GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 20, 2023

Satish Ramade
Margarets Meadows, LLC
5257 Coldwater Rd.
Remus, MI 49340

RE: License #: AL370264709
Investigation #: 2023A1033065
Margarets Meadows

Dear Mr. Ramade:

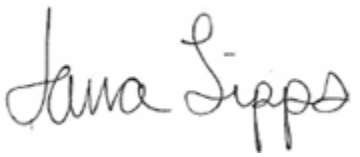
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9730.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL370264709
Investigation #:	2023A1033065
Complaint Receipt Date:	08/25/2023
Investigation Initiation Date:	08/30/2023
Report Due Date:	10/24/2023
Licensee Name:	Margarets Meadows, LLC
Licensee Address:	5257 Coldwater Rd. Remus, MI 49340
Licensee Telephone #:	(248) 470-4862
Administrator:	Satish Ramade
Licensee Designee:	Satish Ramade
Name of Facility:	Margarets Meadows
Facility Address:	5257 Coldwater Road Remus, MI 49340
Facility Telephone #:	(989) 561-5009
Original Issuance Date:	10/11/2004
License **Status:**	REGULAR
Effective Date:	10/23/2021
Expiration Date:	10/22/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct care staff were not properly prepared to meet the care needs of former Resident A. They did not have a Hoyer lift, ordered for mobility, and were not capable of managing his care needs.	No
Direct care staff were not providing proper wound care and personal care to former Resident A while he was a resident of the facility.	No
Former Resident A's Xarelto medication was not administered as prescribed.	Yes
The direct care staff are not offering nutritious, hot meals, to the residents. Meals are microwaved.	No
The direct care staff do not keep the resident bedrooms clean and sanitary.	No

III. METHODOLOGY

08/25/2023	Special Investigation Intake 2023A1033065
08/30/2023	Special Investigation Initiated – Telephone call made- Interview with complainant via telephone.
08/30/2023	Contact – Telephone call made- Interview with Citizen 1 via telephone.
09/08/2023	Inspection Completed On-site- Interview with Home Manager, Pam Pardee, direct care staff, Jordan Wilson, Resident A, and Resident B. Completed walkthrough of the facility. Reviewed facility menus for the past six months. Initiated review of former Resident A's resident record.
09/08/2023	Inspection Completed-BCAL Sub. Compliance
09/26/2023	Contact - Telephone call made. Interview with direct care staff, Savannah Miller, via telephone.
09/26/2023	Contact - Telephone call made. Interview with direct care staff, Mickala Flores, via telephone.
10/10/2023	Contact – Telephone call made. Attempt to interview Careline Physician Services provider, Amelia Albachten. Message left with Careline Physician Services office. Awaiting response.

10/10/2023	Contact – Telephone call received. Interview with Amelia Albachten, Careline Physician Services, Nurse Practitioner.
10/10/2023	Contact – Telephone call made. Interview with registered nurse, Elizabeth Fowler, with The Care Team.
10/19/2023	Exit Conference Conducted via telephone with licensee designee, Satish Ramade.

ALLEGATION:

- **Direct care staff were not properly prepared to meet the care needs of former Resident A. They did not have a Hoyer lift, ordered for mobility, and were not capable of managing his care needs.**
- **Direct care staff were not providing proper wound care and personal care to former Resident A while he was a resident of the facility.**

INVESTIGATION:

On 8/25/23 I received an online complaint regarding the Margarets Meadows adult foster care facility (the facility). The complaint alleged direct care staff were not equipped to manage the care needs of former Resident A. On 8/30/23 I interviewed Complainant regarding the allegations. Complainant advised that Citizen 1 had more detailed and current information regarding these allegations.

