GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 22, 2024

Megan Fry
MCAP Holt Opco, LLC
Suite 115
21800 Haggerty Road
Northville, MI 48167

RE: License #: AL330404597
Investigation #: 2024A1033023
Prestige Way #2 (Poplar Cottage)

Dear Ms. Fry:

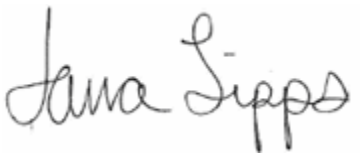
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL330404597
Investigation #:	2024A1033023
Complaint Receipt Date:	01/05/2024
Investigation Initiation Date:	01/09/2024
Report Due Date:	03/05/2024
Licensee Name:	MCAP Holt Opco, LLC
Licensee Address:	Suite 115 21800 Haggerty Road Northville, MI 48167
Licensee Telephone #:	(517) 694-2020
Administrator:	Megan Fry
Licensee Designee:	Megan Fry
Name of Facility:	Prestige Way #2 (Poplar Cottage)
Facility Address:	4300 Keller Road Holt, MI 48842
Facility Telephone #:	(517) 694-2020
Original Issuance Date:	11/02/2020
License **Status:**	REGULAR
Effective Date:	05/01/2023
Expiration Date:	04/30/2025
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's personal clothing and hygiene products are missing from the facility.	No
The direct care staff are not following the physician's order to provide foot care for Resident A.	No
Resident A's alternating pressure mattress for his bed was not working properly and not attended to by direct care staff.	No
Resident A is not being provided a diabetic diet as ordered by his physician.	Yes
Resident A's personal care is not being attended to regularly by direct care staff.	No
The carpet in Resident A's bedroom is stained and in poor repair.	No
Additional Findings	Yes

III. METHODOLOGY

01/05/2024	Special Investigation Intake 2024A1033023
01/09/2024	Special Investigation Initiated – Telephone call made- Interview with Citizen 1, via telephone.
01/09/2024	APS Referral- Referral stemmed from denied APS referral.
01/16/2024	Inspection Completed On-site- Interviews with direct care staff/Resident Care Coordinator, Darlene Gonzalez, Director of Dining Services, Aaron Biller, direct care staff, Heidi Smith, & Resident A. Review of Resident A's resident record initiated.
01/26/2024	Contact - Document Received- Email correspondence received from Executive Director, Zachary Fisher.
02/14/2024	Contact – Telephone call made- Attempt to interview direct care staff, Tim Nolan, via telephone. Voicemail message left, awaiting response.
02/15/2024	Contact – Telephone call made- Interview with direct care staff, Heaven Abram, via telephone.
02/23/2024	Exit Conference

	Conducted via telephone with licensee designee, Megan Fry. Voicemail message left.

ALLEGATION: Resident A's personal clothing and hygiene products are missing from the facility.

INVESTIGATION:

On 1/5/24 I received an online complaint regarding the Prestige Way #2 (Poplar Cottage) adult foster care facility (the facility). The complaint alleged that Resident A has had several personal clothing items and personal hygiene items come up missing while he has been a resident at the facility. On 1/9/24 I interviewed Citizen 1, via telephone. Citizen 1 reported that she is a family member of Resident A. She reported that Resident A has resided at the facility for about two years. Citizen 1 reported that she has purchased multiple sweatsuit outfits for Resident A that have come up missing at the facility. She reported direct care staff lose them and have not been able to locate them. Citizen 1 reported she does the laundry for Resident A which means these items should not be laundered by the direct care staff and should not be missing. Citizen 1 reported that she also purchases personal hygiene products for Resident A such as shampoo, lotion, deodorant and so forth. She reported that on numerous occasions she has come to the facility and these products are not able to be found and Resident A should not have been able to go through these products as quickly as they seem to disappear. Citizen 1 reported that she has asked about these missing items and has not received any resolution regarding the whereabouts of these products. Citizen 1 could not provide a timeline for when she last purchased personal care products for Resident A. The items she alleges are missing are as follows:

- Charcoal sweatsuit with matching pants and sweatshirt.
- Navy blue sweatsuit with matching pants and sweatshirt.
- Black sweatsuit with matching pants and sweatshirt.
- Burgundy sweatsuit with matching pants and sweatshirt.
- Eucerin Lotion
- Arm & Hammer Deodorant

