RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

October 22, 2018

Sami Al Jallad
Turning Leaf Residential Rehabilitation Services
P.O. Box 23218
Lansing, MI 48909

RE: License #: AS330087739
Investigation #: **2018A0783054**
Spruce Cottage

Dear Mr. Al Jallad:

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) 284-9720.

Sincerely,

Leslie Barner, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330087739
Investigation #:	2018A0783054
Complaint Receipt Date:	08/28/2018
Investigation Initiation Date:	08/29/2018
Report Due Date:	10/27/2018
Licensee Name:	Turning Leaf Residential Rehabilitation Services
Licensee Address:	621 E. Jolly Rd. Lansing, MI 48910
Licensee Telephone #:	(517) 393-5203
Administrator:	Audrey Rock
Licensee Designee:	Sami Al Jallad
Name of Facility:	Spruce Cottage
Facility Address:	621 E. Jolly Rd. Lansing, MI 48910
Facility Telephone #:	(517) 393-5203
Original Issuance Date:	12/01/1999
License Status:	REGULAR
Effective Date:	03/20/2017
Expiration Date:	03/19/2019
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A should be in a regular nursing home.	No
Resident A has been feeling like he wants to kill someone but has been able to hold off.	No
Staff members put Resident A's medication in his food.	No
Resident A is not treated with consideration and respect at the facility.	No
Staff at the facility are giving Resident A "uppers."	No
The resident bedrooms at the facility are too small.	No
Additional Findings	Yes

III. METHODOLOGY

08/28/2018	Special Investigation Intake 2018A0783054
08/29/2018	Special Investigation Initiated - On Site
08/29/2018	Inspection Completed On-site
08/29/2018	Contact - Face to Face Interview with administrator Audrey Rock, direct care staff member Keanna Adams, clinical therapist Tami Carter, and Resident A
08/29/2018	Contact - Document Received Resident A's resident record
09/25/2018	Contact - Document Received Email message from central intake with additional information for SIR #2018A0783054
10/11/2018	Inspection Completed On-site

10/11/2018	Contact - Face to Face Interviews with assistant case manager Breona Clawson, program manager Ken Evans, direct are staff members Bri Sephers and Ambur Florez, and Resident A
10/16/2018	Exit Conference With administrator Audrey Rock due to licensee designee being unavailable

ALLEGATION:

Resident A should be in a regular nursing home.

INVESTIGATION:

On August 28, 2018 I received an anonymous complaint via central intake that stated Resident A should be in a regular nursing home but was placed at the facility by his guardian because it is more affordable than a nursing home.

On August 29, 2018 I completed an unannounced onsite inspection and interviewed facility administrator Audrey Rock who stated Resident A was admitted to the facility on 7/9/18 and that he requires supervision in the community, assistance with personal care such as eating, toileting and bathing, and supervision for taking medication. Ms. Rock said Resident A does not require continuous nursing care.

On August 29, 2018 I interviewed direct care staff member Keanna Adams who stated she has worked at the facility for 5 months and is familiar with Resident A. Ms. Adams said Resident A requires supervision in the community, assistance with toileting and bathing, and supervision for medication administration. Ms. Adams said Resident A told her he would rather reside in a nursing home, but he does not require continuous nursing care.

On August 29, 2018 I interviewed Resident A who stated other than struggling with mobility, he is healthy. Resident A denied that he has any health condition that requires continuous nursing care.

On August 29, 2018 I reviewed Resident A's written *Health Care Appraisal* signed by doctor Joseph Armovit and dated 7/16/18. The *Health Care Appraisal* stated Resident A is diagnosed with hypothyroidism, dysphasia, and schizophrenia. There is nothing on the *Health Care Appraisal* that indicates Resident A requires continuous nursing care.

