GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 1, 2024

Anna Sullivan
Christian Haven Home
704 Pennoyer
Grand Haven, MI 49417

RE: License #: AH700236766
Investigation #: 2024A1028064
Christian Haven Home

Dear Anna Sullivan:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH700236766
Investigation #:	2024A1028064
Complaint Receipt Date:	06/27/2024
Investigation Initiation Date:	07/03/2024
Report Due Date:	08/27/2024
Licensee Name:	Christian Haven Inc.
Licensee Address:	704 Pennoyer Ave. Grand Haven, MI 49417
Licensee Telephone #:	(616) 842-0170
Authorized Representative/Administrator:	Anna Sullivan
Name of Facility:	Christian Haven Home
Facility Address:	704 Pennoyer Grand Haven, MI 49417
Facility Telephone #:	(616) 842-0170
Original Issuance Date:	06/01/1999
License Status:	REGULAR
Effective Date:	04/28/2024
Expiration Date:	07/31/2024
Capacity:	60
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility did not ensure Resident A received emergency medical services in a timely manner.	Yes
Resident B fell in the bathroom on an unknown date in January 2024 and facility staff had Resident A assist them to help Resident B up from the floor.	No
The facility did not provide Resident A showers in accordance with the service plan.	No
The facility is short staffed.	No
The facility did not follow the service plan pertaining to Resident A's insulin pump device.	No
Resident A was given an unknown medication.	No
Resident B was given the incorrect dosage of Warfarin on 5/20/2024.	No
Resident A's and Resident B's clothing went missing at the facility.	No
The facility did not follow Resident A's special diet.	No
Additional Findings	No

III. METHODOLOGY

06/27/2024	Special Investigation Intake 2024A1028064
07/03/2024	Special Investigation Initiated - Letter
07/03/2024	APS Referral
07/09/2024	Contact - Face to Face Interviewed facility Admin/Anna Sullivan at the facility.
07/09/2024	Contact - Face to Face Interviewed facility Employee A at the facility.

07/09/2024	Contact - Face to Face Interviewed Employee B at the facility.
07/09/2024	Contact - Document Received Received requested documentation from AR/Admin/Anna Sullivan.

This special investigation will only address allegations pertaining to potential violation(s) of Homes for the Aged (HFA) rules and regulations.

ALLEGATION:

The facility did not ensure Resident A received emergency medical services in a timely manner.

INVESTIGATION:

On 6/27/2024, the Bureau received the allegations through the online complaint system.

On 7/3/2024, Adult Protective Services (APS) made referral to Homes for the Aged (HFA) through Centralized Intake.

On 7/9/2024, I interviewed facility administrator, Anna Sullivan, at the facility who reported Resident A and Resident B were admitted to the facility on 12/22/2023. Ms. Sullivan confirmed Resident A incurred a medical event on 2/29/2024 with Resident B notifying facility staff that Resident A was not well with staff arriving at the apartment to assess Resident A. Staff took Resident A's blood sugar and it was 37. A staff member called emergency services and then notified Resident A's family member. Ms. Sullivan reported there was some misunderstanding between a care staff member on duty and the family member about calling emergency services, but Ms. Sullivan confirmed emergency services were called prior to the family member being notified of Resident A's medical event. Emergency services arrived and treated Resident A on site with the family member staying overnight at the facility to monitor Resident A. Ms. Sullivan provided me with the requested documentation for my review.

On 7/9/2024, I interviewed Employee A whose statement was consistent with Ms. Sullivan's statement.

On 7/9/2024, I reviewed the requested documentation which revealed the following:

- On 2/29/2024 at 4:15am, Resident B alerted staff that Resident A was not well.
- Staff on duty observed Resident A in [their] chair unresponsive and shaking.
- Staff took Resident A's blood sugar, and it was 37.

- Staff called for help from other staff and discovered the insulin pump was not connected.
- Other staff member went to call emergency services.
- The family member arrived as staff was making call to emergency services.
- The family member reported [they] “had seen this before with [Resident A]” and requested sugar packets to administer to Resident A.
- After a few minutes, the family member agreed to let staff call emergency services.
- Emergency services arrived and treated Resident A onsite.
- The family member stayed overnight at the facility to continue to monitor Resident A.
- Resident A’s service plan was developed on 12/27/2023 with the provision that Resident A and the family member agreed to manage prescribed insulin pump to include supplies, administration, and maintenance of all diabetic supplies and insulin pump.
- The service plan was signed by Resident A and the family member on 1/3/2024.

