GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 28, 2022

Louis Andriotti, Jr.
IP Vista Springs Timber Ridge Opco, LLC
Ste 110
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #: AL190383349
Investigation #: 2022A0577029
Vista Springs Gardenside at Timber Ridge

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 facility will remain on the provisional license status at this time. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (231) 922-5309.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL190383349
Investigation #:	2022A0577029
Complaint Receipt Date:	03/22/2022
Investigation Initiation Date:	03/22/2022
Report Due Date:	05/21/2022
Licensee Name:	IP Vista Springs Timber Ridge Opco, LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(303) 929-0896
Administrator/Licensee Designee:	Louis Andriotti
Name of Facility:	Vista Springs Gardenside at Timber Ridge
Facility Address:	16260 Park Lake Road East Lansing, MI 48823
Facility Telephone #:	(517) 339-2322
Original Issuance Date:	11/14/2016
License **Status:**	1ST PROVISIONAL
Effective Date:	12/21/2021
Expiration Date:	06/20/2022
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident D was neglected by the facility direct care staff members and fell injuring her face. Resident D then was left in bed for long periods of time.	No
Residents are not being administered their medication as prescribed.	Yes
Resident D was served food that had been left in Resident D's room for many days.	No
Additional Findings	Yes

III. METHODOLOGY

03/22/2022	Special Investigation Intake 2022A0577029
03/22/2022	Special Investigation Initiated – Telephone call to Tom Hilla, APS Clinton Co.
03/22/2022	APS Referral
03/22/2022	Contact - Telephone call made to Relative A1
03/22/2022	Contact - Telephone call made- Staff Interviewed.
03/22/2022	Contact - Document Received- IR's Received.
03/24/2022	Contact - Telephone call received- Relative D1.
03/25/2022	Contact - Telephone call made- Interview with Kathryn Haviland, Careline Hospice, RN.
03/25/2022	Inspection Completed On-site- Interviews, medication review and documents received.
03/30/2022	Contact - Document Sent to Sarah Teller, Clinical Manager with Careline Hospice.
03/31/2022	Contact - Document Received from Sarah Teller, Clinical Manager with Careline Hospice.

04/04/2022	Contact - Telephone call made to Ajasia Ball, direct care staff member.
04/05/2022	Contact-Telephone call made to Kassandra Jarrell, direct care staff member.
04/05/2022	Inspection Completed-BCAL Sub. Non-Compliance
04/05/2022	Exit Conference with Lou Andriotti licensee designee Lou Andriotti.
04/26/2022	Exit Conference with licensee designee Lou Andriotti and team.

ALLEGATION: Resident D was neglected by the facility direct care staff members and fell injuring her face. Resident D then was left in bed for long periods of time.

INVESTIGATION:

On March 22, 2022, a complaint was received reporting Resident D is a 94-year-old resident living at the facility who is being neglected. The complaint stated Resident D is being left in her bed for long periods of time after a fall occurred on March 16, 2022, causing injuries to Resident D's face.

On March 22, 2022, I interviewed Relative D1 who reported she was notified by Resident D's hospice nurse of Resident D falling on March 16, 2022 but it was hours after the fall occurred. Relative D1 reported when she arrived at the facility during the afternoon hours on March 16, 2022, Resident D was not able to communicate, was speaking "non-sense", only could ask for water, did not understand or know what was going on around her, and could only grimace. Relative D1 reported she advised direct care staff members she did not want Resident D moved from her bed due to the condition Resident D was in. Relative D1 reported she arrived at the facility on Sunday, March 20, 2022 to find Resident D sitting in a wheelchair, slumped over. Relative D1 provided photos of Resident D's face taken on March 16, 2022, the day of the fall, and photos of Resident D's face taken on March 18, 2022. The photos documented the left side of Resident D's face from her nose to her forehead and showed what appeared to be red scrapes or rug burns, bruising, a bump above her left eye, black and blue colored swollen shut left eye, and a rug burn on forehead about two inches long and an inch wide.

