STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

January 31, 2023

Shahid Imran
Hampton Manor of Adrian, LLC
7560 River Road
Flushing, MI 48433

RE: License #: AH460406857
Investigation #: 2023A1027026
Hampton Manor of Madison

Dear Mr. Imran:

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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH460406857
Investigation #:	2023A1027026
Complaint Receipt Date:	01/03/2023
Investigation Initiation Date:	01/03/2023
Report Due Date:	03/02/2023
Licensee Name:	Hampton Manor of Adrian, LLC
Licensee Address:	7560 River Road Flushing, MI 48433
Licensee Telephone #:	(734) 673-3130
Authorized Representative/ Administrator:	Shahid Imran
Name of Facility:	Hampton Manor of Madison
Facility Address:	1491 E. US-223 Adrian, MI 49221
Facility Telephone #:	(517) 759-7799
Original Issuance Date:	12/10/2021
License Status:	REGULAR
Effective Date:	06/10/2022
Expiration Date:	06/09/2023
Capacity:	120
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents lacked protection and safety. Residents were neglected.	Yes
Medications were passed incorrectly or not at all.	No
The facility lacked an organized program for falls, medication disposal, controlled medications, communication of resident's medical issues, resident's rights, laundry completion, and staff working under the influence of drugs.	No
The facility is short staffed on weekends.	No
The kitchen lacked cleaning.	No
The facility lacked cleaning.	No
Additional Findings	Yes

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

01/03/2023	Special Investigation Intake 2023A1027026
01/03/2023	Special Investigation Initiated - Letter Email sent to APS providing referral information
01/03/2023	APS Referral Sent by email
01/05/2023	Contact - Document Received Email received from APS worker providing resident's names and emergency contact information
01/25/2023	Contact - Telephone call received Telephone call completed with APS worker

01/27/2023	Inspection Completed On-site
01/31/2023	Inspection Completed-BCAL Sub. Compliance
01/31/2023	Contact – Document Sent Email sent to Ms. Parish requesting additional documentation
02/10/2023	Contact – Document Received Email received from Ms. Parish with the requested documentation
02/27/2023	Exit Conference Conducted by email with authorized representative Shahid Imran and Ms. Parish

ALLEGATION:

Residents lacked protection and safety. Residents were neglected.

INVESTIGATION:

On 1/3/2023, the department received a complaint through the online complainant system which read Resident A pressed her call pendant and staff did not respond timely. The complaint read Resident A fell and hit her head. The complaint read Resident B had falls. The complaint read Resident C fell and hit her head, then received no treatment. The complaint read Resident D had an intestinal blockage and passed away. The complaint read call lights were not being responded to timely. The complaint read resident's personal care was not being completed. The complaint read resident's briefs were not changed, showers were not completed, and their urinals were full. The complaint read resident's service plans were not updated.

On 1/3/2023, I emailed a referral to Adult Protective Services (APS).

On 1/25/2023, a telephone interview was conducted with the APS worker who stated she spoke with the Resident A, B, and C's guardians who stated it took a long time for staff to answer call lights. The APS worker stated she substantiated that Resident A was on the floor after a fall for 45 minutes and had to call the facility front desk to receive staff assistance.

On 1/27/2023, I conducted an on-site inspection at the facility. I interviewed Operations Director Reggie Parish who stated Resident A had a fall in which "she was on the floor longer than she should have been." Ms. Parish stated Resident A called the building phone and staff responded. Ms. Parish stated the three employees on duty that night were terminated. Ms. Parish stated staff were trained to respond to resident's emergency call pull cords immediately and their call pendants within three to five minutes. Ms. Parish stated would need to contact the

call pendant program to inquire if she could obtain call light response logs. Ms. Parish stated Resident B had frequent falls in which she would pick herself back up and would not always press her call pendant for staff assistance. Ms. Parish stated staff have implemented corrective measures for Resident B such providing reminders to use her call pendant, completing frequent checks, and ensuring her room pathways were clear. Ms. Parish stated she had discussed moving Resident B into memory care with her family, however they have declined the transfer at this time. Ms. Parish stated Resident B's family implemented a baby monitor system in which staff maintain a monitor as well as conduct frequent checks. Ms. Parish stated Resident C had fallen and not informed staff. Ms. Parish stated Resident C's family sought medical treatment for her. Ms. Parish stated Resident D's illness was reported to her medical professional at Careline Hospice in which she was transferred to the hospital and passed away.