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: **(c) Assure the availability of emergency medical care required by a resident.**

ANALYSIS:	It was alleged the facility did not ensure that Resident A received emergency medical care during a low blood sugar event. Interviews, on-site investigation, and review of documentation reveal the following: • Resident A incurred a medical event on 2/29/2024 requiring emergency services. • Emergency services were called but there is conflicting evidence between staff interviews and what was documented in the record as to whether it was prior to the family member being called and arriving on the scene and agreeing that emergency services be called. • Also, Resident A and Resident B were [their] own persons at the time of the medical event and the facility did not require the family member's permission to call emergency services. Due to the conflicting information between staff interviews and what was documented in the record, it cannot be determined if staff called emergency services in a timely manner and/or prior to the family member arriving at the facility. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B fell in the bathroom on an unknown date in January 2024 and facility staff had Resident A assist them to help Resident B up from the floor.

INVESTIGATION:

On 7/9/2024, Ms. Sullivan reported Resident B had a couple of falls at the facility but at no time did Resident A ever assist staff in helping Resident B off of the floor. Ms. Sullivan reported staff never requested assistance from Resident A or Resident B when a fall occurred. Resident A would want to help Resident B when a fall occurred, but staff did not let Resident A help and Resident A would become abrasive at times because staff refused to allow [them] to help. Ms. Sullivan provided me with the requested documentation for my review.

On 7/9/2024, Employee A reported Resident B incurred a couple of falls while at the facility, but only staff assisted Resident B up from the floor. Resident A did not assist staff at any time during a fall and would intermittently become abrasive with staff when staff refused to allow Resident A to assist Resident B.

On 7/9/2024, I reviewed the requested documentation which revealed the following:

- On 3/1/2024, Resident B pushed alarm pendant and staff found Resident B sitting on the floor in [their] room. Resident B stated [they] slipped out of bed onto the floor and could not get back up because [they] had on socks. [Resident B] stated [they] did not hit [their] head. Resident B was assisted back to bed. Resident A was a witness to Resident B's fall.
- On 5/18/2024, Resident A pushed alarm pendant for Resident B and staff found Resident B sitting on the floor on the side of the bed facing the nightstand. Resident A asked staff to help Resident B off the floor and reported Resident B slid to the floor. Staff asked what happened and Resident B reported "I don't know what happened. I just slid on the floor." Resident B reported [they] did not hit [their] head. Staff assessed Resident B and assisted Resident B off of the floor.
- On 5/20/2024, staff entered Resident B's room to do a wake-up check and Resident B stumbled to the door. Staff inquired if Resident B was ok with Resident B reporting "it feels like everything is spinning". Resident B's legs and arms were observed by staff to be very swollen. No fall reported.
- On 5/22/2024, the physician saw Resident B at the facility to address resident's fall, high blood pressure, and swelling in ankles and wrists.

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.
ANALYSIS:	It was alleged that Resident B fell in the bathroom on an unknown date in January 2024 and facility staff had Resident A assist them to help Resident B up from the floor. Interviews, the onsite investigation, and review of documentation reveal no evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not provide Resident A showers in accordance with the service plan.

INVESTIGATION:

On 7/9/2024, Ms. Sullivan reported Resident A demonstrated refusals of showers and requested that [they] only receive one shower per week because it was taxing

for Resident A to complete. Ms. Sullivan reported the service plan still allotted for two showers weekly, but Resident A had the right to refuse showers and when Resident A refused, the facility honored the refusal. The refusals of showers were documented as well.

On 7/9/2024, Employee A's statement was consistent with Ms. Sullivan's statement.

On 7/9/2024, I reviewed the requested documentation which revealed the following:

- Resident A required one person assistance to shower.
- Resident A was to receive two showers per week per the service plan.
- On 1/7/2024, 1/22/2024, 5/15/2024, 5/19/2024, 5/29/2024, and 6/2/52024, Resident A refused showers.
- On 2/28/2024, Resident A requested [they] would like showers changed to one time per week because "it takes too much out of [Resident A]". The designated family member was present when Resident A made request to staff. Staff alerted the facility supervisor about Resident A's request.