On 8/30/23 I interviewed Citizen 1 who reported that she is the spouse of former Resident A. She reported that former Resident A was admitted to the facility around April 2023 and was discharge from the facility in May 2023. She reported that when Resident A was admitted to the facility, he could stand and transfer with the assistance of one direct care staff member. Citizen 1 reported that on 5/23/23 former Resident A had a fall at the facility and was readmitted to the hospital for diagnosis of Deep Vein Thrombosis (DVTs), Pulmonary Embolisms (PEs), secondary infection related to ongoing wound care of skin fold fungus infection and a pressure sore on the heel of his right foot. She reported that the day prior to this hospitalization, 5/22/23, she had received a telephone call from the visiting nurse who made visits to former Resident A at Margarets Meadows. She reported she did not recall the name of this nurse. She reported that this nurse reported that she had made a visit to former Resident A and noted that he had a wound the size of a baseball covering the entire heel of his right foot. Citizen 1 reported that it had been reported by this nurse that it appeared the direct care staff had not removed former Resident A's socks to provide foot care/hygiene care. Citizen 1 reported that this nurse also expressed concerns about former Resident A's skin care, and personal hygiene needs, explaining that she had educated the direct care staff to wash the affected

skin fold area, pat dry, and then apply Nystatin Powder to the affected area. Citizen 1 reported direct care staff had verbalized that former Resident A had refused his baths and personal care attempts, but Citizen 1 reports that former Resident A had stated to her that he asked for baths and the staff reported to him that they did not have time. Citizen 1 reported that when former Resident A returned to the facility after his hospital stay (5/23/23) that he was then ordered a Hoyer lift and the direct care staff were to be transferring him with a Hoyer lift. Citizen 1 reported that she never saw a Hoyer lift at the facility for former Resident A's use. Citizen 1 reported that former Resident A was moved from this facility at the end of May 2023 and is now deceased.

On 9/8/23 I completed an unannounced on-site investigation at the facility. I interviewed Home Manager, Pam Pardee. Ms. Pardee reported that she manages the direct care staff, but she does not provide direct care to residents of the facility. She reported that she has been working in this role since January 2022. Ms. Pardee reported that former Resident A was admitted to the facility on 3/25/23 and discharged on 5/24/23. Ms. Pardee reported that former Resident A was uncooperative with care on frequent occurrences. She reported he declined wearing incontinence briefs or using the restroom provided to him and preferred to utilize his bedside commode. She reported he had loose stools on his way from his bed to his bedside commode and required assistance with his personal hygiene due to this. Ms. Pardee reported that former Resident A frequently refused showers that were offered by direct care staff. She further reported that upon his admission the direct care staff were provided with information that former Resident A was ambulatory with minimal assistance, but he rarely wanted to walk or get out of his bed. Ms. Pardee reported that she felt the direct care staff were able to manage his care needs as they always staff at least two direct care staff per shift and at times former Resident A did require a two-person assist with mobility and transfers. She reported that she did not hear any concerns expressed by direct care staff, former Resident A, or outside parties.

On 9/8/23, during on-site investigation, I interviewed direct care staff, Jordan Wilson. Ms. Wilson reported that she has worked at the facility for about one year. She reported that she recalled former Resident A and his care needs. Ms. Wilson reported that former Resident A required assistance from direct care staff with toileting, showering, dressing, and most personal care needs. She reported that he could be "very stubborn" and he wanted to stay in his room most of the time. Ms. Wilson reported that former Resident A refused personal care/showers on a regular basis, and she would need to use redirection tactics to get him to agree to receive his personal care/hygiene. She reported that former Resident A had redness on his skin under his arms, across abdomen and chest. She reported direct care staff consulted the visiting physician group, Careline Physician Services, to get a prescription for this rash. She reported former Resident A was ordered a Nystatin Powder for this redness. Ms. Wilson reported direct care staff never had to use a Hoyer lift to transfer former Resident A. She reported direct care staff used a two-person assist model for mobility and transfers with this resident due to his weakness

and his size as he was over 400lbs. She reported that former Resident A chose to use the bedside commode in his bedroom, and he would frequently have accidents on his way from his bed to the bedside commode. Ms. Wilson reported that she felt the direct care staff were adequately trained and physically capable of handling former Resident A's care needs.

