3rd shift med tech to call (hospice of Michigan) and let them know mobile x still hasn't shown up yet and resident is wanting to move around and still complaining of pain.*
> *11/24/21: (Medication technician) called Hospice of Michigan and spoke with Dominique on-call after hours nurse, stated she will be reaching out to Cynthia (hospice nurse came earlier to assess resident) for her to follow up with mobile x to see if they are running behind due to resident still in pain and trying to move (resident did receive 1 PRN tramadol earlier for pain). Hospice will be reaching back to us.*
> *11/25/21: Spoken to Cynthia via phone from Hospice of Michigan. According to x-ray, resident has L hip fx per family, resident is not to be sent out. Resident will be under bedrest to stay comfortable. Nurse also stated Dr. Lainga will fax new med orders to pharmacy.*

*11/25/21: Talked with (Hospice of Michigan) the med orders that they have for pain management are Tramadol 50mg tablet 2x daily and as a PRN 2x daily for pain. (Hospice of Michigan) will be sending out a nurse with hard script and for transfers/repositing every 2 hr also will be faxing over updated med list."*

| **APPLICABLE RULE** | |
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| **R 325.1921** | **Governing bodies, administrators, and supervisors.** |
| | **(1) The owner, operator, and governing body of a home shall do all of the following:**<br>**(c) Assure the availability of emergency medical care required by a resident.** |
| **ANALYSIS:** | Review of observation notes and interviews with staff members, revealed Resident A fell at the facility. Following the fall, the facility contacted and worked closely with Hospice of Michigan to provide appropriate follow up. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Resident B was not checked on.**

**INVESTIGATION:**

The complainant alleged Resident B was found face down in his room and had deceased. The complainant alleged Resident B was to be checked on every two hours and was not checked on appropriately. The complainant alleged Resident B passed away at 1:00am but was not found until 4:00am.

Ms. Gill reported Resident B passed away on 11/30/21. Ms. Gill reported earlier in the day Resident B was taken out of the facility by his family for an outpatient procedure. Ms. Gill reported Resident B retuned to the facility late in the evening and the family did not provide any discharge paperwork or recommendations from the physician. Ms. Gill reported caregivers came into Resident B's room in the morning for a blood glucose check and found Resident B deceased. Ms. Gill reported Resident B was not on two-hour checks and was independent.

On 1/27/22, I interviewed caregiver Tanya Bosse by telephone. Ms. Bosse reported Resident B returned late in the evening on 11/29/21. Ms. Bosse reported when Resident B was dropped off by family, the family would not provide discharge paperwork. Ms. Bosse reported the family reported Resident B needed his evening medication. Ms. Bosse reported Resident B was at baseline and returned to his room.

I reviewed the schedule for 11/30/21. The schedule revealed on third shift Jarrod Jones, Alex Ross, and Jennifer Piggue worked.

On 1/28/22, I interviewed caregiver Jarrod Jones by telephone. Mr. Jones reported he does not remember providing care to Resident B.

On 1/28/22, I interviewed caregiver Alex Ross by telephone. Ms. Ross reported she was aware Resident B passed away at the facility, but she did not work on the floor that Resident B resided on.

I reviewed Resident B's service plan. The service plan revealed Resident B was independent with mobility and transfers. There was no mention of frequency of checks with Resident B.

I reviewed observation notes for Resident B. The notes read,

*"11/26/21: resident will be having a procedure done on Monday 11/29/21 at Muskegon Surgical Associates. Resident daughter will be picking him up around noon. Residents daughter provided staff with instructions, copy is hung up in 3rd floor nurse station. Daughter provided the two different soaps that are to be used for his shower that is to be done 2 day prior on 11/27 and also on on 11/29. As stated on instruction sheet resident is to only take his blood pressure medication the morning of the procedure with a sip of water. Resident is to take half of normal insulin dose of (40ml) and give 20 ml only on the morning of procedure as well.*
*11/29/21: (Resident B) returned from hospital around 10:30pm asked for a copy of discharge paperwork from the hospital and POA wouldn't give me a copy of hospital discharge paperwork. The POA had stated that he hospital paperwork only had stated that he needed 3 hours of sleep and his medications.*
*11/29/21: Staff administer medication check BP was 189/114 pulse 90 will check BP in a hour.*
*11/30/21: Follow up: Blood pressure was retaken at this time it was 137/98.*
*11/30/21: Resident was pronounced dead by Dr. Buchannan at 0643. Family requested staff call Systema's on Harvey. The all was placed and Systema's will be coming. Family requested resident not be moved or cleaned up, this was told me by 1st shift neighborhood director. Family is here awaiting the funeral home."*

| **APPLICABLE RULE** | |
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| **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.** |

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| **ANALYSIS:** | Review of Resident B's service plan and observation notes revealed lack of evidence to support the allegation Resident B was not checked on. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Medication technicians are not trained**.

**INVESTIGATION:**

The complainant alleged medical technicians are providing care and are not trained to do so.

