GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 15, 2021

Anne Kesler
Country Woods Assisted Living, LLC
8504 Doe Pass
Lansing, MI 48917

RE: License #: AM230388695
Investigation #: 2022A0783004
Country Woods Assisted Living

Dear Ms. Kesler:

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,

Leslie Herrguth, 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 #:	AM230388695
Investigation #:	2022A0783004
Complaint Receipt Date:	10/20/2021
Investigation Initiation Date:	10/21/2021
Report Due Date:	12/19/2021
Licensee Name:	Country Woods Assisted Living, LLC
Licensee Address:	8504 Doe Pass Lansing, MI 48917
Licensee Telephone #:	(517) 224-8300
Administrator:	Anne Kesler
Licensee Designee:	Anne Kesler
Name of Facility:	Country Woods Assisted Living
Facility Address:	7021 Hartel Road Potterville, MI 48876
Facility Telephone #:	(517) 224-8300
Original Issuance Date:	08/27/2019
License Status:	REGULAR
Effective Date:	02/27/2020
Expiration Date:	02/26/2022
Capacity:	12
Program Type:	AGED ALZHEIMERS

ALLEGATION(S)

	Violation Established?
On October 18, 2021, staff member Aneica Black was scheduled to work alone and one resident admitted to the facility requires assistance from two staff members.	No
Medications that were prescribed to residents who have passed away or discharged are not disposed of timely.	Yes
Residents are given discharged residents' prescription medication if refills are not obtained in a timely manner.	No

II. METHODOLOGY

10/20/2021	Special Investigation Intake – 2022A0783004
10/21/2021	Special Investigation Initiated – Telephone call with Complainant
10/27/2021	Inspection Completed On-site
10/27/2021	Contact - Face to Face interviews with licensee designee Anne Kesler and home manager Ronda Ballman
10/27/2021	Contact - Document Received – Written assessment plans, Health Care Appraisals, and medication administration records for each resident
12/02/2021	Contact - Telephone call made to former direct care staff member Janet Turner
12/07/2021	Contact - Telephone call made to direct care staff member Aneica Black
12/08/2021	Exit Conference with Anne Kesler

ALLEGATION:

On October 18, 2021, staff member Aneica Black was scheduled to work alone and one resident admitted to the facility requires assistance from two staff members.

INVESTIGATION:

On October 20, 2021, I received a complaint via email that stated on October 18, 2021, during the night shift, staff member Aneica Black was scheduled to work alone when one resident requires assistance from two people.

On October 21, 2021, I spoke to Complainant who verified the allegations in the written complaint and stated Ms. Black telephoned another direct care staff member, Janet Turner to come to the facility to assist her on October 18, 2021.

On October 27, 2021, I interviewed licensee designee Anne Kesler who stated there are ten residents currently admitted to the facility in total and no residents presently admitted to the facility require assistance from two staff members for any reason. Ms. Kesler said Resident A requires assistance from one staff member and a Hoyer lift to transfer and that Resident A is "bed bound." Ms. Kesler said there are no other residents who require the use of a Hoyer lift to transfer. Ms. Kesler stated between the hours of 2:00 pm and 4:00 pm and 8:00 pm and 6:00 am, one staff member is scheduled to work, and two staff members are scheduled to work during the morning, early afternoon, and evening hours. Ms. Kesler stated she does not admit residents to the facility who require assistance from more than one staff member for any reason. Ms. Kesler stated and showed me and employee schedule to verify that staff members Aneica Black and Janet Turner regularly work alone from 8:00 pm until 6:00 am.

