GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 14, 2022

Lucijana Tomic
Emerald Meadows
6117 Charlevoix Woods Ct.
Grand Rapids, MI 49546-8505

RE: License #: AH410343036
Investigation #: 2022A1010026
Emerald Meadows

Dear Ms. Tomic:

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 a date.

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) 356-0183.

Sincerely,

Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 260-7781

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410343036
Investigation #:	2022A1010026
Complaint Receipt Date:	02/15/2022
Investigation Initiation Date:	02/15/2022
Report Due Date:	04/17/2022
Licensee Name:	Providence Operations, LLC
Licensee Address:	18601 North Creek Drive Tinley Park, IL 60477
Licensee Telephone #:	(708) 342-8100
Administrator:	Katie Kirchner
Authorized Representative:	Lucijana Tomic
Name of Facility:	Emerald Meadows
Facility Address:	6117 Charlevoix Woods Ct. Grand Rapids, MI 49546-8505
Facility Telephone #:	(616) 954-2366
Original Issuance Date:	08/26/2013
License Status:	REGULAR
Effective Date:	03/07/2021
Expiration Date:	03/06/2022
Capacity:	60
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident E is missing supplies needed for his wound care treatment.	No
There are not enough staff at the facility to meet resident care needs.	Yes

III. METHODOLOGY

02/15/2022	Special Investigation Intake 2022A1010026
02/15/2022	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
02/15/2022	APS Referral APS referral emailed to Centralized Intake
02/23/2022	Inspection Completed On-site
02/23/2022	Contact - Document Received Received resident service plan and staff schedule
04/14/2022	Exit Conference Completed with Ms. Kitchner and licensee authorized representative Lucijana Tomic

ALLEGATION:

Resident E is missing supplies needed for his wound care treatment.

INVESTIGATION:

On 2/15/22, the Bureau received the allegations from the online complaint system. The complaint read, “There has been stuff missing from [Resident E’s] room and management will not come talk to him.”

On 2/15/2022, I emailed an Adult Protective Services (APS) complaint to Centralized Intake.

On 2/23/2022, I interviewed administrator Katie Kirchner at the facility. Ms. Kirchner reported Resident E has two bottles aerosol spray wound cleaner in his room. Ms. Kirchner stated one of the bottles had a broken spray nozzle, therefore it was removed from his room. Ms. Kirchner said staff have not removed any other items from Resident E's room. Ms. Kirchner reported Resident E has been overusing the wound care spray, therefore he is only allowed to have two bottles in his room at a time. Ms. Kirchner explained Resident E receives in home care services for wound treatment. Ms. Kirchner stated Resident E has a history of being verbally aggressive with staff.

Ms. Kirchner provided me with a copy of Resident E's service plan for my review. The *TOILETING* section of the plan read, "Needs assistance to change incontinency product. [Resident E] has wound care spray to be used after each change. Requires assistance with peri-care." The *BEHAVIORS* section read, "[Resident E] exhibits normal, functional behavior patterns with occasional verbally abusive behavior." The plan did not outline Resident E's home care service or wound care treatment received through an outside agency.

On 2/23/2022, I interviewed care staff person Princess Leon at the facility. Ms. Leon reported Resident E was supposed to have saline spray and bandages for his wound care in his room. Ms. Leon denied knowledge regarding where these items went. Ms. Leon stated Resident E's saline spray and bandages were replenished and staff are now labeling all these items in Resident E's room. Ms. Leon reported labeling Resident E's wound care supplies has alleviated the issue of Resident E missing items.

On 2/23/2022, I interviewed Resident E at the facility. Resident E reported the medical supplies for his wound care treatment were delivered to the facility, however they were placed in the staff med room. Resident E stated initially staff did not know the supplies belonged to him. Resident E said it was discovered the supplies belonged to him, so staff labeled the supplies and placed them in his dresser drawer. I observed Resident E's wound care supplies were in his drawer and labeled with his name. Resident E reported he never went without wound care treatment despite having his supplies misplaced.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**

ANALYSIS:	The interviews with staff and Resident E revealed he received wound care treatment through a home health agency. Resident E's wound care supplies that were delivered were temporarily misplaced until staff discovered they were for Resident E. The supplies were labeled and placed in Resident E's room after they were located. There is insufficient evidence to suggest Resident E's wound care treatment was disrupted when this occurred.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There are not enough staff at the facility to meet resident care needs.

