GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 10, 2021

Brian Pangle
Clark Retirement Community Inc.
1551 Franklin SE
Grand Rapids, MI 49506

RE: License #: AL410238271
Investigation #: 2021A0357022
Oxford Manor West

Dear Mr. Pangle:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required.

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. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410238271
Investigation #:	2021A0357022
Complaint Receipt Date:	09/15/2021
Investigation Initiation Date:	09/20/2021
Report Due Date:	10/15/2021
Licensee Name:	Clark Retirement Community Inc.
Licensee Address:	1551 Franklin SE Grand Rapids, MI 49506
Licensee Telephone #:	(616) 278-6543
Administrator:	Brian Pangle
Licensee Designee:	Brian Pangle, Designee
Name of Facility:	Oxford Manor West
Facility Address:	2457 Forest Hill Ave. SE Kentwood, MI 49546-8257
Facility Telephone #:	(616) 954-2970
Original Issuance Date:	09/10/2002
License Status:	REGULAR
Effective Date:	03/10/2020
Expiration Date:	03/09/2022
Capacity:	20
Program Type:	AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The family was not given a Resident Care Agreement for Resident A at the time of her admission.	No
Resident A received a Chemical restraint without less restrictive alternatives being considered.	No
Facility staff were administrating to Resident A Depakote delayed release 250 mg in crushed form, and they put it into food or drink. This medication cannot be crushed.	Yes
It took 10 to 12 days to start treatment of UTI for Resident A.	Yes
An EKG was ordered but the family was not notified of the results.	No
Resident A was discharged for poor behavior, but her lack of "standard of care" could have caused some of her behaviors.	No
Upon discharge Resident A's family requested a copy of the complete resident record but were only given one doctor report and an incomplete medication record.	Yes
Reclining chairs are used to "confine" residents.	No
Resident A's personal belongings were locked in closet.	No
Resident A's special diet was not followed, and Resident A experienced a loss in weight.	No
Resident A's family members were not given appropriate notice of Resident A's discharge.	No
Additional Findings	Yes

III. METHODOLOGY

09/15/2021	Special Investigation Intake 2021A0357022
09/20/2021	Special Investigation Initiated - Telephone
09/20/2021	Contact - Telephone call made Telephone call made to the Licensee Designee/Administrator, Brain Pangle.
09/20/2021	Contact - Document Received From Licensee Designee/Administrator with questions how to prepare.
09/20/2021	Contact - Document Sent Sent information.
09/20/2021	Contact - Document Received Email received from Brian Pangle, the Licensee Designee that

	Nicole Swart, is a member of his Executive Team and that she would be my primary interface on behalf of the Administrator. He requested information on content of the complaint.
09/21/2021	Contact - Telephone call made To Family Member 1.
09/22/2021	Contact Face-To-Face interview with Family Member 1 and Family Member 2.
09/22/2021	Contact Document Received Family Member 1 and Family Member 2 provided documentation.
09/22/2021	Contact Document Received Received a message from Nicole Swart MPA, BSW, Executive Director.
09/24/2021	Contact - Document Received Received an email from Nicole Swart, MPA, BSW, Executive Director
09/28/2021	Contact - Document Received Received an email from Nicole Swart with her explanation of her progress with the investigation.
09/30/2021	Contact - Document Received Nicole Swart sent me an email with attached documents including Residency Agreement signed by DPOA, Resident A's Mercy Health Laboratory Fax report with Urinalysis, Urine Cultures, Interdisciplinary Notes, Resident A's August MAR, Physician Orders, Resident A's Care Plan, Resident A's diet and weights.
09/30/2021	Contact - Document Received Nicole Swart sent the Petition for Mental Health Treatment.
10/21/2021	Inspection Completed On-site
10/21/2021	Contact - Face to Face Interviews conducted face-to-face with Amy Leep, RN, NHA, consultant for Clark Retirement and with Christina Turkewycz, Director of Dementia Services and Life Enrichment. Reviewed parts of Resident A's file including Resident A’s Medication Administration Record for August and September 2021.
10/25/2021	Contact - Document Received Received an email from Amy Leep, RN, NHA, with a typed

	timeline on the care of Resident A at Oxford Manor West.
10/27/2021	Contact – Telephone -Call made to Family Member 1 and Family Member 2.
10/27/2021	Contact – Telephone -Call made to Family Member 3 for telephone interview.
10/28/2021	Contact - Document Received Ms. Leep provided a copy of the Discharge Medication Reconciliation.
11/01/2021	Contact telephone call received from Ms. Leep.
11/01/2021	Contact Documents received From Ms. Leep.
11/05/2021	Inspection made on site.
11/05/2021	Interview with three direct care staff, Carrie Howell, Kirian Santiago, and Jessie Canacho.
11/08/2021	APS referral.
11/10/2021	Telephone exit conference with the Licensee Designee, Brian Pangle.

ALLEGATION: The family was not given a Resident Care Agreement for Resident A at the time of her admission.

INVESTIGATION: On 09/20/2021 I received a complaint reporting the following: *'1. No written resident care agreement at time of admission. 2. Chemical restraint used without considering less restrictive alternatives that we are aware of. Doubled Risperdal after one doll incident with another resident. 3. Giving Depakote delayed release (250mg tablet) in crushed form. 4. Took 10 to 12 days to start treatment of UTI and ordered EKG and never notified of results, so not sure if EKG was given. 5. Was discharged for poor behavior, but her lack of "standard of care" could have caused some of her behavior. 6. Upon discharge we requested complete resident record. They gave us one Dr. report and an incomplete medication record. 7. Observed reclining chairs that the residents are unable to get out of on their own. 8. Personal belongings locked in closet. 9. Special diet. Was put on fresh bites program for finger food. Not observed.'*

On 09/22/2021, I conducted a face-to-face interview with Family Member 1 (FM1) and Family Member 2 (FM2). They said they did not receive a Resident Care

Agreement at the time of Resident A's admission 07/13/2021. They stated they had received a packet of papers from Clark at admission which they showed to me. Contained in these papers was a Resident Care Agreement signed by FM1 dated 07/21/2021. They also had a copy of "Clark Retirement Community, Inc. Residency Agreement Assisted Living," dated 07/12/2021. This document was also signed by FM1 on 07/21/2021. I explained that they did have the licensing required form of the Resident Care Agreement and they acknowledged they had the required Resident Care Agreement. FM1 and FM2 then stated that they had not been appraised of the facility's plan to discharge Resident A and it came as "more of a surprise" to them. They also reported that Resident A's family members were not given an appropriate notice that a discharge was coming. They also complained that they had not received or signed an assessment plan for Resident A.

On 09/30/2021, I received an email with attachments from Nicole Swart, MPA, BSW, Executive Director for Clark Retirement Community Inc., the Licensee. Ms. Swart stated that the Resident Care Agreement was given to the family along with their Residency Agreement signed by DPOA (FM1) on 07/12/2021. She sent a copy of the signed Residency Agreement which included the date of occupancy of 07/13/2021. I reviewed this document and it contained all of the required information that is in the rule for the resident care agreement.

On 11/10/2021, I conducted a telephone exit conference with the Licensee Designee, Brain Pangle and he agreed with my conclusion.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the**

	transportation services that are provided at an extra cost. **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.** **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R400.15315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.**
ANALYSIS:	Nicole Swart stated that they provided the family with the required Resident Care Agreement along with their Residency Agreement which was signed by Resident A's DPOA/Family Member 1. Family Member 1 and Family Member 2 both acknowledged they had received a Resident Care Agreement on 07/12/2021. They also acknowledged they had a copy of the Clark Retirement Community, Inc. Residency Agreement, Assisted Living which was signed by the DPOA/Family Member 1. It was determined that the Resident Care Agreement was provided to the family on 07/12/2021 and there is no rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A received a Chemical restraint without less restrictive alternatives being considered.

