GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 4, 2022

Louis Andriotti, Jr.
Vista Springs Riverside Gardens LLC
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #:	AH410397993
Investigation #:	2022A1021024
	Vista Springs Riverside Gardens

Dear Mr. Andriotti, Jr.:

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

License #:	AH410397993
Investigation #:	2022A1021024
Complaint Receipt Date:	01/25/2022
Investigation Initiation Date:	01/25/2022
Report Due Date:	03/24/2022
Licensee Name:	Vista Springs Riverside Gardens LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Administrator:	Susan Alveshere
Authorized Representative:	Louis Andriotti, Jr
Name of Facility:	Vista Springs Riverside Gardens
Facility Address:	2420 Coit Ave. NE Grand Rapids, MI 49505
Facility Telephone #:	(616) 365-5564
Original Issuance Date:	07/22/2020
License Status:	REGULAR
Effective Date:	01/22/2022
Expiration Date:	01/21/2023
Capacity:	70
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A’s oxygen removed.	No
Insufficient staff at the facility.	No
Resident A’s medication orders were not followed.	Yes
Resident B did not receive medications.	Yes
Residents do not receive personal hygiene.	Yes
Laundry is not done.	No
Facility is not clean.	No
Additional Findings	Yes

III. METHODOLOGY

01/25/2022	Special Investigation Intake 2022A1021024
01/25/2022	Special Investigation Initiated - Telephone interviewed complainant
01/25/2022	APS Referral
02/04/2022	Inspection completed on site
02/07/2022	Contact-Telephone call made Interviewed Emmanuel Hospice case manager Audrey Post
02/07/2022	Contact-Telephone call made Interviewed Emmanuel Hospice nurse Mal Klino
02/08/2022	Contact-Telephone call made Interviewed shift supervisor Kathy Andrews
02/11/2022	Contact-Telephone call made Interviewed case manger Caitlin George

	Exit Conference

ALLEGATION:

Resident A's oxygen removed.

INVESTIGATION:

On 1/25/22, the licensing department received a complaint with allegations Resident A's oxygen was incorrectly removed.

On 1/25/22, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 1/25/22, I interviewed the complainant by telephone. The complainant alleged on 1/11/22 the facility transferred Resident A to his chair to eat dinner. The complainant alleged the facility took off the oxygen because the facility was having a difficult time feeding him. The complainant alleged caregivers left Resident A and Resident A then became unresponsive.

On 2/4/22, I interviewed wellness officer Vicki Dean at the facility. Ms. Dean reported when this event occurred, meals were being served in residents' room due to a Covid-19 outbreak. Ms. Dean reported Resident A was placed in his chair to eat dinner. Ms. Dean reported Resident A was having a difficult time eating and therefore the oxygen was removed. Ms. Dean reported Resident A did not have an order for continuous oxygen and therefore the oxygen could be removed. Ms. Dean reported Resident A had a change in condition and therefore Emmanuel Hospice and family was contacted. Ms. Dean reported prior to this incident, Resident A was having episodes of blank stares and not responding to stimuli. Ms. Dean reported Resident A now has an order for continuous oxygen.

On 2/4/22, I interviewed facility nurse Jennifer Slater by telephone at the facility. Ms. Slater reported Resident A's order for oxygen was for as needed and was not continuous. Ms. Slater reported if vitals are taken during a change in condition, it is not required for caregivers to document the vitals as it is not a scheduled task.

On 2/7/22, I interviewed Emmanuel Hospice case manager Audrey Post by telephone. Ms. Post reported on 1/11/22, Resident A did not have an order for continuous oxygen. Ms. Post reported per report from the facility, oxygen was removed, and Resident A had a change in condition as observed by skin was clammy and Resident A was unresponsive. Ms. Post reported by removing 2L of oxygen for a short amount of time that it would not cause a major change in condition. Ms. Post reported that since this event occurred Resident A now has an order for continuous oxygen.

On 2/7/22, I interviewed Emmanuel Hospice nurse Mal Klino by telephone. Ms. Klino reported she was contacted by the facility because the resident was unresponsive. Ms. Klino reported when she arrived at the facility, Resident A was responsive but was fatigued. Ms. Klino reported Resident A was able to answer simple questions. Ms. Klino reported the facility reported Resident A's oxygen was taken off during dinner time so that he could eat. Ms. Klino reported the facility reported Resident A became unresponsive, the oxygen was replaced, and hospice was contacted. Ms. Klino reported Resident A's oxygen order was for as needed.