On 1/16/24 I conducted an unannounced on-site investigation at the facility. I interviewed direct care staff/Resident Care Coordinator, Darlene Gonzalez. Ms. Gonzalez reported Citizen 1 completes Resident A's laundry and to her knowledge this has happened Since Resident A's admission to the facility. Ms. Gonzalez reported that there is a laundry basket in Resident A's bedroom with a sign that states "Do not do resident's laundry." Ms. Gonzalez reported that she was unaware of any missing personal items for Resident A except a small black decorative pillow that was in a chair in his bedroom. She reported that this did come up missing and was replaced by the facility. Ms. Gonzalez reported Resident A's personal care items are stored in his nightstand by this bed. She reported Resident A requests direct care staff to put his deodorant and lotion on him multiple times during the day,

which makes these products not last as long as would be anticipated. Ms. Gonzalez reported Resident A's toiletries are not mixed or mingled with any other residents' toiletries.

During the on-site investigation on 1/16/24 I toured Resident A's bedroom and interviewed Resident A. I observed that in Resident A's closet was a large cardboard box with writing on the outside that stated, "Please place dirty's in here for [Citizen 1] to wash. Thanks." I observed on his nightstand, near his bed, the following items:

- Pro Silk Body lotion
- Oral Health Rinse
- Aim toothpaste (large), Crest toothpaste (small), toothbrush
- Petroleum Jelly
- Deodorant
- Silkience Hair Care Pro Formula 2-1 shampoo & conditioner

I attempted to interview Resident A on this date. He was talkative and seemed to enjoy the attention of others but had difficulty maintaining focus during the interview. He did not report any concerns about missing personal care items or clothing.

During on-site investigation on 1/16/24 I interviewed direct care staff, Heidi Smith. Ms. Smith reported that Resident A's clothing is laundered by Citizen 1. She reported that she has not heard complaints from Citizen 1 about missing clothing items for Resident A. Ms. Smith reported Resident A's personal hygiene products are kept in or on the nightstand next to his bed in his bedroom. She reported that sometimes the hygiene products are kept in Resident A's bathroom. Ms. Smith reported that a small black pillow did come up missing from Resident A's bedroom and this pillow has been replaced by the facility.

On 2/15/24 I interviewed direct care staff, Heaven Abram, via telephone. Ms. Abram reported that she works the day shift at the facility and has worked there for about six months. Ms. Abram reported Resident A's clothing is laundered by Citizen 1 who visits Resident A on a regular basis. Ms. Abram reported that when she first started working at the facility it was not immediately explained to her that this was the case. Ms. Abram reported that there have been instances when a new caregiver would have been unaware of this process and laundered Resident A's clothing by mistake. Ms. Abram reported Citizen 1 has expressed to her, on one occasion that Resident A had a shirt that was missing. She reported she had looked for the shirt and did not locate the missing shirt for Citizen 1. Ms. Abram was unsure whether anyone else was able to locate the missing clothing. She reported this was the only instance of missing clothing she was made aware of. Ms. Abram reported that Resident A's personal hygiene products are kept by his bed in and on his nightstand. She reported that the other residents have individual shower caddy's in the shower room but since Resident A is usually provided personal care in his room, the hygiene products are kept in his bedroom. Ms. Abram reported she was unaware of any complaints or instances where Resident A's hygiene products have been missing.