On March 22, 2022, Tom Hilla Clinton County DHHS Adult Protective Services (APS) Specialist (APS) provided me with a copy of staff progress notes from March 16, 2022 documenting the following information:

- 3/16/22 7:00am by Yenexis Zamora, Medication Treatment Professional- "[Resident D] would benefit from bed railing. Was moving a lot through the night and was getting very close to the edge of the bed, very lucky she did not fall out of bed."
- 03/16/22 7:30am by Yenexis Zamora, Medication Treatment Professional- "During shift swap, we heard a thud and ran to [Resident D's] room based off behavior during the night found her on the floor prone position. Assessment done, minor scrapes and bruises found. Hospice and Dia Malhotra, DCS. notified. Hospice came to evaluate."
- 03/16/22 6:45pm by Cassandra Jarrell, Medication Treatment Professional-"This morning at 7:30am, [Resident D] was found on the floor next to her bed. The 3rd shift med tech Yenexis and I were starting count and going over the previous night when we heard a bang, Yenexis ran to [Resident D's] room and when we entered, she was found in prone position on the floor directly beside her bed. I assessed her from where she laid, did not see any marks on her from the position she was in. When we got her into supine position, she had a hematoma above her left eye and face abrasions on the whole left side. Her left knee also had a mark. I contacted hospice and got the on-call nurse. Her hospice nurse arrived around 10am. She assessed her and her niece also came out. She now has a crush order for meds. Comfort meds are in place, they are DC'ing her regular meds. Morphine needs to be given every 4 hours for comfort and Ativan as needed as well."

On March 22, 2022, I interviewed direct care staff member (DCS) Yenexis Zamora who reported she worked on March 15, 2022 from 7:00pm-7:00am. Ms. Zamora reported it was between 7:00am and 7:30am on March 16, 2022, at shift change, when herself, and DCS Cassandra Jarrell were doing medication count when they heard a loud noise. Ms. Zamora reported herself and Ms. Jarrell found Resident D on the floor next to her bed face down. Ms. Zamora reported they put Resident D back into bed, observed her for injuries and Ms. Jarrell called hospice to report the fall and requested Resident D be evaluated by hospice.

On March 25, 2022, I interviewed Registered Nurse (RN) Kathryn Haviland who works with Careline Health Group and provides hospice care to Resident D. Ms. Haviland reported on March 16, 2022, Careline Health Group triage received a call around 8:05 am reporting Resident D fell around 7:15am. Ms. Haviland reported she arrived at the facility at 10:07am, completed an assessment on Resident D and found Resident D to have a left eye abrasion, rug burn on left cheek, speech nonsensical, and left pupil non-reactive. Ms. Haviland reported she contacted Relative D1 and it was decided to discontinue all of Resident D's regularly prescribed medications and proceed with hospice comfort care medications due to the decline of Resident D's health and current condition. Ms. Haviland reported from March 17, 2022, until Resident D passed away on March 24, 2022, Resident D was seen by hospice nursing services daily. Ms. Haviland reported on March 17, 2022, she documented in her notes that Resident D had a "measurable decline, was fully incontinent, was asking for mother, and requested

[Resident D] be repositioned every two hours as tolerated." Ms. Haviland reported this direction to reposition Resident D every two hours as tolerated was told to DCS Cassandra Kebler.

On March 25, 2022, during my onsite investigation I requested and received a copy of Resident D's *Functional Evaluation Quarterly Assessment* completed on March 02, 2021 by Stacey Keast with Vista Springs-Timber Ridge documenting the following:

- Physical Functioning/Ambulation: [Resident D] needs limited assistance - [Resident D] is highly involved in activity, staff provide non-weight bearing touch assistance, may require frequent reminders and/or guided maneuvering with ambulation, staff may perform setup help with walker, cane or positioning furniture.
- Fall Prevention: Extensive assistance-may have history of falls, requires frequent non-weight bearing touch assistance with routine ambulation, stabilization and/or transfers.
- Ambulation: Ambulatory with assistive device.

This was the most recent copy of the *Functional Evaluation Quarterly Assessment* for Resident D located in Resident D's resident record.

