GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 25, 2022

Satish Ramade
Margaret's Meadows, LLC
5257 Coldwater Rd.
Remus, MI 49340

RE: License #: AL370264709
Investigation #: 2022A1029019
Margaret's Meadows

Dear Mr. Ramade:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL370264709
Investigation #:	2022A1029019
Complaint Receipt Date:	12/27/2021
Investigation Initiation Date:	12/27/2021
Report Due Date:	02/25/2022
Licensee Name:	Margaret's Meadows, LLC
Licensee Address:	5257 Coldwater Rd., Remus, MI 49340
Licensee Telephone #:	(989) 561-5009
Administrator:	Satish Ramade
Licensee Designee:	Satish Ramade
Name of Facility:	Margaret's Meadows
Facility Address:	5257 Coldwater Road, Remus, MI 49340
Facility Telephone #:	(989) 561-5009
Original Issuance Date:	10/11/2004
License Status:	REGULAR
Effective Date:	10/23/2021
Expiration Date:	10/22/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

ALLEGATION(S)

	Violation Established?
The facility does not have adequate staffing.	No
Resident J and E did not receive their medications as prescribed.	Yes
The facility does not have staff trained in medication administration to administer medications.	Yes
Resident G did not receive lab readings from the Internalized Normalized Ratio (INR) machine to measure his blood levels for his Coumadin medication.	Yes

II. METHODOLOGY

12/27/2021	Special Investigation Intake 2022A1029019
12/27/2021	Special Investigation Initiated – Telephone to complainant
01/12/2022	Contact - Document Sent to Careline for documents
01/12/2022	Contact - Telephone call made to Careline to request orders
01/15/2022	Contact - Document Received Email from Satish Ramade with requested documents
01/19/2022	Contact - Document Received -New concerns regarding staffing
01/21/2022	Contact - Telephone call made to Careline Physicians Group Lindy Hilding
01/21/2022	Contact - Document Received -Medication records reviewed that were sent from Satish Ramade.
01/21/2022	Contact - Telephone call received from Lindy Hilding
01/21/2022	Contact - Face to Face with Staff 1, Staff 2, Resident A, Resident G, and Resident J
02/01/2022	Contact - Document Received Email from Satish Ramade

02/04/2022	Contact - Document Received - Satish Ramade sent over the *Assessment Plans, Health Care Appraisals*, and the January direct care staff member schedule at Margaret's Meadows
02/04/2022	Contact - Telephone call made to Staff 3
02/04/2022	Contact - Telephone call made to Staff 4
02/08/2022	Contact - Telephone call made Careline Hospice, McKenzie McCann
02/08/2022	Contact - Telephone call received from Careline administrator, Patti Rohn. Message left.
02/14/2022	Contact - Telephone call made to Relative J1 and J2, spoke to Relative J2
02/14/2022	Contact - Telephone call made to Careline Patti Rohn
02/14/2022	Contact - Telephone call received from Relative J2
02/14/2022	Contact - Telephone call made to Staff 8- wireless customer unavailable. No ability to leave message.
02/14/2022	Contact - Telephone call made to Staff 12, wrong number
02/14/2022	Contact - Telephone call made to Staff 7. Mailbox full.
02/14/2022	Contact - Telephone call made to Staff 6. Left a message.
02/14/2022	Contact - Telephone call made to Staff 5
02/14/2022	Contact - Telephone call received from Staff 5
02/14/2022	Contact - Telephone call made to Staff 8
02/14/2022	Exit conference with Satish Ramade
02/15/2022	Contact – Telephone call to Lindy Hilding

ALLEGATION:

The facility does not have adequate staffing.

INVESTIGATION:

On December 27, 2021, a complaint was received via a rejected Adult Protective Services referral from Centralized Intake stating Margaret's Meadows did not have adequate staffing to provide for the residents' care needs.