On August 29, 2018 I reviewed Resident A's written *Assessment Plan for AFC Residents* signed by Resident A's guardian, Resident A, and the licensee on 7/11/18. The written assessment plan stated Resident A communicates needs, understands verbal communication, is alert to surroundings, follows instructions, is capable of bathing, grooming, and dressing himself, is mobile with the use of a walker, will become established with a primary care physician, dentist, and eye doctor in the Lansing area, and will be seen by a psychiatrist every six months. There is nothing in the written assessment plan that indicates Resident A requires continuous nursing care.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(1) A licensee shall not accept, retain, or care for a resident who requires continuous nursing care. This does not preclude the accommodation of a resident who becomes temporarily ill while in the home, but who does not require continuous nursing care.
ANALYSIS:	Based on statements from Ms. Rock, Ms. Adams, and Resident A as well as written documentation in Resident A's resident record there is lack of evidence to support the allegation that Resident A requires continuous nursing care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A has been feeling like he wants to kill someone but has been able to hold off.

INVESTIGATION:

On August 28, 2018 I received an anonymous complaint via central intake that stated Resident A has been residing at the facility for several years and has resided in mental health facilities for the past 23 years. The complaint stated Resident A has been in a total of 17 mental health hospitals for the criminally insane due to being convicted of three murders and nine attempted murders. The complaint stated Resident A has been feeling like he wants to kill someone, but he has been able to hold off.

On August 29, 2018 I interviewed facility administrator Audrey Rock who stated Resident A was admitted to the facility on 7/9/18 from Caro Center psychiatric hospital. Ms. Rock said Resident A has schizophrenia and suffers from delusions. Ms. Rock said Resident A has never been convicted of murder or attempted murder. Ms. Rock said when Resident A was admitted to the facility he expressed that he used to have a "killer complex" but is now cured. Ms. Rock denied that Resident A has expressed that he wants to kill someone since he was admitted on 7/9/18.

On August 29, 2018 I interviewed direct care staff member Keanna Adams who stated Resident A was admitted to the facility in July 2018 and that he "talks to himself a lot and says things that are delusional." Ms. Adams said Resident A has vocalized that he is being poisoned or that something in the water is making everyone crazy but that he has never vocalized anything she would interpret as aggressive or threatening. Ms. Adams said she does not believe Resident A has a criminal history, as that was never brought to her attention. Ms. Adams said Resident A has never said he wanted to kill anyone.

On August 29, 2018 I interviewed facility therapist Tami Carter who stated she has met with Resident A on several occasions, including earlier that day. Ms. Carter denied that Resident A has ever expressed any homicidal ideology or stated that he felt like killing anyone. Ms. Carter denied that Resident A has been convicted of murder or attempted murder and confirmed that he has been hospitalized for mental health treatment "many times" due to delusions from Schizophrenia.

On August 29, 2018 I interviewed Resident A who denied that he has been feeling like killing anyone. Resident A said he was accused of murdering three people but stated he did not do it. Resident A said he gets along with everyone and does not want to kill anyone.

On August 29, 2018 I reviewed *CLS Staff Notes* for Resident A from 7/9/18 – 8/29/18. I read every note from every shift and there is no indication that Resident A ever expressed any homicidal ideation, made any threats, or said he felt like killing someone.

On August 29, 2018 I reviewed Resident A's written *Assessment Plan for AFC Residents* signed by Resident A's guardian, Resident A, and the licensee on 7/11/18. The assessment plan stated Resident A stated he does not get upset, that he is a perfect gentleman, and that he had a killer complex but is cured. There is nothing in the assessment plan to indicate Resident A has homicidal ideation.