INVESTIGATION: On 09/22/2021, I conducted an interview with FM1 and FM2. They explained that Resident A was admitted to the facility on July 13, 2021, Tuesday at 12:00 PM and the family members left the facility at 3:00 PM. FM1 stated that he was contacted by Clark at 5:00 PM and they explained that Resident A hit a resident and she cannot stay at Clark. FM1 and FM2 stated that Family Member 4 (FM4) arrived at the facility to drop off a night light and discovered that Resident A was being put into an ambulance to be sent to the Spectrum Emergency Department. FM1 and FM2 explained that FM4 went to the hospital and was with Resident A and they were in line waiting for care when Clark staff called and told him to bring Resident A to Pine Rest ER. They went to Pine Rest and the staff at Pine Rest asked why they had left the hospital ER. The staff explained they did not have a room for Resident A so they could not accept her. FM1 stated that FM4 brought Resident A to his home and Resident A spent the night with him. In the morning of 07/14/2021, the family members took Resident A back to the hospital Emergency Room at 8:00 AM. Resident A was given Ativan at 9:00 AM and at 3:45 PM. Resident A was released from Spectrum ER at 10:00 PM and was sent by ambulance to Brightwell Psychiatric Hospital in East Lansing. FM2 stated that the hospital Emergency Room had discovered that Resident A had a slight UTI (Urinary Tract Infection). FM2 stated that Resident A was started on Risperdal and Depakote and later on Remeron on July 21, 2021, while she was at Brightwell. FM1 stated he, FM3 and Family Member 5 (FM5) had met with staff, Julie, Mary Ziomkowski, Administrator/ RN and Christina Tukewycz to discuss what had happened upon Resident A's admission to the home. FM1 and FM2 explained that Resident A was released from Brightwell around 1:00 PM on 07/29/2021 and returned to Oxford Manor West by ambucab. FM1 stated on 07/29/2021, Ms. Ziomkowski called FM1 to inform him that Resident A was doing well, and maybe just a little agitated. On 07/30/2021, FM1 said he had a phone conversation with Ms. Ziomkowski who stated that Resident A had a good night sleep and was still sleeping at 8:20 AM. Ms. Ziomkowski recommended not having any of the family visit until the following week. FM2 stated on 08/04/2021, they started Resident A on Xanax to treat anxiety and it was prescribed for seven days. She reported that Ms. Ziomkowski had called Brightwell to find out why the doctor had decreased Resident A's Risperdal from .25 to .20 3 x per day. Resident A was exhibiting anxiety and she was not able to sit. On 08/10/2021, FM1 said he learned that the previous day Resident A had grabbed another resident's arm to take her doll from her. As a result, they were going to increase the Risperdal in the morning from .25 to .5. FM2 stated they stopped Resident A's Xanax and started Adderall on 08/11/2021.

On 09/30/2021, I received a response from Ms. Swart concerning the Risperdal. She wrote that there were many notes typed in the Interdisciplinary Notes that indicate the attempts made for less restrictive alternatives to support Resident A with redirection, walks outdoors, a caring team member tucking her back into bed when she was feeling anxious. She wrote: *'The physician order to increase the Risperdal was a recommendation from Team Health on 8-11-2021. There does not appear to be any specific incident leading up to his recommendation other than what the charting indicates in the previous several days. This medication was discontinued*

on 8-25-2021. (She attached the August MAR) Due to this medication being discontinued, it does not show up on this month's end MAR..'

On 09/30/2021, I reviewed the Interdisciplinary Notes. On 08/03/2021, the notes written by staff Carrie Howell stated Resident A was very anxious and came in the dining room and yelled and tried to take other resident's food and drink and staff were unable to re-direct her. Resident A continued to hover over the other residents while they were trying to eat their food. The notes by Ms. Howell on 08/07/2021, stated Resident A was very anxious and they administered Xanax twice and it was not effective, and she continued to be anxious throughout the day. Ms. Howell's notes for 08/08/2021 stated Resident A was very anxious and agitated and staff had to be with her 1-on-1 throughout the shift. Xanax was not effective. She was very loud and very unsteady on her feet. *'She was hallucinating and speaking to no one or to chair or couches or picking at resident's clothes and trying to pick up things that are not there off the floor and when staff would try to redirect resident, resident would get mad and swat at staff. Resident is walking around with her eyes closed.'*

On 08/08/2021, Ms. Howell wrote that Resident A was taking her clothes off and would only sit for 5 minutes or less and she would get up and sometimes run down the hallway. On 08/09/2021, it was noted by Georgie Scholtens that Resident A was observed anxious and restless all day. Resident A was on a 1-on-1 with staff the entire 1st shift. Xanax was not effective. She was very unsteady on her feet and Ms. Scholtens had to catch her from falling multiple times. Resident A was observed to be hallucinating and picking things up off the ground that were not there. She was observed poking other residents and taking their items and food. She also swatted at staff's hand after trying to help her. It was documented that Resident A *'Is becoming more combative when agitated.'* Notes by Lera Davis LPN dated 08/10/2021, wrote the following: *'@ 1:00 pm observed (Resident A) with (Resident B) agitated regarding a doll. (Resident B) refused to hand her the doll, (Resident A) became combative pulled her arm aggressively on resident left arm, immediately notified lead care partner of incident. Notified Dr. Neubig 8/10/201 @ 9:30 AM. Notified DOPA 08/10/2021 @ 9:35 as well as supervisor @7:45.'* Ms. Davis documented on 08/10/2021, the following: *'Orders received per psych recommendations, increase Risperdal to .5mg BID in the morning and at noon and to continue with 0.25 at HS…'*

On 09/30/2021, I reviewed the "Physician's Orders," for Resident A. On 08/10/2021, Dr. Elizabeth Neubig MD prescribed Risperdal 0.25 mg tablet [Risperidone] -1 tab by mouth at bedtime For Psychosis…Last dose: 08/24/2021, at HS. On 08/10/2021, Physicians Orders, by Doctor Neubig read: "Risperdal 0.5 mg tablet [Risperidone] – 1 tab by mouth twice daily (AM & Noon) For Psychosis, BID." Dr. Neubig noted in her orders that this was for Psychosis.

On 10/25/2021, I received an email from Amy Leep, RN, NHA, and attached to the email was a typed timeline for Resident A. She documented that on 08/03/2021 Resident A was given a new diagnosis of Anxiety and Restlessness. On 08/11/2021

she reported that Team Health made recommendations to increase Risperdal and try Adderall. On 08/11/2021, Ms. Leep wrote on the timeline that there was a medication adjustment of Risperdal 0.5 -1 tab by mouth twice daily am/pm continue 0.25mg at bedtime. On 08/11/2021, there was a medication change of Adderall XR 5mg cap in am for *'Dementia with extreme unattentiveness.'* Dr. Neubig prescribed the increase in the Risperdal and prescribed the Adderall. Ms. Leep put on her timeline for the allegation of chemical restraint the following: *'Documentation Supports Non-Medicinal and Medicinal interventions used to improve quality of life and keep resident and others safe.'*

On 10/25/2021, I reviewed a "Psychiatric Evaluation," Created by Elizabeth Oman, PA, concerning Resident A. This document stated that Resident A was referred by Dr. Elizabeth Neubig, MD., because Resident A was a new patient with dementia with behaviors. This document contained a history of present illness. "*The patient is a new patient with dementia and agitation. She was sent to Brightwell inpatient psych the first day she arrived at Keller Lake facility. She was doing well for about 1 week, but now she cannot settle down. She is nonstop wandering. She cannot have her meals with the group due to her walking around disrupting others and taking food off their plates. She has tried to hit another resident today during my visit and observation of her behaviors. She did yell at staff and at residents, she was upsetting all the residents with her yelling and fidgeting with other residents clothing for things that were not there. She was agitated to talk about her history today. She did say to staff "mind will not stop." She pointed to her head today and said, "won't stop."* The report stated she has agitation, restlessness, and reaches for things that are not there. She has verbal aggression, physical aggression, combativeness, severe restlessness. Her cognition is confusion with cognitive impairment and had disorientation. She has psychomotor agitation, and she has advanced dementia. She has to be fed before others due to her wandering and taking food off their plates. She is agitated and has psychomotor agitation. Her mood is anxious, irritable, and her thoughts are disorganized. She has visual hallucinations and has poor memory. The Care Plan Recommendations: *'Recommend increase Risperdal 05 mg AM, and noon, and 0.25 mg at hs. Recommend adding Adderall XR 5 mg to see if her racing thoughts in her brain can be slowed down. May need to titrate dose. Monitor the patient for increased anxiety.'* Elizabeth Oman, PA, recommended to '*discontinue the PRN (as needed) Xanax as it is not helping her.'*

On 11/10/2021, I conducted a telephone exit conference with the Licensee Designee, Brain Pangle and he agreed with my conclusions.