On 9/26/23 I interviewed direct care staff, Savannah Miller, via telephone. Ms. Miller reported that she recalled providing care for former Resident A. She reported that former Resident A "hated" showers and getting out of bed. She reported that he only wanted the staff to bring him food or help him go to the bathroom. Ms. Miller reported that the direct care staff usually offered former Resident A a shower each day as he frequently refused showers. She further reported Resident A developed a yeast infection on his skin from not showering. She reported that from the best of her memory the yeast infection was under his arms. Ms. Miller reported that former Resident A typically required one direct care staff member to assist with mobility and transfers as he required assistance to stand and then he could walk with his walker once he was standing. Ms. Miller reported that she does not recall former Resident A having a Hoyer lift ordered for his care and noted that the direct care staff did not use a Hoyer lift to care for him. She reported that she felt the direct care staff members were capable of caring for former Resident A's care needs but his tendency to refuse care caused barriers to providing adequate care.

On 9/26/23 I interviewed direct care staff, Mickala Flores, via telephone. Ms. Flores reported that she has worked at the facility for about one year and did recall providing care to former Resident A. She reported that former Resident A required almost total care. She further reported direct care staff provided toileting, showers, assistance with mobility and transfers and more. Ms. Flores reported that former Resident A did have some skin redness under his armpits and across his abdomen. She reported direct care staff applied a Nystatin powder for the skin irritation that was prescribed by former Resident A's medical provider. Ms. Flores reported former Resident A required one direct care staff member to assist with mobility and transfers when he first admitted to the facility and near the end of his stay he needed two direct care staff members to assist with mobility and transfers. Ms. Flores stated, "I don't believe so" when asked if a Hoyer lift was used for former Resident A.

During on-site investigation on 9/8/23 I reviewed former Resident A's resident record. I reviewed the *Assessment Plan for AFC Residents* form dated 3/25/23. On page 2 of this form under section, *II. Self Care Skill Assessment*, it indicates that former Resident A did require the assistance of a walker for walking/mobility, and did require assistance with toileting, bathing, and dressing. Under subsection, *J. Use of Assistive Devices,* it notes, "sometimes needs help moving in wheelchair." Under section, *III. Health Care Assessment*, subsection, *D. Special Equipment Used (wheelchair, walker, Cane, etc.)*, it states "Yes" and "walker, wheelchair" is listed in the narrative. There is no notation on this assessment plan that former Resident A required more than a one-person assist with mobility/transfers/personal care.

During onsite investigation on 9/8/23 I reviewed the document, *Margaret's Meadows Admission Skin Assessment,* dated 3/25/23. On this document, under "Assistive Device" it states, "wheelchair, walker". Under "Ambulatory" it states, "yes". Under the section, "Assist of 1 or 2" is written, "Usually only one person may require two." Under the section, "Incontinent/continent" the word "continent" is circled.

During on-site investigation on 9/8/23 I reviewed the toileting log for former Resident A. This log is used by direct care staff to track when direct care staff are checking on residents for toileting needs and tracking results of these checks. I reviewed former Resident A's logs for the dates 3/25/23 through 5/10/23. These logs documented that direct care staff were checking on former Resident A at least every two to three hours and aiding with toileting needs which included providing incontinence care when required.

