GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 28, 2022

Kimberlee Waddell
NRMI LLC
160
17187 N. Laurel Park Dr.
Livonia, MI 48152

RE: License #: AL630412118
Investigation #: 2022A0602035
North Ridge

Dear Ms. Waddell:

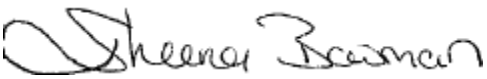
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (248) 975-5053.

Sincerely,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630412118
Investigation #:	2022A0602035
Complaint Receipt Date:	06/09/2022
Investigation Initiation Date:	06/10/2022
Report Due Date:	08/08/2022
Licensee Name:	NRMI LLC
Licensee Address:	160 - 17187 N. Laurel Park Dr. Livonia, MI 48152
Licensee Telephone #:	(734) 646-4603
Administrator:	Kimberlee Waddell
Licensee Designee:	Kimberlee Waddell
Name of Facility:	North Ridge
Facility Address:	25911 Middlebelt Farmington Hills, MI 48336
Facility Telephone #:	(248) 516-1370
Original Issuance Date:	06/01/2022
License Status:	TEMPORARY
Effective Date:	06/01/2022
Expiration Date:	11/30/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The residents are not being changed as often as they should be.	Yes
Staff are blocking out resident's names in the computer system, which prevents the resident from showing up as present at the AFC group home. Nurses aren't checking, so medications aren't being dispensed as they should be. The staff is boosting oxygen levels as opposed to taking the residents out for help and proper dosing.	Yes
Lack of staffing has led to a tremendous amount of resident neglect.	No

III. METHODOLOGY

06/09/2022	Special Investigation Intake 2022A0602035
06/10/2022	Special Investigation Initiated - Telephone Message left for the complainant.
07/13/2022	Special investigation reassigned to Sheena Bowman.
09/07/2022	Contact - Document Received This SIR #2022A0602035 was transferred to licensing consultant, Sheena Bowman on 09/07/22 from licensing consultant Cindy Berry.
09/22/2022	Inspection Completed On-site I completed an unannounced onsite. I interviewed the Residential Program Manager, Salina Brown and Resident C. I received copies of staff assignment sheet/15 minutes check, and a copy of the staff schedule.
09/23/2022	Contact - Document Received I received a copy of all the residents MAR's for the month of September 2022.
10/17/2022	Contact - Telephone call made I made a telephone call to the respiratory therapist, Andrea Hobson. The allegations were discussed.

10/19/2022	Contact - Telephone call made I made a telephone call to Person 1. The allegations were discussed.
10/19/2022	Contact - Telephone call made I made a telephone call to Person 2. The allegations were discussed.
10/19/2022	Contact - Face to Face I completed an unannounced onsite. I observed Resident S, I interviewed Resident J, I interviewed Resident E, I interviewed Person 3, I interviewed Person 4, and I interviewed Resident W. I received copies of Resident J and Resident S shower sheets as well as the shower schedule for all of the residents.
10/24/2022	Contact - Document Received I received a copy of Resident S and Resident J assessment plans.
10/25/2022	Exit Conference I attempted to complete an exit conference with the licensee designee Kim Waddell via telephone however; there was no response. Therefore, I completed an exit conference with Ms. Waddell via email.

ALLEGATION:

The residents are not being changed as often as they should be.

INVESTIGATION:

The abovementioned allegations were assigned to licensing consultant, Cindy Berry on 06/09/22 however; by 07/13/22, the special investigation was not complete nor was an onsite completed. At this time, the investigation was re-assigned to licensing consultant, Sheena Bowman via email however; the actual special investigation was not assigned to Ms. Bowman's caseload until 09/07/22. The specific allegations are: the residents are not being changed as often as they should be. The residents are being blocked out in the computer system which is indicative of them not being in the facility when the residents are there. Nurses are not checking for them, so their medications aren't being dispensed as they should be. The staff is boosting oxygen levels as opposed to taking the residents out for help and proper dosing. Lack of staffing has led to a tremendous amount of resident neglect.

On 09/22/22, I completed an unannounced onsite. I interviewed the Residential Program Manager, Salina Brown and Resident C. I received copies of staff assignment sheet/15 minutes check, and a copy of the staff schedule.