On August 29, 2018 I reviewed Resident A's *Person Centered Plan* (PCP) dated 7/9/18. One of the goals listed in Resident A's PCP was "The client will evidence absence of homicidal or aggressive thoughts and/or behaviors toward others." The objective for that goal was "verbalizations and behaviors do not reflect thoughts of homicide or aggression toward others." The interventions for that goal were behavior management and individual counseling. The staff instructions for that goal were

"staff will provide opportunities for skill development through engagement in evidence based day treatment groups and psycho-education. Staff will encourage appropriate and active participation in such activities – prompting, guiding, and redirecting as needed. Staff will ensure materials are presented to client at an appropriate level based on level of education/impairment." The PCP stated Resident A "is educated, has a great sense of humor and is willing to participate in treatment despite believing there is no cure for mental illness. [Resident A] requires 24/7 supervision, monitoring and treatment due to his long history of hospitalizations and chronic mental illness. Factors that may impact treatment: cognitive, age specific, communication, and physical limitations. [Resident A] has a long history of mental illness. He was originally hospitalized at the age of 19. Symptoms include: depressed mood, elevated mood, anxiety, insomnia, auditory and visual hallucinations, religious preoccupation, racing thoughts, tangential thinking, rambling speech, agitation, and aggression."

APPLICABLE RULE	
R 400.14301	**Resident rights; licensee responsibilities.**
	(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 and determined 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.**
ANALYSIS:	Based on statements from Ms. Rock, Ms. Adams, Ms. Carter, and Resident A, Resident A has not expressed either verbally or behaviorally that he wanted to kill someone since he was admitted to the facility on 7/9/18. However, based on his written PCP, if Resident A does have homicidal or aggressive thoughts or behaviors there is a written plan in place to address those thoughts and behaviors. There is lack of evidence that the amount of personal care, supervision, and protection required by the resident is not available in the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff members put Resident A's medication in his food.

INVESTIGATION:

On September 25, 2018 I received an email message from central intake containing additional information pertaining to the complaint filed on 8/28/18 which stated staff

members put Resident A's medication in his food, including pills that keep him up all night.

On October 11, 2018 I interviewed facility case manager assistant Breona Clawson who stated she is familiar with Resident A. Ms. Clawson said Resident A has been diagnosed with dysphasia and cannot swallow pills, so all his medication is crushed and administered in yogurt or apple sauce. Ms. Clawson said Resident A's physician ordered that his medication be crushed. Ms. Clawson said when the medication is administered in yogurt or apple sauce Resident A is verbally told that his medication is in the yogurt or apple sauce and is also told specifically what medication is being administered. Ms. Clawson said Resident A has been diagnosed with schizophrenia and is paranoid. Ms. Clawson said Resident A has expressed believing that staff members are altering his medication because it must be administered in crushed form and Resident A has been consistently refusing to take his medication.

On October 11, 2018 I interviewed facility assistant program manager Ken Evans who stated he is familiar with Resident A. Mr. Evans said Resident A has a dysphasia care plan that requires all his food to be pureed to the consistency of apple sauce and his medication to be crushed and administered in apple sauce or yogurt. Mr. Evans said before crushing the medication and administering it in apple sauce or yogurt, direct care staff members "present the medication first," then ask Resident A if he wants to take then medication, then crush it and place it in apple sauce or yogurt if he agrees to take the medication. Mr. Evans said Resident A has been diagnosed with schizophrenia and has paranoid delusions that his medication is being altered because it must be crushed. Mr. Evans stated for that reason, Resident A has been refusing to take his medication.

On October 11, 2018 I interviewed direct care staff member Ambur Florez who stated she is familiar with and has administered medication to Resident A. Ms. Florez said Resident A has difficulty swallowing so his food must be pureed to the consistency of apple sauce and his medication must be crushed because Resident A is not capable of swallowing pills. Ms. Florez said she was trained to inform Resident A of each medication that is being administered in apple sauce and to determine whether he wishes to take the medication. Ms. Florez said the medication is never "hidden" in the food and that Resident A refuses all medication. Ms. Florez said Resident A believes direct care staff members crush the medication because they are trying to hide medication in his food, but the medication is crushed per Resident A's care plan because he would choke on a pill if he tried to swallow one.