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:	A review of the Interdisciplinary Notes indicated Resident A was very anxious and agitated over several days and these moods were increasing. She was hallucinating and speaking to no one or picking at resident's clothes and trying to pick up things that were not there. When staff tried to redirect Resident A, she would get mad and swat at staff. Resident A was reportedly becoming increasingly combative when agitated and was unable to sit still long enough to eat or relax. Resident A's physician, Dr. Elizabeth Neubig had referred Resident A for a Psychiatric Evaluation by Elizabeth Oman, PA, related to dementia with behaviors. Elizabeth Oman, PA completed a psychiatric evaluation on Resident A and recommend an increase of the Risperdal and adding of the Adderall XR to help Resident A, along with the recommendation of discontinuing the PRN Xanax. Dr. Neubig prescribed .5 Risperdol on 08/10/202 to address Resident A's increased anxiety, aggression and hallucinations. During the investigation it was noted that Resident A had exhibited numerous behaviors that affected other residents. The staff were unable to redirect Resident A and, on several shifts, she required one-on-one staffing to keep her and other residents safe. Dr. Neubig prescribed the increase in the Resident A's Risperdol. The facility did not use medication to restrict Resident A's movements or to immobilize her.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility staff were administrating to Resident A Depakote delayed release 250 mg in crushed form, and they put it into food or drink. This medication cannot be crushed.

INVESTIGATION: On 09/22/2021, I conducted a face-to-face interview with FM1 and FM2. FM2 stated that when Resident A was at Brightwell she was prescribed and administered Depakote 250 mg which was delayed release medication. She reported that the family researched this medication and they found that because it is a delayed release medication it could not be crushed. On 10/27/2021, I spoke with FM1 by telephone to clarify some questions. FM1 stated that he witnessed facility

staff administer Resident A's medications in her liquids. He said the staff said she did not take the tablets and the Depakote Sprinkles had not been ordered until the care Conference conducted on 08/27/2021. He stated that the staff had trouble giving Resident A's medications to her. He said they mashed her medications in her food such as applesauce or custard. On 10/27/2021, I spoke with FM2 by telephone. She stated she did not observe staff crush the medications, but she witnessed staff bring a spoon full of ice cream with various colors in it and the staff acknowledged that Resident A often refused medications and she would not swallow her pills, so the staff choose to crush the pills. She stated on a date unknown, the staff (unknow), handed her a spoon full of ice cream which contained many colors, including blue and red in it and she said she could see the medications had been crushed and then put in the ice cream. The staff had to go and help someone else, so she was left holding the spoon. FM2 stated the staff came back to give Resident A the ice cream with the crushed medications in it. She said she visited Resident A many days and observed staff bring in puddings and drinks such as juice with the crushed medications in them. She reported that Resident A did not like to take the juice with the medications in it and this was concerning to FM2 because Resident A was not drinking enough and if she developed a dislike for the juice then she might not drink it and she felt she really needed the fluids. FM2 was unable to provide the dates that she had observed Resident A's medications crushed in food or drink but reported it was for a very long time.

On 09/30/2021, I received and reviewed Interdisciplinary Notes. On 07/29/2021, the note by Lera Davis, LPN stated that Resident A arrived at the facility around 1:30 PM. It was noted that Resident A's medications are *'given crushed in a liquid beverage as non-compliance has been noted when attempting to give them whole form orally from spoon, lemonade is her favorite…'* On 07/29/2021, the Interdisciplinary Notes contained an entry by Audrea Morrissey that read: *'This LCP noticed crushed meds I.D. note. Some medications received from pharmacy are not to be crushed, such as Depakote delayed release…This LCP tried giving resident's pills whole- and was effective with some reluctance.'*

On 09/30/2021, Nicole Swart sent me her response to the allegation related to the crushing of the Depakote, delated release. She wrote: *'There does not appear to be an order for Depakote to be crushed. This was noted by LCP (lead care partner) when resident was having difficulty taking medications whole. She did take them whole, but the order was changed to Depakote Sprinkles-that was a medication change from the tabs on 08/28/2021.'*

On 09/30/2021, Ms. Swart sent me an email with attachments. One of the attachments was the information she had received from Brightwell Behavioral Health, which I reviewed. Resident A's Medication Record recorded Depakote 250 mg, BID, starting on 07/15/2021. A document untitled, dated 07/28/2021, recorded Resident A's medication as *'Risperdal 0.25mg PO TID, Depakote Springles 250mg PO TID, Galantamine 16mg PO daily, and Melatonin 5mg PO Q HS. Plan:*

1. Dementia with behavioral disturbances-Continue Galantamine 16mg PO daily and Depakote sprinkles 250mg PO TID.'

On 10/21/2021, I conducted Interviews, face-to-face, with Amy Leep, RN, NHA, consultant for Clark Retirement and with Christina Turkewycz, Director of Dementia Services and Life Enrichment. Ms. Leep reported that Resident A's MAR's were seven pages in length. There were no written instructions that stated, 'Do Not Crush' or 'Crush medications.' She reported that the Depakote tablet was "time extended released," and therefore should not be crushed and there was not an order to crush Resident A's medications.

On 10/25/2021, Ms. Leep emailed me with an attachment of her timeline related to Resident A. Her outline recorded the date of 08/28/2021 with Medication adjustment. *'Depakote Sprinkles 250 mg-changed from tab to sprinkles related to needing to start to crush medications.*' In her time-line Ms. Leep documented that she had spoken to Team Lead Carrie Howell and she had stated, *'I don't crush her meds but when we gave them, she would chew them up and spit them out.'*

On 10/28/2021, Ms. Leep sent me a copy of the Brightwell Behavioral Health "Discharge Medication Reconciliation." This document recorded Resident A's Discharge Medication was Depakote 250mg PO TID, behaviors related to Dementia. This was the information the facility had received from Brightwell Behavioral Health, which I reviewed. Resident A's Medication Record recorded Depakote 250 mg, BID, starting on 07/15/2021. Ms. Leep stated they had to follow the medication recorded on the Discharge Medication Reconciliation from Brightwell and Depakote sprinkles was not on this document.

On 11/02/2021, I received documents from an email with attachments from Ms. Leep. We also spoke by telephone. Ms. Leep reported that immediately upon learning of the allegation of the crushing of Resident A's medication, Depakote, she provided training to all the staff that administer resident medications. She explained that she provided list of medications at each nurse's station/medication cart that can be crushed and ones that cannot be crushed. The document she sent to me was labeled *'Medication Crushing. All people with medications that need to be crushed will have an order to crush medications. Audit will be done to change all medications that need to be crushed to a crushable form.'* She stated that she worked with Dr. Neubig and all resident medications were reviewed and reconciled to be crushed or not crushed according to physician orders. She trained the staff to know medications that have ER or XL cannot be crushed. Ms. Leep also sent the names of staff that were trained on 10/08/2021 and explained that if a resident's medications needed to be crushed or they changed it to a liquid medication.

On 11/10/2021, I conducted a telephone exit conference with the Licensee Designee, Brain Pangle and agreed with my conclusion.

APPLICABLE RULE	
R 400.15312	**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 S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	FM1 and FM2 reported that they observed staff administer crushed medications in custard, ice cream, or applesauce, to Resident A on multiple occasions. Lera Davis, LPN wrote that Resident A arrived at the facility on 07/29/2021. She documented that Resident A's medications are given crushed in a liquid beverage as non-compliance has been noted when attempting to give them orally. Ms. Nicole Swart sent me her response to the allegation related to the crushing of the Depakote, delated release, and she acknowledged that there was not an order to crush the Depakote. Ms. Amy Leep, RN, BSN, NHA, acknowledged that the Depakote tablet was "time extended released," and therefore should not be crushed and there was not an order to crush Resident A's medications. There is a preponderance of evidence that Resident A was administered her medications, which included Depakote tablets crushed in food. Both FM1 and FM2 witnessed and acknowledge staff administering Resident A's medication in food or juice. Lear Davis LPN, documented in the Interdisciplinary Notes on 07/29/2021, that Resident A's medications are given crushed in a liquid beverage.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: It took 10 to 12 days to start treatment of UTI (urinary Tract Infection) for Resident A.

INVESTIGATION: On 09/22/2021 I conducted a face-to-face interview with FM1 and FM2. They both explained that while Resident A was in the emergency room on 07/14/2021, at Spectrum they diagnosed Resident A as having a UTI. They were hoping that when she went to Brightwell that she would receive medications to address it. They stated that Resident A returned to Oxford Manor West on 07/29/2021. FM1 said he met with Dr. Nuebig on 08/11/2021 and they discussed her medications. He learned that Dr. Neubig thought they would check if Resident A had a bladder infection. FM2 stated that they thought the facility had a urine test completed on 08/10 or 08/11/2021 and that Dr. Neubig received positive results for a UTI for Resident A on 08/12/2021. They had expected to receive a call from the facility on 08/13/2021 but no call was received. On 08/16/2021, FM1 was told by a nurse while visiting with Resident A that Resident A did have UTI. FM1 then requested a meeting with Dr. Neubig and Dr. Neubig told FM1 that she had put in an order for antibiotics for Resident A's UTI. Before FM1 and FM2 left the facility Dr. Neubig stopped back in Resident A's room and told FM1 and FM2 that she had put in a second order for Resident A's UTI medications, and it would be started that night. FM1 and FM2 expressed their concern that it had taken 10 to 12 days to start Resident A's treatment for the UTI.