While on-site, I interviewed Resident A whose statements were consistent with Ms. Parish. Resident A stated her fall was on 11/22/2022 and staff checked her call pendant afterwards to ensure it was working appropriately. Resident A stated her call pendant was working appropriately. Resident A stated it was an isolated incident and most staff were "good workers."

While on-site, I interviewed Resident B who responded that staff were "nice." Resident B stated she could not remember falling. I observed Resident B's monitoring system which worked appropriately.

While on-site, I interviewed Resident E who stated staff "do really well" when assisting her with care.

While on-site, I interviewed Resident F who stated if he wanted anything, staff would help him and "I'm satisfied" with the care the at the facility.

While on-site, I observed 21 assisted living and 12 memory care residents. The residents appeared groomed and dressed in clean clothing.

While on-site, I observed two male resident bathrooms in which the urinals were empty.

While on-site, I reviewed the staff's daily checklist titled *Walk Through Checklist for* the month of January 2022 which staff were to check on all residents and report was to be given to the next shift.

I reviewed the facility's admission contract which read in part there three levels of services provided. The contract read in part for Level 1 residents received laundry services and weekly housekeeping. The contract read in part for Level 2 residents received Level 1 services as well as staff member assistance with transfers/mobility, incontinence care, bathing up to twice weekly, and grooming. The contract read in part for Level 3 residents received Level 1 and 2 services in addition to one to two

staff assistance for bathing twice weekly, two staff members for transferring, specialty diet, monitoring of nutritional intake, and full incontinence care.

I reviewed Resident A's service plan dated 9/7/2022 which read she moved into the facility on 9/8/2022. The plan read in part Resident A was independent with personal hygiene, dressing, mobility, and transferring. The plan read in part Resident A was a fall risk and her last fall was 18 months ago.

I reviewed Resident B's service plan dated 12/29/2022 which read she moved into the facility on 3/8/2022 and had a diagnosis of Dementia. The plan read in part that she required reminders for meals, as well as some hands-on assistance for personal hygiene, showering, dressing, and mobility. The plan read Resident B was fall risk.

I reviewed Resident C's service plan dated 12/29/2022 which read she moved into the facility on 8/29/2022 and had a diagnosis of Dementia. The plan read in part Resident C required reminders for meals, as well as some hands-on assistance for personal hygiene, showering, and dressing. The plan read Resident C was a fall risk.

I reviewed Resident D's service plan read she moved into the facility on 12/27/2021 in which she was independent with personal hygiene, dressing, mobility, and transferring in which she required to use her walker and for meals

I reviewed the January 2023 shower logs for Residents A, B, C and G which read consistent with the facility's admission contract and the resident's services plans

I reviewed the facility's occurrences reports for Residents A, B, C and G. Resident A's occurrence report dated 11/22/2022 read in part she was sent the emergency room for an evaluation of high blood pressure. Resident B, C and G's occurrence reports for November and December 2022, as well as January 2023. The occurrence reports read in part Resident B, C and G had falls, some requiring emergency medical services to be called.

I reviewed an incident report for Resident D dated 10/21/2022 and sent to the Department on 10/24/2022. The report read Resident D had labs, an x-ray and stool sample completed which were normal. The report read Resident D requested to the go to the hospital after finding out her tests were normal because she felt something was not right. The report read Resident D was sent to the emergency room and her healthcare provider was notified.