On October 11, 2018 I interviewed direct care staff member Bri Sephers who stated she is familiar with Resident A. Ms. Sephers said Resident A has difficulty swallowing so all his food must be pureed to the consistency of apple sauce and all his medication must be crushed and administered in food. Ms. Sephers stated Resident A is notified what medication is being administered and given the opportunity to decide if he wants to take the medication before it is crushed and placed in food. Ms. Sephers said Resident A regularly refuses to take his prescribed

medication but that he is more likely to accept the medication if it is administered in milk rather than apple sauce.

On October 11, 2018 I interviewed Resident A who said he believes staff members are trying to hide medication in his food. Resident A said he has no teeth and difficulty swallowing so all his food is pureed. Resident A said direct care staff members put his medication in apple sauce, yogurt, or milk rather than giving him pills and if staff members are not attempting to hide his medication they should give him the pills. Resident A said staff members ask him if he wants to take his medication and if he answers affirmatively staff members administer the medication in food or milk. Resident A denied that staff members are putting medication in his food without informing him but stated he believes direct care staff members should not be putting his medication in food at all.

On August 29, 2018 and October 11, 2018, I reviewed Resident A's resident record. Resident A's *Health Care Appraisal* dated 7/16/18 stated a diagnosis of dysphasia and stated solid food should be pureed to consistency of apple sauce. Resident A's *Assessment Plan for AFC Residents* dated 7/11/18 stated Resident A "needs his food pureed as he does not have any teeth; client stated that he does choke sometimes."

APPLICABLE RULE	
R 400.14304	**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: **(m) The right to refuse treatment and services, including the taking of medication, and to be made aware of the consequences of that refusal.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Based on interviews with Ms. Clawson, Mr. Evans, Ms. Florez, Ms. Sephers, and Resident A as well as written documentation Resident A has been diagnosed with dysphasia and has difficulty swallowing so his medication is crushed and put in apple sauce, yogurt, or milk. Based on statements from everyone interviewed Resident A is informed each time his medication is to be administered and given the opportunity to refuse the medication. There is lack of evidence to support the allegation that Resident A's right to refuse medication has been violated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is not treated with consideration and respect at the facility.

INVESTIGATION:

On August 28, 2018 I received an anonymous complaint via central intake that stated Resident A can't sleep at night because staff member at the facility are trying to make him "go crazy."

On September 25, 2018 I received an email message from central intake containing additional information pertaining to the complaint which stated televisions at the facility are left on all night, the staff members come into the residents' rooms at 2:00 am and wake them up, Resident A's roommate turns on the light at 3:00 am, snores and wakes Resident A, which the staff members do not address. The email message stated due to the snoring, Resident A has had two nervous breakdowns and has slept a total of ten hours in three months. The email message stated Resident A has requested to speak to the facility social worker multiple times and she has not met with him.

On August 29, 2018 I interviewed Resident A who stated he has difficulty sleeping because his roommate makes noise and snores all night and turned on the light at 3:00 am which also which also makes it difficult for him to sleep. Resident A said he has reported this concern to direct care staff members who have not addressed the concern.

On August 29, 2018 I interviewed facility administrator Audrey Rock who stated no staff member has reported to her that Resident A is having trouble sleeping but that he does have a history of insomnia.

On August 29, 2018 I interviewed direct care staff member Keanna Adams who stated she has worked at the facility for 5 months and is familiar with Resident A but

does not work the night shift. Ms. Adams said the night staff members that she relieves in the morning have told her that Resident A was up all night due to his roommate snoring. Ms. Adams said Resident A told her he can't sleep at night because his roommate snores, so Resident A sleeps on the couch in the living room sometimes.

On August 29, 2018 I interviewed facility clinical therapist Tami Carter who said Resident A mentioned that his roommate snores which makes it difficult for him to sleep.