On December 27, 2021, I interviewed Lindy Hilding, MSW, NP who is the nurse practitioner assigned to Margaret Meadows through Careline Physicians Health Group. NP Hilding stated this is the worst staffing situation she has observed at Margaret's Meadows. She stated she has spoken with licensee designee Satish Ramade regarding the lack of staffing. During her last phone conference with licensee designee Ramade regarding staffing, NP Hilding stated she suggested having an LPN hired and stated this would be helpful to provide support for the direct care staff members however Mr. Ramade stated this was not in his budget. In December 2021, there were 14 residents at Margaret's Meadows and 12 of them were provided hospice services through Careline Hospice. At the time of the special investigation, FP Hilding stated there were two residents that require the assistance of two direct care staff members for mobility assistance: Resident F and Resident K.

On January 19, 2022, additional concerns were received via the BCHS online complaint system regarding low staffing. A complaint was received stating that the facility should have three direct care staff members working as it's too much work for two direct care staff members.

On January 21, 2022, I contacted NP Hilding who confirmed Resident K and Resident F required two person assistance for mobility and transferring. NP Hilding stated Resident K required assistance to transfer, reposition, and was in bed most of the time.

On January 21, 2022, I interviewed Staff 1 at Margaret's Meadows. She stated her current role is Mr. Ramade's office assistant. She stated she does not work as a direct care staff member and mostly takes care of office work. She has worked at Margaret's Meadows for three weeks. She stated staff schedules are completed by Mr. Ramade. She stated there are currently three residents (Residents E, F, and K) who require the assistance of two direct care staff members for mobility and transferring. During the on-site investigation, I observed two direct care staff members working with Staff 1. Staff 1 stated there was a third direct care staff member but they left at 1:00 p.m. Staff 1 stated Mr. Ramade is at the facility Monday – Thursday and some Fridays as well. Staff 1 also stated direct care staff members are responsible for preparing and cooking all resident meals as well doing the cleaning and laundry for residents. During the January 21, 2022, onsite investigation, there were 14 residents residing at Margaret's Meadows according to Staff 1.

On January 21, 2022, I interviewed Staff 2 at Margaret's Meadows who stated there are currently two residents who require the assistance of two direct care staff members for mobility and transferring. Staff 2 stated those two residents are Resident K and Resident F.

I interviewed Resident G at Margaret's Meadows. He stated he has a history of falling because he will try to reach for something and fall. He stated he feels the staff at Margaret's Meadows do a nice job. He said he has a problem with dandruff and wants to make sure he gets a shower each week and he typically does this on Sunday. He felt they could use more staff to help because they seem busy but he does not have to wait for something to be done.

I interviewed Resident J at Margaret's Meadows who stated she likes living at Margaret's Meadows because she does not have to cook or clean. She said the only time she feels they have an issue not having enough staff to work is if the weather is bad and someone cannot come in right away. She has never had to wait for assistance and does not have a call button.

On February 4, 2022, licensee designee Satish Ramade sent over the *Assessment Plans, Health Care Appraisals*, and the January 2022 staffing schedule for Margaret's Meadows. According to the *Assessment Plans* and *Health Care Appraisals* there are three residents who are fully ambulatory, eight residents who require one direct care staff member to assist and three residents, Resident F, Resident K, and Resident P who require two direct care staff members to assist with personal care, transfer, and mobility assistance at the time of this interview. There is a new resident, Resident P, who was recently admitted who also requires two direct care staff member assistance. As of February 15, 2022, Resident P was the only resident requiring the assistance of two direct care staff member due to the other residents (Resident F and Resident K) being discharged or passing away. Most of the residents residing at Margaret's Meadows require assistance with all activities of daily living and/or are diagnosed with dementia.

According to my review of the January 2022 direct care staff member schedule, all day, afternoon, and third shifts had adequate coverage of at least two direct care staff members on the schedule. On January 9, 2022, the shifts changed from eight hour shifts to twelve hours to assist in coverage.