On 09/30/2021, I received documents related to Resident A's UTI. In the Interdisciplinary Notes dated 08/11/2021, the note by Lera Davis read: *'Written orders received to test urine for UTI: foul smelling…'* On 08/12/2021, Senada Jelovac, note read as follows: *'Resident's husband is informed ….about the urine sample.'* On 08/18/2021, the note by Senada Jelovac read *'*…Amoxicillin 500 mg tid x 7 days for UTI…' On 09/01/2021, Lera Davis wrote: *'Written order received to check for UTI with C&S if indicated due to the continued behaviors.'*

On 09/30/2021, Ms. Swart documented that Resident A was treated for a UTI upon admission to Brightwell. It was noted that '*Fosfomycin was given in the emergency department and five-day course completed. Follow-up labs completed on 07/25/2021 indicate ua positive four (sic) leukocyte esterase with full results pending.'* A Progress note written on 07/26/2021, indicates *'UA relevant for calcium oxalate, WBCS and RBCS with full culture pending.'*

On 09/30/2021 Ms. Swart stated that on 08/11/2021, a UA was ordered by Clark due to foul smelling urine for Resident A. Lab results received 08/18/2021 indicated *'(Resident A) UA LABS 9-2021" treatment of Amoxicillin started on 8-19 and received 8-20. We did recognize an error and abx resumed on 08/23/2021. Treatment completed.'*

On 10/21/2021, Amy Leep RN, BSN stated Resident A received the right antibiotic for the first three days. She explained that Senada Jelovac wrote the order incorrectly which resulted in Resident A not receiving the antibiotic continuously and therefore she missed two days which was a total of six doses. Ms. Jelovac wrote the Amoxicillin order for the UTI 500mg tab 3x/day x seven days-ordered for seven doses

versus three doses for seven days. Therefore, the medication stopped at the seventh dose. Ms. acknowledged that Resident A did not receive three doses of her prescribed antibiotic on 08/21/2021 and on 08/22/2021, but this error was corrected on 08/23/2021. She reported there will be corrective action for Medication Input error.

On 10/21/2021, I reviewed the Physician's orders and Dr. Neubig had issued a new order dated 08/23/2021 for Amoxicillin 500 mg capsule [generic] – take 1 by mouth 3 times a day tid x 5 days for UTI. According to Ms. Leep, Dr. Neubig caught the error.

On 11/10/2021, I conducted a telephone exit conference with the Licensee Designee, Brain Pangle and he agreed with my conclusion.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A's Urinalysis was taken on 08/11/2021, and the Laboratory report returned on 08/18/2021. Amoxicillin started on 08/19/2021. Ms. Leep acknowledged that the order was written incorrectly by writing it for seven doses instead of seven days. She acknowledged that Resident A missed two days of the antibiotic, three times per day. This was corrected on 08/23/2021 when Dr. Neubig discovered the error and ordered Amoxicillin for three times a day for five days.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: An EKG was ordered but the family was not notified of the results.

INVESTIGATION: On 09/22/298021, I conducted a face-to-face interview with FM1 and FM2. Both family members reported they were told that Resident A needed an EKG, and they were aware that Dr. Neubig was ordering an EKG for Resident A. FM1 stated that he had not been notified if the EKG was completed or what the results were of the test.

On 09/30/2021, I received and reviewed the Interdisciplinary Notes on Resident A. On 08/12/2021 staff Carrie Powell had recorded the following: *'Resident had an EKG performed today…'* On 08/12/2021, I reviewed note by Senda Jelovac which read: *'Received a EKG results. Dr. Neubig has been notified.'* On the same dated Ms. Jelovac had entered the following note: *'Resident's husband (FM1) is informed about the ekg and the urine sample'.*

On 10/21/2021, I conducted a face-to-face interview with Senda Jelovac and she reported that she did notify FM1 by telephone about the completion of the EKG and the results. She stated that she had documented this information in the Interdisciplinary Notes.

On 11/10/2021, I conducted a telephone exit conference with the Licensee Designee, Brain Pangle and he agreed with my conclusion.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	A Licensee, with a resident's cooperation, shall fallow the instructions, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (d) Other resident health care needs that can be provided in the home. The refusal to follow instructions and recommendations shall be recorded in the resident's record.
ANALYSIS:	FM1 stated that he had not been notified by the facility staff that the EKG had been completed or what were the results of the EKG. Interdisciplinary Notes completed by Senda Jelovac on 08/12/2021 documented that that the EKG for Resident A had been completed and she noted on the same day that she had I informed FM1 about the EKG. Ms. Jelovac also informed me that she had called FM1 concerning the EKG on 08/12/2021. There is documentation along with a verbal statement that FM1 was notified of the completion of the EKG and informed by Senda Jelvoac by telephone on 08/12/2021. Therefore, a preponderance of evidence indicates that FM1 was notified of the EKG completion.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A was discharged for poor behavior, but her lack of "standard of care," could have caused some of her behaviors.

INVESTIGATION: On 09/22/2021, I conducted a face-to-face interview with FM1 and FM2. Both FM1 and FM 2 stated that Resident A had been sent to the emergency room hours after her admission to the facility on 07/13/2021. Recommendations from the facility included for her to go to Pine Rest. The family took Resident A to Pine Rest but they did not have available admission at that time, so the family took

Resident A to FM1's home and she spent the night. The next day they took her back to the emergency department of the hospital. They both reported that they learned of Brightwell in Lansing, MI which would admit her, so she was transported to the Brightwell facility on 07/14/2021. After two weeks she was transferred back to Oxford Manor West on 07/29/2021. FM1 and FM2 reported that Resident A was receiving the medication Depakote in tablet form for a month. They both observed that Resident A's medications were crushed and administered in foods or liquids when they visited Resident A. They decided to research the medication Depakote. They reported that they learned that the Depakote tablet was delayed release and should only be swallowed whole and should not be crushed. They said they learned that Depakote tablets have a special coating to prevent the entire tablet from breaking down at the same time, controlling the amount of medicine released into your system. FM1 and FM2 both reported from their observations, that Resident A was receiving the (crushed) Depakote tablet until Depakote sprinkles were prescribed just the day before she left which was on Labor Day weekend. FM2 and FM2 both expressed their belief that because of the crushed Depakote, Resident A was not receiving the proper amount of the prescribed medication and therefore she continued with aggressive behaviors, or the medication contributed to her aggressive behaviors because it was not administered correctly. They went on to say that if the medication had been administered correctly that her behaviors could have improved but the physician did not prescribe the Depakote Sprinkles until one day before her discharge. Therefore, the Depakote sprinkles did not have enough time to take effect and possibly impact Resident A's aggressive behaviors. They reported that they had received a 24-hour notice of discharge from the facility because of Resident A's aggressive behaviors. During the interview FM1 acknowledged that during a Care Conference with Dr. Neubig, she had told him that Resident A's Depakote Levels were taken and found to be in the proper range.

On 09/30/2021, I received and reviewed Interdisciplinary Notes documented on Resident A from 07/13/2021 through 09/05/2021. The notes revealed that Resident A was poking other residents and was taking other resident's items and food. She became combative with another resident and pulled her arm aggressively. She had been observed with anxious pacing and running the halls up and down. She was noted to be aggressive toward staff and other residents and was yelling all the shift. Often, she could not sit down. She pinched a male resident, scratched a staff and pushed others. She was not able to follow directions. PRN (as needed) medications did not change her behaviors nor did her regular medications. She would take off her clothing multiple times during a shift. Numerous times the notes indicated she hit staff and was found touching other resident's belongings. Her regular prescribed medications did not have an effect on her negative behaviors. At times she threw her breakfast, spit out her food and water, yelled and pulled on other residents. She was often aggressive with combative behaviors. She grabbed another resident's breast, punched a staff in the nose and in the face. She would be up 3:00 AM and go in and out of other resident's rooms, pushing doors and setting off alarms and climbing on tables. She bit another resident on their chest/breast and left a bruise on her nose. When staff attempted to get Resident A ready for bed she hit, kicked, and punched

staff in the face, and she did this serval times. She jumped on another resident's lap and refused to get off and became combative with staff that attempted to help her off the other resident. The notes also stated that on several occasions she attempted to leave the facility and tried to get outdoors.