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.
ANALYSIS:	It was alleged the facility did not provide Resident A showers in accordance with the service plan. Interviews, the onsite investigation, and review of documentation reveal no evidence to support this allegation. Resident A had a documented history of refusals of showers. The facility provided showers in accordance with the service plan and honored Resident A's intermittent refusals when asked to shower. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is short staffed.

INVESTIGATION:

On 7/9/2024, Ms. Sullivan reported the facility is not short-staffed and that call-ins are rare. Ms. Sullivan reported each shift is fully staffed and that when a call-in occurs, there are staff available to fill the call-in to ensure no shift is short staffed.

Ms. Sullivan provided me with the working staff schedules for my review from May 2024 to July 2024.

On 7/9/2024, Employee A's statement was consistent with Ms. Sullivan's statement.

On 7/9/2024, I reviewed the working staff schedules and noted an appropriate amount staff to resident ratio, with very little call-ins.

**Please note that the working staff for schedules for February 2024 to April 2024 were recently reviewed during the on-site facility inspection in April 2024 and no concerns were noted during the inspection.

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:	It was alleged the facility was short staffed. Interviews, onsite investigation, and review of documentation reveal there is no evidence to support this allegation. The facility demonstrates an appropriate staff to resident ratio. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not follow the service plan pertaining to Resident A's insulin pump device.

INVESTIGATION:

On 7/9/2024, Ms. Sullivan reported Resident A was [their] own person but had a designated family member in place that agreed to manage Resident A's insulin pump and all associated supplies. Ms. Sullivan reported that at the time of admission, Resident A's designated family member agreed to supply, administer, and maintain all diabetic supplies and the insulin pump with the designated family member and Resident A signing the service plan in agreement upon admission. The insulin pump was registered to a phone application on the designated family member's cellphone so [they] could manage Resident A's blood sugar and insulin. Ms. Sullivan reported when Resident A entered the facility [they] were presented as being independent with use of insulin pump, but Resident A quickly began to demonstrate otherwise, so Resident A and [their] designated family member were conferenced with to find an

alternative solution. Ms. Sullivan reported due to the number of incidents of mismanagement by Resident A, a sliding scale was recommended by the physician so the facility could take over management of the insulin, but Resident A and the designated family member were not agreeable to the sliding scale and chose to wait until an upcoming endocrinology doctor appointment to determine the next steps in Resident A's diabetic management. Ms. Sullivan reported Resident A moved out of the facility before the sliding scale recommendation or any other recommendation could be reviewed and potentially implemented for Resident A. Ms. Sullivan also reported the facility conferenced with Resident A and the designated family member multiple times about the concern of Resident A's mismanagement of the insulin pump. Ms. Sullivan reported the facility also conferenced with Resident A and the designated family member about the supplies needing to be sent to the home of the designated family member due to the facility not handling the management of the insulin pump supplies. Ms. Sullivan reported the supplies kept being sent to the facility despite the facility requesting the supplies be kept with the designated family member as agreed upon in the service plan.

On 7/9/2024, Employee A's statement was consistent with Ms. Sullivan's statement.

On 7/9/2024, Employee B's statement was consistent with Ms. Sullivan's statement and Employee A's statement.

On 7/9/2024, I reviewed the requested documentation which revealed the following:

- The service plan reads: *Resident prescribed insulin w/pump. Resident/Family supplies, administers, and maintains all diabetic supplies and insulin w/pump.*
- On 1/11/2024, Resident A couldn't find tubing for insulin pump. Staff assisted Resident A to find tubing which was found attached to Resident A's body. Resident A reported [they] had checked and did not see it on [their] body.
- On 1/13/2024, Resident A reported the insulin pump came out and blood sugar was 354.
- On 1/2/2024, Resident A's blood sugar was extremely low. Resident A was given crackers and orange juice and it rose to 94. Facility staff called family and was instructed to give Resident A peanut butter crackers and apple juice that Resident A already had in [their] room.
- On 2/10/2024, Resident A's blood sugar was 357 and Resident A gave [their self] an insulin dosage with blood sugar dropping to 257. Resident A stated [they] felt better, and facility staff monitored.
- On 2/12/2024, Resident A's blood sugar dropped to 69. Staff provided Resident A a peanut butter sandwich and apple juice. Resident A also reported [they] ate an orange sugar tablet as well with blood sugar rising to 207. Staff documented concerns about Resident A being able to continue to self-administer sugar pill.
- On 2/26/2024, Resident A had high blood sugar due to eating peanut butter pie for dessert. Blood sugar was 300 and staff reminded Resident A to give [their self] insulin with blood sugar later dropping to 109.