On 09/22/22, I interviewed the Residential Program Manager, Salina Brown. Regarding the allegations, Ms. Brown stated she is not aware of the allegations. Ms. Brown stated staff are required to complete a staff assignment sheet and 15 minutes check for each resident during each shift. I received an example of this form. One side of the form has the residents name, date, and which tasks need to be completed for the individual resident. The other side of the form has a 15-minute timetable starting at 12:15 am and ending at 11:45 pm. This side of the form includes a section for staff to document their observation for each resident. The staff must initial and sign below this form acknowledging they understand their assigned responsibilities in regard to general tasks, general supervison, and specific supervison for the resident.

Ms. Brown stated none of the residents have any skin breakdowns which are caused from not having their briefs changed on a regular basis. Ms. Brown explained that team leaders and staff ensure the staff assignment/15-minute check form is completed at the end of every shift as part of their shift change duties. During every shift change, the staff currently working and the staff starting their shift walk around to every resident's bedroom to check on each resident to ensure all of their needs have been met including changing their briefs. Ms. Brown stated in the event a staff assignment/15-minute check form is not completed at the end of a shift, the staff responsible would be instructed to complete the form before their shift ends. Ms. Brown stated she checks the staff assignment/15-minute check forms at the end of every week. Ms. Brown denied any reports have been made from June 2022 until now of any resident not getting their briefs change as required. Ms. Brown stated she finds out everything that happens at the AFC group home.

On 09/22/22, I interviewed Resident C. I observed Resident C laying in bed connected to his oxygen machine. Resident C stated he tries to be as independent as possible. Resident C bathes himself and uses the bathroom on his own. Resident C does not wear briefs.

On 10/17/22, I made a telephone call to the respiratory therapist, Andrea Hobson. Regarding the allegations, Ms. Hobson denied observing any resident with a soiled brief. It's Ms. Hobson understanding that the staff change the resident's briefs on a regular basis and as needed. Ms. Hobson does not have any safety concerns nor any concerns regarding the residents not being properly cared for. Ms. Hobson stated she takes very good care of her residents, and she does not have any concerns with the staff not doing their jobs.

On 10/19/22, I made a telephone call to Person 1. Regarding the allegations, Person 1 works during the week and weekends during the afternoon shift. Person 1 has observed residents sitting in soiled briefs on occasions. Person 1 stated when they have noticed a resident in a soiled brief, they will change the resident or ask a staff member to do so. The staff are expected to document brief changes on the 15-minute check sheets. At minimum residents are checked on by staff every hour.

On 10/19/22, I made a telephone call to Person 2. Regarding the allegations, Person 2 stated at times residents are not getting their briefs changed quickly enough as sometimes it may take 1-3 hours before their brief is changed. Person 2 stated there is not a lack of staff at the AFC group home therefore; there is no excuse for a residents brief to not be changed on a regular basis. Person 2 stated the residents briefs are not being changed on a regular basis because the staff are not completing their 15-minute checks like they are supposed to. Person 2 stated Resident S currently needs to be changed and she needs a shower. Resident S brief has not been changed from 7:00am through 2:20pm.

On 10/19/22, I completed another unannounced onsite. I observed Resident S in her bedroom. Resident S is wheelchair bound. I was informed that Resident S brief was changed shortly before my arrival. Resident S bedroom was observed to have an odor of urine. Resident S was sitting in her wheelchair on top of a pad and her hoyer lift swing was underneath the pad. The pad was fresh as it had just been changed when Resident S brief was changed. However, the hoyer lift swing was wet due to the previous pad that was on top of the hoyer lift swing was soiled in urine. Resident S sneakers were observed on the floor. Pictures were taken of Resident S sneakers as they were observed to be soiled in urine by Person 2. Person 2 stated Resident S socks must have been changed as well as they were observed to be dry. Pictures of Resident S pad and hoyer lift swing were also taken. I attempted to interview Resident S however; I could not understand her. Person 2 stated Resident S will not receive a shower today because one staff member left for the day and another staff member is transporting therefore; the home is down two staff members. Person 2 stated Resident S should be receiving a shower three times a week.