On 9/8/23, during on-site investigation, I reviewed the document, Shower/Bed Baths/Refusals, for former Resident A for the dates 3/25/23 through 5/21/23. I observed the following information from this documentation:

- The week of 3/27/23 through 4/2/23 there were no notations of showers offered or refused to this resident.
- The week of 4/3/23 through 4/9/23 there was documentation of former Resident A having a shower on 4/7/23 and refusing showers on 4/3/23 and 4/4/23.
- The week of 4/10/23 through 4/16/23 there was documentation of Resident A refusing showers each day, except on 4/15/23 when it is noted he received a bed bath on this date.
- The week of 4/17/23 through 4/23/23 there was documentation of former Resident A having a shower on 4/18/23, and no other documentation of refusals or bed baths noted.
- The week of 4/24/23 through 4/30/23 there was documentation of Resident A having a bed bath on 4/24/23 and 4/26/23. There were no other notations of refusal or showers on this week's log.
- The week of 5/1/23 through 5/7/23 there was documentation of former Resident A refusing showers each day of this week.
- The week of 5/8/23 through 5/14/23 there was documentation of former Resident A refusing showers on 5/8, 5/9, 5/10, & 5/14, there was documentation of a bed bath provided on 5/11/23, and a notation that the resident was in the Emergency Department on 5/13/23.
- The week of 5/15/23 through 5/21/23 there was a notation of a bed bath provided on 5/18/23, a refusal on 5/17/23 and the resident being in the Emergency Department from 5/19 through 5/21.

On 9/8/23, during on-site investigation, I reviewed the documents *Careline Physician Services Order Form*, dated 4/12/23 & 4/26/23. On the form dated, 4/12/23, is noted, "New order Nystatin-powder. Apply thin layer to rash under skin folds three times a day as needed." On the form dated 4/26/23 is noted, "Change Nystatin Powder to three times daily, scheduled." This order is written by provider, Amelia Albachten.

On 9/8/23, during on-site investigation I reviewed the *Medication Administration Records* (MARs) for former Resident A for the months, March 2023, April 2023, and May 2023. I observed that the direct care staff documented as needed applications of the Nystatin Powder on the following dates:

- 4/15/23: administered in the evening
- 4/16/23: administered in the morning
- 4/18/23: administered in the afternoon
- 4/22/23: administered in the morning
- 4/24/23: administered in the afternoon

I observed that the direct care staff documented three times daily routine doses of the Nystatin Powder from 4/26/23 through 5/11/23. Zero doses were administered between 5/12/23 through 5/14/23 due to resident being in the Emergency Department. Doses resumed 5/15/23 through 5/17/23. The MAR indicated a refill of the Nystatin was needed 5/18/23. The Nystatin Powder was continued 5/19/23 at 8pm and Resident A returned to the hospital on 5/20/23.

On 10/10/23 I interviewed Amelia Albachten, FNP-C, Careline Physician Services, Nurse Practitioner. Ms. Albachten reported that she is a Nurse Practitioner who provides primary care services to residents of the facility. She reported she has worked with residents of the facility for the past 1.5 years. Ms. Albachten reported that former Resident A was a resident she provided services to at the facility. She reported that he was a large gentleman and did develop issues with a yeast infection on his skin under his left armpit. She reported that she felt the direct care staff were applying the Nystatin Powder correctly as she would note when she made visits to former Resident A that he had dried powder on his skin where the yeast infection was. She reported that this yeast infection would drain fluid, and this would cause increased difficulties in keeping the resident clean and dry. Ms. Albachten reported that The Care Team home health agency was also involved with former Resident A's care, and he was being seen by a physical therapist and a registered nurse. She reported that the registered nurse had reported to her on 5/10/23 that there were concerns about former Resident A needing proper hygiene and that a new wound to his right heel was found on this date. Ms. Albachten reported that a boot was ordered for the resident's right leg due to this heel wound. Ms. Albachten could not recall whether this resident refused his personal care or was open to receiving personal care from direct care staff. Ms. Albachten reported that to her knowledge a Hoyer lift was never ordered for this resident.