On February 4, 2022, I interviewed direct care staff member, Staff 3, who has been employed at Margaret's Meadows for two months. She has been there as a direct care staff member but she will work on the “floor training” the staff. Currently at Margaret's Meadows there are two residents, Resident F and Resident K, who require two person assistance. On third shift there are two direct care staff members scheduled and two, sometimes three, during the day. She does not feel there are enough direct care staff members because it is hard to get everything done but despite this did not describe any time resident needs were not met.

On February 4, 2022, I interviewed direct care staff member, Staff 4. She worked third shift while she was there. It was her and one other staff member during the night shift. Every night she worked, there was two people total assigned as direct care staff members. She normally worked with the same two people most of her time there, Staff members 5 and 7. There are residents who need the assistance of two direct care staff member Resident F and Resident K for activities of daily living (ADL). She worked the night shift but she never saw Resident F out of bed. Sometimes she was there during the day and she never saw her out of the bed. Resident C was also a two person assist but she moved to a new facility recently. While she worked third shift, she checked and changed the residents as needed. They would be checked every two hours. If they woke up during the night, they would spend time with the resident. They would do laundry, cleaning, dishes that were left, as well as food prep for the next day. The checks were done every two hours were not documented every two hours but she knows Mr. Ramade was looking into a system for this before she stopped working there.

On February 14, 2022, I spoke with Patti Rohn, Careline Hospice administrator and she felt that she sent their aide out three times per week to bathe or provide other personal care tasks to hospice residents on Monday, Wednesday, and Friday. RN McKenzie McMann was also going out two or three times each week to evaluate residents as well.

On February 14, 2022, I interviewed licensee designee, Satish Ramade. He stated there were several deaths in the facility which is hard on the caregivers and the business. There are currently eight residents in the facility. Mr. Ramade stated Resident K's family decided to move him into full time hospice care at another facility this past weekend. Mr. Ramade stated Resident P, who was admitted to the facility on February 7, 2022, is the only resident who requires two direct care staff members to assist with transfers and mobility. Mr. Ramade stated Resident P has a Hoyer lift and a wheelchair. Mr. Ramade stated direct care staff members were trained through DME to use Resident P's Hoyer lift. and he has a hoyer lift and a wheelchair. The staff received training for a hoyer through DME company and his caregiver assisted them. Mr. Ramade stated that he always ensures there are at least two direct care staff members working at a time on both shifts. They have recently switched to twelve hour shifts instead of eight hours which has improved coverage. He has also not had a problem with call-ins like he did in the past.

On February 14, 2022, I spoke with Relative J2. She has been to the facility. Recently she has felt the staffing has been better. Whenever she has been there, there is always two people there. She has dropped her Resident J off once on a Friday around 10:30 pm. during third shift hours and when she came back, there were two direct care staff members that were working that assisted her to get settled back into her room.

On February 14, 2022, I interviewed direct care staff member, Staff 5. When he worked third shift then he would work with one other person. There was never a time that he was by himself on third shift with the exception of a few minutes when the second person would go outside to smoke. He felt that two people were able to perform the third shift duties on third shift.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	There is a sufficient direct care staff member on duty at all times at Margaret's Meadows for the supervision, personal care, and protection of the residents. During the review of the direct care staff member schedule for December 2021 and January 2022, there was always at least two direct care staff members on per shift as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident J and E did not receive their medications as prescribed.

INVESTIGATION:

On December 27, 2021, a complaint was received via a denied Adult Protective Services referral from Centralized Intake alleging that Resident J received Aspirin 81 mg when it was no longer an active order.

On December 27, 2021, I interviewed nurse practitioner from Careline Physicians Health Group Lindy Hilding, MSW, NP. She stated Resident J's Aspirin 81 mg was discontinued on July 30, 2021, and there was no longer an active order. NP Hilding stated Resident J has received this medication since July 2021 despite there being no prescription for the medication. NP Hilding stated she did not realize the medication was being administer to Resident J until a request for refill was received in December 2021. NP Hilding stated the process for the orders with Margaret's Meadows is that Careline will fax the new and discontinued orders over from their fax machine and this will be transcribed into the AFC's medication administration records. She does not know who was responsible for this back in July 2021 when this order should have been processed. NP Hilding was not able to provide the order discontinuing Resident J's Aspirin 81mg.