On 2/13/24 I sent an email correspondence to Executive Director of the facility, Mr. Fisher, requesting a copy of Resident A's *Inventory of Valuables* form. On 2/20/24 Mr. Fisher responded to this request noting he did not have a copy of this form on file in Resident A's resident record. Through this email correspondence I also inquired of Mr. Fisher whether he had conversations with Citizen 1 concerning missing clothing and personal care items. Mr. Fisher reported that he started in his current position in February of 2023. He reported that after he assumed this role, he had several conversations with Citizen 1 regarding missing clothing items, which were all noted to have gone missing prior to February of 2023. Mr. Fisher reported that he had no knowledge of what occurred in the facility prior to his starting date in this position and worked with her on a solution. He reported that Citizen 1 had identified that she would begin washing Resident A's laundry to eliminate missing items. He reported that there were no new clothing items reported missing after this conversation. He reported that recently Citizen 1 made a complaint about personal care items missing, such as deodorant and soap. He reported Citizen 1 could not recall when these items were delivered to the facility and the length of time the direct care staff were using the items. Mr. Fisher reported Resident A requires, at times, daily bed baths and does go through his soap and deodorant quickly. Mr. Fisher reported that a solution was initiated with Citizen 1 whereby she would report to himself or Ms. Gonzalez when she drops off new personal care items, so that the administrative staff can keep track of how quickly these items are being used to better know if it is Resident A's personal use, or someone else is using the items. Mr. Fisher reported that Citizen 1 was agreeable to this plan. Mr. Fisher further reported that Citizen 1 had expressed that a small black pillow had been missing from Resident A's bedroom and he was not able to locate this pillow and therefore purchased a new pillow for Resident A to replace the missing pillow.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(j) The right of reasonable access to and use of his or her personal clothing and belongings.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Based upon interviews with Citizen 1, Ms. Gonzalez, Ms. Smith, Ms. Abram, Resident A, & Mr. Fisher, as well as a walkthrough of Resident A's resident bedroom and review of Resident A's resident record it can be determined that there is not sufficient evidence to suggest that Resident A's clothing and personal care items have been misplaced or stolen at the facility. Mr. Fisher did report that a pillow was missing at one time from Resident A's bedroom and explained that the resident's pillow was replaced with another pillow and this situation was discussed with Citizen 1. Mr. Fisher reported that he has held several conversations with Citizen 1 in attempts to accommodate her concerns about Resident A's personal care items and clothing and has worked with her on active solutions to these issues.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The direct care staff are not following the physician's order to provide foot care for Resident A.

INVESTIGATION:

On 1/5/24 I received an online complaint regarding the facility. The complaint alleged direct care staff are not providing the care that is ordered for Resident A's feet. On 1/9/24 I interviewed Citizen 1 via telephone. Citizen 1 reported that at some point (date unknown) in the year 2022 Resident A developed a fungus on his left great toe. She described it as a "horrific" foot fungus. Citizen 1 noted that she reported this fungus to Ms. Gonzalez and some of the other direct care staff members (names she could not recall). Citizen 1 reported Ms. Gonzalez noted she would have the podiatrist look at Resident A's feet. Citizen 1 reported that the podiatrist (name unknown) did visit Resident A and Citizen 1 was able to meet this provider one time. She reported at the time of that meeting (date unknown) the podiatrist had noted that Resident A's toenail may need to be removed. Citizen 1 reported that this podiatrist ceased visits to the facility, and she is unaware if the new provider has made visits to Citizen 1 regarding his foot fungus. Citizen 1 reported that in the Summer of 2023 Resident A's right great toe also developed a foot fungus. She reported that she spoke with Resident A's regular medical provider, "Dr. Andrew", regarding the issue. Citizen 1 reported that "Dr. Andrew" ordered Vicks VapoRub for Resident A's foot fungus, but she is not certain that the direct care staff have been administering this topical medication as she cannot smell it when she visits Resident A at the facility.

On 1/16/24 I conducted an unannounced, on-site investigation, at the facility. I interviewed Ms. Gonzalez regarding the allegation. Ms. Gonzalez reported that Andrew Johnson, Nurse Practitioner, is Resident A's regular medical provider. She reported that he makes weekly visits to the facility and provides care for multiple residents who reside at the facility. Ms. Gonzalez reported that in November 2023

Mr. Johnson ordered the Vicks VapoRub for Resident A's foot fungus, at the request of Citizen 1. She reported that the direct care staff have been administering the medication as it was prescribed by Mr. Johnson. Ms. Gonzalez reported that in September 2022 Resident A was first seen by the facility podiatrist for the suspected foot fungus. She reported that this provider has since left the practice and the facility administration was required to find another provider for podiatry services. She reported that there was a lapse in care as this took longer than anticipated to find a willing podiatry provider to make visits to the facility. She reported that they currently are using the Home MD company for podiatry services. Ms. Gonzalez reported that Mr. Johnson has also been involved in the foot care provided to Resident A and made a visit to Resident A regarding this issue on 6/12/23. She reported that Mr. Johnson has ordered antibiotics for Resident A's toe fungus and Resident A's foot fungus has improved in recent months.

During on-site investigation on 1/16/24 I interviewed Ms. Smith regarding the allegation. Ms. Smith reported that Resident A's toes have improved in recent months. She reported that the direct care staff are administering the Vicks VapoRub ordered by Mr. Johnson on a regular basis.