I also requested and received a copy of Resident D's *Assessment Plan for AFC Residents* from Susan ODell-Shilton, Administrator who provided me with a copy of an *Assessment Plan for AFC Residents* for Resident D that was not signed or dated. Ms. ODell-Shilton reported the *Assessment Plan for AFC Residents* was completed after Resident D's fall on March 16, 2022. This *Assessment Plan for AFC Residents* provided the following information:

- "Moves Independently in Community: Resident is currently bed bound per family request.
- Participates in Social Activities: Is bed bound
- Toileting, Bathing, Grooming, Dressing, Person Hygiene, Walking/Mobility; Resident is a 1-person assist.
- Physical Limitations: bed bound per family."

On April 05, 2022, I interviewed DCS Cassandra Jarrell who reported she worked March 16, 2022 from 7:00am-7:00pm and during shift change was counting medications with DCS Yenexis Zamora when they heard a noise down the hallway. Ms. Jarrell reported Ms. Zamora stated, "that is [Resident D] and they went to [Resident D's] bedroom found [Resident D] on the floor laying in a prone position with the left side of her face on the floor." Ms. Jarrell reported she noticed Resident D's bed being higher than normal and asked Ms. Zamora why the bed was so high to which Ms. Zamora reported Resident D had been playing with her bed controls all night and she must have raised it. Ms. Jarrell reported they assisted Resident D with rolling over and saw that Resident D had rug burns on the left side of her face and a hematoma over her left eye. Ms. Jarrell reported they were able to assist Resident D back into bed and she contacted Careline Hospice around 8:00am to report the fall and requested Resident D

be evaluated due to injuries Resident D sustained to her face during the fall. Ms. Kebler reported a nurse from Careline Hospice arrived at the facility around 10:00am and completed an assessment on Resident D. Ms. Jarrell reported Resident D was started on comfort care measures after her fall. Ms. Jarrell reported Resident D did not require any hands-on assistance when transferring or walking, prior to her fall on March 16, 2022. Ms. Jarrell reported Resident D was "pretty independent", prior to fall.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered during the investigation it has been found Resident D was provided supervision, protection, and personal care as defined in the act and as specified in Resident D's written assessment plan. Prior to March 16, 2022, Resident D was active and fully ambulatory with the assistance of a walker and needed minimal hands-on care from direct care staff. After Resident D's fall on March 16, 2022, Resident D declined in health and required additional hands-on care from staff. In conjunction with Resident D's hospice provider, Resident D's was prescribed comfort care medications and direct care staff were directed to reposition Resident D every two hours only as Resident D could tolerate this. These hospice physician orders were in line with the request from Resident D's family. There is no evidence direct care staff members were leaving Resident D in bed for extended periods of time without a physician's order.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Residents are not being administered their medication as prescribed.

INVESTIGATION:

On March 22, 2022, a complaint was filed alleging falsification of multiple resident medication administration records. Specifically, the complaint alleged that Resident D's hospice agency was not notified after she refused her morphine medication. Another complaint was filed on March 20, 2022, alleging direct care staff members had documented Resident D refused all her prescribed medications however Resident D was never actually given her medications by direct care staff members. Complainant

reported Resident D was only given one dose of medication on March 20, 2022, in the morning.

During my onsite investigation I requested and received copies of Resident D's medication administration record (MAR) for March 2022. Per my review of Resident D's March 2022 MAR I found the following:

- Resident D was not administered her Levothyroxine 50 mcg tablet, 1 time a day on March 11 and 12, 2022. Per the MAR,
- Resident D was prescribed Morphine 100mg/5mL, every four hours and on March 21, 2022 at 12:00am and 4:00am the MAR is documented as refused (IR received for this incident).