On 09/30/2021, I received a typed response from Nicole Swart. Her report responded to the allegation, and she stated in her report that *'(Resident A) was discharged because she was a risk to herself and to others within the organization. Clark wanted nothing more than to support and care for her, but it became evident her needs were greater than Clark was able to provide for while allowing all to thrive and keeping her and the other residents safe from harm.'*
On 10/21/2021, I conducted an interview face-to-face with Amy Leep, RN, NHA, consultant for Clark Retirement and with Christina Turkewycz, Director of Dementia Services and Life Enrichment. We discussed the complaint and both Ms. Leep and Ms. Turkewycz, reported that Resident A had physically harmed their staff. Resident A refused to take her medications. Ms. Leep explained that Resident A was receiving Depakote which is a anti-seizure medication, but it can help with behaviors and be a mood stabilizer. Ms. Leep reported that Resident A's Depakote levels were found to be at therapeutic levels. She also stated that if they gave her more of the Depakote it could become toxic to her which is very dangerous. She also explained that too much Depakote could cause Resident A to become sluggish and become very slow in her movements. Ms. Leep stated that they had requested that the family send Resident A back to Brightwell for more services but FM1 decided not to send her back to Brightwell. Therefore, they did not feel they could meet Resident A's assessed needs and they issued a 24-hour discharge notice.

On 10/25/2021, I received a time-line report from Amy Leep. Her report read that (Resident A) was discharged *'related to her risk to herself, and others and it was ordered to send her back to psych hospital and husband refused to have her transferred back to Brightwell. Clark is unable to meet care needs at this time.'*

On 11/02/2021 I spoke with Ms. Leep and Dr. Elizabeth Neubig by telephone. Dr. Neubig stated that she had explained to FM1 that Resident A's Depakote was at the therapeutic levels. She reported that on 08/03/2021 her levels were at 61. On 08/18/2021, Resident A's levels were taken again and found to be at 75. The acceptable range is 50 to 100. She explained that Depakote is a seizure medication, but it can help with behaviors. She also reported that it can become toxic. She acknowledged that the Depakote tablet should not have been crushed and she did not prescribe for any of Resident A's medications to be crushed. Ms. Leep stated that they recognized the issue of crushing Resident A's medications and once they were made aware of this practice, they immediately remedied the problem to prevent Resident A or any other resident from receiving any crushed medications that cannot be crushed.

On 11/00/2021, I conducted a telephone exit conference with the Licensee Designee, Brain Pangle and he agreed with my conclusion.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	FM1 and FM2 stated that they witnessed Resident A's medications being administered to Resident A, when the medications were crushed and were put in foods or liquids and expressed their opinion that this may have contributed to Resident A's behaviors. Ms. Elizabeth Neubig, MD acknowledged that she had not prescribed Resident A's medications to be crushed but that Resident A's Depakote levels were taken twice and both times they were found to be in therapeutic range. The Interdisciplinary Notes documented by staff noted Resident A's numerous aggressive, combative behaviors resulting in injuries to other residents and staff. Nicole Swart, and Amy Leep both stated that Resident A was discharged because she was a danger to herself, staff and other residents. Resident A was protected because her Depakote levels were found to be in the therapeutic range. She was a risk to other residents, staff and herself. Clark staff could not meet her assessed needs and therefore asked the family to have her return to Brightwell and the family refused.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Upon discharge Resident A's family requested a copy of the complete resident record but were only given one doctor report and an incomplete medication record.

INVESTIGATION: On 09/22/2021, I conducted a face-to-face interview with FM1 and FM2. FM1 stated before the discharge (date not provided) he had asked Carrie Howell about getting Resident A's medical record and she told him he could pick it up the day she leaves but that they send medical information to the facility she is transferring too. He stated on the day of Resident A's discharge 09/05/2021, (Sunday) he spoke with Lera Davis who provided him a three-page statement by Dr. Neubig and a partial

medication record. He stated that he wanted Resident A's entire medical record, but they could not provide the information. FM1 stated that on the day of discharge the staff had given him Resident A's medication in a Ziplock bag. FM1 stated he went back on Tuesday, (09/07/201) and requested Resident A's complete medical record. He stated Ms. Lera Davis could not provide him with the medical records. He reported that he was not provided with any information on how to obtain Resident A's medical records and was not referred to any staff to follow up with.

On 09/30/2021 I reviewed the Interdisciplinary Notes. On 09/02/2021, Lera Davis documented the following: *'Chest x-ray 2 views AP/LAT order STAT to rule out TB for pre-admission process. Document will be scanned over to Provisions.'* The note by Carrie Howell dated 09/05/2021 read as follows: *'Residents family arrived around 10a,m, and finished removing residents items out of facility. LCP gave family residents med to take to new facility. Family left with resident at 11:30a.m. to take to new facility.'*
On 09/30/2021, I received and reviewed the response from Nicole Swart. Her response read as follows: *'Nicole Swart received a phone call from (FM2) on 09/28/2021. (FM2) indicated her dad (FM1) had asked Lear for copies of records and was provided with some, but they wanted more. We spent several minutes on the phone detailing the request. Nicole explained the formal med records request process and received (FM1) email to send him the documents to sign and return. (FM1) was emailed on 09/29/2021 as indicated to Amy*.'

On 10/21/2021, I conducted a face-to-face interview with Amy Leep, RN, NHA, consultant for Clark Retirement and with Christina Turkewycz, Director of Dementia Services and Life Enrichment. Ms. Leep stated that they gave FM1 Resident A's medical sheets. She then explained that they have a process to obtain medical records by completing a consent for records. Once they have the release, they can provide the records. She stated she was not aware that FM1 had requested Resident A's entire medical record.

On 10/25 I received an email from Amy Leep, RN, NHA, with a typed timeline on the care of Resident A at Oxford Manor West. She wrote the following: *'When we found out about the request, we asked him (FM1) to sign a Medical Release of Medical Records on 09/30/2021 and he received the records on 10/05/2021.'*

On 11/10/2021, I conducted a telephone exit conference with the Licensee Designee, Brain Pangle and he did not agree with my conclusion. He stated they did respond efficiently and quickly to the family's request to obtain Resident A's medical records.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**

	(8) At the time of discharge, a licensee shall provide copies of resident records to the resident and his or her designated representative when requested, and as determined appropriate, by the resident or his or her designated representative. A fee that is charged for copies of resident records shall not be more than the cost to the licensee of making the copies available.
ANALYSIS:	FM1 stated she requested Resident A's medical record on the day of discharge 09/05/2021 but did not receive her medical records. FM1 stated he went back to the facility on Tuesday 09/07/2021 and requested Resident A's medical records and was again not given them. FM2 acknowledged that on 09/28/2021 Nicole Swart provided the process to obtain Resident A's medical record and they were ultimately obtained. There is sufficient evidence that FM1 was not provided with copies of Resident A's records upon discharge after his request on 09/05/2021, and again when he returned to the facility on 09/07/2021. He was not provided with information on how to secure copies of Resident A's medical file.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: **Reclining chairs are used to "confine" residents.**

INVESTIGATION: On 09/22/2021, I conducted a face-to-face interview with FM1 and FM2. They both explained that they had observed residents in chairs that the residents were trying to get out of, but they could not. They both stated that the residents were confined. FM2 stated the residents in the chairs could not release the chairs themselves. She stated they were dependent on the staff to come and release the chairs to get a resident out of them. She explained that staff encouraged Resident A to not sit on the couch but to sit in these chairs. She stated she witnessed the staff immediately put the chair back for Resident A and raise the footrest She said she knew Resident A would not know how to release the chair and therefore she would be in the chair until a staff member came to get her out. She thought this was a way to confine Resident A's movement.