During the on-site investigation I reviewed the following documents:

- Daily shift documentation, dated 6/9/23, and completed by Ms. Gonzalez, reads, "Resident has dry skin on feet and his right big toes a small sore on the outer edge of his nail. This was cleaned and bandaged. Avalon NP Andrew Johnson will evaluate on Monday June 12 and podiatry will check on June 29."
- Daily shift documentation, dated 11/7/23, completed by Ms. Gonzalez, reads, "Resident's sister would like him to use Vicks vapor rub on his feet."
- *New Prescription Summary*, dated 11/6/23. Under section, *Prescription As Follows*, it reads, "Take 1 application topical every night at bedtime. Apply vick's vaporub to bilateral great toes qhs for onychomycosis. Family to provide med." The order was issued by Andrew Johnson.
- *Medication Administration Record* (MAR) for the month of December 2023 for Resident A. "Vick Vaporub Oin" is listed on the MAR with the directive, "Apply to bilateral great toes daily at bedtime for onychomycosis". The origination date of this order is listed as 11/6/23. This medication is documented as being administered each day of the month, except for 12/1/23, 12/9/23, 12/10/23, & 12/13/23. For each of these instances it is documented on the MAR that "resident refused" is the reason the medication was not administered.
- *Encounter – Home Visit Date of service [Resident A],* dated 6/12/23, and electronically signed by Andrew Johnson. This note records the *Chief Complaint* for the visit on page 1, as, "[Ms. Gonzalez] reports right great toe inflammation and oozing and requests a visit for possible ingrown toenail."

On 1/26/24 I received an email correspondence from Mr. Fisher. Mr. Fisher provided copies of documentation of podiatry visits that Resident A was provided while at the facility. My observations of these documents are as follows:

- Resident A received podiatry visits from Kristi S. Schons, D.P.M., on the following dates, 11/15/21, 2/4/22, 4/15/22, 7/7/22, 9/15/22, 11/18/22, 1/20/23, 4/13/23, 6/30/23.
    - Each of these documented podiatry visits from Dr. Schons noted a recommended follow up with podiatry in 2-3 months or sooner if needed.
    - Each of Dr. Schons notes reviewed contained the narrative, “there are no signs of bacterial subungual infections or ulcerations at this time.”
- Resident A received podiatry visits from Thomas Finn, Doctor of Nursing Practice (DNP) on 11/21/23 & 1/24/24. The visit notes reviewed from Mr. Finn do not identify any significant problems or interventions required of direct care staff for Resident A’s foot care.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	Based upon interviews with Citizen 1, Ms. Gonzalez, Ms. Smith, & Mr. Fisher as well as review of Resident A’s resident record, there is not sufficient evidence direct care staff are not providing for Resident A’s care of his foot fungus. There was regular documentation of physician appointments with Resident A to assess and treat the foot fungus, as well as documentation on the MAR for December 2023 that the medication prescribed for the foot fungus has been administered on a regular basis and the days it was not administered were due to Resident A refusing the medication. There is not adequate information to determine that the direct care staff are not providing for Resident A’s podiatry needs.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A’s alternating pressure mattress for his bed was not working properly and not attended to by direct care staff.

INVESTIGATION:

On 1/5/24 I received an online complaint regarding the facility. The complaint alleged that Resident A has been prescribed an alternative pressure mattress (air mattress) to go on his bed on top of his regular mattress. The complaint alleges that this air mattress malfunctioned, and the direct care staff did not address the problem immediately, causing the mattress to be flattened and putting Resident A at risk for

pressure ulcers on his skin. On 1/9/24 I interviewed Citizen 1, via telephone. Citizen 1 reported that the week of 1/1/24 She made a visit to Resident A at the facility and found his air mattress unplugged from the wall outlet. She reported that she discovered one of the prongs on the electrical cord was broken and the air mattress could no longer be plugged into the wall. Citizen 1 reported that she spoke with direct care staff, Bonita Gibbs, about the air mattress being in disrepair and Ms. Gibbs reported to Citizen 1 that there was a work order placed to repair the plug on the air mattress. Citizen 1 reported that the air mattress had been fixed within two business days, but the air mattress was still not working correctly as of 1/7/24 as it was not positioned correctly on Resident A's bed. She reported this caused the air to not flow correctly through the air mattress.

On 1/16/24 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Gonzalez regarding the allegation. Ms. Gonzalez reported that Resident A's air mattress had been in disrepair and has since been remedied. She reported that an electrician had to come to the facility to replace the outlet for the air mattress and the medical equipment company, responsible for the air mattress, came out and replaced the broken plug. Ms. Gonzalez reported that the air mattress was only in disrepair for one day before it was fixed.