During my onsite investigation I also completed a medication audit for the month of March 2022 for the current six residents in care documenting the following discrepancies:

- Resident K and Resident L did not have any medication discrepancies.
- Resident G
    - On March 11, 2022 Resident G did not receive the following medication at 7:00pm and 8:00am-Prescribed Naproxen 220mg, take one tablet by mouth three times a day and Donepezil 10mg, take one tablet by mouth daily.
- Resident I
    - On March 11 and 12, 2022 Resident I did not receive Levothyroxine 50mcg, take one tablet my mouth daily at 6AM.
    - On March 13, 2022 Resident I was not administered the 1:00pm dosage of Acetaminophen, 325mg, take 2 tablets by mouth three times daily.
    - On March 21, 2022 Resident I's medications were marked as refused: 4:00am Hydrocodone-Acetaminophen 5-325mg take 1 tablet every 6 hours; 6:00am-Levothyroxine 50mcg, take one tablet my mouth daily. (IR received for this incident)
- Resident J
    - On March 8 and 9, 2022 Resident J did not receive cod liver supplements due to the prescription not being refilled in a timely manner.
    - On March 11, 12, and 16, 2022 Resident J did not receive Levothyroxine, 50mcg tablet one time a day at 6:00am.
    - March 15-20, 2022 Resident J did not receive Melatonin 3mg due to the medication not being refilled in a timely manner. (IR received for this incident)
- Resident K
    - On March 5-7, 2022 Resident K did not receive Aspirin 81mg due to the prescription not being refilled in a timely manner. (IR received for this incident)

On March 22, 2022 I received the following *AFC Licensing Division-Incident/Accident Report*s documenting medication errors:

- On 03/21/2022 at 8:00am involved were [Resident D] and DCS Yenexis Zamora. Facility was notified by Hospice Nurse of [Resident D] not receiving Morphine at-12:00am and 4:00am. Staff stated resident was sleeping and did not administer medication. Upon investigation, Quality Assurance Nurse noticed that resident missed a dose of Morphine on 3/17/22 due to the inability to open narcotics drawer, staff requested assistance on unlocking the drawer, medication was unable to be administered due to being too close to next dose. Completed by Jennifer Slater, LPN.
- On 03/21/2022 at 5:00pm involved were [Resident J] and DCS Dia Melhotra regarding staff noticed [Resident J] was out of Melatonin on 02/28/2022, staff notified family medication needed to be refilled or replaced, staff continued to notify family and on 03/07/2022 family agreed the facility could order Melatonin from pharmacy. Staff noticed on 03/08/22 [Resident J] was out of Cod Liver Oil Supplement; medication was order from pharmacy and delivered on 03/09/22. Completed by Jennifer Slater, LPN.
- On 03/21/2022 at 8:00am involved were [Resident I] and DCS Yenexis Zamora regarding staff noted that [Resident I] did not receive scheduled dose of Norco 5/325mg and Levothyroxine during night shift. Health and Wellness Coordinator was notified by staff of missed medication. Completed by Jennifer Slater, LPN.
- On 03/21/2022 at 4:00pm [Resident K] and Dia Melhotra, DCS regarding staff noted that [Resident K] was out of Aspirin 81mg on 03/05/22, called family to obtain medication, family delivered medication on 3/7/22. Completed by Jennifer Slater, LPN.

On March 22, 2022, I spoke with Tom Hilla, Adult Protective Service Specialist with Clinton County Department of Health and Human Services. Mr. Hilla reported he completed an onsite investigation and made face to face contact with Resident D but was not able to interview Resident D as she was actively passing away. Mr. Hilla reported he received copies of incident reports, prescriptions, Medication Pass History report for Resident D from March 17, 2022 – March 22, 2022, Prescription and Progress Note from Careline Hospice, and staff progress notes from March 16, 2022.

Mr. Hilla also provided a copy of prescription order from Jennifer Clark, Nurse Practitioner with Careline Hospice and Med Pass History for Resident D documenting the following information:

- Order Number 34162, Jennifer Clark, NP with Careline Hospice-Order date 3/16/2022 10:27am.
    - Order Description: Problem: Patient with recent fall. Patient with extensive facial bruising, eye swelling, and unreactive pupil. Patient with difficulty taking scheduled pain medication this am. Intervention: V.O. per Jennifer

Clark, NP D/C scheduled Norco. Schedule Morphine Concentrate 0.25ml PO Q 4 Hours. Keep PRN Order. Pathways will be started. Facility to apply ice 3 times a day as tolerated for 20 minutes. Staff may crush medications. Per DPOA request all non-comfort medications be D/C. Goal: Patient's pain will be controlled.