- On 2/29/2024, Resident B alerted staff that Resident A was not feeling well. Blood sugar was 37 and staff discovered the insulin pump was not connected. Designated family member and emergency services were alerted with emergency services arriving and treating Resident A onsite at the facility.
- On 3/1/2024, Resident A's blood sugar was 407. Family present and blood sugar was checked later, and it dropped to 137.
- On 3/9/2024, Resident A was provided orange juice and peanut butter sandwich due to low blood sugar. Resident A rechecked blood sugar and reported it had risen.
- On 3/25/2024, Resident A's blood sugar was 215. No abnormal behaviors and no signs of discomfort. Staff monitored.
- On 3/28/2024, Resident A requested peanut butter sandwich due to low blood sugar. As peanut butter sandwich was delivered to Resident A's room, Resident A reported [their] blood sugar was going back up due to eating snacks that were already in the room. Resident A still ate the peanut butter sandwich and blood sugar was 107. No other concerns noted.
- On 4/1/2024, Resident A's blood sugar was 247. Staff monitored Resident A with Resident A reporting [they] would wait until morning to take insulin dosage.
- On 4/3/2024, Resident A demonstrated confusion about the time-of-day and reported [they] were changing something on the insulin pump and must have gotten confused. Resident A also reported the insulin pump may need to be fixed due to giving error messages. Resident A's blood sugar was 241.
- On 4/5/2024, Resident A demonstrated confusion and agitation, refusing prescribed onsite facility X-ray appointment.
- On 4/5/2024 at 8:30pm, Resident A's blood sugar was 281 with Resident A reporting [they] were going to take insulin. Staff monitoring.
- On 4/5/2024, the designated family called the facility at 11:15 pm about due to receiving notification through the phone app that Resident A's blood sugar was 55. Staff went to Resident A's room and observed Resident A already drinking orange juice and eating cookies. Staff also provided Resident A a peanut butter sandwich and an additional glass of orange juice per designated family member's request via phone call. Designated family member arrived at the facility shortly after phone call and stayed until Resident A's blood sugar stabilized. Blood sugar eventually dropped to 134.
- On 4/6/2024 at 7:44pm, Resident A's blood sugar was 307 with Resident A reporting [they] were going to administer [their self] insulin. At 8:35pm, the blood sugar was rechecked, and it was 330. Resident A reported [they] forgot to take their bolus after lunch and would do it now. Designated family member notified and instructed Resident A to put insulin pump at 22 to resolve high blood sugar.
- On 4/11/2024, Resident A's blood sugar was 211at 7:00 pm and had risen to 249. Resident A reported [they] would administer [their self] insulin. Staff monitoring.
- On 4/12/2024, the designated family member called the facility at 11:40 pm about due to receiving notification through the phone app that Resident A's

blood sugar was 49. The designated family member requested the facility to provide Resident A orange juice. The facility provided Resident A orange juice with the designated family member arriving at the facility shortly after the phone call. Resident A's blood sugar rose to 120 and the designated family member stayed with Resident A until 6:00am to monitor Resident A.