During the on-site investigation on 1/16/24 I interviewed Ms. Smith. Ms. Smith reported that Resident A's air mattress had fallen into a state of disrepair and once notified of the issue the direct care staff placed a work order and the mattress was repaired in a period of 24 to 48 hours.

During the on-site investigation on 1/16/24 I reviewed Resident A's resident record. I reviewed the following documents:

- Sparrow Medical Supply Delivery Ticket, dated 1/2/24. This document noted, "PT has an RX for repair PT owned air mattress. PT has an APP from us. Go out and fix or replace when able."
- I also reviewed daily shift documentation from direct care staff providing for Resident A's care. I observed that on 1/3/24 it was documented by Ms. Gonzalez, "Sparrow Med Supply replaced bed pump today."

During on-site investigation on 1/16/24 I observed Resident A's air mattress to be fully functioning. Resident A reported no issues with his air mattress.

On 2/15/24 I interviewed Ms. Abram, via telephone. Ms. Abram reported that she was unaware of an issue with Resident A's air mattress, and she has no knowledge of a period where the mattress was not working correctly.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's

	physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Based upon interviews conducted with Citizen 1, Ms. Gonzalez, Ms. Smith, & Resident A, as well as review of Resident A's resident record, it can be determined direct care staff were made aware that Resident A's air mattress was not properly functioning and in disrepair, they then contacted Sparrow Medical Supply and arranged for the mattress to be repaired. There is not sufficient evidence that there was a significant lapse in time from the point the direct care staff were made aware of the issue and the time when they acted on the issue and contacted Sparrow Medical Supply for resolution. At the time of the on-site investigation the air mattress was functioning properly, and no issues could be identified.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A is not being provided a diabetic diet as ordered by his physician.

INVESTIGATION:

On 1/5/24 I received an online complaint regarding the facility. The complaint alleged that the direct care staff are not providing Resident A with a diabetic diet, as ordered by his physician. On 1/9/24 I interviewed Citizen 1 regarding the allegation. Citizen 1 reported that Resident A is diabetic and should be provided a diabetic diet. She reported that when she has visited Resident A, he will be consuming a meal that direct care staff have provided for him and the contents do not appear to comply with a diabetic diet. For example, Citizen 1 reported that she has observed direct care staff offer Resident A a peanut butter and jelly sandwich, potato chips, and a cookie as a meal. Citizen 1 also reported that she does not feel the direct care staff are monitoring Resident A's blood glucose levels. She reported that she is not certain this is ordered by the physician but found it concerning that Resident A is diabetic and does not appear to be provided a diabetic diet or has direct care staff monitoring his blood glucose levels.

On 1/16/24 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Gonzalez regarding the allegation. Ms. Gonzalez reported that the nutrition services are overseen by Aaron Biller, Director of Dining. She reported that what is listed on Resident A's *Health Care Appraisal* form under the section, Special Diet, is "ADA" diet, which she reported means, American Diabetic Diet. Ms.

Gonzalez reported that when a resident is admitted to the facility, or when a resident diet changes, the update is sent to the dietary department to be instituted for that resident. Ms. Gonzalez reported that she feels Resident A is being offered a diabetic diet. Ms. Gonzalez further reported that Resident A's physician discontinued the requirement to check Resident A's blood glucose levels and therefore the direct care staff are no longer monitoring this for Resident A.

During on-site investigation I interviewed Mr. Biller. Mr. Biller reported that when a new resident is admitted to the facility, he will receive dietary orders within three hours of the admission. He reported that this is how he is made aware of any special diets a resident may be ordered. Mr. Biller reported that a diabetic diet would contain lower carbohydrates, higher amounts of protein, and low sugar. He reported that he believes Resident A is being served a diabetic diet, but he tends to refuse the first option he is provided. Mr. Biller reported that frequently Resident A will refuse the meal offered to him and request a peanut butter and jelly sandwich instead.

During the on-site investigation I interviewed Resident A. Resident A was eating lunch in his bedroom when I arrived. He had a peanut butter and jelly sandwich on his tray that he was consuming. He was also provided tortilla chips and a cup of water to drink. Resident A reported that his favorite foods are peanut butter and jelly sandwiches, donuts, and ice cream.