- Current Ordered Medications: 03/16/2022
  - DC-Baclofen 10mg tablet, 0.5 tablet, 3 times daily
  - DC-Cymbalta 30mg, delayed release, 1 capsule, daily
  - DC-Hydrocodone 5mg-acetaminophen 325mg, 1 tablet, every 6 hours
  - DC-Ibuprofen 400mg, 1 tablet, 4 times daily/PRN
  - DC-Levothyroxine 50mcg, 1 tablet, daily
  - DC-Losartan 25mg, 1 tablet, daily
  - DC-Polyethylene Glycol 3350 17gram/dose oral, per instructions, daily
  - ADD-Morphine Concentrate 100mg/5ml, .025mL, every 4 hours, oral

- Med Pass History for Resident D from 3/17/2022-03/22/2022
  - 3/17/2022 Morphine 10mg/5mL passed at 12:00am, 10:49am, 4:00am, 9:11am (refused-other, can't get into narc draw, waiting on pharmacy to come unlock-CaJ), 11:57am, 4:06pm and 8:01pm
  - 03/18/2022 Morphine 10 mg/5mL passed at 12:00am, 4:11am, 7:38am, 12:18pm, 5:28pm, 10:10pm
  - 03/19/2022 Morphine 10mg/5mL passed at 1:53am, 4:53am, 8:08am, 12:04pm, 4:03pm, 8:16pm
  - 03/20/2022 Morphine 10mg/5mL passed at 12:27am, 4:27am, 8:17am, 12:21pm, 4:09pm, 8:31pm
  - 03/21/2022 Morphine 10mg/5mL passed at no note for med passed at 12:00am and 4:00am, 7:11am (note entered twice for same time documenting Refused-Refused by Resident, YeZa), 7:53am, 12:16pm, 4:39pm, 7:42pm
  - 03/22/2022 Morphine 10mg/5mL passed at 6:31am, 11:36pm, 3:59am, 5:03am, 7:39am, 8:09am, 12:01pm

On March 22, 2022 I interviewed Relative D1 who reported she spoke with administrator Susan O'Dell-Shilton by telephone on March 21, 2022 and was told a staff has been suspended for not providing Resident D their morphine as prescribed. Relative D1 reported she was told by staff the keys to the medication cart were locked in the narcotic safe and the staff member could not get into the medication cart so the medications were not administered on March 17, 2022. Relative D1 reported they were also told Resident D refused her medication on March 21, 2022 and Relative D1 stated, "[Resident D] was not able to verbally communicate with anyone after her fall on March 16, 2022, the only things they could understand was when she was in pain due to her

groaning and facility expressions." Relative D1 did not think it was possible for Resident D to verbally refuse medicine as she was no longer capable of speaking or understanding.

On March 22, 2022, I interviewed DCS Yenexis Zamora, DCS who reported she worked on March 20, 2022, from 7:00pm-7:00am and it was reported to her all Resident D's medications in pill form had been discontinued so Resident D was only on liquid medication moving forward. Ms. Zamora reported no medications showed on Resident D's Medication Administration Record (MAR) to be administered at midnight for Resident A on March 21, 2022. Ms. Zamora reported she went through the MAR around 6:00am on March 21, 2022 to administer early morning medications to residents and it popped up that Resident D was supposed to be administered morphine at 4:00am. Ms. Zamora reported she told DCS Cassandra Kebler at shift change she did not notice the 4:00am medication for Resident D. Ms. Zamora reported she received a call from administrator Susan O'Dell-Shilton requesting Ms. Zamora complete an IR regarding Resident D's missed medications. Ms. Zamora reported she did not report to anyone Resident A was sleeping at 12:00am and 4:00am and this was the reason the morphine medication was not administered. Ms. Zamora reported she marked the medications as refused that were not passed due to her not being aware of the medication change. Ms. Zamora reported she did not work on March 17, 2022, so she was not aware of the medication cart keys being locked in the cart.