On 10/10/23, I interviewed registered nurse, Elizabeth Fowler, with The Care Team. Ms. Fowler reported she had been involved with former Resident A's care while he was at the facility. She reported she had concerns about the care and noted it was questionable whether he was receiving adequate care. She reported that former Resident A had difficulties with yeast infections on his skin, due to skin folds and moisture. She reported that the direct care staff were applying the Nystatin Powder

that was ordered but she is not sure they were applying it as directed. She reported that the instructions given to the direct care staff were to wash the affected area, pat the affected area dry, and apply the powder. Ms. Fowler reported that she felt, based on how former Resident A's skin would look when she would visit him, that the powder was just being reapplied on top of old powder and the washing component was not being performed. She reported that she does not have evidence to support this assumption. Ms. Fowler reported that former Resident A was "reluctant" to accept care. She reported that she would have to hold conversations with him about the importance of the hygiene care being completed for proper skin care. She noted that after she would discuss this with the resident he would agree to care. Ms. Fowler reported that she had spoken with Ms. Pardee about her concerns related to former Resident A's personal hygiene needs not being attended to and she felt her concerns were not heard or addressed. She reported that she feels this resident's care suffered based on former Resident A's size being a challenge to the direct care staff, the resident having minimal motivation, and the direct care staff not providing quality care. She further reported that the direct care staff did advise her that this resident was refusing personal care, but also reported that former Resident A would tell her the direct care staff were not offering personal care. Ms. Fowler reported that former Resident A was working with a physical therapist through The Care Team. She reported that their goal was always for him to walk independently and that a Hoyer lift was never ordered for his care.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**

ANALYSIS:	Based upon the interviews conducted and the documentation reviewed in the resident record there is not adequate evidence to suggest that the direct care staff were not prepared or capable of providing the level of care required for former Resident A. There have been multiple statements indicating that former Resident A routinely refused or denied personal care to be provided to him. The direct care staff documented administering the Nystatin Powder for his yeast infection and documented regular, routine, toileting checks and offers for showers/bed baths to this resident. However, there have been statements made regarding assumptions that the care was not being offered or provided to former Resident A, there is no substantial proof that this care was not provided/offered. In reviewing all the documentation in the resident record and interviewing the direct care staff and outside providers, there was not an individual with knowledge of a Hoyer lift being ordered for former Resident A's mobility/transfers. Therefore, no violation is established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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 upon interviews with Citizen 1, multiple direct care staff, Ms. Albachten, & Ms. Fowler, as well as review of the documentation in former Resident A's resident record, there is not substantial evidence to prove that former Resident A was not provided with supervision, protection, and personal care as defined in his written assessment plan. His assessment plan did not list a Hoyer lift as being an ordered device for mobility/transfers and updated documentation from outside providers did not list a Hoyer lift being ordered for mobility and transfers. There was documentation in the form of daily toileting logs and weekly shower logs that identified care being provided/offered to this resident and the resident's frequent refusals of the care being offered. At this time there is not substantial evidence to suggest that former Resident A's personal care needs were not being attended to by the direct care staff.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Former Resident A's Xarelto medication was not administered as prescribed.

INVESTIGATION:

On 8/25/23 I received an online complaint which alleged that former Resident A's Xarelto medication was not administered as it was prescribed for the duration of former Resident A's time residing at the facility. On 8/30/23 I interviewed Citizen 1 regarding former Resident A's Xarelto medication. Citizen 1 reported that former Resident A had been sent to the McLaren Hospital Emergency Department in Mt. Pleasant, MI, on 5/11/23 for an acute episode. Citizen 1 reported that she had been advised by a nursing staff member (name unknown) at the McLaren Hospital Emergency Department, that there was evidence former Resident A did not receive his prescribed blood thinner (Xarelto) medication for a significant period.