On 10/19/22, I interviewed Resident J. Resident J has lived in the AFC group home for a couple of months. Resident J does not like living at the AFC group home because he is use to living at home. Resident J stated he is not being mistreated at the AFC group home. Resident J is self-sufficient however he needs assistance with wound care, showering, and changing his colostomy bag. Resident J has not witnessed any abuse or neglect in the AFC group home. Resident J stated staff will talk down to certain residents who can’t defend themselves and; they act like they are better than people. Resident J stated the staff are on a power trip because when a resident ask them to do something they will make the resident wait even if they are not busy. Resident J would not give details about a specific instance however; he stated staff spend time on their cell phones and they hide out in other residents bedrooms.

Resident J stated he takes a shower twice a week. Resident J would prefer to take more showers if it wasn’t such a burden on the staff members. Resident J stated a month ago he wasn’t getting showered at all because he wasn’t on the shower schedule as he had recently moved into the AFC group home. Therefore, no staff member would give him a shower because he wasn’t on the schedule.

On 10/19/22, I interviewed Resident E. Resident E has lived at the AFC group home since March 2022. Resident E is satisfied with living at the AFC group home. Resident

E is ambulatory. Resident E stated staff take good care of her. Resident E's daughter visits the home a couple times a week to give Resident E a shower. It is Resident E's preference to not have staff assist her with showering. Resident E wears a pad, but she is capable of taking herself to the bathroom.

On 10/19/22, I interviewed Person 3. Regarding the allegations, Person 3 works the day shift. The residents are changed 2-3 times per shift or as needed. Person 3 stated residents have sat in soiled clothing for 30 minutes or more but less than an hour before they are changed. Person 3 stated it can take a staff member 30-45 minutes to change one resident. Person 3 stated overall the AFC group home is a good facility and the staff care for the residents and; they do the best they can. Person 3 stated she has seen worse AFC group homes.

On 10/19/22, I interviewed Person 4. Regarding the allegations, Person 4 works the day shift. There have been instances where residents have sat in soiled clothing for 30-35 minutes. Person 4 stated the circumstances surrounding why a resident was sitting in soiled clothing is unknown to them. The residents are expected to be checked every 15 minutes to see if they need to be changed. Person 4 stated residents are receiving their showers three times a week.

On 10/19/22, I interviewed Resident W. Resident W has lived in the AFC group home since October 2022. Resident W likes living at the AFC group home. Resident W is wheelchair bound. The staff are taking good care of Resident W. Resident W requires assistance with showering. Resident W receives 3-4 showers a week and she is ok with that. Resident W stated her briefs are changed every 3-4 hours or as needed. Resident W denied ever sitting in a soiled brief. Resident W has two call buttons and staff respond whenever she uses her call button.

On 10/19/22, I received a copy of the shower calendar. There are three columns for midnights, days, and afternoons. In each column, the calendar list which residents are scheduled to be showered Sunday through Saturday. I observed every resident to be listed at least three times on the calendar. Resident S is scheduled to receive a shower during the day shift on Monday's, Wednesday's, and Friday's. According to Person 2, Resident S did not receive her scheduled shower today (Wednesday). Resident J is scheduled to receive a shower during the afternoon shift on Tuesday's, Thursday's, and Saturday's.

On 10/19/22, I received a copy of Resident J and Resident S shower history chart. According to Resident J's shower history, he did not receive a shower on his scheduled days on 10/15/22 (Saturday) or 10/13/22 (Thursday). On 09/06/22, 09/10/22, 09/20/22, 09/22/22, 09/24/22, 09/27/22, 09/29/22, 10/01/22, 10/04/22, 10/08/22, and 10/11/22 there was a comment that stated, "correcting documentation med/tx completed". I was informed by Person 2 that this comment means that either the task was completed late or not at all, and a staff member or program manager enters this comment to make it look like the duty was completed even if it wasn't. There were no additional comments providing a date as to when the shower was completed.

According to Resident S shower history, she did not receive a shower on her scheduled days on 10/10/22, 10/12/22, 10/14/22, 09/30/22, 09/19/22, 09/09/22, 09/05/22. On 09/30/22, 09/21/22, and 09/07/22 there was a comment stating Resident S shower was given late but, it did not provide a date or time the shower was given. On 09/02/22, there was a comment stating “correcting documentation med/tx completed”.