I reviewed Resident D's medical progress notes from Careline Physician Services in which she was evaluated by a nurse practitioner at the facility on 9/8/2022, 9/15/2022, 10/13/2022 and 10/20/2022.

I reviewed the facility's employee handbook which read consistent with statements from Ms. Parish regarding the chain of command for staff to follow for reporting and expectations for staff to complete incident or occurrence reports.

I reviewed the facility's fall policy which read consistent with the occurrence and incident reports reviewed.

I reviewed the Department's facility file incident reports dated from November 2022 through January 2023 in which the file lacked incidents reports for falls with injury or hospitalizations for Residents A, B, and C.

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.
For Reference: R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
For Reference: R 325.1922	**Admission and retention of residents.**
	(**5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.**

ANALYSIS:	Review of facility documentation revealed Resident A was independent with her activities of daily living, however Residents B, C, and D required staff assistance. There was lack of evidence to support resident’s lacked personal care including their briefs being changed, showers, and full urinals. Interviews with Ms. Parish and Resident A revealed she had a fall in which staff had not responded timely to her call pendant. Review of Resident A’s service plan revealed it was not updated with her most recent fall. Although the facility was unable to provide call light response logs, the facility lacked protection and safety of Resident A in accordance with this rule and their staff training procedure. Thus, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medications were passed incorrectly or not at all.

INVESTIGATION:

On 1/3/2023, the department received a complaint through the online complainant system which read resident’s medications were passed incorrectly or not at all.

On 1/27/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Parish who stated resident’s medications were administered as per their physician’s orders. Ms. Parish stated employees were trained to administer medications through Michigan Assisted Living Association (MALA) in which there were six trainings and a test after each. Ms. Parish stated employees must pass the six tests and provide the certificates of completion to her to be maintained in their file. Ms. Parish stated she terminated a previous employee for “pre-popping medications and initialing them as given.”

While on-site, I interviewed Employee #1 who stated she administered each resident’s medication individually which was the facility’s policy and procedure. Employee #1 stated she ensured residents received their medications as prescribed. Employee #1 stated she observed other staff administering resident’s medications per the facility’s policy and procedure. I observed inside the drawers of medication cart #1 assigned to Employee #1, which was organized, and all medications remained in their appropriate packaging.

While on-site, I interviewed Employee #2 whose statements were consistent with Employee #1. I observed inside the drawers of medication cart #2 assigned to Employee #2, which was organized, and all medications remained in their appropriate packaging.

While on-site, I observed Employee #2 administer medications to a resident in which she appeared to follow the facility's policy and procedure.

While on-site, I observed a document titled *Training for New Hires HFA* which read consistent with statements from Ms. Parish and provided staff information to access the facility's training program on-line.

While on-site, I interviewed Residents A, E, F and G who stated they had received their medications as prescribed.

While on-site, I reviewed the facility's medication administration policy which read consistent with staff interviews.

I reviewed Resident A, B, C and G's December 2022 and January 2023 medication administration records (MARs) which read staff initialed their medications as administered per physician orders.

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:	Interviews with Ms. Parish and two medication technicians revealed staff administered resident's medications per physician orders and the facility's policy. Resident attestations, observations and review of facility documentation revealed staff supported staff interviews. Based on this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility lacked an organized program for falls, medication disposal, controlled medications, communication of resident's medical issues, resident's rights, laundry completion, and staff working under the influence of drugs.

INVESTIGATION:

On 1/3/2023, the department received a complaint through the online complainant system which read residents had falls and incident reports were not completed. The

complaint read medications were not being taken of out of the medication cart after resident's passed away. The complaint read the controlled medication books did not match the medications in the controlled medication drawers. The complaint read different shifts did not follow up on medical problems such as a resident couldn't breathe, and staff called the "RCC" instead of calling 911. The complaint read residents did not have rights when the family wanted something done. The complaint read staff worked "high."