Ms. Gill reported all medication technicians are trained in providing care and administering medications. Ms. Gill reported the facility has an orientation process and then on the job training. Ms. Gill reported medication technicians shadow a medication technician and complete a checklist prior to administering medications. Ms. Gill reported yearly medication technicians complete a supervisory visit in which a supervisor observes the medication technician complete a medication pass.

On 1/21/22, I interviewed medication technician Jody Welch at the facility. Ms. Welch reported she was trained in medication administration prior to administering medications.

I reviewed Ms. Welch complete a medication pass. I observed Ms. Welch prep, administer, and chart the administration.

Due to not having a staff member name, I randomly chose four medication technicians' employee files to review. The files revealed all medication technicians completed caregiver training and medication technician training prior to administering medications.

| **APPLICABLE RULE** | |
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| **R 325.1931** | **Employees; general provisions.** |
| | **(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following:**<br>**(g) Medication administration, if applicable.** |

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| **ANALYSIS:** | Interviews with staff members, observation of a medication pass, and employee file review revealed medication technicians are trained at the facility. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Resident C was not provided medication on leave of absence**.

**INVESTIGATION:**

The complainant alleged Resident C left the facility for the Christmas holiday. The complainant alleged the facility provided Resident C with seven days of medications. The complainant alleged Resident C has been gone over seven days and the facility has not done anything to check on the resident him or give him his medications for the days he has been gone.

Ms. Gill reported Resident C was a short stay as the family was planning on having Resident C returned to Chicago. Ms. Gill reported the facility provided Relative C1 with seven days' worth of medications for his leave of absence over the Christmas holidays. Ms. Gill reported when Resident C did not return, the facility contacted the family with no response. Ms. Gill reported the facility contacted APS because the family would not return telephone calls. Ms. Gill reported the family then contacted the facility and let them know Resident C had returned to Chicago.

On 1/21/22, I interviewed admissions coordinator Katie Smith at the facility. Ms. Smith reported Resident C would often leave the facility on the weekends to see family. Ms. Smith reported on 12/24/21, Relative C1 came into the facility to pick up medications for Resident C. Ms. Smith reported it was believed Resident C would be out of the facility for seven days. Ms. Smith reported when Resident C did not return, the family and APS was contacted. Ms. Smith reported the facility contacted the appropriate people when Resident C did not return to the facility.

On 1/27/22, I interviewed medication technician Rhonda Sullivan by telephone. Ms. Sullivan reported she worked on 12/24/21. Ms. Sullivan reported Relative C1 came and requested Resident C's medications because he was taking Resident C out for the holidays. Ms. Sullivan reported Relative C1 reported Resident C would return on 1/1/22. Ms. Sullivan reported the facility was not aware Relative C1 was taking Resident C out for this long. Ms. Sullivan reported she provided Relative C1 with the required medications. Ms. Sullivan reported Resident C would leave the facility for short amount of time, but it was always with Relative C1.

I reviewed the medication administration record (MAR) for Resident C. The MAR

revealed it was noted Resident C did not receive medications from the facility on 12/25/21-12/31/21.

I reviewed observation notes for Resident C. The notes read,

> *"12/24/21: Resident out for supper.*
> *1/04/22: Report made to APS due to inability to make contact with the resident or his son. Per electronic medical records the resident was sent with 7 days of medications and that time period has exhausted. The resident is at risk for harm due to the risk of him not receiving his medications and unknown whereabouts."*

I reviewed the incident report completed by the facility. The narrative of the incident report read,

> *"On 12/25/21, the Shift Supervisor reported that (Relative C) requested the residents' medications that he would need while he was going on an LOA with his family. She reported that 7 days of medications were given to the resident's guardian. Resident did not return to the facility as expected. Staff and the administrator attempted to contact the resident and his guardian without success. On 1/4/22 administrator made a report to APS to report that (Resident C) may be at risk for harm due to the lack of prescription medications. APS reported that the guardian was aware prior to (Resident C)'s admission to CCAL that he was unable to take the resident out of the state. APS agent arrived in the facility to investigate the incident. A call was received from a female, believes to be his daughter, she was upset and using vulgar language. She verbalized that (Resident C) was with her in Chicago and he would not be returning to the facility despite the direction given by the court. She also verbalized that law enforcement came to her home however she did not state whether she made contact with them."*

| **APPLICABLE RULE** | |
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| **R 325.1932** | **Resident medications.** |
| | **(4) If a resident requires medication while out of the home, then the home shall assure that the resident, or the person who assumes responsibility for the resident, has all of the appropriate information, medication, and instructions.** |
| **ANALYSIS:** | Interviews with caregivers and document review revealed Relative C1 received medications for Resident C for the leave of absence. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Facility does not follow diabetic diets**.

**INVESTIGATION:**

The complainant alleged the facility does not follow diabetic diet for the diabetic residents. The complainant alleged residents have high blood glucose levels and do not feel well due to not eating the correct foods.