On 2/8/22, I interviewed shift supervisor Kathy Andrews by telephone. Ms. Andrews reported she was the shift supervisor on 1/11/22. Ms. Andrews reported the facility was serving meals in resident rooms due to a Covid-19 outbreak at the facility. Ms. Andrews reported Resident A and Resident B were eating dinner in their room and Resident A requested to be in chair to eat and therefore Resident A was moved to his chair for dinner. Ms. Andrews reported Resident A's oxygen order was for as needed and the oxygen was removed. Ms. Andrews reported Resident A and Resident B were eating and doing well with dinner. Ms. Andrews reported the resident next door pushed the call pendent and Ms. Andrews reported she left the room to respond to the call pendent. Ms. Andrews reported she was absent from the room for a short amount of time. Ms. Andrews reported Resident B pressed the call pendent and she returned. Ms. Andrews reported Resident B requested a blanket for Resident A. Ms. Andrews reported she observed Resident A to be sweaty and staring at her. Ms. Andrews reported she knew Relative A1 would be calling soon on the video device, so she had another co-worker contact Emmanuel Hospice for a nurse to come and evaluate Resident A. Ms. Andrews reported the oxygen was removed for no more than 30 minutes. Ms. Andrews reported Resident A has had episodes of staring and non-responding. Ms. Andrews reported Emmanuel Hospice and Relative A1 came to the facility. Ms. Andrews reported Resident A came around and was back to baseline. Ms. Andrews reported Resident A sometimes requires 1:1 feeding assistance but other days he does not. Ms. Andrews reported caregivers will get Resident A set up, assist him with eating, and then evaluate if it is safe to leave. Ms. Andrews reported Resident A was eating his dinner fine, so it was determined it was safe to leave to respond to the call pendent.

I reviewed Resident A's service plan. The service plan read,

> *"Provide assistance with eating. Encourage resident to feed self if able, assist when needed. If resident has private home care or hospice scheduled please verify task is complete."*

I reviewed facility documentation. The documentation read,

> *"spoke with hospice nurse today she was asking for anything was needed for him, I stated no. We had discussed his O2 status and that we now have it in ECP as continuous air. She stated to me that him not having it on for the short time of*

a meal would not have caused him to be the way he was the day that the son said was an issue. But this has since been changed to continuous O2 and has remained this way."

I reviewed Emmanuel Hospice documentation. The docucementation read,

"1/11/22: Facility staff called and reported patient was unresponsive, eyes open but not responding. Skin clammy and moist to touch. Upon this writer arrival patient in bed asleep. Patient woke up easily to this writer's voice and gentle touch. This writer asked patient if he was doing ok and patient replied yeah. No signs or symptoms of pain noted, patient appears comfortable at this time. Patient's son (Relative A1) arrived shortly after this writer arrival. This writer informed patient's son, patient appears to be doing ok at this time and continues to be in the transitional phase of dying. Facility staff came to the room during the visit and reported patient ate dinner but she removed the oxygen during dinner so patient " can eat better", patient oxygen saturation dropped down to 85% right after dinner and then the incident happened. Patient appears fatigued during the visit, keeps closing his eyes and falling to sleep. This writer educated facility staff oxygen should not be removed during meals if patient oxygen stats drops and patient is uncomfortable. Son verbalized how unsatisfied he was with the care that facility provided to his father. Active listening and emotional support provided. Son verbalized he was exhausted, this writer encouraged him to get some sleep and return to facility tomorrow as patient appears comfortable at this time and back to baseline. 24/7 hospice availability reinforced.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	On 1/11/22, Resident A's oxygen was removed for a short amount of time which was consistent with Resident A's service plan. Review of documentation and interviews conducted revealed the facility appropriately followed Resident A's service plan and oxygen order.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Insufficient staff at the facility.

INVESTIGATION:

The complainant alleged there is insufficient staff at the facility as residents will press call pendent for assistance and it takes a long time for staff to respond. The complainant alleged residents can wait up to 30 minutes for assistance.