On 1/27/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Parish who stated staff completed incident reports for falls which were emailed to the Department. Ms. Parish stated staff also completed occurrence reports to communicate incidents to the shift supervisors and resident care coordinator. Ms. Parish stated there have been four resident deaths since the facility had opened. Ms. Parish stated resident's medications no longer needed or used were sent back to the pharmacy in which the pharmacy would credit the resident's account. Ms. Parish stated she could not recall any resident who had difficulty in breathing. Ms. Parish stated communication regarding resident's care was to be reported to the shift supervisor then to the resident care coordinator who then would collaborate with the nurse and manager if needed. Ms. Parish stated resident's medical conditions were communicated appropriately. Ms. Parish stated employee's acknowledgement of receiving a copy of the resident's rights was in their employee handbook. Ms. Parish stated residents and their families also received a copy of their rights when they sign their admission contract. Additionally, Ms. Parish stated the resident's rights were posted at the entrance of the facility and in the memory care. Ms. Parish stated all residents had rights to make decisions for themselves, however if a durable power of attorney was activated or there was a court appointed guardian, then decisions would be discussed with those appointed persons. Ms. Parish stated resident's laundry was completed on their shower days and often completed daily in the memory care. Ms. Parish stated she had not observed employees working "high." Ms. Parish stated she has worked all shifts in which she had not observed staff under the influence of drugs or alcohol. Ms. Parish stated per the employee handbook, she would send any suspected staff working under the influence to *Worksphere* for testing.

While on-site, I observed the occurrence and incident report binders for December 2022 and January 2023. The binders read staff documented and communicated resident's occurrences or incidents such as falls or transfers to the hospital.

While on-site, I observed medication carts #1 and #2. I observed Employee #1 assigned to cart #1 and Employee #2 assigned to cart #2 each review the medications within their cart to ensure they were prescribed for residents currently residing in the facility. I observed the pharmacy bins in the locked medication room in which medications were returned to the pharmacy.

Additionally, while on-site, I observed Employee #1 count 25 narcotic medication cards or bottles in the narcotic drawer of medication cart #1 in which each

medication count corresponded to their individual count sheets in the narcotic count book. I observed Employee #2 count 21 narcotic medication cards or bottles in the narcotic drawer of medication cart #2 in which each corresponded to their individual count sheets in the to the narcotic count book. Employee #1 and #2 stated each shift completes a narcotic count. I observed the narcotic count books for medication cart #1 and #2 which read consistent with statements from Employee #1 and #2.

While on-site, I interviewed Employee #1 and #2 who stated they had not observed staff working under the influence. Employee #1 and #2 stated they would immediately report staff suspected of working under the influence of drugs or alcohol to Ms. Parish.

While on-site, I interviewed Residents A, E, F and G who all stated their laundry was completed timely. Resident G stated he thought staff completed laundry "too often." I observed Resident A, E, F and G's laundry baskets within their apartments which appeared to have none or minimal laundry.

While on-site, I reviewed the binder containing hallway task lists which read in part staff were expected to complete a "walk-through" their assigned area with the on-coming shift staff to ensure their task list was completed. For example, some of the tasks included were but not limited to staff reporting to the next shift, ensure laundry was done and garbage was to be removed from resident's rooms.

I reviewed the facility's employee handbook which read consistent with statements from Ms. Parish in relation to resident's laundry and their substance abuse policy. The handbook read in part resident's bed linens shall be changed and laundered at least once weekly or more often if soiled. The handbook read in part if an employee refused to submit a drug or alcohol test, it would be considered misconduct and shall be subject to discipline up to and including termination.

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:	Attestations from staff and residents, as well as documentation review and observations revealed the facility maintained an organized program for the following: documenting resident’s falls, removal of medications from the medication cart, controlled medication counts, communication of resident’s medical issues, resident’s rights, laundry completion, and staff working under the influence. Thus, this violation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is short staffed on weekends.

INVESTIGATION:

On 1/3/2023, the department received a complaint through the online complainant system which read the facility was short staffed on weekends.