On January 15, 2022, Licensee designee Satish Ramade sent over Resident J's medication administration records (MAR) for my review. According to my review of Resident J's MAR, she received Aspirin 81mg from July 2021 until December 31, 2021,

when there is a notation to hold on December 10, 2021, for a refill of the medication. The start date was February 1, 2021, with an unknown prescriber. Mr. Ramade did not have any record of Resident J's Aspirin 81mg being discontinued. According to NP Hilding, Resident J should not have been receiving Aspirin since she is diagnosed with a GI bleed and this order was discontinued on July 30, 2021.

On January 21, 2022, I interviewed Resident J at Margaret's Meadows. Resident J stated she takes a lot of medications and the direct care staff members give them to her. She was not familiar if she takes Aspirin or not as part of her prescribed medications.

On February 4, 2022, I interviewed direct care staff member Staff 3 who has been employed at Margaret's Meadows for two months. Staff 3 stated Resident J is no longer on the Aspirin 81 mg and the medication was removed from Resident J's MAR. She did not know the medication order was changed nor did she receive any order discontinuing the medication so Resident J continued to receive the Aspirin 81mg. She said that McKenzie McMann from Careline Hospice and Staff 1 made sure that each of the medications have current orders for them. They had some medications they discontinued and those were all taken out of the cart recently so this error does not occur again. Staff 3 stated she does not have access to the resident's medication orders.

On February 14, 2022, I interviewed administrator Patti Rohn from Careline Hospice - Saginaw. Ms. Rohn stated the medications are received from a local pharmacy in Mt. Pleasant. She stated that if there was a new order for a medication or one is discontinued, RN McCann would update this in the resident's medication administration record. Ms. Rohn stated she performed a medication count with RN McCann at the facility in December 2021 and there were no concerns other than expired medications that needed to be discarded which were left in the medication cart.

The new order was requested from Careline Hospice however, the only documentation received were progress notes from Resident J's hospice visits. The progress notes from June 29, 2021, included documentation that Aspirin 81mg was an active order. Progress notes from December 28, 2021, included documentation of "DO NOT GIVE PATIENT ASPIRIN. Aspirin is not an active order." There is no documentation that Mr. Ramade or the staff at Margaret's Meadows received a discontinued order for Aspirin 81 mg for Resident J.

On February 14, 2022, I interviewed licensee designee, Satish Ramade regarding Resident J's Aspirin prescription. Mr. Ramade stated the facility may have received an order discontinuing Resident J's Aspirin medication but a copy of the discontinued order was not available and that the Aspirin was put on hold as of January 1, 2022.

On February 14, 2022, I spoke with Relative J2 who stated Resident J has lived in the facility just over a year. She stated that in December 2021 she discovered Resident J was still being administered Aspirin 81 mg. Relative J2 stated Resident J was

experiencing a GI bleed at the time and Relative J2 did not believe Resident J was supposed to be receiving this medication so she questioned it. Relative J2 stated she was told it was administered because it was on Resident J's MAR. Relative J2 also stated she was concerned about Resident J's Aldactone dosage as Relative J2 thought this had also been changed to a lower dosage in December 2021. According to Relative J2, Resident J's Aldactone 50 mg was supposed to change to 25mg dose in December 2021 and she was concerned she was not receiving the correct amount.

I reviewed Resident J's MAR for Aldactone 25 mg (generic name Spironolactone). Initially, this medication was listed on her MAR under Spironolactone 50 mg effective September 29, 2021, with instructions to take for seven days which was done correctly until October 5, 2021. On October 6, 2021, there was documentation in the MAR that the Spironolactone 25 mg changed to AM and the October 2021 MAR included instructions that it should be taken at 8:00 a.m. for 90 days. The dosage was set at 25 mg until November 29, 2021, when there is a note the dosage was updated on this day back to 50 mg until December 17, 2021. According to Resident J's MAR, Spironolactone 50 mg was discontinued on December 17, 2021. On December 18, 2021, Aldactone 25 mg was prescribed and given correctly at 25 mg according to the order. Careline Hospice progress notes from December 28, 2021, included documentation that Spironolactone 50mg will be discontinued and she will start Aldactone 25 mg one tablet by mouth daily in the AM for six months.