- On 4/19/2024, the designated family member reported Resident A got a new pump and had already administered insulin.
- On 4/24/2024 at 8:15am, the designated family member called the facility due to receiving notification through the phone app that Resident A's blood sugar was low. The designated family member requested the facility administer to orange juice and cookies and to let Resident A know [they] were on [their] way to the facility. After arriving at the facility, the designated family member reported the insulin pump was giving the wrong reading and Resident A's blood sugar was not low. Blood sugar was 129.
- On 4/25/2024 at 2:00 pm, Resident A's blood sugar was 369, but designated family was present and ensured insulin was administered to Resident A.
- On 4/25/2024, the designated family member was at the facility most of day to monitor Resident A due to blood sugar being 400.
- On 4/25/2024 at 5:13 pm, designated family member reported Resident A's blood sugar is 300 but the pump is not showing anything, so [they] will take Resident A to emergency room after dinner.
- On 4/25/2024 at 8:45 pm, the designated family member reported Resident A's blood sugar is still high but coming down.
- On 4/26/2024, Resident A's blood sugar was 220 at 11:30pm. At 5:40am, it was 163 and Resident A was provided chicken noodle soup to see if Resident A could tolerate it.
- On 4/30/2024, Resident A received diabetic supplies of Dexcom sensor (30, Dexcom G6 transmitter kit x 2. Supplies were put in overflow cabinet at the facility.
- On 5/1/2024, Resident A's blood sugar was high around dinner time, with the designated family member arriving to assist Resident A.
- On 5/3/2024 at 8:07 pm, Resident A is going to give [their self] insulin. Staff to monitor.
- On 5/11/2024, Resident A's blood sugar was 357 with the designated family member calling facility and instructing Resident A to self-administer insulin. Staff to monitor.
- On 5/15/2024 at 5:29 pm, the insulin pump isn't displaying numbers. Resident A reported the designated family member is on the way to assist them with insulin pump.
- On 5/15/2024 at 8:38 pm, Resident A's pump still not displaying blood sugar levels but Resident A tested blood sugar using needle and it was 449. Resident A to give self insulin.
- On 5/18/2024, Resident A was demonstrating confusion and refused meals. Resident A asked staff to look at blood sugar. Staff called designated family member and facility supervisor about Resident A's demonstrated confusion.

- On 5/19/2024, Resident A's blood sugar was 310 at 7:37 pm with Resident A giving self insulin. At 8:37 pm, Resident A's blood sugar was still 307. Staff had Resident A recheck at bedtime and it dropped to 232. No other concerns.
- On 5/27/2024, the designated family member called and instructed Resident A to double insulin because blood sugar was too high. Resident A reported they gave [their self] 44 units and that the monitor was on all night. Staff reported the monitor only read HIGH.
- On 6/5/2024, Resident A moved out of the facility.
- Evidence of communication with the physician.
- Evidence of communication with designated family member.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) A service plan must identify prescribed medication to be self-administered or managed by the home.
ANALYSIS:	It was alleged the facility did not follow the service plan pertaining to Resident A's insulin pump device. Interviews, onsite investigation, and review of documentation reveal there is no evidence to support this allegation. Resident A and the designated family member signed Resident A's service plan on 1/3/2024 agreeing to manage all supplies, administration, and to maintain all diabetic supplies and insulin with pump. The facility monitored Resident A for safety and due to demonstrated intermittent confusion with insulin pump. The facility demonstrated consistent communication with Resident A, the designated family member, and the physician as well to ensure Resident A's health and wellbeing. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was given an unknown medication.

INVESTIGATION:

On 7/9/2024, Ms. Sullivan reported no knowledge of Resident A being given an unknown pill with green beads on the inside of it that burned Resident A's throat on 5/29/2024. Ms. Sullivan reported Resident A demonstrated confusion concerning [their] medications at times and refusals intermittently as well. Ms. Sullivan reported

the facility followed all physician orders for medication administration. Ms. Sullivan provided me the requested documentation for my review.

On 7/9/2024, Employee A's statement was consistent with Ms. Sullivan's statement.

On 7/9/2024, Employee B's statement was consistent with Ms. Sullivan's statement and Employee A's statement.

On 7/9/2024, I reviewed Resident A medication administration record which revealed the following:

- On 5/29/2024, Resident A refused a multivitamin tablet due to Resident A *stating it is not hard to swallow but makes [their] throat sore.*
- Resident A was prescribed one multivitamin tablet to take by mouth once daily.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	It was alleged Resident A was administered an unknown medication on 5/29/2024. Interviews, on-site investigation, and review of documentation reveal there is no evidence to support this allegation. On 5/29/2024, facility staff attempted to administer Resident A the prescribed multivitamin in accordance with physician orders and Resident A refused to complaints of the medication making [their] throat sore. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B was given the incorrect dosage of Warfarin on 5/20/2024.

INVESTIGATION:

On 7/9/2024, Ms. Sullivan reported Resident B was given new orders for Warfarin on 5/23/2024, but on 5/29/2024 Resident B was administered an incorrect amount of Warfarin. The medication error was immediately reported to Resident B's physician with the physician instructing all Warfarin to be held for two days. Ms. Sullivan

reported an internal corrective action was made to ensure the medication error would not occur again and the staff member was given re-education and re-training as well.