On 9/8/23 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Pardee on this date. Ms. Pardee advised that former Resident A resided at the facility from 3/25/23 through 5/24/23. She reported that former Resident A was discharged from his former placement, a nursing home, to the facility on 3/25/23. Ms. Pardee reported that when a resident is discharged to the facility from a nursing home the nursing home staff will send over a list of current medications and send any medications that they have ordered for the resident as well as call in prescriptions for any medications they may not currently have on site. Ms. Pardee reported that when a nursing home needs to send a prescription to the pharmacy for the facility to obtain for a resident, she requests that the prescription is

sent to the Downtown Drugs Pharmacy. Ms. Pardee reported she is not aware of who may have sent any prescription orders to the pharmacy for former Resident A's admission to the facility.

During on-site investigation on 9/8/23 I interviewed Ms. Wilson. Ms. Wilson reported that when the nursing home sends a resident's medication list to the facility, for admission, the facility direct care staff will contact the resident's physician to reconcile the medication list with the medications that were sent, from the nursing home, to see if they need to order any medications for the resident. Ms. Wilson reported she does not recall who completed this process for former Resident A's medications as that was in March 2023.

During on-site investigation I reviewed the document, [nursing home] Order Summary Report, dated 3/22/23, found in former Resident A's resident record. Ms. Pardee reported that this document is the documentation that was provided to the facility for former Resident A upon his admission. On page 4 of the document is a list of medications. On this list is, "Xarelto Oral Tablet 20 MG (Rivaroxaban) Give 1 tablet by mouth one time a day related to Paroxysmal Atrial Fibrillation." This medication was noted to be ordered on 3/6/23, started on 3/7/23, and contained no discontinuation date for this medication.

During on-site investigation I reviewed the MARs for former Resident A for the months, March 2023, April 2023, and May 2023. I found that the Xarelto medication does not appear listed on any of the reviewed MARs.

During on-site investigation I reviewed the document, *McLaren Central Michigan Patient Summary/Discharge Instructions, Orders and Medications*, for former Resident A. On page 8 of this document is a list of medications. On this list is, "Rivaroxaban (Xarelto 20mg oral tablet) 1 tabs oral every day. Refills 1. Ordering Physician: Beatty, PA, Jean Margaret-Mills. Last Dose: 5/13/23, Next Dose: tonight."

On 10/19/23 I interviewed licensee designee, Satish Ramade, via telephone, regarding the allegation. Mr. Ramade reported he wanted to investigate the issue with the Xarelto medication for former Resident A. Mr. Ramade did respond to this allegation and reported that when the direct care staff were reviewing former Resident A's paperwork that was supplied by the nursing home, upon admission, they did make a notation about the Xarelto not being provided and called the nursing home to discuss this with their staff. Mr. Ramade reported the nursing home staff reported to the facility that Resident A was no longer taking the Xarelto. Mr. Ramade reported that when Resident A was admitted to the hospital in May 2023 and the discharge paperwork reported that Xarelto was a medication to be "continued" on the medication list, the direct care staff at the facility did not observe this as they were looking for any new or discontinued medications.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon the interviews with Citizen 1, Ms. Pardee, Ms. Wilson, & Mr. Ramade, as well as review of the documentation in former Resident A's resident record, it can be determined that former Resident A was prescribed and taking Xarelto medication prior to his admission to the facility and even though Mr. Ramade reported the nursing home provided a verbal statement reporting this medication had been discontinued, the medication reappeared as an active medication when Resident A was hospitalized in May 2023. The Xarelto medication should have appeared on the MAR for the month of May beginning on 5/14/23 and this is not recorded on former Resident A's MAR for May 2023. The direct care staff at the facility had access to this discharge paperwork and are responsible to reconcile any medications on this paperwork for the residents they are providing care to. After review of former Resident A's resident record it can be concluded that this resident did not receive his Xarelto medication as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The direct care staff are not offering nutritious, hot meals, to the residents. Meals are microwaved.