On 10/24/22, I received a copy of Resident S and Resident J assessment plan. Resident J’s assessment plan was completely blank as none of the questions were answered. Resident J’s assessment plan was not signed by the licensee designee. Resident J’s guardian signed the assessment plan on 07/24/22. Resident S assessment plan is dated 08/23/22. Resident S assessment plan indicates that she has a shower chair, and she needs assistance with bathing and personal hygiene. Resident S assessment plan does not explain how often Resident S should be bathed.

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:	Based on my findings and information gathered, there is sufficient information to confirm that Resident S is not being treated with dignity nor is her personal needs being attended to at all times. On 10/19/22, I observed Resident S bedroom to have an odor of urine. I observed Resident S sitting in her wheelchair and her Hoyer lift swing was underneath her. The Hoyer lift swing was wet due to the previous pad that was on top of it was soiled in urine. Person 2 confirmed that Resident S brief was changed right before I entered the AFC group home. However, Resident S was sitting in a soiled brief from 7:00am to 2:20pm. Resident S sneakers were also observed to be soiled in urine.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.

ANALYSIS:	Based on my findings and information gathered, there is sufficient information to confirm that Resident S and Resident J were not being bathed at least weekly. Resident J confirmed that a month ago he wasn't getting showered at all because he wasn't on the shower schedule therefore; no staff member would give him a shower because he wasn't on the schedule. On 10/19/22, I reviewed the shower schedule and the shower history chart for Resident S and Resident J. Resident J is scheduled to receive a shower during the afternoon shift on Tuesday's, Thursday's, and Saturday's. According to Resident J's shower history, he did not receive a shower on his scheduled days on 10/15/22 (Saturday) or 10/13/22 (Thursday). On 09/06/22, 09/10/22, 09/20/22, 09/22/22, 09/24/22, 09/27/22, 09/29/22, 10/01/22, 10/04/22, 10/08/22, and 10/11/22 there was a comment that stated, "correcting documentation med/tx completed". I was informed by Person 2 that this comment means that either the task was completed late or not at all, and a staff member or a residential program manager enters this comment to make it look like the duty was completed even if it wasn't. There were no additional comments providing a date as to when the shower was completed. With that said, it appears that Resident J did not receive a shower during the week of 10/09/22 through 10/15/22, or the week of 10/02/22 through 10/08/22 as 10/06/22 (Thursday) is not listed on the shower history chart and; the aforementioned comment above is listed for 10/04/22 and 10/08/22. Resident S is scheduled to receive a shower during the day shift on Mondays, Wednesdays, and Fridays. Person 2 confirmed that Resident S did not receive her scheduled shower on 10/19/22 which was a Wednesday. According to Resident S shower history, she did not receive a shower on her scheduled days on 10/10/22, 10/12/22, 10/14/22, 09/30/22, 09/19/22, 09/09/22, 09/05/22. On 09/30/22, 09/21/22, and 09/07/22 there was a comment stating Resident S shower was given late but, it did not provide a date or time the shower was given. On 09/02/22, there was a comment stating "correcting documentation med/tx completed". Resident S did not receive a shower during the week of 10/09/22 through 10/15/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	On 10/24/22, I reviewed Resident J's assessment plan. The assessment plan was not completed as none of the questions were answered. Furthermore, the assessment plan was not signed by the licensee designee.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff are blocking out resident's names in the computer system, which prevents the resident from showing up as present at the AFC group home. Nurses aren't checking, so medications aren't being dispensed as they should be. The staff is boosting oxygen levels as opposed to taking the residents out for help and proper dosing.

INVESTIGATION:

On 09/22/22, Ms. Brown explained that if a resident is on a leave of absence for 24 hours of more, staff are required to block their names out of their computer system, which prevents the resident from showing up as present at the AFC group home. This is a requirement for billing purposes. Ms. Brown stated the same task is completed if a resident is in the hospital for too long. The staff members do not have access to block out a resident in the computer system as only a nurse or an administrative member has that authority. Ms. Brown denied ever hearing about a nurse or an administrative member blocking out a resident who is actually present in the AFC group home nor would there be a reason for someone to do that. Ms. Brown stated there are employees who are required to complete a daily census report on the number of residents that are present in the AFC group home. The census report coincides with what is documented in the computer system. If the census report did not coincide with the documentation in the computer system regarding the number of residents, a staff member would catch the discrepancy as the staff would not be able to complete their care for the resident. Therefore, a discrepancy such as this would not go unnoticed throughout an entire shift without it being corrected.