On March 25, 2022, I interviewed RN Kathryn Haviland with Careline Health Group. Ms. Haviland reported Resident D has been on hospice since 9/22/21 and received nursing, social work, and home help/bath aide. Ms. Haviland reported on the morning of March 21, 2022 as she was entering the facility, she was stopped by a staff asking questions regarding Resident D's Morphine whether it was a PRN or a scheduled medication. Ms. Haviland reported she went into the facility, spoke with DCS Erika Dumont, and explained that Resident D's Morphine is a regularly scheduled medication, not a PRN, and needs to be administered as prescribed. Ms. Haviland reported Ms. Dumont reported Resident D did not receive her Morphine throughout the night as prescribed but was documented as refused.

On March 25, 2022, during my onsite investigation I interviewed DCS Cassandra Kebler who reported she worked from 7:00am-7:00pm on March 21, 2022. Ms. Kebler stated that during shift change DCS Yenexis Zamora reported to Ms. Kebler that she did not realize Resident A's morphine prescription had been changed to every four hours so Ms. Zamora did not administer Resident A's Morphine medication at 12:00am and 4:00am. Ms. Kebler reported Ms. Zamora went into the MAR and put refused as the reason Resident D's morphine was not administered for 12:00am and 4:00am. Ms. Kebler reported Ms. Zamora put refused for all of the residents medications she did not administer on March 20 and 21, 2022.

Special Investigation #2021A0466049, dated November 16, 2021, cited violation of Rule 400.15312 (2) after a resident did not receive multiple doses of Warfarin medication as prescribed due to the medication not being filled timely. The approved Corrective

Action Plan (CAP) submitted by licensee designee Lou Andriotti stated all medication technician will be trained on the proper medication administration techniques including how to order medications timely and a health and wellness officer will do "daily medication audits to verify medication and supplements are being properly distributed per doctor's orders." This CAP was signed and dated by Lou Andriotti on February 7, 2022.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered during the investigation there was significant evidence found to support the allegations of residents not being administered their medications as prescribed. On March 22, 2022, the department received four *AFC Licensing Division-Incident/Accident Report* (IR) documenting Resident D, Resident I, Resident J, and Resident K did not receive their medications due to direct care staff members not passing them or the facility not having the medications to pass. I completed a medication audit of each resident's medication administration record on March 25, 2022 and verified the errors documented in the submitted *AFC Licensing Division-Incident/Accident Reports* along with multiple other times residents did not received medication as prescribed.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR#2021A0466049 AND CAP DATED February 07, 2022]**

ALLEGATION: Resident D was served food that had been left in Resident D's room for many days.

INVESTIGATION:

On March 22, 2022, the complaint alleged Resident D was fed food that was left in Resident D's room from March 18, 2022 through March 21, 2022.

On March 22, 2022, Relative D1 reported a pudding like substance was brought to Resident D's room on March 18, 2022 and was left in Resident D's bedroom through the weekend. Relative D1 reported she left the food there to see how long staff would let it remain in Resident D's bedroom. Relative A1 reported when she was at the facility on March 21, 2022, the bowl of pudding was still in Resident D's bedroom.

On March 25, 2022, I interviewed Resident D's hospice nurse RN Kathryn Haviland who reported on March 18, 2022, she documented in her chart that during her time with Resident A that Resident A did eat some oatmeal. Ms. Haviland reported she was at the facility again on March 21, 2022, and per her notes her visit began around 9:12am and no food was observed in Resident D's bedroom. Ms. Haviland reviewed her coworkers notes from March 19, 2022 and March 20, 2022, and nothing was documented about Resident D eating or food being seen in Resident D's bedroom.

On March 25, 2022, during my onsite investigation I requested a copy of Resident D's progress notes from March 16, 2022-March 25, 2022 and on March 18, 2022 DCS Erika Dumont documented that at 10:45am Resident D "ate a half bowl of oatmeal, drank a lot of fluids and states she is comfortable." On March 19, 2022, the progress notes documented that at 2:30pm DCS Yuliya Savchyk went into Resident D's room during lunch to assist with feeding, [Resident D] ate a little bowl of mashed potatoes and drank plenty of water. There was nothing documented about food being left in Resident D's bedroom.