INVESTIGATION:

On 8/25/23 I received an online complaint alleging that the direct care staff are not providing nutritious, hot meals, to the residents. Further alleging that the meals at the facility are microwaved and not cooked in an oven or on a stovetop. On 8/30/23 I interviewed Citizen 1. Citizen 1 reported that she had observed, upon visits to the facility, that the meals did not appear to be nutritious in nature. She reported frequently seeing tater tots and unknown meats being served. She reported that there were times the meat was not identifiable. She further reported that there was rarely a fruit or vegetable option available for the residents' consumption and that she witnessed meals being microwaved instead of being cooked in an oven.

On 9/8/23 I completed an on-site investigation at the facility. I interviewed Ms. Wilson. Ms. Wilson reported that all hot meals at the facility are prepared in the oven or on the stovetop. She reported that the direct care staff do use the microwave if a resident has opted to wait until later to consume their meal. She reported they do this for reheating purposes.

On 9/8/23, during on-site investigation, I interviewed Resident B. Resident B reported that she is pleased with the meals being offered and feels that they are adequate and nutritious.

On 9/8/23, during on-site investigation, I interviewed Resident C. Resident C reported that she enjoys the meals at the facility and has no concerns about the quality of food being provided at this time.

On 9/26/23 I interviewed Ms. Miller regarding the allegation. Ms. Miller reported that the direct care staff prepare all hot meals in the oven or on the stovetop. She reported that she feels they offer a variety of options and always have a fresh/healthy option.

On 9/26/23 I interviewed Ms. Flores regarding the allegation. Ms. Flores reported that the direct care staff cook all hot meals in the oven or on the stovetop. Ms. Flores reported feeling that the meals are “pretty well balanced” and that each day the meals are different to provide for variety.

During on-site investigation on 9/8/23 I reviewed the menus for the facility for the time period March 27, 2023 through April 15, 2023 and July 30, 2023 through September 2, 2023. I found the menus to contain a variety of food choices and fresh options on these menus.

During the on-site investigation on 9/8/23 I arrived at the facility to observe the noon meal service. I observed chicken nuggets and tater tots being prepared for the lunch meal. These items were prepared in the oven. The refrigerator had fresh foods available for consumption on this date.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based upon interviews with Ms. Wilson, Citizen 1, Resident B, and Resident C, as well as review of past menus and observations made during the on-site investigation, it can be determined that the direct care staff are using the oven/stovetop to prepare hot meals and are offering a variety of meal options to the current residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The direct care staff do not keep the resident bedrooms clean and sanitary.

INVESTIGATION:

On 8/25/23 I received an on-line complaint alleging that the direct care staff are not keeping resident bedrooms clean and sanitary. On 8/30/23 I interviewed Citizen 1, via telephone. Citizen 1 reported that her spouse, former Resident A, had resided at the facility and she frequently had issues with his bedroom not being clean. She reported that former Resident A had difficulties getting from his bed to his bedside commode and would have frequent accidents of bowel on the carpet in the bedroom. She reported that she visited former Resident A on at least three separate occasions to find feces covering his bedside commode and on his bedroom carpet. She reported that she was assured by facility direct care staff that they clean the facility every night. Citizen 1 further reported that former Resident A's bedroom frequently smelled of feces/urine and after complaints were made to the direct care staff there were still issues with finding the bathroom, carpet, and bedside commode covered in feces. Citizen 1 reported that there was one evening that a staff member came into former Resident A's bedroom on the midnight shift and bleached his carpet to remove the bowel movement stain. She reported that this then ruined the carpet in the bedroom.

During on-site investigation on 9/8/23 I interviewed Ms. Pardee. Ms. Pardee reported that there are cleaning tasks assigned to the direct care staff on each shift throughout the day. She reported that former Resident A did have frequent accidents on his way from his bed to the bedside commode. She did not report noticing these accidents not being cleaned by direct care staff.

During on-site investigation on 9/8/23 I interviewed Ms. Wilson. Ms. Wilson reported that direct care staff are each assigned cleaning duties per shift each day. She reported that this usually happens between meals, or on the night shift when residents are sleeping. Ms. Wilson reported that former Resident A did have frequent issues with being incontinent on his way from his bed to the bedside commode.