During the on-site investigation on 1/16/24 I interviewed Ms. Smith. Ms. Smith reported that Resident A's diet is managed by the dietary staff, and she is not aware of the diet he is currently being provided.

During the on-site investigation I reviewed the following documents in Resident A's resident record:

- *Health Care Appraisal* dated 4/4/22. Under the section, *Special Dietary Instructions and Recommended Caloric Intake*, it reads, "regular diet".
- *Health Care Appraisal,* dated 12/5/22. Under the section, *Special Dietary Instructions and Recommended Caloric Intake*, it reads, "ADA diet".
- *New Prescription Summary,* dated 12/19/22, issued by provider, Andrew Johnson. On this document, under section, *Prescription as follows*, it reads, "discontinue blood sugar checks".
- *Assessment Plan for AFC Residents,* dated 4/11/23. On page 3, under the section, *Special Diets*, it is noted that there is "No" special diet ordered or provided.
- *Physician Dietary Orders,* dated 6/21/23, and signed by Ms. Gonzalez. This document notes that Resident A receives a "Regular Diet – No Restriction".

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	Based upon interviews with Citizen 1, Ms. Gonzalez, Mr. Biller, Ms. Smith, & Resident A, as well as review of Resident A's resident record it can be determined that Resident A was ordered a diabetic diet on his *Health Care Appraisal* form on 12/5/22 and this diet does not appear to have been implemented within the facility. Upon review of Resident A's documentation, the dietary orders on file with the dietary department are dated for 6/21/23 but do not include the addition of the diabetic diet, which was added to Resident A's *Health Care Appraisal* in December of 2022. This document has not been modified since the addition of the diabetic diet directive and there was no documentation provided to establish that the diabetic diet had been discontinued. Furthermore, Resident A's *Assessment Plan for AFC Residents* form was also not updated with the addition of the diabetic diet order. Even though, Resident A verbalizes that he prefers to eat foods that are higher in sugar, this does not overrule the necessity of Resident A's documentation to be updated with current information so that the diabetic diet ordered by his provider can be instituted for Resident A. Therefore, a violation has been established that the direct care staff did not have adequate knowledge of the diabetic diet that was ordered for Resident A on 12/5/22 per his *Health Care Appraisal* form.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's personal care is not being attended to regularly by direct care staff.

INVESTIGATION:

On 1/5/24 I received an online complaint regarding the facility. The complaint alleged that Resident A has not been receiving regular opportunities to shower and have his personal care needs met by direct care staff. On 1/9/24 I interviewed Citizen 1, via telephone. Citizen 1 reported that she will make visits to Resident A at the facility, and he will have a noticeable body odor. She reported that recently Resident A states he has asked for a shower for the past two to three weeks and has not received a shower. Citizen 1 reported that she had spoken with Ms. Gibbs about Resident A needing a shower and Ms. Gibbs reported to her that Resident A refuses

showers. Citizen 1 reported that Resident A had a history of refusing showers about a year prior but has since had his medications updated and has not been displaying these behavioral issues as of late. Citizen 1 reported that she has assisted Resident A with his personal care because he has requested her assistance and noted that the direct care staff are not bathing him regularly.

On 1/16/24 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Gonzalez. Ms. Gonzalez reported that each resident is scheduled for two showers per week, but Resident A will receive more than this as he requests additional showers. She reported that the direct care staff are no longer getting Resident A into the shower, but instead provide a full bed bath as Resident A prefers bed baths and will fight with direct care staff when they attempt to get him into the shower area.

During on-site investigation I attempted to interview Resident A regarding his personal care needs and direct care staff providing his personal care. Resident A presented as difficult to maintain focus on the questions being asked and more interested in socializing with direct care staff who would walk by his resident bedroom. He did not directly answer the questions asked of him pertaining to his personal care needs.

During on-site investigation on 1/16/24 I interviewed Ms. Smith. Ms. Smith reported that the direct care staff do not get Resident A into the shower, but instead provide full bed baths. She reported that Resident A will ask for bed baths daily and bed baths are provided to him at least two to three times per week, if not more. She reported that sometimes Resident A will ask to get into the shower for his personal care, but then when they attempt this, he fights with direct care staff, making this an unsafe experience for Resident A and the direct care staff members.