Ms. Dean reported the facility has adequate staff to meet the needs of the residents. Ms. Dean reported the facility has 55 residents. Ms. Dean reported on first shift there are at minimum five caregivers with two medication technicians, on second shift there are at minimum two caregivers and two medication technicians, and on third shift there are at minimum two caregivers with one medication technician. Ms. Dean reported there is no mandation policy in place. Ms. Dean reported if there is a staff shortage, the facility will ask caregivers to pick up open shifts. Ms. Dean reported care coordinators will also work the floor, if needed. Ms. Dean reported caregivers are expected to respond to a call light within ten minutes. Ms. Dean reported if a call light is not answered within ten minutes, she will receive a text message to alert her of the call light. Ms. Dean reported it will then escalate to Ms. Slater and the administrator. Ms. Dean reported there is adequate staff to meet the needs of the residents.

On 2/4/22, I interviewed medication technician Brittany Fletcher at the facility. Ms. Fletcher reported there is adequate staff to meet the needs of the residents. Ms. Fletcher reported caregivers are to respond to a call light within ten minutes. Ms. Fletcher reported caregivers usually meet this goal. Ms. Fletcher reported no concerns with lack of staff at the facility.

On 2/4/22, I interviewed caregiver Bree Davis at the facility. Ms. Davis staffing statements were consistent with those made by Ms. Fletcher.

On 2/4/22, I interviewed Resident B at the facility. Resident B reported care staff are good at responding to her call pendent. Resident B reported no concerns with lack of staff or lack of responding to call lights.

I reviewed call light response times for Resident B for 1/16/22-1/23/22. I only reviewed pendent pushes. Resident B had 96 pendent pushes with an average response time of four minutes.

I reviewed staff schedule for 1/19/22-2/1/22. The schedule revealed the staffing guidelines were met as told by Ms. Dean.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable

	of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Interviews conducted, documents reviewed, and call light response times revealed there is adequate staff at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's medication orders were not followed.

INVESTIGATION:

The complainant alleged Resident A's medications were to be discontinued because he was near end of life. The complainant alleged the facility did not follow these orders and continued to provide medications.

Ms. Dean reported the facility had no communication from Emmanuel Hospice that medications were to be discontinued. Ms. Dean reported the facility completed an investigation and learned that hospice providers were leaving orders within the facility and not providing them to the appropriate people. Ms. Dean reported the facility provided re-education to outside providers that they are to check in with the health and wellness office at every visit and leave orders in their office. Ms. Dean reported the hospice company is responsible for providing medication orders and changes to the pharmacy. Ms. Dean reported the pharmacy, HomeTown Pharmacy in Rockford, had no record of discontinuing medications for Resident A.

Ms. Post reported that hospice will discontinue oral medications if a resident is transitioning to end of life. Ms. Post reported Resident A has shown signs he was transitioning but has since improved. Ms. Post reported there was a breakdown in communication between the hospice company and the facility as orders were not communicated correctly to the facility. Ms. Post reported the hospice company is now to communicate changes to the administrator and place orders in the appropriate mailbox.

On 2/8/22, I interviewed pharmacy technician HomeTown Pharmacy Cassidy Lunen. Ms. Lunen reported the pharmacy did not receive any orders to discontinue medications. Ms. Lunen reported on 1/6/22, an order was received for a comfort pack medication which was delivered to the facility.

On 2/11/22, I interviewed Emmanuel Hospice case manager Caitlin George by telephone. Ms. George reported she was Resident A's case manager. Ms. George reported on 1/8/22, Resident A was declining and was transitioning to end of life care. Ms. George reported orders were written to discontinue medications and only

use comfort care medications. Ms. George reported the prescriptions were sent to HomeTown Pharmacy for the comfort care medications and the order to discontinue medications were provided to the medication technician Brittany Fletcher. Ms. George reported the administrator had left for the day, so the order was provided to the medication technician. Ms. George reported she always ensures orders are provided to a caregiver that is responsible for the resident medications.

Ms. Fletcher reported she remembered Resident A's medications were discontinued. Ms. Fletcher reported she does not recall receiving medication orders from Emmanuel Hospice.

I reviewed the medication administration record (MAR) for Resident A for January 2022. The MAR revealed Resident A received all prescribed medications for the month of January 2022.