Ms. Brown stated there was one incident that occurred at South Ridge, which is a different group home that she works for. Ms. Brown stated at South Ridge there is a resident who is re-admitted every other weekend for respite. Ms. Brown stated there

was one instance when this resident had just arrived at South Ridge and he had not been entered in the computer system yet. When she saw that he was not admitted into the computer system, she emailed the admission department to get him re-admitted into the computer system. Ms. Brown stated this incident occurred around June or July 2022.

Ms. Brown stated staff members administer medications to the residents and they are good with communicating with the nurses. Ms. Brown stated there has never been an issue with staff not administering medications to the residents. Ms. Brown stated Resident C is the only resident at the AFC group home who is on oxygen. Ms. Brown stated she could not explain the allegations about “taking the residents out for help and proper dosing”. Ms. Brown stated only the respiratory therapist can decide whether or not to turn up a resident’s oxygen level. Ms. Brown stated typically a residents oxygen level is no more than two liters. There is no benefit to boosting a resident’s oxygen level however; it can make a resident’s health worse.

On 09/22/22, Resident C stated he has never seen anyone tamper with his oxygen. The staff make sure Resident C’s oxygen is on the right level. Resident C stated his oxygen is always on one liter. Resident C stated his oxygen use to be on two liters, but it was decreased to one liter about a month ago. Resident C stated at nighttime he uses a moisturizer air mask to make sure his tracheostomy is clear. Resident C confirmed that no one has boosted his oxygen level. Resident C stated he spends the majority of his time in his bedroom. Resident C goes to work on Monday’s, Wednesday’s, and Friday’s. Resident C stated he has not seen any residents in the AFC group home on oxygen. Resident C stated the staff take good care of him. The staff are happy to do what Resident C ask them to do. The staff administer Resident C’s medications through his tube. Resident C cannot digest anything orally.

On 09/23/22, I received a copy of the September MAR’s for every resident. According to the MAR for Resident J, he is prescribed Aquacel Xtra/ADV twice a day at 9:00am and 9:00pm. There were missing staff initials on 9/3/22 for the am dose, on 9/4/22 – 9/6/22 for the pm dose, on 9/14/22, 9/15/22, and 9/17/22 for the pm dose.

According to the MAR for Resident Y, she is prescribed Artificial tears every two hours while awake. The midnight shift did not administer this medication on 09/14/22. On 09/22/22, Resident Y was not administered Aspirin as it was not available. Resident Y is prescribed Aspirin once daily. Resident Y’s Xlear Sinus medication was not available on 09/09/22. Resident Y is prescribed Xlear Sinus three times a day (6:00am, 1:00pm, 9:00pm). Resident Y’s Ipratroplum was not available on 09/09/22. Resident Y is prescribed Ipratroplum three times a day (6:00am, 1:00pm, 9:00pm).

According to the MAR for Resident E, she was not administered Fluticasone 50mg or Lidocaine on 09/09/22 as there were no staff initials on the MAR. According to the MAR comments, Fluticasone 50 mg was not available on 09/12/22. Resident E’s vital signs were not checked on 09/09/22 as there were no staff initials on the MAR. It is prescribed for Resident E’s Lidocaine pad 5% to be removed daily at bedtime. On 09/02/22,

Resident E's Lidocaine pad was not removed because it was never placed on during the daytime as prescribed.

According to the MAR for Resident S, her Famotidine 40mg was not administered as it was not available on 09/03/22. Resident S Levetiraceta 100mg was not administered as it was not available on 09/12/22. On 09/17/22, Resident S was not administered Senna as the medication was not available.

According to the MAR for Resident P, he was not administered Murine Ear Sol as it was not available on 09/05/22 through 09/08/22.

According to the MAR for Resident K, she is prescribed Nystatin four times a day (10:00am, 1:00pm, 5:00pm, 9:00pm). Resident K was not administered Nystatin 10:00am dose on 09/19/22 as the medication was not available. Resident K was not administered Nystatin 1:00pm dose on 09/19/22 as it was not available. Resident K was not administered Enoxaparin injection on 09/21/22 as it was not available. According to Resident K's MAR comments, it is instructed to not leave her in wet clothing, and she should be changed as soon as identified.