During on-site investigation on 1/16/24 I reviewed the following documents:

- *[Resident A] Shower Schedule*. This document notes, “All resident’s [sic] are to receive 2 bath’s/shower’s per week (includes washing hair, cleaning fingernails, trimming/filing fingernails)”. Resident A was listed on this document as receiving showers/baths on Tuesdays and Fridays, on first shift, with a make up day of Sundays.
- *Assessment Plan for AFC Residents* form, dated 4/11/23. On page 2 under the section, *II. Self Care Skill Assessment*, subsection, *Bathing*, it indicates that Resident A does need assistance with bathing. There was no narrative listed in this section, just “yes”. Under the same section, subsection, *Personal Hygiene*, it states, “Extensive: Caregiver performs most grooming or personal hygiene but resident is able to assist.”
- *Avalon Physician Services,* prescription dated 12/19/22, signed by Mr. Johnson, reads, “Discontinue pharmacy order to get patient up in chair due to frequent refusal. Add orders to care plan instead.”
- Daily shift documentation from direct care staff. I observed the following entries:

- 4/19/23, documented by Ms. Gonzalez, “Resident continues to be uncooperative with staff when attempting to provide care. Staff is often unable to get resident to take his medications or even get him to allow them to change his brief/clothes. He refuses showers/baths.”
- 4/9/23, documented by Ms. Gonzalez, “Resident has been uncooperative with staff. He will not allow them to change him and becomes belligerent when staff attempts to assist him.”

On 2/15/24 I interviewed Ms. Abram, via telephone, regarding the allegation. Ms. Abram reported that Resident A usually receives bed baths due to his limited mobility and endurance. She reported that Resident A becomes upset and fearful when the staff try to take him to the shower room as he must be transported using the Hoyer lift and this can be stressful for him. She reported that Resident A is blind, and she feels that this can play a factor in his fear when he is moved from his resident bedroom. Ms. Abram reported that recently Citizen 1 has requested that Resident A receive more showers in the shower room, and they are trying to accommodate this request, but Resident A does prefer a bed bath. Ms. Abram reported that she has no concerns about Resident A’s personal hygiene and noted she feels all staff are providing for his personal care and maintaining his hygiene appropriately.

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 upon interviews with Citizen 1, Ms. Gonzalez, Ms. Smith, & Ms. Abram, as well as review of Resident A’s resident record it can be determined that there is not adequate evidence Resident A is not receiving regular personal care and bathing/showering assistance from direct care staff members. Mr. Johnson had written an order acknowledging Resident A’s refusals to get out of bed, on 12/19/22. Multiple direct care staff acknowledged that they are bathing Resident A frequently, and that Resident A prefers a bed bath to a shower. Resident A presented as clean and well kept during the time of the on-site investigation and a shower schedule was reviewed identifying that Resident A receives, at minimum at least two showers/bed baths per week.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The carpet in Resident A's bedroom is stained and in poor repair.

INVESTIGATION:

On 1/5/24 I received an online complaint regarding the facility. The complaint alleged that Resident A's flooring in his bedroom is stained and in poor repair. On 1/9/24 I interviewed Citizen 1. Citizen 1 reported that Resident A's carpet has multiple stains on it from spilled drinks in his bedroom. She reported that these stains are red in color and difficult to clean. She reported that she had been trying to keep up with the stains and clean them herself, but it is becoming too difficult to manage as there are so many stains. Citizen 1 reported that she spoke with Ms. Gonzalez regarding the carpeting and was told that the administration at the facility has determined that they will not clean the carpet and suggested that Citizen 1 could pay to have the carpet replaced on her own. Citizen 1 reported that she was not happy with this response and has since brought in her own carpet to lay down over the existing carpet to cover the stains.

On 1/16/24 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Gonzalez. Ms. Gonzalez reported that Resident A's carpet is stained with multiple red stains as Resident A had thrown fruit punch drinks at the staff members on multiple occasions. She reported that they had the carpets cleaned on one occasion, but it did not resolve the issue. Ms. Gonzalez reported that Citizen 1 was told that she could pay for the cost to replace the carpet and Citizen 1 decided to purchase an area rug to go over the existing carpet to cover the stains.

During the on-site investigation on 1/16/24 I observed Resident A's resident bedroom and the condition of the carpet in the bedroom. I observed the newly purchased area rug that Citizen 1 had brought to the facility to cover the existing stains. Under the area rug were several large stains that were red in color. The carpet appeared to be in decent repair, except for the visible stains. There were no holes, tears, or other signs of damage to the existing carpet, beyond the stains. I observed the carpet to be clean but stained. It did appear that there were efforts made to clean the stains, but they were not able to be returned to the normal color of the carpet.