On August 29, 2018 and October 11, 2018, I interviewed program manager Ken Evans who stated Resident A had a roommate who snored at night, but that roommate has been removed from Resident A's bedroom and Resident A is now alone in a double occupancy bedroom. Mr. Evans said Resident A complained that he couldn't sleep at night but based on conversations with direct care staff members who regularly work the night shift and a review of case notes maintained by the staff members, it appears that Resident A typically goes to bed by 1:00 am and sleeps through the night. Mr. Evans said Resident A is chronically incontinent, so staff members encourage him to get up and use the bathroom, or have his brief changed if it is wet to avoid skin breakdown from being left in a wet adult incontinence brief. Mr. Evans said Residents are encouraged to keep the television at a low level during sleep hours in the living room and that there is no television in Resident A's bedroom. Mr. Evans said the facility does not employ a social worker and that assistant case manager Breona Clawson speaks to Resident A weekly.

On October 11, 2018 I interviewed facility assistant case manager Breona Clawson who said she is familiar with Resident A and speaks with him directly at least once weekly. Ms. Clawson acknowledged that Resident A complained about his roommate snoring and that as of approximately three weeks ago Resident A's roommate is no longer in the room with Resident A and Resident A is alone in a double occupancy bedroom. Ms. Clawson said Resident A historically suffers from insomnia but based on case notes that she has reviewed, Resident A sleeps through the night most nights. Ms. Clawson said residents are able to watch television in the living room when they desire but are encouraged to keep the volume low when other residents are asleep. Ms. Clawson said there is no television in Resident A's bedroom. Ms. Clawson said Resident A wears an adult incontinence brief and that staff members may wake him at night to have his brief changed if they observe that he is wet. Ms. Clawson said this is done in an effort to avoid skin breakdown or other possible negative outcomes from being left in a wet adult incontinence brief. Ms. Clawson said there is no "facility social worker," but stated as assistant case manager, she is probably "the closest thing" to a facility social worker. Ms. Clawson said she makes face–to–face contact with Resident A at least once weekly.

On October 11, 2018 I interviewed direct care staff member Ambur Florez who stated she is familiar with Resident A and regularly works until 12:00 am. Ms. Florez denied that Resident A expressed to her that he has difficulty sleeping. Ms. Florez

said at this time Resident A does not have a roommate. Ms. Florez said Resident A typically goes to bed at 10:00 pm and is sleeping when she checks on him every 15 minutes throughout the night. Ms. Florez said Residents, including Resident A do watch television in the living room during the night but are encouraged to maintain the volume at a low level. Ms. Florez said there is no television in Resident A's bedroom. Ms. Florez said Resident A has never requested to have the television turned down. Ms. Florez said Resident A is chronically incontinent and if a direct care staff member observes that he is wet during the night, he/she will wake Resident A to encourage him to change his brief and get dry clothing and bedding if needed. Ms. Florez said there is no "facility social worker" and that Resident A has not requested to speak with anyone at the facility that she is aware of.

On August 29, 2018 I reviewed *CLS Staff Notes* for Resident A for the month of August 2018 which includes information about Resident A's activities and behaviors staff members have documented during each shift. Based on the notes, Resident A "was asleep during most of the observations" from 11:00 pm to 7:00 am during 24 of 30 nights. In a note dated 8/16/18 direct care staff member Coteze Clark documented that Resident A "was awake most of shift. [Resident A] kept complaining about roommate snoring that he possibly was losing sleep and tried to sleep on the couch. [Resident A] then went to sleep numerous hours later."

On August 29, 2018 I reviewed Resident A's *Person Centered Plan* dated 7/9/18 which stated Resident A suffers from insomnia.