On 1/27/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Parish who stated she was working to hire additional staff because she was required to terminate five staff. Ms. Parish stated the facility maintained all their own employees and was not utilizing agency at this time. Ms. Parish stated staff worked three shifts: 7:00 AM to 3:00 PM, 3:00 PM and 11:00 PM and 11:00 PM to 7:00 AM. Ms. Parish stated for both weekdays and weekends, the staff schedule consisted of five staff assigned to first and second shifts, then three staff assigned to third shift. Ms. Parish stated there were currently 25 assisted living and 14 memory care residents. Ms. Parish stated all residents currently required no more than one person assist for their activities of daily living, however staff were scheduled to accommodate if a resident required two-person assist.

While on-site, I reviewed the staff schedule dated 12/1/2022 through 2/5/2023 which read consistent with statements from Ms. Parish.

While on-site, I interviewed Employee #1 and #2 whose statements were consistent with Ms. Parish.

While on-site, I interviewed Resident E, F and G who stated staff responded to their call pendants and assisted them when needed.

While on-site, I observed three staff assigned to the assisted living and two staff assigned to the memory care unit. I observed dietary and activities staff assist residents during their lunch meal. Additionally, I observed call pendants were responded to in a timely manner.

I reviewed the resident census which read consistent with statements from Ms. Parish.

I reviewed Resident A's service plan which read she was independent with care. I reviewed Resident B, C, and G's service plans which read they required one person assist for care.

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:	Staff and resident attestations, observations and review of facility documentation revealed the facility scheduled staff in accordance with the resident's services plans, thus this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The kitchen lacked cleaning.

INVESTIGATION:

On 1/3/2023, the department received a complaint through the online complainant system which read the kitchen was "disgusting."

On 1/27/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Parish who stated the facility maintained a clean kitchen. Ms. Parish stated kitchen staff cleaned after every meal as well as followed a check-off list per the facility's policy.

While on-site, I observed the kitchen after lunch was served in which the floors and stainless-steel countertops appeared clean. I observed clean plates stacked neatly on stainless steel shelves under the counter. I observed clean pots and pans stacked neatly on a stainless-steel shelf under the counter. I observed the shelving units were clean and organized. I observed the ice machine was working appropriately and appeared clean. I observed the dry storage area was clean in which the food was dated and organized. I observed inside the walk-in refrigerator and freezer were working appropriately, the food inside each was organized, and the floors appeared clean.

While on-site, I interviewed Employee #4 who assisted with serving resident's food and stated she had observed kitchen staff cleaning consistently after every meal served.

I reviewed the facility's cook job description and weekly kitchen task list which read consistent with observations of the kitchen and statements from Employee #4.

APPLICABLE RULE	
R 325.1976	**Kitchen and dietary.**
	(12) Food service equipment and work surfaces shall be installed in such a manner as to facilitate cleaning and be maintained in a clean and sanitary condition, and in good repair.
ANALYSIS:	Staff attestations and observations revealed the kitchen was maintained in a manner which appeared clean, organized and in good repair thus this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There was food left over night and moldy food in the kitchen refrigerators.

INVESTIGATION:

On 1/3/2023, the department received a complaint through the online complainant system which read food was left over night in the refrigerators. The complaint read there was moldy food in the kitchen refrigerators.

On 1/27/2023, I conducted an on-site inspection at the facility. I observed one large walk-in kitchen refrigerator in which food was dated, stored appropriately and had not been kept overnight. I observed food such as but not limited to vegetables, meats and dairy products which appeared fresh and ready for consumption.

I reviewed the cook job description which read in part they were to work with the Dining Services Manager to ensure that leftovers were used, and inventories were properly managed. The job description read in part that the kitchen staff were to be familiar and comply with all state and local health department practices, safety practices and infection control practices.