INVESTIGATION:

On 2/15/22, the complaint read, "the management is not staffing the facility. There were 17 residents when [Resident E] moved, there are not 60. There was one aid [sic] for 40 people last night. There is no staff to help the residents. There are residents yelling for help in the middle of the night, some with breathing problems and staff was unable to check on them because they were the only one working."

On 2/23/22, Ms. Kirchner reported there is an adequate number of staff on each shift to ensure resident care needs are met consistent with their service plans. Ms. Kirchner stated the facility is staffed as follows:

1st shift

- Two medication technicians (med techs) in the general assisted living area
- One med tech in the secured memory care unit
- Two resident care staff person in the general assisted living area
- One resident care staff person in the secured memory care unit

2nd shift:

- Two medication technicians (med techs) in the general assisted living area
- One med tech in the secured memory care unit
- Two resident care staff person in the general assisted living area
- One resident care staff person in the secured memory care unit

3rd shift

- One med tech in the general assisted living area
- One med tech in the secured memory care unit

- One care staff person in the general assisted living area

Ms. Kirchner stated there are 37 residents in the general assisted living area and 14 residents in the secured memory care unit. There are two residents in the general assisted living area who require transfer assistance from two staff persons and no residents in the secured memory care unit who require the assistance from two staff persons to transfer.

On 2/23/22, Ms. Leon's statements regarding the number of staff on each shift were consistent with Ms. Kirchner. Ms. Leon stated shift vacancies primarily occurred on the weekend. Ms. Leon reported staff volunteers were used to fill shift vacancies. Ms. Leon said resident care needs were met consistent with resident service plans. Ms. Leon reported things such as water passes, and trash being taken out sometimes occurred late if there are any shift vacancies. Ms. Leon stated staff use two-way radios to communicate during shifts.

On 2/23/22, I interviewed med tech Ariana Cole at the facility. Ms. Cole's statements were consistent with Ms. Leon.

On 2/23/22, I interviewed Resident A at the facility. Resident A said all her care needs were met by staff. Resident A denied concerns regarding staffing at the facility. Resident A reported staff responded promptly when she used her pendant to summon them for assistance.

On 2/23/22, I interviewed Resident B at the facility. Resident B's statements regarding staffing at the facility were consistent with Resident A.

On 2/23/22, Resident E reported that approximately one week ago there was one staff person working on his hallway. Resident E stated he heard a resident calling out for help for approximately one hour during third shift. Resident E said he pushed his pendant to request a brief change and have staff check on the resident, however it took staff over a half hour to respond. Resident E reported there are often long pendant response times during third shift. Resident E stated there have been several incidents during third shift when residents on his hall fall and the staff response time is well over a half an hour. Resident E was unable to provide the residents names.

On 2/23/22, I interviewed Resident F at the facility. Resident F reported all his care needs were met by staff. Resident F stated he used his pendant once and staff responded quickly. Resident F said some days there appears to be more staff than others, however his needs are still met.

On 3/21/22, I reviewed the staff schedule from 2/13/22 through 2/19/22. The staff schedule read there was one med tech in the general assisted living area and One med tech in the secured memory care unit from 11:00 pm until 7:00 am on 2/14/22. There were no other staff scheduled. The staff schedule was consistent with

Resident E's statements. The schedule also read there was one med tech in the general assisted living area and one med tech in the secured memory care unit on 2/18/22 from 11:00 pm until 7:00 am. There were shift vacancies in the general assisted living area from 7:00 am until 3:00 pm on 2/14/22, 2/15/22, and 2/19/22.

On 3/21/22, Ms. Kirchner confirmed there was one staff person in the secure memory care unit and one person in the general assisted living area on 2/19.

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:	The interview with Resident E, along with review of the staff schedule, revealed there were shift vacancies leaving residents who required transfer assistance from two staff persons with only one staff person available in the general assisted living area.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Lucijana Tomic and Ms. Kitchner by telephone on 4/14/22.

IV. RECOMMENDATION

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

Lauren Wohlfert 03/21/2022

Lauren Wohlfert Date
Licensing Staff

Approved By:

Andrea L. Moore 04/12/2022

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