According to the MAR for Resident R, he was not administered his Artificial tears on 09/18/22 at 7:00pm. Resident R was not administered his Gemfibrozil 600mg on 09/18/22 at 5:00pm. It is prescribed for Resident R Lidocaine pad to be removed at bedtime however; this was not completed on 09/18/22. Resident R was not administered Novolog flex pen on 09/18/22 at 4:30pm. It is prescribed for staff to offer Resident R something for pain and if he does want something for pain, a PRN should be given. However, on 09/18/22 at 7:00pm, Resident R was not offered something for pain.

According to the MAR for Resident M, he was not administered Ferrous Sulfate on 09/16/22 as the medication was not available.

According to the MAR for Resident C, he is prescribed Colgate Hydris dry mouth four times a day (5:00am, 11:00am, 5:00pm, 9:00pm). Resident C was not administered this medication as it was not available on 09/10/22 at 5:00pm, 09/11/22 at 9:00pm, 9/12/22 at 5:00am or 09/12/22 at 11:00am. Resident C is prescribed to have his vital signs checked every shift. Resident C's vital signs were not checked on 09/14/22 at 1:00pm as there were no staff initials or comments.

According to the MAR for Resident L, she is prescribed three cans of Replete fiber. Resident L was not administered this medication on 09/21/22 as there were no staff initials.

According to the MAR for Resident T, he was not administered Hydrocortisone 5mg on 09/22/22 at 7:00am as there were no staff initials.

According to the MAR for Resident W, she was not administered Calcium Carbonate 600mg on 09/15/22 at 3:00pm as there were no staff initials. Resident W was not administered Esatalopram 10mg as the medication was not available. Resident W was not administered Fish oil 1000mg as the medication was not available.

On 10/17/22, Ms. Hobson stated she works Monday-Friday at the AFC group home. Ms. Hobson is also on-call 24/7. Ms. Hobson only cares for the residents who have a respiratory condition. Ms. Hobson provides treatment for two residents at the AFC group home (Resident C and Resident R). Ms. Hobson stated Resident R only receives oxygen a nighttime through his CPAP machine. Ms. Hobson stated only she or a nurse have the authority to adjust a residents oxygen level. Ms. Hobson denied being aware of any staff member adjusting a residents oxygen level. Ms. Hobson does not have any concerns with any resident's oxygen machine being tampered with. Ms. Hobson stated she does not have any authority to block out a resident in the computer system.

On 10/19/22, Person 1 stated the majority of the residents medications are administered by the direct care staff. The nurses will sometimes administer the narcotic medications. Person 1 stated the nurses have the authority to block out residents in the computer system, but they do not know if staff have the authority to do so. If a resident needs to be blocked out of the computer system, typically it is done by a nurse, nurse manager, or the division manager. Person 1 is not aware of any instances where a resident was blocked out of the computer system while the resident was actually present in the AFC group home. Person 1 does not know how someone could block a resident out of the computer system if the resident is present in the AFC group home. Person 1 has never heard of anyone intentionally blocking a resident out of the computer system knowing the resident is present in the AFC group home.

Person 1 stated in the event a medication is not available in the AFC group, a staff member will notify them. Occasionally there has been instances where a resident was not administered their medications because it was not available. Person 1 stated it can take up to two days to receive a refill for a medication especially if a refill is requested on the weekends. Person 1 is not aware of anyone boosting a residents oxygen level. Person 1 stated resident's oxygen is maintained by the nurses.

On 10/19/22, Person 2 stated the direct care staff members are responsible for administering medications. There have been occasions where residents were not administered their medications due to the AFC group home not having the medication refilled ahead of time. It takes about 24 hours to have a medication refilled. There have been occasions where residents did not receive their medications on time due to an emergency or staff had to leave their shift early.

Person 2 stated any staff member can block a resident out of the system via Quick MAR. Person 2 is not aware of anyone blocking a resident out of the system knowing the resident is present in the AFC group home. Person 2 stated a residents oxygen level can only increase up to three liters with an order from a doctor. Person 2 stated typically the AFC group home does not keep any residents whose oxygen level is on

four liters. Only a nurse or respiratory therapist can boost a residents oxygen level. It is not believed that a staff member would change a residents oxygen level.

On 10/19/22, Resident J stated staff administer his morning and evening medications on time. However, when Resident J needs a pain pill, he has to track down a staff member to get it.