On October 27, 2021, I interviewed home manager and direct care staff member Ronda Ballman who stated there are ten residents admitted to the facility in total and none of them require assistance from two staff members for any reason. Ms. Ballman said one staff member is scheduled to work from 8:00 pm to 6:00 am and two staff members work during waking hours. Ms. Ballman described Resident A as "bed ridden," and stated he needs help from one staff member who uses a Hoyer lift to transfer Resident A from his bed to his wheelchair. Ms. Ballman said Resident B is also "bed ridden," but only requires assistance from one staff member for anything. Ms. Ballman stated the remaining eight residents are easily assisted by one staff member. Ms. Ballman stated she has worked alone at the facility and cleaned, prepared meals for the following day, helped Residents with toileting and "turning" every two hours, "and still had extra time."

On December 7, 2021, I spoke to direct care staff member Aneica "Annie" Black who stated there are no residents admitted to the facility who require assistance from two staff members for any reason. Ms. Black said she worked alone on October 18,

2021, from 10:00 pm until 6:00 am on October 19, 2021. Ms. Black said on that date two residents fell, which is unusual for both residents, so she called licensee designee Anne Kesler and home manager Ronda Ballman to come to the facility and assess those residents, which they did. Ms. Black denied that she needed assistance from another staff member to assist Resident A, Resident B, nor any other resident. Ms. Black said she only called Ms. Kesler and Ms. Ballman to assess the residents who fell because falling was unusual for both residents. Ms. Black stated one staff member can use a Hoyer lift to transfer Resident A and no other residents require the use of a Hoyer lift for transferring. Ms. Black described the facility as "quiet at night," and stated most residents sleep through the night. Ms. Black said on October 18, 2021, and every other day she worked alone she was able to complete all tasks related to resident care independently.

On December 2, 2021, I spoke to direct care staff member Janet Turner who stated Resident A and Resident B require assistance from one person and a Hoyer lift to transfer. Ms. Turner stated one staff member can use the Hoyer lift to transfer Resident A and Resident B. Ms. Turner stated the remaining eight residents admitted to the facility are able to transfer and ambulate with little to no assistance from any staff member. Ms. Turner said she regularly worked alone during resident sleeping hours from 8:00 pm until 6:00 am and was able to complete all aspects of resident care independently. Ms. Turner denied that Ms. Black ever called and asked her to come to the facility and assist her with anything when she was not scheduled to work.

On October 27, 2021, I received and reviewed the current written resident register which indicated there were ten residents admitted to the facility on October 20, 2021, when the written complaint was received.

On October 27, 2021, I received and reviewed the employee schedule for October 2021 and noted that generally, one staff member is scheduled to work from 2:00 pm to 4:00 pm and during resident sleeping hours from 8:00 pm until 6:00 am. There were generally two staff members scheduled to work the remaining hours. I noted that staff member Aneica Black was scheduled to work alone from 8:00 pm until 6:00 am on October 18 – 19, 2021.

On October 27, 2021, I received and reviewed each resident's current written *Assessment Plan for AFC Residents* including Resident A's written assessment and Resident B's written assessment. Neither Resident A's nor Resident B's written assessment plans indicated either resident required assistance from two staff members for any reason. The remaining eight written assessment plans were reviewed and none of them documented that any resident requires assistance from two staff members for any reason.

On October 27, 2021, I received and reviewed each resident's current written *Health Care Appraisal* including Resident A's and Resident B's written *Health Care Appraisals*. Resident A's written *Health Care Appraisal* dated April 23, 2021, stated

Resident A uses a wheelchair for ambulation. Resident A's written *Health Care Appraisal* described Resident A as "alert, calm, in no acute distress." Resident A's written *Health Care Appraisal* stated Resident A has a history of traumatic brain injury and "a stage 1 ulcer, difficulty hearing, dysphasia and risk of aspiration, urinary incontinence, and multiple fractures of the cervical spine." Resident A's written *Health Care Appraisal* which was signed by a physician did not indicate that Resident A requires assistance from two staff members for any reason. Resident B's written *Health Care Appraisal* dated January 21, 2021, described Resident B as "fully ambulatory" and having "moderate dementia." Resident B's written *Health Care Appraisal* which was signed by a physician did not indicate Resident B needs assistance from two staff members for any reason.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on statements from Ms. Kesler, Ms. Ballman, Ms. Black, Ms. Turner, and written documentation at the facility there is lack of evidence to indicate that any resident at the facility including Residents A and B require assistance from two staff members for any reason. The interviews conducted and written documents reviewed indicated there were always sufficient direct care staff on duty to provide services to residents based on their written assessment plans throughout the month of October 2021 including October 18, 2021.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications that were prescribed to residents who have passed away or discharged are not disposed of timely.