On 7/9/2024, I reviewed the requested documentation which revealed the following:

- Resident B was to be administered half of 1 tablet of 2.5mg (½ tablet = 1.25mg) on Monday, Tuesday, Thursday, Friday, Saturday, and Sunday in the evening.
- On 5/29/2024, Resident B was administered a 1 whole tablet of Warfarin 2.5mg at 7:41am.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	It was alleged Resident B was given the incorrect dosage of Warfarin on 5/20/2024. Interviews, on-site investigation, and review of documentation reveal the following: • Resident B was administered an incorrect dosage of Warfarin on 5/29/2024. Resident B was administered a 1 whole tablet of Warfarin 2.5mg at 7:41am instead of being administered half of 1 tablet of Warfarin (½ tablet = 1.25mg) in evening. • Resident B was given the incorrect dosage at the wrong time of day. However, the facility immediately observed the medication error and notified the physician immediately. The facility also put an internal corrective action plan into place and the staff member was provided re-education and re-training immediately to ensure competency and to prevent a reoccurrence of medication administration errors. The facility took immediate and appropriate measures to immediately the medication administration error, to re-educate and re-train staff, and to prevent a reoccurrence. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's and Resident B's clothing went missing at the facility.

INVESTIGATION:

On 7/9/2024, Ms. Sullivan reported in January 2024 that Resident B requested a staff member assist [them] with reorganizing [their] and Resident A's clothes in the shared dresser so Resident B would have enough room for [their] clothes. The staff member assisted Resident B in reorganizing the shared dresser and bagged the clothing that was removed from the dresser. The staff member called the family member to let [them] know that the clothing was removed from the dresser per Resident B's request, and it was bagged and left in Resident A's and Resident B's room next to the dresser for pick-up by the family member. Ms. Sullivan reported the clothing was never picked up by the family member and that the family member did not inquire about the whereabouts of the clothing until April 2024. It cannot be determined where the clothing is or if it was picked up by another family member. Ms. Sullivan reported Resident A and Resident B's laundry was completed in accordance with their service plans and that both residents had clothing at the facility.

On 7/9/2024, Employee A's statement was consistent with Ms. Sullivan's statement.

On 7/9/2024, I reviewed Resident A and Resident B's service plan which revealed the facility managed laundry services for both residents.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(3) The home shall make adequate provision for the laundering of a resident's personal laundry.
ANALYSIS:	It was alleged Resident A and Resident B's clothing went missing at the facility. Interviews, onsite investigation, and review of documentation reveal there is no evidence to support this allegation. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not follow Resident A's special diet.

INVESTIGATION:

On 7/9/2024, Ms. Sullivan reported Resident A is diabetic but was not prescribed a special diet by the physician. Ms. Sullivan reported Resident A made their own food

choices and was encouraged to make healthy choices, but Resident A did not always make healthy choices. Resident A's service plan notates to limit concentrated sweets. Ms. Sullivan reported there are sugar free options and diabetic friendly food options available at the facility, but Resident A would choose sugary food items.

On 7/9/2024, Employee A's statement is consistent with Ms. Sullivan's statement.

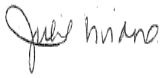
On 7/9/2024, I reviewed Resident A's service plan which revealed the following:

- Resident A does not have a prescribed diabetic diet or special diet.
- Concentrated sweets provided by the facility dietary department were to be limited for Resident A.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(4) Medical nutrition therapy, as prescribed by a licensed health care professional and which may include therapeutic diets or special diets, supplemental nourishments or fluids to meet the resident's nutritional and hydration needs, shall be provided in accordance with the resident's service plan unless waived in writing by a resident or a resident's authorized representative.
ANALYSIS:	It was alleged the facility does not follow Resident A's special diet. Interviews, onsite investigation, and review of documentation reveal that while Resident A has a diabetes diagnosis, Resident A is not prescribed a special diet. Concentrated sweets were notated to be limited per Resident A's service plan, but Resident A was [their] own person and despite staff encouragement, Resident A did not always make healthy food choices. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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



7/22/2024

Julie Viviano Date
Licensing Staff

Approved By:

07/30/2024

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