On 10/19/22, Resident E stated staff administers her medications as prescribed. There haven't been any instances where Resident E was not administered her medications.

On 10/19/22, Person 3 stated on occasions residents do not get their medications as prescribed due to the medications not being re-ordered for a refill. Person 3 stated staff members and nurses have access to block residents out of the computer system. Person 3 denied blocking a resident out of the computer system when the resident is actually present in the home. Person 3 denied being aware of anyone intentionally blocking a resident out of the computer system knowing the resident is present in the home. Person 3 is not aware of any staff member boosting a residents oxygen level.

On 10/19/22, Person 4 stated there are seldom instances where residents are not administered their medications due to the medications not being refilled. Person 4 does not have access to block out residents in the computer system. Person 4 does not know if any staff members have the authority to block out a resident in the computer system. Person 4 denied knowing about any staff member boosting a residents oxygen level.

On 10/19/22, Resident W stated she receives her medications as prescribed and; there has never been an instance where she didn't get her medications.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 09/23/22, I received a copy of the September MARs for every resident. The following medications were not administered as prescribed: According to the MAR for Resident Y, she is prescribed Artificial tears every two hours while awake. The midnight shift did not administer this medication on 09/14/22. On 09/22/22, Resident Y was not administered Aspirin as it was not available. Resident Y is prescribed Aspirin once daily. Resident Y's Xlear Sinus medication was not available on 09/09/22. Resident Y's Ipratroplum was not available on 09/09/22.

	According to the MAR comments for Resident E, Fluticasone 50 mg was not available on 09/12/22. It is prescribed for Resident E's Lidocaine pad 5% to be removed daily at bedtime. On 09/02/22, Resident E's Lidocaine pad was not removed because it was never placed on during the daytime as prescribed. According to the MAR for Resident S, her Famotidine 40mg was not administered as it was not available on 09/03/22. Resident S Levetiraceta 100mg was not administered as it was not available on 09/12/22. On 09/17/22, Resident S was not administered Senna as the medication was not available. According to the MAR for Resident P, he was not administered Murine Ear Sol as it was not available on 09/05/22 through 09/08/22. According to the MAR for Resident K, she is prescribed Nystatin four times a day (10:00am, 1:00pm, 5:00pm, 9:00pm). Resident K was not administered Nystatin 10:00am dose on 09/19/22 as the medication was not available. Resident K was not administered Nystatin 1:00pm dose on 09/19/22 as it was not available. Resident K was not administered Enoxaparin injection on 09/21/22 as it was not available. According to the MAR for Resident R, he was not administered his Artificial tears on 09/18/22 at 7:00pm. Resident R was not administered his Gemfibrozil 600mg on 09/18/22 at 5:00pm. It is prescribed for Resident R Lidocaine pad to be removed at bedtime however; this was not completed on 09/18/22. Resident R was not administered Novolog flex pen on 09/18/22 at 4:30pm. It is prescribed for staff to offer Resident R something for pain and if he does want something for pain, a PRN should be given. However, on 09/18/22 at 7:00pm, Resident R was not offered something for pain. According to the MAR for Resident M, he was not administered Ferrous Sulfate on 09/16/22 as the medication was not available. According to the MAR for Resident C, he is prescribed Colgate Hydris dry mouth four times a day (5:00am, 11:00am, 5:00pm, 9:00pm). Resident C was not administered this medication as it was not available on 09/10/22 at 5:00pm, 09/11/22 at 9:00pm, 9/12/22 at 5:00am or 09/12/22 at 11:00am.

	According to the MAR for Resident W, Resident W was not administered Esatalopram 10mg as the medication was not available. Resident W was not administered Fish oil 1000mg as the medication was not available.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	On 09/23/22, I received a copy of the September MAR's for every resident. The following medications were missing staff initials: According to the MAR for Resident J, he is prescribed Aquacel Xtra/ADV twice a day at 9:00am and 9:00pm. There were missing staff initials on 9/3/22 for the am dose, on 9/4/22 – 9/6/22 for the pm dose, on 9/14/22, 9/15/22, and 9/17/22 for the pm dose. According to the MAR for Resident E, she was not administered Fluticasone 50mg or Lidocaine on 09/09/22 as there were no staff initials on the MAR. Resident E's vital signs were not checked on 09/09/22 as there were no staff initials on the MAR. According to the MAR for Resident C, he is prescribed to have his vital signs checked every shift. Resident C's vital signs were not checked on 09/14/22 at 1:00pm as there were no staff initials or comments. According to the MAR for Resident L, she is prescribed three cans of Replete fiber. Resident L was not administered this medication on 09/21/22 as there were no staff initials.