On December 27, 2021, a complaint was received via a denied adult protective services referral from Centralized Intake alleging that Resident E did not receive her Morphine every six hours as prescribed.

On December 27, 2021, I interviewed Careline nurse practitioner Lindy Hilding, MSW, NP. She stated that Resident E did not receive her Ativan and Morphine as prescribed. She is at the end of life stages and is in the active phase of passing. She stated Resident E's Hospice team told direct care staff members to administer Resident E Ativan as needed but Morphine was prescribed every six hours. NP Hilding stated this was not done because there was no direct care staff member working that was trained in medication administration to pass Resident E medication so Resident E went without her prescribed pain medication. NP Hilding cited an incident which occurred when a direct care staff member thought Resident E was having a seizure on an unknown date around mid-December and needed Ativan but there was no direct care staff member working who was trained in medication administration so Resident E went without any medication.

On February 4, 2022, I interviewed direct care staff member, Staff 3 who has been employed at Margaret's Meadows for two months. She stated she was informed about Resident E having a seizure but not receiving any medication the morning after this allegedly occurred in mid-December 2021. Staff 3 did not remember an exact date. Staff 3 stated she was unsure why Resident E went without medication as Mr. Ramade was available at the facility and could have passed Resident E the medication.

On February 14, 2022, I interviewed Patti Rohn, administrator from Saginaw Careline Hospice. She was also told there was a direct care staff member from Margaret's Meadows that was “on call” to administer medications. She was aware there were times that Mr. Ramade did not have someone scheduled who was trained to administer medications and this was a process in place until those people could be fully trained. Resident E was a hospice patient. She was not familiar with any incident where Resident E did not her medications. According to the Medication Administration order for Resident E, in January 2022, her Lorazepam (Ativan) 1 mg every six hours and Morphine 100 mg per 5 ml. two times per day in addition to .25 every two hours of morphine. These were included in a comfort pack for medications in January. These were not PRN and were prescribed medications. On January 13, 2022, Ms. Rohn stated there was an order to discontinue all medications except for the comfort pack medications. Ms. Rohn stated Resident E passed away on January 26, 2022, at Margaret's Meadows. During the month of January, she would have needed the comfort pack medications every six hours according to Ms. Rohn.

On February 14, 2022, I interviewed licensee designee, Satish Ramade who stated he was aware of the concern regarding residents not receiving medications as prescribed for a number of reasons. Mr. Ramade stated he was aware one of those reasons was due to there not being a direct care staff member trained in medication administration working during all nighttime hours. Mr. Ramade stated he is available during nighttime hours on Mondays, Tuesdays, Wednesdays, and Thursdays to assist if residents need any medications, including PRNs, passed during nighttime hours. Mr. Ramade stated that while he was working to train additional direct care staff members in medication administration, he had assigned Staff 7 to administer medications at night when he was unavailable. Mr. Ramade stated if Staff 7 was not already working, she had agreed to be “on-call” to come in to pass a medication if needed.

On February 14, 2022, I interviewed former direct care staff member Staff 5 who was employed there about a month ago. Staff 5 stated he was familiar with the situation that Resident E needed Ativan and Morphine because she was screaming in pain. Hospice told him to give her the medication because she would not get there until 6:30 but Staff 5 stated he would not do this because he was not trained to administer medications and did not feel comfortable doing so without being trained. He called Mr. Ramade and Mr. Ramade told him to contact the on call staff person, Staff 7, to administer the medications. Staff 5 stated Staff 7 resides in Mt. Pleasant about 20 minutes away from the facility so Resident E had to wait about 30 minutes for the medication. Staff 5 stated he called hospice around 12:30 am. She was prescribed this medication every six hours. Staff 7 administered the Morphine at 1:00 am to Resident A and Staff 3 administered the next dose at 7 am the following morning. Staff 5 stated Resident E would lie in bed screaming in pain but Mr. Ramade told him that she would be fine. Staff 5 stated this happened a few times where Resident E experienced break through pain in between medication passes.