APPLICABLE RULE	
R 400.14304	**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: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Based on statements from everyone interviewed and written documentation at the facility Resident A suffers from insomnia. Based on interviews Resident A did complain that his roommate snored which kept him awake and Resident A is no longer assigned to the same bedroom as that resident. Mr. Evans, Ms. Clawson and Ms. Florez all indicated Resident A is chronically incontinent and is woken by staff members at night if they determine that Resident A is wet and needs his brief, clothing, or bedding changed. Staff notes indicated Resident A "was asleep during most of the observations" almost every night in August 2018. Everyone interviewed stated there is a television in the living room and not in Resident A's bedroom and that the television is maintained at a low volume during sleeping hours. Mr. Evans, Ms. Clawson and Ms. Florez denied that there is a social worker employed by the facility and said that as assistant case manager Ms. Clawson speaks to Resident A weekly. There is lack of evidence to support the allegation that Resident A is not treated with consideration and respect at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff at the facility are giving Resident A "uppers."

INVESTIGATION:

On August 28, 2018 I received an anonymous complaint via central intake that stated staff members at the facility are giving Resident A "uppers" and he can't sleep at night and hallucinates as a result.

On August 29, 2018 I interviewed facility administrator Audrey Rock who stated Resident A is prescribed several medications that have a sedative effect but stated none of Resident A's prescribed medication could be considered a stimulant or an "upper." Ms. Rock stated staff members only administer medication to Resident A that was prescribed by his doctors and staff members do not administer "uppers" to Resident A. Ms. Rock said she has never observed that a direct care staff member gave Resident A an "upper" and nobody has ever reported that allegation to her. Ms. Rock said Resident A has a history of insomnia and a diagnosis of schizophrenia with delusions and hallucinations.

On August 29, 2018 I interviewed program manager Ken Evans who stated Resident A is prescribed several "psychotropic" medications to help with "agitation" or to stabilize Resident A's mood. Mr. Evans said none of Resident A's prescribed medication have a stimulant effect or could be considered "uppers." Mr. Evans said all Resident A's medication is administered per a written physician's order and that

staff members do not administer “uppers” to Resident A. Mr. Evans said he has never observed that a direct care staff member gave Resident A an “upper” and nobody has ever reported that allegation to him.

On August 29, 2018 I interviewed direct care staff member Keanna Adams who stated she administers medication to Resident A. Ms. Adams stated Resident A is prescribed several medications but none of them have a stimulant effect or would be considered “uppers.” Ms. Adams stated she has never administered any medication to Resident A that was not prescribed by a physician nor has she ever witnessed or heard of another staff member doing so.

On October 11, 2018 I interviewed direct care staff member Ambur Florez who stated she administers medication to Resident A. Ms. Florez stated Resident A is prescribed several medications to manage his diagnosed schizophrenia but none of them are stimulants or would be considered “uppers.” Ms. Florez said she has never administered any medication to Resident A that was not prescribed by a physician nor has she ever witnessed or heard of another staff member doing so.

On October 11, 2018 I interviewed direct care staff member Bri Sephers who stated she administers medication to Resident A. Ms. Sephers stated Resident A is not prescribed any stimulants or “uppers.” Ms. Sephers said she has never administered any medication to Resident A that was not prescribed by a physician nor has she ever seen or heard of another staff member doing so.

On August 29, 2018 I reviewed written physician’s orders for Resident A’s medication. Based on the written physician’s orders Resident A is prescribed Haloperidol (2 ml at noon and 2 ml at bedtime), Invega (inject intramusculary every four weeks), Clonidine (one tablet by mouth twice a day), Lasix (one tablet by mouth once a day), Synthroid (take one tablet by mouth daily, 30 to 60 minutes before breakfast), Thera – M Caplet (take one tablet by mouth daily), Flomax (take one capsule by mouth at bedtime) , Nyamyc powder (apply liberally to groin area twice a day), and Colace (take one capsule by mouth twice a day as needed).