On 09/30/2021, I received and reviewed Nicole Swart's written response to the allegation of the chairs being used as a way to confine residents. She had the staff complete a questionnaire about the recliner chairs. She documented that *'staff were asking if this is referring to the residents who are-due to their diagnosis-in a Broda chair and a specific chair for their comfort? Reclining chairs are not used as restraints- many residents lay back and nap in some common areas. (Resident A's) charting indicates she did this too.'*

On 09/30/2021, received and reviewed the questionnaire, that was given to staff to respond to the question of *'Have you ever observed a resident in a recliner chair that is not able to get out on their own?'* I reviewed the responses of seven staff. Staff Linda (unable to read the last name) dated 09/29/2021 stated no to the question. Staff Shanice Hill signed the form on 09/30/2021, and she wrote "No." Staff K. Santiago signed the form on 09/29/2021 and she wrote the following: *'No, all residents who sit in a recliner are always observed by staff members. So that we can help and assist them out if we needed to.'* Staff Aylin Padilla signed the form on 09/29/2021. She wrote the following: *'No, all residents who are in a recliner always have a staff member present so we are able to help and assist them out if we need to.'* Staff Amarech Someno signed the form on 09/29/2021. She wrote the following*: 'No, but staff has to watch when the Resident gets restless to prevent falling.'* Staff Lainey Peterson wrote the following: *'Yes, residents in recliners typically don't transfer alone. Memory care residents don't always know how to use a call light so having residents in recliners in the living room makes it accessible to see when residents need assistance from chair.'*

On 10/21/2021, I conducted a face-to-face interview with Ms. Leep and Ms. Turkewycz. Ms. Leep explained that a Broda chair is not a geri-chair. The Broda chairs are designed to give proper positioning to a resident who cannot walk or stand on their own. She stated these are not restraints for residents. They are designed to provide proper positive positioning and support. She stated that staff do need to help these residents.

On 10/25/2021, I received and reviewed Ms. Leep's timeline related to Resident A. Her report read: *'Audit done and there are two residents with service plans to use a Geri-chair and a Broda chair related to their current functional level. Neither resident can stand or ambulate. They are on a transition list to move to a higher level of care when a bed opens. Educated staff on restraints and the difference between positioning devices, restraints, and support equipment on October 4, 2021.'*

On 10/27/2021, I conducted a telephone interview with Family Member 4 (FM4). She stated that she visited Resident A many times while she was in Oxford Manor West. She reported that she has observed residents in these chairs that when tipped back the residents would attempt to get out of the chair, but they could not. She thought there were three or four of these types of chairs and they were located in the area like a living room where the residents watch TV and there were also couches there. She reported that on the side of the chair there were levers that when you pushed them the chair would lean back, and the footrest would come up. She said there was a button to push to release the footrest and for the back of the chair to come back up. She said she observed residents trying to figure out how to release the footrest and the back of the chair, but the residents were unable to do it. She said they would try to get out of the chair but after a while they just gave up. She stated that these chairs did not work like a normal recliner. She stated she was going to leave one day (date unknow) and she brought Resident A to the area of the chairs and couches. She said Resident A attempted to sit down on the arm of the couch, but a staff member

encouraged Resident A to sit in one of these chairs. FM4 said the staff said to Resident A to sit right here in this chair and the minute Resident A was seated in the chair the staff person laid her right back and the footrest came up. She said that Resident A has significant dementia, and she knew that Resident A would not be able to figure out how to release the chair so she could get up on her own. She reported the first thought she had was the staff was doing this to keep Resident A confined so she would not have to look after her because she could not get out of the chair on her own. She stated that it would take sufficient amount of strength and know how to release these chairs. She stated that she did not see any resident successfully release these chairs, but she did observe them struggling to get out of the chairs. She was convinced the chairs confined the residents.

On 11/05/2021, I conducted an inspection at the facility. I sat in the Broda (reclining chair) and I was able to pull the lever on the side of the chair to tip back and to raise the footrest. I was able to release the footrest by pulling the button on the right inside of the chair. I observed two residents in Broda chairs. Both appeared to be comfortable. I did not see them struggle in anyway. I observed the third resident in a geri-chair that allowed the resident to lay flat, and she appeared to be sleeping and in no distress to get up. I conducted interviews with three staff who were on duty at the time of my inspection, Carrie Howell, Kirian Santiago, and Jessie Canacho. All three acknowledged they worked in the facility, and they cared for Resident A. All three denied that they had never put Resident A in the Broda Chair. In a very rare occasions, she might have sat in the Broda Chair but she never was in one for more that 15 minutes and usually it was five minutes or less because she was always on the go and hardly ever sat down. All three staff admitted that if Resident A showed any signs of restlessness, during these short intervals, they helped her out of the chair in the rare chance she sat in one. All three acknowledged that they were always there to help the residents when any resident was in the Broda chair or the Grei-chair. All three staff stated that they have never allowed a resident to struggle while sitting in the Broda Chair. The staff interviews were consistent with their written signed statements and also were consistent with the other staff's signed statements. I was not able to observe Resident A in a chair because she had been discharged before I received the complaint.

On 11/19/2021 I completed an exit conference by telephone with the Licensee Designee, Brian Pangle and he agreed with my conclusion.

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:	FM2 and FM4 both stated that they witnessed residents struggling unsuccessfully to get out of a type of a recliner chair. They both stated that Resident A was encouraged to not sit on the couch but to sit in the recliner chair and the staff pulled the leg rest up and the back of the chair went down. They stated that Resident A was unable to release herself from the recliner chair. Six out of seven staff reported that they had not observed residents struggle to get out of the chair. In addition, these six staff each reported that they were close by to observe and to help the resident if they wanted to get up from the chair. They acknowledged that the residents do require help and they provide the help to each time they see the need. Ms. Leep stated that they do use the Broda Chairs, which are designed to give proper positioning to a resident who cannot walk or stand on their own. She stated these are not restraints for residents. While in the facility on 11/05/2021 I did not observe any residents struggle to get out of their chair. There is not a preponderance of evidence that residents were put in a Broda or Geri-chair to restrain or restrict their movements. The response by direct care staff was consistent that they do not let any resident struggle in a chair. They all acknowledged that if they see a resident struggle to get out of a chair they immediately help. Therefore, there is no violation to this rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A's personal belongings were locked in a closet.

INVESTIGATION: On 09/22/2021, I conducted a face-to-face interview with FM1 and FM2. They both reported that Resident A's closet was locked, and Resident A could not access her personal belongings.

On 09/30/2021, I received a typed response from Nicole Swart. The following was included in her report: *'This may be specific to residents who are noted to be at*

greater risk of falls reaching into and removing items-clothes- from their closets. A full audit being obtained.'

On 09/30/2021, I received an email from Nicole Swart with an attachment. The attachment was a Questionnaire completed by seven staff, which I reviewed. '*Staff Interview Questions, Have you locked personal belongings in a closet that is not accessible to the resident?'* A staff by the name of Linda (I could not read her last name) answered "No," and signed the form on 09/29/2021. Shanice Hill signed the form on 09/30/2021 and she wrote *'Yes. When residents aren't able to use things such as lotion and toothpaste properly for their safety things are occasionally put away.'* Sheila Hendrick signed the form on 09/30/2021. She wrote the following: *'Only when not using their personal items correctly that they have to be lock in their closet till using them.'* K. Santiago signed the form on 09/29/2021. She wrote the following: *'Yes, I work in an advanced dementia unit where most if not all residents are wanders and leaving closets open could be a safety hazard. Resident also will wander into other resident room and take belonging that don't belong to them.'* Aylin Padilla, signed the form on 09/29/2021. She wrote the following: *'Yes, we work in an advanced dementia unit where most if not all residents are wanders and leaving closets unlocked could be a safety hazard. (soaps, toothpaste) Residents also will wander into each other's rooms and take belongings that don't belong to them making it hard for us to track missing items down.'* Amavech Someno signed the form on 09/29/2021. It read as follows: *'Yes to keep the residents belongings safe and clean, so the other residents would not get in and nothing comes out missing.'* Laniey Peterson signed the form on 09/29/2021. She wrote the following: *'Yes, several closets are locked due to the care plan. Residents rummage through their own closets other residents too. Some residents will change numerous amounts throughout the day which can be unsafe. Also residents sometimes thing they need to pack all of their clothing and this causes distress.'*

On 10/21/2021, I conducted a face-to-face interview with Amy Leep and Christiana Turkewycz. They were unaware that there is an actual rule that residents are to have reasonable access to their personal clothing and belongings. I provided consultation that if the residents need their personal belongings and clothes locked up for safety or other reasons, they can seek a variance to the rule and the department will decide if a variance is granted. Ms. Leep explained that when she was made aware of the locking of resident's personal belongings and clothing, she immediately went to the unit and checked every closet. She stated she unlocked each one if she found it locked and she instructed each staff person to not lock the resident's closets from now on.