During my onsite investigation I interviewed DCS Yuliya Savchuk who reported she worked from March 19-21, 2022 from 7:00am-3:00pm and reported throughout her shifts she encourage Resident D to eat. Ms. Savchuk reported she does not remember seeing food being left in Resident D's bedroom. Ms. Savchuk denied the allegations of food being left at Resident D's bedside for days.

On March 25, 2022 I interviewed DCS Cassandra Kebler who reported she worked on March 19 and 20, 2022 and did not notice food sitting in Resident D's bedroom during her shift. Ms. Kebler reported Relative D1 was visiting Resident D on March 19, 2022 and during this visit, Ms. Kebler reported she brought pureed cheesecake into Resident D's bedroom and encouraged Relative D1 to feed Resident D if she awakes and is hungry. Ms. Kebler reported the cheesecake was never opened and so was disposed of later. Ms. Kebler denied the allegations of food being left at Resident D's bedside.

APPLICABLE RULE	
R 400.15402	**Food service.**
	(3) All perishable food shall be stored at temperatures that will protect against spoilage. All potentially hazardous food shall be kept at safe temperatures. This means that all cold foods are to be kept cold, 40 degrees Fahrenheit or below, and that all hot foods are to be kept hot, 140 degrees Fahrenheit or above, except during periods that are necessary for preparation and service. Refrigerators and freezers shall be equipped with approved thermometers.

ANALYSIS:	Based on the information gathered during the investigation it has been found food was brought to Resident D's bedside to assist Resident D with eating, but there was insufficient evidence found to support the allegation of food being left at Resident D's bedside for days.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On March 25, 2022, during my onsite investigation I requested and received a copy of Resident D's *Assessment Plan for AFC Residents* which was completed but was not signed by the resident or resident's designated representative. There was no supporting documentation found verifying that the *Assessment Plan for AFC Residents* was completed with Resident D or Resident D's designated representative. Administrator Susan ODell-Shilton reported she was unable to find Resident D's previous assessment plans and had recently completed the current assessment plan but has not had Resident D's designated representative sign the current plan.

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 or 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 on file in the home.
ANALYSIS:	Resident D's *Assessment Plan for AFC Residents* had recently been completed by administrator Susan O'Dell-Shilton. There was no documentation in Resident D's resident record verifying that either Resident D or Resident D's designated representative had participated in the completion of this assessment plan. There was no other plan to review in Resident D's resident record. It has been found Resident D did not have an Assessment *Plan for AFC Residents* completed annually.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On March 25, 2022, during my onsite investigation I requested and received a copy of Resident D's *AFC-Resident Care Agreement.* Upon my request I received two copies of an *AFC-Resident Care Agreement* for Resident D, one being completed on June 23, 2020, while the second care agreement was completed but did not have any signatures from Resident D or Resident D's designated representative to verify the care agreement was reviewed by Resident D or Resident D's designated representative.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.
ANALYSIS:	Based on the information provided on March 25, 2022, Resident D's *AFC-Resident Care Agreement* was last completed on June 23, 2020 and an updated agreement was provided with no required signatures or dates of completion to provide verification of the agreement being reviewed by Resident D or Resident D's designated representative. It has been found Resident D's Based on the information provided on March 25, 2022, Resident D's *AFC-Resident Care Agreement* was not reviewed annually.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/26/2022, a second exit conference was held with licensee designee Lou Andriotti, AFC Area Manager Dawn Timm, AFC licensing consultant Bridget Vermeesch and multiple administrative staff members involved with the licensee. During the meeting, Mr. Andriotti outlined a number of changes he has installed in the facility since the issuance of the provisional license including the involvement of Margaret Chamberlain, HealthCap, and a change in administrator. All of these services are striving to provide daily review of medication administration, care services to residents and overall quality of services to assure compliance with licensing rules. The licensee has also placed a voluntary ban on admission to the facility and will confer with the licensing consultant prior to admitting a new resident. The current census of the building is six residents for this 20 capacity building.

IV. RECOMMENDATION

On December 21, 2021, a provisional license was issued after substantial quality of care violations were found during Special Investigation 2022A0577047. Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains unchanged.

Bridget Vermeesch 04/28/2022

Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 4/28/2022

Dawn N. Timm Date
Area Manager