I reviewed hospice documentation. The documentation read,

> *1/8/22: Video call received from son Adrian. Update also given to him. He appears accepting of assessment that Patient is exhibiting increased signs of changes. towards end of life. Writer reviewed that patient's at times do continue to "rally" as he has done previously, however eventually the declines continue. Writer reviewed comfort kit medication and Adrian is accepting of them. Writer reviewed need to discontinue routine medications due to dysphagia and overall decreased level of consciousness. Adrian is also accepting of discontinuation of routines and utilizing only comfort medications. Adrian reports desire for Becky MSW to continue with previously discussed plan to hire private duty caregivers. Writer explained decreased appetite and need for nutritional intake at end of life. He confirms understanding but " still want them to try". Jade (NP) called and update given. New orders obtained to discontinue routine medications and order remaining comfort kit medications. Scripts sent to hometown pharmacy. Written orders for comfort kit and 2 hour turning given to Brittany. education provided regarding symptom management. 24/7 availability reinforced."*

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Review of documentation and interviews conducted revealed physician orders were not followed as Resident A's medications were to be discontinued and comfort care medications were to be administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B did not receive medications.

INVESTIGATION:

The complainant alleged Resident B did not receive scheduled Tylenol medication on 1/13/22.

Ms. Slater reported Relative A1 provides over the counter medication, like Tylenol, instead of ordering through the facility pharmacy. Ms. Slater reported Resident B has a supply of overstock medications located in a locked cabinet in the room. Ms. Slater reported on 1/13/22, the supply of Tylenol located in the medication cart ran out. Ms. Slater reported the medication technician told the shift supervisor and the shift supervisor found the medication in the locked cabinet. Ms. Slater reported Resident B did receive the medication and did not miss the medication. Ms. Slater reported the medication was administered late and the medication technician did not go back and chart that the medication was found and administered to Resident B. Ms. Slater reported the facility provided re-education with the medication technicians on locating extra supply of medications.

I reviewed Resident B's MAR. The MAR revealed Resident B was prescribed Acetaminophen Arthritis 650mg with instruction to administer one tablet by mouth at bedtime. The MAR revealed Resident B did not receive this medication on 1/13/22 with reasoning "do not have any in cart."

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Interviews with management revealed Resident B's prescription Acetaminophen could not be found but was located and administered to Resident B. However, review of the MAR revealed there were initials that the medication was not administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents do not receive personal hygiene.

INVESTIGATION:

The complainant alleged Resident A and Resident B do not receive showers.

Ms. Dean reported residents are to receive two showers a week. Ms. Dean reported when residents receive a shower, caregivers are to document that a shower was provided. Ms. Dean reported at times Resident B will refuse a shower and therefore only receive one shower a week. Ms. Dean reported Resident A receives bed baths due to being bed bound. Ms. Dean reported Resident A receives bed baths from Emmanuel Hospice and the facility. Ms. Dean reported the facility is working with Emmanuel Hospice and the private duty company on when Resident A is receiving a bed bath because at times Resident A has received multiple bed baths in one week.

Ms. Slater reported caregivers are to document on the electronic charting program (ECP) when a care task is completed. Ms. Slater reported at times caregivers will not document that a task was refused by a resident.

I reviewed the service plan for Resident A. The service plan read,

> *"Resident is a two assistance for transfers with hoyer and one assist for lower and upper body. Provide assistance with bathing/showering. If resident has private home care scheduled, please verify that task is complete. Weekly Monday, Thursday."*

I reviewed the Task Administration Record (TAR) for Resident A for December 2021 and January 2022. In December 2021, a shower was completed on 12/6, 12/13, 12/20, 12/23. In January 2022 a shower was completed on 1/3, 1/6,1/13, 1/17, 1/20, 1/24, and 1/31.

I reviewed the service plan for Resident B. The service plan read,

> *"Provide assistance of two staff with getting in and out of shower with washing and drying lower body. If resident has private home care scheduled, please verify that task is complete. Weekly Tuesday and Friday."*

The TAR for December 2021 for Resident B revealed bathing assistance was completed on 12/3,12/7,12/10, 12/14, 12/24, and 12/28. In January 2022 bathing assistance was completed on 1/4, 1/11, 1/14, 1/21, 1/25.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Review of the TAR revealed staff could not demonstrate that Resident B received a weekly bath in December 2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Laundry is not done.

INVESTIGATION:

The complainant alleged that Resident A and Resident B do not have clean bedding and laundry is not done. The complainant alleged that Resident B often has urine-soaked bedding.

Ms. Dean reported laundry for each resident is completed once a week or more if required. Ms. Dean reported the facility has a housekeeping department and laundry aid that is responsible for laundry tasks. Ms. Dean reported bedding is to be changed daily or more if required.

Ms. Fletcher reported Resident B will often wet the bed which results in soiled sheets. Ms. Fletcher reported caregivers are good at changing bedding and ensuring the Resident A and B have clean bedding.