On 10/25/2021 I received an email with an attachment of Ms. Leep's typed timeline. She documented the following*: 'When we received the concern, we identified that non-compliance to regulations. We went room to room unlocking any rooms with locked wardrobes on 10/04/2021. We removed the keys from the Team Lead cupboards and have done weekly audits with 100% compliance. Education done*

with all staff on 10/04/2021 going over resident rights. Educated by Consultant on 10/21/2021 that we can notify the agency to ask for a variance if needed for safety.'

Ms. Leep informed me that this is their plan of correction for this rule violation. The Licensee has therefore provided a plan of corrections for this rule.

On 11/10/2021, I conducted a telephone exit conference with the Licensee Designee, Brain Pangle and he agreed with my conclusion.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(j) The right of reasonable access to and use of his or her personal clothing and belongings.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	FM1 and FM2 both stated that Resident A's closet was locked, and it contained her personal belongings and clothes. Seven staff acknowledged that they had locked personal belongings in a closet that is not accessible to the resident. Six of the seven staff acknowledged residents' personal belongings and clothing were locked, primarily for safety. Ms. Leep stated that she went through each resident room by room to unlock each closet that she found locked. During this investigation it was determined that the facility had locked the closets of the residents which did allow access to their personal belongings and their clothing. Upon learning of this practice, they immediately unlocked all of the closets. They have provided a plan of correction to this rule and the department accepts this a plan of correction.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A was put on a special diet which was not observed and Resident A experienced a loss in weight.

INVESTIGATION: On 09/22/2021, I conducted a face-to-face interview with FM1 and FM2. FM1 reported that Mary Ziomkowski, the head nurse had resigned her position, and this was difficult for the family because she had come to their home and evaluated Resident A and had explained that she thought they could care for Resident A. She had been involved up until she left her position. FM1 stated that Resident A was very restless, and she had difficulty sitting down to eat a meal. FM1 reported that they had had a Care Conference on 08/27/2021with Lera Davis, LPN, Mary Ziomkowski, Director, Christina, LE, and Kayla, Dietary and discussed their concerns about Resident A's weight loss. At this meeting staff had recommended to provide Resident A with "Fresh Bites." FM1 stated that there was an order for the "Fresh Bites." FM 1 and FM2 both stated that when they visited Resident A, they did not observe Resident A having the "Fresh Bites." They did not provide specific dates of their visits with Resident A. They described the "Fresh Bites," as having foods that Resident A could pick up and eat while walking. They were reportedly hoping that this would help her consume more food and help prevent any more weight loss. They stated she lost 12 pounds in the month of August 2021.

On 09/30/2021, Nicole Swart sent an email with attachments. One of the attachments was sheet entitled: "Dietary Communication," for Resident A. In this same document was recorded: "Adaptive Equipment for Special Notes: Fresh Bites." The name of Lera Davis LPN was noted and the date was recorded as 08/27/021. I also received and reviewed "Resident Vial Stats" which recorded Resident A's weights. On 07/13/2021, her weight was recorded as 132.70. On 08/16/2021 the weight was recorded as 125.10 and her weight recorded on 08/27/2021 was 120.90.

On 09/30/2021, I received and reviewed the Interdisciplinary Notes, dated 08/27/2021, completed by Mary Zimkowski and read in part*: 'We discussed at length (Resident A's) continued behaviors at mealtimes (inability to sit through a meal, wondering at mealtimes, taking oof off other's plates, food acceptance on average 50% and perpetual anxiety, restlessness and wandering.) …Kayla(Perry) discussed the Fresh Bites, which may improve (Resident A's) ability to eat on the go.'* Later on the same date Ms. Zimkowski added an additional note which read: *'Spoke with Dr. Nuebig – orders received …Fresh Bites. Service Plan and care guides updated for staff…(FM1) informed on the ….and diet change. Orders received…and to add Fresh Bites. Service Plan and care guides updated for staff…'* On 08/27/2021, the note by Kiran Santiago-Oliveras read as follows: *'Staff on 2nd shift has been giving resident fresh bite food since she doesn't sit and eat on the go.'* A note by Sejla Kunic, dated 08/30/2021, read as follows: *'Resident refused supper and spits out when offered food or water.'*

On 09/30/2021, Nicole Swart identified other Interdisciplinary Notes concerning Resident A's issues with eating. On 08/04/2021, Carrie Howell, wrote the following: *'Resident became very anxious just before lunch and staff sat with resident in alcove area for her meal and that did not last very long. She proceeded to come in dining room and yell and try to take other resident's food and drinks and staff was unable to*

re direct resident. She continues to hover over the other residents while they were trying to eat their food…' On 08/07/2021, Carrie Howell documented the following: *'resident is very tired but cannot sit still long enough to eat or relax.'* On 08/11/2021, Kiran Santiago-Oliveras wrote the following note: *'Staff redirected resident for supper resident are 25% and she will not sit for staff.'* On 08/12/2021 Kiran Santiago-Oliveras wrote the following note: *'For supper resident will not sit and eat, when staff tried to feed resident, she refused.'* On 08/16/2021, Kiran Santiago-Oliveras wrote the following note: *'For supper resident ate 50%.'*

On 09/30/2021, I reviewed Nicole Swart written response to the allegation. She documented the following: *'Physician order and ID note from Care Conference for Fresh Bites. Charting indicate she was provided with this. Resident's weight upon admission to Brightwell that was also resident's "admit" date to Clark was 129.1 Resident's weight was indicated to be 126 while at Brightwell on 07/27/201. Discharge weight from Brightwell to Clark noted to be 128.4 on 07/29/2021…'*

On 10/21/2021, I conducted a face-to-face interview with Ms. Leep and Ms. Turkewyc. They both reported that Resident A would not sit down to eat a meal. They stated that 'Fresh Bites' foods are the same food provided on the menu and therefore "Fresh Bites' was not a special diet but in fact the same foods only served to eat with your hands. They called Kayla Perry, the Dietary Manger into our meeting. Ms. Perry stated that as soon as they received the order for 'Fresh Bites' on 08/27/2021, they changed Resident A's diet order to be served at every meal with 'Fresh Bites.' She explained it has to do with the texture of the foods. She stated it is the same foods served on the menu, but it is soft and easier to pick up and eat which allows Resident A to be mobile while eating. She stated they severed Resident A with 'Fresh Bites' for every meal since 08/27/2021.

On 10/25/2021, I received a typed timeline from Ms. Leep. She documented the following: *'Diet in place for entire stay is General with thin liquids, on August 27, 2021, it was added to make texture "fresh bites" which is a special texture option to make food more portable. Such as "mashed potato balls" food that can be carried. A communication form was completed and given to the kitchen on 8/27/2021.'*

On 11/10/2021, I conducted a telephone exit conference with the Licensee Designee, Brain Pangle and he agreed with my conclusion.

APPLICABLE RULE	
4 400.15313	**Resident nutrition**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	On 08/27/2021 at a Care Conference "Fresh Bites" was recommended for Resident A. Fresh Bites is designed for the

	food to be portable. Ms. Perry stated that the order in the kitchen for Resident A was changed to fresh bites on 08/27/2021, and that the fresh bites were served at every meal from 08/27/2021. Interdisciplinary Notes on Resident A were consistent that Resident A had difficulty sitting down to eat a meal. These notes by staff indicated that she would eat 50% or 25% of her meals or she would spit out the food or the water. There is not a preponderance of evidence that Resident A was not provided with fresh bites for each of her meals.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A's family members were not given appropriate notice of Resident A's discharge.