INVESTIGATION:

On October 20, 2021, I received a complaint via email that stated there is a locked drawer underneath the printer in the facility office that contains medications from discharged residents. The complaint stated this medication was just witnessed two days ago and that if the licensee is aware a representative from LARA is coming to the home, she removes the medication.

On October 21, 2021, I spoke to Complainant who verified the allegations in the written complaint and stated only licensee designee Anne Kesler and the home manager Ronda Ballman have access to the medication referenced in the complaint.

On October 27, 2021, I completed an unannounced onsite inspection at the facility and noted a locked, two-drawer filing cabinet in the office that contained medication. I requested that the cabinet be opened and compared the medication in the drawers to the current resident register and determined there were medications in the cabinet prescribed for residents who were deceased or no longer admitted to the facility. For Resident C who passed away on August 14, 2021, I observed the medications acetaminophen and Buspar. For Resident D who passed away on September 27, 2021, I observed the medications Ultram, Ativan, Oxycodone, haloperidol, hyoscyamine sulfate, and acetaminophen suppositories. For Resident E who passed away on June 3, 2021, I observed the medications Morphine and Santyl Ointment. For Resident F who moved to another facility on August 5, 2021, I observed the medication Buspirone. I also noted medications that were on current residents' current medication administration logs that had been sent by the pharmacy for a "cycle fill," but were not yet needed by residents.

On October 27, 2021, I spoke to Licensee Designee Anne Kesler who verified there is a locked filing cabinet in the facility office that only she and Ms. Ballman had access to, but Ms. Kesler denied that she was aware the cabinet contained medications including narcotic medications that were prescribed for residents who have passed away or were discharged from the facility. Ms. Kesler said as the home manager it is Ms. Ballman's responsibility to properly dispose of medications that are no longer needed. Ms. Kesler stated she believed the medications were in the locked filing cabinet because Ms. Ballman intended to destroy the medications or send the medications back to the pharmacy. Ms. Kesler stated she expected Ms. Ballman to dispose of any medications belonging to residents who have passed away or discharged within one month of no longer needing the medication for the resident.

On October 27, 2021, I spoke to home manager and direct care staff member Ronda Ballman who verified there is a locked cabinet in the facility office for which only she and Ms. Kesler have keys to unlock. Ms. Ballman said some of the medications in the filing cabinet at the time of the unannounced onsite inspection needed to be "destroyed or sent back to the pharmacy." Ms. Ballman stated she requested that a representative from the pharmacy take the no longer needed prescription medication, but the person did not take the medication. Ms. Ballman stated she was unaware there were medications in the cabinet from residents who passed away months prior, as it was Ms. Kesler's responsibility to properly dispose of the unneeded medication.

On December 2, 2021, I spoke to former direct care staff member Janet Turner who stated she administered medication to residents at the facility as part of her job

responsibilities. Ms. Turner stated there was a locked cabinet in the facility office that only Ms. Kesler and Ms. Ballman could unlock. Ms. Turner stated she believed the cabinet contained medications that needed to be destroyed or sent back to the pharmacy.

On December 7, 2021, I spoke to direct care staff member Aneica Black who stated she administers medication at the facility as part of her job responsibilities. Ms. Black said acknowledged a locked cabinet in the facility office and stated she believes it contains medication that is no longer used by current residents and needs to be destroyed or returned to the pharmacy.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	Based on my observations at the unannounced onsite inspection and interviews with Ms. Kesler, Ms. Ballman, Ms. Turner, and Ms. Black it can be determined that there were medications at the facility that were prescribed for residents who were either deceased or discharged, including narcotic medication, that belonged to residents who passed away as long ago as June 2021. Thus, prescription medication that was no longer needed by multiple residents was not disposed of after consultation with a pharmacist; rather the medication was stored at the facility in a locked cabinet.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are given discharged residents' prescription medication if refills are not obtained in a timely manner.