Resident B reported the facility ensures Resident A and herself have clean laundry. Resident B reported no concerns with lack of clean bedding.

I observed a caregiver in Resident A and Resident B's room. The caregiver was changing bedding for Resident B. I observed there to be a laundry bin for dirty laundry that did have some items in the bin. I did not observe any foul smells that would indicate urine was present in Resident A and B's room.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(3) The home shall make adequate provision for the laundering of a resident's personal laundry.
ANALYSIS:	Observations made at the facility and interviews conducted revealed lack of evidence to support the allegation laundry is not completed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility is not clean.

INVESTIGATION:

The complainant alleged the facility is not clean, Resident A and Resident B's room is not clean, and bugs are found in the facility.

On 2/4/22, I interviewed housekeeper Brenda Waite at the facility. Ms. Waite reported every day housekeeping is responsible for tidying up residents' rooms, vacuuming, and cleaning the bathroom. Ms. Waite reported housekeeping staff do not move residents' personal belongings. Ms. Waite reported care staff are responsible for taking out trash. Ms. Waite reported the facility has had no issues with bugs. Ms. Waite reported the facility has Griffin Pest Control that comes monthly to provide routine maintenance to the facility.

On 2/4/22, I interviewed caregiver Bree Davis at the facility. Ms. Davis reported she has not observed Resident A and Resident B's room to be dirty. Ms. Davis reported the facility is kept clean.

Resident B reported caregivers keep the room very clean. Resident B reported she has never observed any bugs at the facility. Resident B reported she has no concerns with cleanliness of the facility.

I observed Resident A and Resident B room. The room was cluttered as observed by multiple boxes, clothing, and personal belongings. However, the room was not dirty as I observed for the trash to be emptied, no litter on the floor and the bathroom was clean.

I observed the facility. I did not observe any cleanliness issues. I did not detect any foul odors throughout the facility.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Observations made at the facility and interviews conducted revealed lack of evidence to support the allegation the facility is not clean.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 2/4/22, I interviewed administrator Susan Alveshere at the facility. Ms. Alveshere reported Relative A1 is the durable power of attorney (DPOA) for Resident A and Resident B. Ms. Alveshere reported the DPOA is not activated, and Resident A and Resident B are both able to make their own decisions.

I reviewed *Family Wellness Planning Conference Form* for Resident A and Resident B. The form revealed Resident A and Resident B were not present during the conference.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(2) The admission policy shall specify all of the following: **(c) That the individual seeking admission and his or her authorized representative, if any, shall participate in the development of the individual's service plan.**
ANALYSIS:	Review of Resident A and Resident B’s service plan revealed the residents did not participate in the development of their service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Alveshere reported Relative A1 has placed an Alexa device in Resident A and Resident B’s room. Ms. Alveshere reported the device is placed in the area that the

residents receive cares. Ms. Alveshere reported the residents and staff are aware there is a video device in the room. Ms. Alveshere reported the facility does have a policy on not allowing video cameras in residents rooms.

I reviewed the facility Health and Wellness Policies. The policy read,

> *"Cameras are not permitted inside a Vista Springs Community with respect to LARA-Community and Health Systems/Adult Foster Care/ Home for the Aged. Cameras will not be utilized resident areas including but not limited to hallways, dining rooms, spas, private rooms, community member's rooms, TV rooms, medication rooms, and offices."*

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 333.20201	**(2) (d) A patient or resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality.**
ANALYSIS:	Interviews conducted revealed Resident A and B have a video monitoring system placed in their room. The facility failed to protect Resident A and B by allowing this device in the room.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/4/22, I conducted an exit conference with authorized representative, administrator, and facility nurse by telephone. Ms. Slater reported the facility did have communication issues between the hospice companies and the facility. Ms. Slater reported she has worked with hospice companies on ensuring orders are provided to the management team. Ms. Slater reported when the medication orders were continued for Resident A, there were no adverse side effects, and the family was happy the medications were continued as Resident A's health had improved.

Ms. Slater reported she has provided education to medication technicians on documenting in the MAR and ensuring the MAR is complete. Ms. Slater reported Resident B would often refuse a shower and this was not documented that a shower was offered. Ms. Slater reported she has provided education with her staff on documenting on the TAR if a resident refuses a shower.

IV. RECOMMENDATION

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

2/11/22

Kimberly Horst — Date
Licensing Staff

Approved By:

03/03/2022

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