APPLICABLE RULE	
R 325.1976	**Kitchen and dietary.**
	(6) Food and drink used in the home shall be clean and wholesome and shall be manufactured, handled, stored, prepared, transported, and served so as to be safe for human consumption.
ANALYSIS:	Observations and review of documentation revealed the facility maintained fresh food which was not maintained overnight thus there was lack of evidence to support this allegation and it was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility lacked cleaning.

INVESTIGATION:

On 1/3/2023, the department received a complaint through the online complainant system which read resident's rooms lacked cleaning. The complaint read resident's beds were not changed nor were their floors cleaned.

On 1/27/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Parish who stated the facility had two housekeepers who alternated days worked and sometimes overlapped hours. Ms. Parish stated a housekeeper was on duty during daytime hours seven days per week. Ms. Parish stated she felt resident's rooms and the facility were well maintained by the housekeeping staff. Ms. Parish stated resident aides were responsible for cleaning resident's toilets daily, making and changing their bed linens, and taking trash out of their rooms. Ms. Parish stated housekeeping assisted with keeping resident's toilets clean as well as with trash removal during their weekly cleaning of each resident's room. Ms. Parish stated she had not received complaints regarding the cleanliness of resident's rooms or the facility.

While on-site, I interviewed Employee #3 whose statements were consistent with Ms. Parish. Employee #3 stated she would be cleaning the memory care unit that day, as well as memory care resident's rooms. Employee #3 stated the cleaning schedule was:

Monday: 100 hallway and resident's rooms
Tuesday: 200 hallway and resident's rooms
Wednesday: 300 hallway and resident's rooms

Thursday: 400 hallway, resident's rooms, and café
Friday: memory care unit and memory care resident's rooms
Saturday: deep clean and sanitize facility, all extra rooms, main lobby areas and any resident's rooms requiring an additional cleaning
Sunday: deep clean and sanitize facility, all extra rooms and main lobby areas and any resident's rooms requiring an additional cleaning

While on-site, I observed Employee #3's housekeeping cleaning records which read the list of resident's rooms in each hallway, café, public restrooms, and physical therapy room. The record read in part housekeeping staff were to check the following: remove trash, clean bathroom, sweep and mop bathroom, check/clean refrigerator, dust, windowsill/windows/mirrors, vacuum then initial the tasks were completed.

While on-site, I observed six memory care resident's rooms which all appeared clean prior to Employee #3 cleaning them. I observed the floors were clean, the bathrooms also appeared clean, resident's beds were made, and the trash was empty or had minimal contents.

While on-site, I interviewed Residents A, E, and F who all stated housekeeping and staff did well cleaning their rooms and the facility.

While on-site, I observed five assisted living resident's rooms which appeared clean including their bathroom areas, their beds were made, and there was minimal trash.

While on-site, I observed all hallways of the facility, the main lobby area, the assisted living resident dining area, four employee sitting areas, two public bathrooms, and the memory care unit in which all appeared very well maintained and clean.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Staff and resident attestations as well as observations and facility documentation revealed the facility was cleaned thoroughly and consistently in which this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Interview with Ms. Parish revealed Resident A had a fall with injury. Review of the Department's facility file revealed this fall was not reported. Additionally, review of the facility's incident and occurrence report binders from November 2022 through January 2023 revealed Resident B had falls on 12/2/2022, two falls on 12/3/2022, and was sent to the emergency department for pain on 12/4/2022, had one fall on 12/10/2022, and had on fall on 1/16/2023 in which she was sent the emergency room. The binders read Resident C had a fall on 12/7/2022 and was sent to the hospital. The binders revealed Resident G had falls on 1/3/2023 and 1/6/2023.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(2) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
For Reference: R 325.1901	**Definitions.**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	Review of the facility's incident and occurrence report binders revealed the facility did not always provide notification to the department for Resident A, B, C and G's incidents. The incidents, such as but not limited to falls with injury, consecutive falls with or without injury and falls requiring medical evaluation at the hospital, in which residents were at risk to suffer more than minimal harm. Thus, a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/13/2023

Jessica Rogers Date
Licensing Staff

Approved By:

02/27/2023

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