INVESTIGATION:

On October 20, 2021, I received a complaint via email that stated medication from discharged residents is kept at the facility and used for other currently admitted residents when refills are not obtained in a timely manner.

On October 21, 2021, I spoke to Complainant who verified the allegations in the written complaint and stated this occurred during the night shift on October 18, 2021.

On October 27, 2021, I completed an unannounced onsite investigation at the facility and reviewed all the medication on site compared to the resident register and current residents' medication administration records. While there were medications at the facility prescribed for residents who have deceased or discharged, there was no written evidence to indicate any of that medication was used nor intended for use by any current resident. The medications were locked and only the licensee designee and home manager had access. The medication cart used by direct care staff members contained all currently prescribed medication for each resident currently admitted to the facility.

On October 27, 2021, I reviewed every resident's written medication administration record for October 18, 2021, and October 19, 2021 and found no written evidence to indicate that any resident was out of any medication. There was no written evidence to suggest that one resident's medication was used for another resident.

On October 27, 2021, I reviewed the employee schedule for October 18, 2021 and noted that staff member Aneica Black worked from 8:00 pm on October 18, 2021 to 6:00 am on October 19, 2021.

On October 27, 2021, I interviewed licensee designee Ann Kesler who stated all medications are refilled on a cycle and the medications are automatically filled and send to the home monthly. Ms. Kelser said any medication prescribed or needed between "cycle fills" is filled at the Meijer Pharmacy. Ms. Kesler denied that she is aware of nor that she ever instructed any direct care staff member to administer one resident's medication to another resident. Ms. Kesler stated all employees have been trained in the proper techniques for administering medication and that per the training, no staff member would give a resident a medication that was not prescribed for that resident, even if it was the same medication prescribed to another resident.

On October 27, 2021, I interviewed direct care staff member and home manager Ronda Ballman who stated all medications are refilled on a cycle and the medications are automatically filled and send to the home monthly. Ms. Ballman said any additional medication prescribed or needed during the month is filled at the Meijer Pharmacy. Ms. Ballman denied that she is aware of nor that she ever instructed any direct care staff member to administer one resident's medication to another resident. Ms. Ballman denied that she ever administered one resident's medication to another resident.

On December 7, 2021, I spoke to direct care staff member Aneica Black who stated she administers medication at the facility as part of her job responsibilities and has never given one resident's medication to another resident. Ms. Black denied that residents' prescribed medications are regularly or even occasionally not at the facility for her to administer. Ms. Black denied that she has ever been instructed to administer one resident's medication to another resident, nor has she done so on October 18, 2021, nor any other day.

On December 2, 2021, I spoke to former direct care staff member Janet Turner who said during one of her scheduled shifts at the facility licensee designee Anne Kesler gave Ms. Turner a medication that was prescribed for one resident and told her to administer the medication to another resident because the second resident was out of that particular medication. Ms. Turner denied that she followed Ms. Kesler's instructions and said she never gave a resident medication prescribed for another resident. Ms. Turner was not able to provide any details such as the date nor the residents involved in the alleged incident.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Although Ms. Turner said she was told to give one resident another resident's medication, she could not provide any details and she denied that she followed those instructions. Based on each resident's written medication administration record, my observations at the onsite investigation, and interviews with Ms. Kesler, Ms. Ballman, and Ms. Black there is lack of evidence to prove that the licensee neglected to take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

III. RECOMMENDATION

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

12/13/21

Leslie Herrguth Date
Licensing Consultant

Approved By:

12/15/2021

Dawn N. Timm Date
Area Manager