During on-site inspection I reviewed the following documents:

- Daily shift documentation from direct care staff. An entry from Ms. Gonzalez, dated 6/9/23, reads, "Resident continues to throw food and drinks at staff on a daily basis."

On 2/15/24 I interviewed Ms. Abram, via telephone, regarding the allegation. Ms. Abram reported that Resident A's resident bedroom is one of the cleanest bedrooms in the facility. She reported that there are red stains on Resident A's carpet as they often serve a fruit punch beverage with lunch and due to Resident A's blindness, he has spilled his glass from time to time. When questioned about the stains that were

further from Resident A's bed, Ms. Abram reported that there have been reports to her from other direct care staff members that Resident A used to throw his beverages at direct care staff to get their attention. She reported that these behaviors have decreased, but the carpet is permanently stained due to these past episodes.

On 2/13/24 I sent email correspondence to Mr. Fisher regarding the carpeting in Resident A's resident bedroom. Mr. Fisher responded to this inquiry on 2/20/24 and reported that he has held several conversations with Citizen 1 regarding the carpeting being stained with "fruit punch." Mr. Fisher reported that the carpeting in the bedroom was new when Resident A moved into the facility and since his move in, Resident A has thrown fruit punch beverages at the direct care staff causing the current stains on the flooring. Mr. Fisher reported that the facility administration has had the flooring steam cleaned several times and the stains do not resolve with steam cleaning. Mr. Fisher reported that it was discussed with Citizen 1 that if the family would like to pay for new carpeting, the facility administration would pay for installation of the new carpeting. Mr. Fisher reported that Citizen 1 opted not to pursue this option, but instead purchased an area rug to cover the existing carpeting and stains. Mr. Fisher reported that the facility administration has cleaned the area rug as well for Resident A.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.
ANALYSIS:	Based upon interviews with Citizen 1, Ms. Gonzalez, Ms. Abram, & Mr. Fisher and observations of Resident A's resident bedroom it can be determined that Resident A's bedroom carpet is stained with multiple red stains, but the carpet was clean and in good repair otherwise. The flooring did appear to have been cleaned, but the stains were not able to be removed. A violation cannot be determined at this time as the flooring was clean and in good repair besides the stains.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on 1/16/24 I reviewed the following documents in Resident A's resident record:

- *Health Care Appraisal* dated 4/4/22. Under the section, *Special Dietary Instructions and Recommended Caloric Intake*, it reads, "regular diet".

- *Health Care Appraisal,* dated 12/5/22. Under the section, *Special Dietary Instructions and Recommended Caloric Intake*, it reads, “ADA diet”.
- *New Prescription Summary,* dated 12/19/22, issued by provider, Andrew Johnson. On this document, under section, *Prescription as follows*, it reads, “discontinue blood sugar checks”.
- *Assessment Plan for AFC Residents,* dated 4/11/23. On page 3, under the section, *Special Diets*, it is noted that there is “No” special diet ordered or provided.
- *Physician Dietary Orders,* dated 6/21/23, and signed by Ms. Gonzalez. This document notes that Resident A receives a “Regular Diet – No Restriction”.

During the on-site investigation I interviewed Ms. Gonzalez, who reported that and “ADA diet” stands for a diabetic diet.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based upon the review of Resident A’s resident record and interview with Ms. Gonzalez it can be determined that Resident A was ordered a diabetic diet on his *Health Care Appraisal*, dated, 12/5/22, but his *Assessment Plan for AFC Residents* form was updated on 6/21/23 and did not include the provision for the newly ordered diabetic diet. Based on this information it can be determined that the direct care staff/licensee designee did not update Resident A’s assessment plan with appropriate changes to his plan of care.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 2/13/24 I sent an email correspondence to Executive Director of the facility, Mr. Fisher, requesting a copy of Resident A’s *Inventory of Valuables* form. On 2/20/24 Mr. Fisher responded to this request noting he did not have a copy of this form on file in Resident A’s resident record.

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	An *Inventory of Valuables* form was not available for review at the time of the on-site inspection in Resident A's resident record. When requesting a copy of this document from Mr. Fisher it was identified by Mr. Fisher that he could not find this document in Resident A's resident record.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/21/24

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Jana Lipps Date
Licensing Consultant

Approved By:

02/22/2024

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Dawn N. Timm Date
Area Manager