On August 29, 2018 I reviewed Resident A’s medication administration record (MAR) for the month of August 2018. Based on the written MAR Resident A is prescribed Haloperidol (2 ml at noon and 2 ml at bedtime), Invega (inject intramusculary every four weeks), Clonidine (one tablet by mouth twice a day), Lasix (one tablet by mouth once a day), Synthroid (take one tablet by mouth daily, 30 to 60 minutes before breakfast), Thera – M Caplet (take one tablet by mouth daily), Flomax (take one capsule by mouth at bedtime) , Nyamyc powder (apply liberally to groin area twice a day), and Colace (take one capsule by mouth twice a day as needed). The written MAR documented that every medication was administered as prescribed or refused by Resident A during the month of August 2018.

On August 29, 2018 I completed an unannounced onsite inspection and reviewed all medications onsite at the facility for Resident A. Every medication on site for

Resident A had a corresponding written physician's order and was documented on the MAR.

On August 29, 2018 I reviewed Resident A's written *Person Centered Plan* (PCP) dated 7/9/18. The written plan documented that Resident A experiences insomnia as well as auditory and visual hallucinations due to "a long history of mental illness."

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on statements from Ms. Rock, Mr. Evans, Ms. Adams, Ms. Florez, and Ms. Sephers Resident A's medication is administered per the written orders completed by Resident A's physicians. Ms. Rock, Mr. Evans, Ms. Adams, Ms. Florez, and Ms. Sephers all denied that Resident A is prescribed or given "uppers" to keep him awake or make him hallucinate. Written documentation at the facility and an unannounced onsite inspection indicated every medication on site is accurately recorded on the MAR and has a corresponding written physician's order for the medication. The MAR indicated Resident A's medication was administered as prescribed or refused by Resident A in August 2018. Resident A's written PCP stated Resident A suffers from insomnia as well as visual and auditory hallucinations. There is lack of evidence to support the allegation that direct care staff members are administering "uppers" or any medication that is not prescribed by a licensed physician.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The resident bedrooms at the facility are too small.

INVESTIGATION:

On September 25, 2018 I received an email message from central intake containing additional information pertaining to the complaint which stated resident bedrooms are too small and the lights are too bright.

On October 11, 2018 I completed an unannounced onsite inspection and measured Resident A's bedroom. At this time Resident A does not have a roommate but the bedroom is set up for two residents to be able to reside in the room. The room measured 11' 1'' X 13' 5'' which is approximately 150 square feet. I observed there is one light fixture in the bedroom.

On October 11, 2018 I reviewed Bureau Information and Tracking System (BITS) for Spruce Cottage which indicated the facility was in full compliance with all physical plant requirements when the original license was issued on 4/19/2000.

APPLICABLE RULE	
R 400.14409	**Bedroom space; "usable floor space" defined.**
	(3) A multioccupancy resident bedroom shall have not less than 65 square feet of usable floor space per bed.
ANALYSIS:	Based on entries in BITS as well as my own measurement of Resident A's bedroom the bedroom has more than 65 square feet of usable floor space per resident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On October 11, 2018 I interviewed assistant case manager Breona Clawson, program manager Ken Evans, and direct care staff members Ambur Florez and Bri Sephers who stated Resident A's medications are crushed with a pill crusher prior to administering them to Resident A because he has difficulty swallowing pills.

On August 29, 2018 I completed an unannounced onsite inspection and reviewed all medications onsite at the facility for Resident A. The medication labels stated among other things Resident A is prescribed one tablet of Clonidine by mouth twice a day, one tablet of Lasix by mouth once a day, one tablet of Synthroid by mouth daily, one

tablet of Thera – M Caplet by mouth daily, one capsule of Flomax by mouth at bedtime, and one capsule of Colace by mouth twice a day as needed. There was no physician's order to crush Resident A's medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on statements from Ms. Clawson, Mr. Evans, Ms. Florez and Ms. Sephers Resident A's medication is crushed prior to administration. The label instructions on Resident A's medication state the tablet or the capsule should be administered to Resident A and do not indicate the medication should be crushed. Thus, Resident A's medication was not given pursuant to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/22/2018

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Leslie Barner Date
Licensing Consultant

Approved By:

10/22/2018

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Dawn N. Timm Date
Area Manager