	According to the MAR for Resident T, he was not administered Hydrocortisone 5mg on 09/22/22 at 7:00am as there were no staff initials. According to the MAR for Resident W, she was not administered Calcium Carbonate 600mg on 09/15/22 at 3:00pm as there were no staff initials.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Lack of staffing has led to a tremendous amount of resident neglect.

INVESTIGATION:

On 09/22/22, Ms. Brown stated there are a total of 18 residents in the AFC group home. There are six staff members during the midnight shift, six staff members during the day shift, and six staff members during the afternoon shift. Ms. Brown explained that on the staff schedule there are some blanks which means she had to assign a staff member from a contract agency due to her regular staff not being available and/or on vacation.

On 09/22/22, I received a copy of the staff schedule. According to the staff schedule for the month of September 2022, I observed between four to seven staff members on schedule for each shift which meets the minimum requirement of having at least one staff on duty for every 15 residents during waking hours and; one staff member on duty for every 20 residents during sleeping hours.

On 10/19/22, Person 1 stated there are approximately four to eight staff members on each shift.

On 10/19/22, Person 2 stated there are approximately five to six staff members each shift. There are 18 residents in the AFC group home. On 10/19/22, the current staff to resident ratio is:

- 4 residents to 1 staff
- 4 residents to 1 staff
- 4 residents to 1 staff
- 3 residents to 1
- 2 residents on a 1:1
- 1 resident is in the hospital

On 10/19/22, Resident E stated she does not know how many staff work on each shift however; she thinks there is not enough staff because there are a lot of people in the home who need help. Resident E stated she knows there are residents who do not get their medications on time because she can hear their call buttons go off for a long

period of time. Resident E stated she knows that residents are not being cared for as quickly as they should because it takes staff too long to respond to call buttons. Resident E does not have a call button because she doesn't need one. Resident S stated the food could be better regarding taste and having more of a variety. Resident E stated she receives three meals a day. Resident E stated Chef Jeff does try to do a good job. I observed two full size refrigerators in the kitchen. Both refrigerators had an adequate supply of food. I also observed the menu and a diet chart. The menu was observed to provide three nutritious meals each day.

On 10/19/22, Person 3 stated there are approximately 5-6 staff members on each shift. Person 3 stated sometimes it feels like the AFC group home is understaffed due to a high turnover rate. Person 3 stated if a staff member calls off then another staff member is called to cover that shift.

On 10/19/22, Person 4 stated there are approximately 5-6 staff members each shift. Person 4 stated there are sufficient staff at the AFC group home.

On 10/19/22, Resident W does not have any complaints about living at the AFC group home. Resident W stated there are always several staff members working at the AFC group home. There are more than 3-4 staff members working. Resident W does not feel like the AFC group home is understaffed. Resident W stated the AFC group home is a good place and staff take care of everyone. Resident W prefers to have her own place, but the AFC group home is a good place.

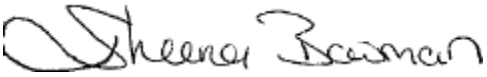
On 10/25/22, I completed an exit conference with the licensee designee Kim Waddell via email as she was not available via telephone. James Para-Cremer was also cc'd on the email. Ms. Waddell was informed which allegations will be substantiated and that a corrective action plan will be required.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	Based on my findings and information gathered, there is not sufficient information to confirm the allegation. There are currently 18 residents in the AFC group home. The staff scheduled confirmed that there are between four to seven staff members on schedule for each shift which meets the minimum requirement of having at least one staff on duty for every 15 residents during waking hours and; one staff member on duty

	for every 20 residents during sleeping hours. Based on all the interviews conducted it was reported that there are at least four staff members on each shift.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

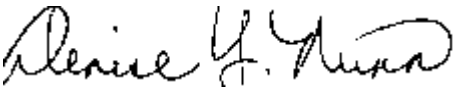
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



10/25/22

Sheena Bowman — Date
Licensing Consultant

Approved By:



10/28/2022

Denise Y. Nunn — Date
Area Manager