On 1/21/22, I interviewed food service director Jean Wall at the facility. Ms. Wall reported the facility uses Gordon Food Services for the menus. Ms. Wall reported the facility uses a Consistent Carb Diet for diabetics. Ms. Wall reported if a resident is diabetic then the facility is following the appropriate diet. Ms. Wall reported the menu has the appropriate amount of sugar and carbohydrates in the diet.

Ms. Gill reported the facility requests a diet order for residents upon admission but that at times a specialized diet order is not obtained.

I reviewed the facility menu for 1/16-1/22. The menu read,

*"Regular/NAS/Consistent CHO."*

I contacted Gordan Food Services to inquire about their menus. I received the following correspondence,

*"We write several different menus in our menu software program, Cycle Menu Management. Our most popular is our Senior Living menu. On this particular menu, we write a Regular diet that is also No Added Salt (3-4 grams/day) and Consistent Carbohydrate (80-100 grams of Carbohydrate per meal). This is one option for a person with diabetes, otherwise we also write a Reduced Carbohydrate diet that includes 65-85 grams of Carbohydrate per meal. These diets are written with a liberalized approach, so desserts are included as long as the entire meal falls within the established carbohydrate range. If not, there are also low sugar or no sugar added items included to achieve the established carbohydrate levels at each meal, every day of the menu."*

| **APPLICABLE RULE** | |
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| **R 325.1952** | **Meals and special diets.** |
| | **(4) Medical nutrition therapy, as prescribed by a licensed health care professional and which may include therapeutic diets or special diets, supplemental nourishments or fluids to meet the resident's nutritional and hydration needs, shall be provided in accordance with the resident's service plan** |

| | |
|---|---|
| | **unless waived in writing by a resident or a resident's authorized representative.** |
| **ANALYSIS:** | Interview with management, review of documents, and correspondence with Gordon Food Service revealed the facility is following a diabetic diet for the residents. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

Ms. Smith reported prior to admission, Resident C was visiting Relative C1 and was found on the streets and was taken to a local hospital. Ms. Smith reported due to Resident C's inability to communicate, he was listed as a "John Doe" until family could be found. Ms. Smith reported Relative C1 gained temporary court appointed guardianship of Resident C. Ms. Smith reported the facility had no knowledge of the leave of absence prior to when Relative C1 came to the facility on 12/24/21 and requested medications for the leave of absence. Ms. Smith reported on 1/3/22 she did not observe Resident C in the dining room or his room. Ms. Smith reported she was told by Ms. Sullivan that Resident C did not return from the leave of absence. Ms. Smith reported she contacted Relative C1 on 1/3/22 to inquire where Resident C was. Ms. Smith reported Relative C1 did not answer her telephone call and she still has not heard from Relative C1.

Ms. Sullivan reported she was not aware Resident C was to have a leave of absence until Relative C1 requested medications on 12/24/21. Ms. Sullivan reported Relative C1 reported Resident C would be absent from the facility for seven days with a planned return day on 1/1/22. Ms. Sullivan reported she believed Resident C would leave with Relative C1 as she provided medications to Relative C1, and Resident C only ever left with Relative C1. Ms. Sullivan reported a short amount of time later she observed Relative C1 not in the facility, but Resident C was still in his room. Ms. Sullivan reported she then observed a young man take Resident C out of the facility. Ms. Sullivan reported she assumed the young man was Resident C's grandson but did not confirm this with the unknown young man. Ms. Sullivan reported she did not report this to management or chart this occurrence because she assumed Resident C was with his grandson and that Resident C had his required medications. Ms. Sullivan reported she did not contact Relative C's family once Resident C did not return to the facility

Ms. Gill reported Resident C was to return to the facility on 1/1/22 but did not return. Ms. Gill reported the facility contacted Adult Protective Services on 1/4/22 because the facility did not know where Resident C was.

Review of observation notes and Resident C's record revealed no documentation of Resident C's leave of absence and return date.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1921** | **Governing bodies, administrators, and supervisors.** |
| | **(1) The owner, operator, and governing body of a home shall do all of the following:**<br>**(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** |
| **For Reference: R 325.1901** | **Definitions.** |
| | **(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.** |
| **ANALYSIS:** | Resident C left the facility on 12/24/21 with an unknown individual with a planned return date on 1/1/22. Resident C did not return to the facility on 1/1/22 and no action was taken by the facility to find Resident C until 1/3/22. The facility did not ensure Resident C was protected while under supervision at the facility by allowing Resident C to leave the facility with an unknown person, not documenting Resident C's leave of absence, and not acting timely in notifying appropriate personnel when Resident C did not return after seven days. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 2/2/22, I conducted an exit conference with authorized representative Danielle Gill by telephone.

## IV. RECOMMENDATION

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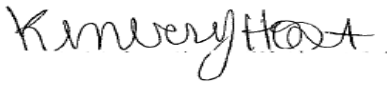
| Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license. |



2/1/22

Kimberly Horst Date
Licensing Staff

Approved By:

02/02/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section