INVESTIGATION: On 09/22/2021, I conducted a face-to-face interview with FM1 and FM2. FM2 stated on 08/2021, that FM1 had requested a meeting with Dr. Elizabeth Neubig. She reported that they discussed Resident A's medication and they were wondering if she would consider Seroquel. FM2 stated that Dr. Neubig agreed that Resident A could be experiencing delirium as they had suggested. As a result, Dr. Neubig reportedly told FM1 and FM2 she would do lab work to check Resident A's Depakote levels in her blood. Last time they had checked her she was in the therapeutic levels. She stated that Dr. Neubig told them she would talk to someone concerning the change of Risperdal to Seroquel. FN2 stated that they had questioned Ms. Turkewycz about Team Health and how could they contact them because they had learned that a Physician's Assistant (PA) had seen Resident A. FM2 stated that on 08/25/2021, FM1 had received a call from Clark about a medication update with stopping Risperdal (antipsychotic), stopping Remeron (for anxiety) and starting Seroquel tomorrow on 08/26/2031. She stated that they had a care conference for Friday 08/27/2021. FM2 stated that FM1 had requested a Team Meeting on 08/27/2021 to discuss with Clark staff their concerns about Resident A. She reported she was at the meeting, and it was the first time they had heard the idea that maybe this facility wasn't the best place for Resident A and maybe the family should consider another facility. She stated that they asked the question whether that would be best for Resident A given the fact that she has gone through two major relocations in the past six weeks. FM2 stated "they told us no, we should wait until her medications were straightened out in one or two months." FM2 stated Resident A was taken off of Haldol on 08/31/2021. FM2 stated that FM1 had met with Senada the nurse after she had called him. She reported that Resident A had had a difficult day were she grabbed and pinched another weak resident's breast and she had hit 2 staff people. She reported that Dr. Neubig and the new Team Health person (name unknown) were meeting to determine their next move. They did not feel they were

meeting Resident A's needs and that another placement would be better for her. FM2 stated that on September 1 (Wednesday) FM1 received a phone call from Lara Davis around 3:30 PM. She said Ms. Davis stated that yesterday's incident was the third resident that Resident A had hit and she was saying that they thought it was her best option to go back to a psychiatric hospital, Brightwell, Pine Rest, or to Indiana with a permanent discharge. FM2 stated that they were to provide one-on-one care for Resident A every day as soon as possible until she was transferred. They informed us that they were having a hard time getting Resident A to take her medications and possibly they could be injected. FM1 stated that on Thursday 09/02/2021, he had received a phone call from Brightwell at 9:00 A.M. asking permission to re-admit Resident A to their facility and he stated he declined to re-admit her. They reported that on September 02/2021 they as a family had received a phone call at 1:50 P.M. from Brian Pangle telling them they had 24 hours to remove Resident A from their facility. FM1 and FM2 stated that they had not received written communications from them which was stated in their contract. FM2 stated FM1 had received an email at 5:10P.M. from Brian Pangle. She provided a copy of his letter/email to FM1. The letter read as follows: *'In connection with our phone conversation earlier this afternoon Clark Retirement Community is initiating the discharge of (Resident A) to your care no later than 5:00pm this Friday afternoon September 3, 2021, I understand you might have a discharge solution for (Resident A) to another facility that would happen by this Sunday September 5, 2021. We will hold (Resident A's) discharge until this Sunday as long as we have a written commitment from you and the admitting facility by 5:00pm tomorrow (Friday afternoon). If we do not receive the written commitment we will discharge (Resident A) to your care tomorrow as indicated above. This Involuntary Transfer is pursuant to Section 15.2 of the Assisted Living agreement signed earlier this summer. Specifically in Section 15.2.3 this "discharge is mandated by MEMBER'S health care needs in accordance with the written orders and medical justification of the attending physician or is mandated by the physical safety of other MEMBER'S and community employees." This discharge is due to both of these conditions. As I indicated over the phone (and our staff has communicated with you at other times) (Resident A) has become more physical and combative, hitting staff members on the chest, arms and earlier today in the face. I am very concerned for the safety of our staff and in particular other residents (who might retaliate). (Resident A) also requires constant one on one care and attention when she is awake and that creates an unsafe situation for our other residents who require are care and attention We strongly recommend you consider readmitting (Resident A) to Brightwell or pursue a voluntary admission to Pine Rest Hospital for additional evaluation and care. As I indicated over the phone there are two additional potential assisted living facility options you could explore-Byron Center Manor or the Lodge at Vista Springs. I am very aware of the difficulty this poses for you and your family. If you have further questions please contact me directly.'*

On 09/30/2021 I received and reviewed the Interdisciplinary Notes. On 08/27/2021, at the Care Conference the note was completed by Mary Ziomkowski. She had written the following: *'We had open conversation with FM1, FM2 and FM4 that the Oxford West may not be the right living environment for (Resident A) due to the small size,*

only two hallways, one common living/dining space, and the nature of the residents- we discussed that if we are unsuccessful in managing (Resident A's) behaviors after an appropriate length of time and attempts, it may be a consideration for family to look at other environments (such as Franklin or other organizations). We answered the family's many questions, reviewed the current orders, and reviewed the current LAA. Family was very thankful for the conference.'

On 09/30/2021 I reviewed the Interdisciplinary Notes dated 08/31/2021 completed by Christina Turkewycz which read as follows: *'Life Enrichment and Dementia Services Manger and first shift Nurse called Licensing Officer to discuss this resident and a potential permanent discharge and what options there are. Staff members discussed the reasons for a potential permanent discharge which include aggressive and combative behaviors with other residents and staff. The Licensing Officer agreed that a discharge from our community would be more than appropriate. Discussed alternative placements at other similar communities to give a resource to the family as well as psychiatric placements. Licensing Officer assured staff members that if we were able to find a psychiatric placement that we could let that facility know it would be a permanent discharge and the resident would not be able to return back to our community. The discharge could be given via 24hr notice or a 30-day notice.'*
I am the Licensing Consultant for Oxford Manor West, and I did speak by telephone with the staff at the facility. I explained that our administrative rules allow for a 30-day discharge for any reason and that the 24-hour discharge notice is if the resident is a substantial risk to herself and others. Serious physical assault is also considered a substantial risk as well as destruction of property and they have the right to issue a discharge notice either of 30 days or a 24-hour notice.

On 09/02/2021 I received a telephone call from Brian Pangle, the Licensee Designee and we discussed the options and the administrative rules. We also exchanged emails and Mr. Pangle provided me with the email he had written for the 24 hours discharge. His letter did include the required information that is contained within our rule.

On 11/10/2021, I completed an exit conference with the Licensee Designee, Brian Pangle and he agreed with my conclusion.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A Licensee who proposes to discharge a resident for any reason listed in subrule (4) of this rule shall take the following steps before discharging the resident: (a) The license shall notify the resident, the resident's designated representative, the responsible agency, and the

	adult foster care licensing consultant not less that 24 hours before discharge. The notice shall be in writing and shall include al of the following information: (i)The reason for the proposed discharge, including the specific nature of the substantial risk. (ii) The alternatives to discharge that have been attempted by the licensee (iii) The location to which the resident will be discharged, if know.
ANALYSIS:	On 08/27/2021, Mary Ziomkowski explained to Resident A's family that they should consider another facility placement for Resident A. Mr. Brain Pangle provided FM1 with the written notification on 09/02/2021 of the 24-hour discharge of Resident A. The licensee followed the pertinent licensing rules for issuing a 24-hour discharge notice for Resident A who had exhibited substantial risk by her aggressive behaviors to other residents and to staff. Therefore, there is no violation established.
CONCLUSION:	VIOLATION NOT ESTABLISED

ADDITONAL FINDINGS:

INVESTIGAITON: On 09/22/2021, I conducted a face-to-face interview with FM1 and FM2. I requested to see Resident A's assessment plan. FM1 stated that the facility had not provided him with her assessment plan.

On 09/30/2021 I received and reviewed the document from Ms. Swart. She stated that the team member who completed the admission work on Resident A is no longer in the employment of Clark.

On 10/21/2021, I met with Ms. Leep and Ms. Turkewycz and I requested to inspect Resident A's required assessment plan. They provided me with a copy of a "Care Plan." This plan had recorded Category: 5 which was about Resident A's care needs, Category: 6 which was about Urinary Incont/Indwelling Cath, Category 11: dealt with Safety/Falls, Category: 12 Nutrition Status, Category:15 Dental Care, Category: 16 Skin Integrity/Pressure Ulcer, Category: 19 Pain and Category: 20 Return to Community. I provided our Assessment Plan for AFC Residents to Ms. Leep. Ms. Leep acknowledged that their "Care Plan" did not address all the elements contained in our assessment plan. They were unable to find any other assessment plans for Resident A.

On 10/25/2021, I received and reviewed Ms. Leep's timeline. She acknowledged that they did not have assessment plan as required in Administrative Rule and Section 3 (9) of 1979 PA 219.

On 11/10/2021, I completed a telephone exit interview with the Licensee Designee, Brain Pangle and he agreed with my conclusion.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident, the resident's designated representative, the responsible agency, if applicable, and the licensee. A Licensee shall maintain a copy of the resident's written assessment plan in the file in the home.
ANALYSIS:	FM1 stated that he was not included in determining the identified needs of Resident A nor in the plan as to how they would meet Resident A's assessed needs. He was not provided with the written assessment plan. The facility failed to provide the required written assessment plan for Resident A and therefore a violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Arlene B. Smith 11/10/2021

Arlene B. Smith, MSW Date
Licensing Consultant

Approved By:

Jerry Hendrick 11/10/2021

Jerry Hendrick Date
Area Manager