During on-site investigation on 9/8/23, I interviewed Resident B in her resident bedroom. Resident B reported that she has no concerns about the cleanliness of the facility and feels the direct care staff help her clean her bedroom when they can assist. I did observe that there were visible crumbs and dirt on the carpet of Resident B's bedroom.

During on-site investigation on 9/8/23, I interviewed Resident C in her resident bedroom. Resident C reported that she has no concerns about the direct care staff

and feel they are providing housekeeping services appropriately. I did observe in Resident C's bedroom the same visible dirt on the floor as was observed in Resident B's bedroom.

During on-site investigation on 9/8/23 I conducted a walkthrough of the facility. I observed that multiple resident bedrooms needed vacuuming as they had visible dirt on the flooring. I also observed a strong smell of urine from several resident bedrooms and observed used resident incontinence briefs thrown away in open trashcans in resident bedrooms. The common areas of the facility, such as dining room, front living room, and kitchen, appeared to be clean and orderly.

On 9/26/23 I interviewed Ms. Miller, via telephone. Ms. Miller reported that the direct care staff who work the overnight shift have the most responsibility with cleaning tasks. She reported that the direct care staff will help a resident clean their bedroom if they request this level of assistance.

On 9/26/23 I interviewed Ms. Flores, via telephone. Ms. Flores reported that each direct care staff member has cleaning tasks that are assigned to them per shift. She reported "we do our best". She further reported that there are days when the facility smells more like urine than on other days, but she was not sure if this could be due to multiple resident incontinence brief changes occurring at the same time. Ms. Flores continued to report that mopping, wiping down handrails and doorknobs is all done on each shift.

On 10/10/23 I interviewed Ms. Albachten regarding the cleanliness of the facility and former Resident A's bedroom. Ms. Albachten reported that she did not recall any issues with cleanliness while she would make visits to former Resident A.

On 10/10/23 I interviewed Ms. Fowler regarding this allegation. Ms. Fowler reported that the main areas of the facility appeared to be in good, clean condition, but she did have issues on several occasions with finding former Resident A's bedroom to have feces covering his bedside commode/toilet.

On 10/19/23 I interviewed licensee designee, Satish Ramade, and Ms. Pardee, via conference call. Ms. Pardee reported that during my on-site investigation when I observed the smell of urine in the facility it was due to multiple residents having incontinence briefs changed at the same time, as it was after lunch and this is a common time for resident incontinence care to occur. She reported that she conducts regular checks of the facility and reported that the direct care staff clean after the meal periods and had not cleaned the resident bedrooms on this date since the noon meal. Mr. Ramade further reported that he makes weekly visit to the facility to monitor cleanliness as this is a primary concern for him.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based upon interviews with Citizen 1, Ms. Wilson, Ms. Flores, Ms. Miller, Ms. Pardee, Mr. Satish, Resident B, and Resident C, as well as observations made during the on-site investigation it can be determined that there is not substantial evidence to determine that the direct care staff are not keeping the facility comfortable, clean, and orderly. Even though, Citizen 1 & Ms. Fowler did report finding former Resident A's bedroom with feces on the bedside commode/toilet and carpet, it was also reported by multiple direct care staff that former Resident A had frequent issues with incontinence of bowel and that they attempted to ensure these were attended to as quickly as possible. The direct care staff all cited a cleaning schedule they follow, and the two residents interviewed were satisfied with the cleaning being provided by direct care staff. I did not make any notations of feces found in resident bedrooms or bathrooms during my unannounced investigation. There was an odor of urine in the facility during this time, but the investigation also occurred around the noon meal, when direct care staff reported they were doing multiple incontinence changes to residents during this time frame.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

10/19/23

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Jana Lipps Date
Licensing Consultant

Approved By:

10/20/2023

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Dawn N. Timm Date
Area Manager