On February 14, 2022, I interviewed direct care staff member, Staff 8 who stated Resident E was not always getting her prescribed Morphine and Ativan before she

passed because there was no one who was medication trained on nights. When she was working third shift, there was no one administering medications at that time in the evening for the last two months. She said they had an on call direct care staff member scheduled to administer medications, Staff 7, who drove to the facility and administered medications. If Mr. Ramade was there, they could wake him to administer the medications but he was not always available especially on the weekends. When she is not working third shift, then the third shift staff members are not always medication trained. She works three nights per week currently and received medication administration training on February 12, 2022.

On February 15, 2022, Mr. Ramade sent the Medication administration record (MAR) over for December 2021 and January 2022 to review. I reviewed Resident E's MAR and noted the following were dates Resident E refused a medication because she was asleep and unable to be aroused on the following days: December 16, 17, 18, 21, 22. My review of Resident E's December 2021 MAR also noted Resident E did not Morphine Sulfate 20 mg / ML as prescribed in the comfort pack for pain as follows:

- December 18 at 12 am, 6 am, 12:00 p.m.
- December 19, 2021 12:00 a.m., 6:00 a.m.
- December 21, 2021 12:00 p.m.
- December 22, 2021 12:00 a.m. (Reason stated is "Was not given on overnight shift" – Result NA), 12:00 p.m.
- December 24, 2021 6:00 a.m., 12:00 p.m.
- December 25, 2021 12:00 a.m. 6:00 a.m., 12:00 p.m., 6:00 p.m.
- December 26, 2021 12:00 a.m. 6:00 a.m., 12:00 p.m., 6:00 p.m.
- December 27, 2021 12:00 a.m. 6:00 a.m., 12:00 p.m., 6:00 p.m.
- December 28, 2021 12:00 a.m. (reason listed as "night nurse not give – missed" and 6:00 a.m.
- December 29, 2021 12:00 a.m., 6:00 a.m.
- December 30, 2021 6:00 p.m.
- December 31, 2021 12:00 p.m.

I also reviewed Resident E's January 2022 MAR which documented Resident E missed several days of medication passes because she was "sick", "throwing up", "resident refusal", or "resident sleeping."

January 2, 2022 she missed her Morphine Sulfate 20 mg/ML on the following days because she was asleep.
January 2, 2022 12:00 a.m. and 6:00 a.m.
January 3, 2022 6:00 p.m.
January 4, 2022 12:00 a.m. 12:00 p.m.
January 5, 2022 12:00 a.m.

There is also a notation on Resident E's MAR for January 24, 2022, at 1:00 a.m. and January 25, 2022, from 1:00 am stating that she did not receive her Lorazepam .5 mg because there was "No med tech on duty".

Starting on January 5, 2022, Resident E was prescribed Morphine Sulfate .25 ML for pain and shortness of breath was started under the tongue two times per day at 8:00 a.m. and 8:00 pm according to Resident E's MAR. Each day from January 5-11, 2022, there is a notation added about a missed medication either because Resident E was sick or was asleep and unable to aroused.

APPLICABLE RULE	
R 400.15312	**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:	There is no indication that Margaret's Meadows received a new order discontinuing Resident J's Aspirin. Mr. Ramade could not produce an order showing that this medication was discontinued and stated in his email on February 15, 2022, that the medication order for the Aspirin for Resident J was put on hold as of January 1, 2022. There are progress notes from Careline Hospice from December 28, 2021, stating to not give Aspirin and that it was no longer a valid order. Consequently, there is not enough information that this medication was not given as prescribed. There is no indication that Resident J's Aldactone/ Spironolactone were not given as prescribed. According to Resident J's MAR On December 18, 2021, Aldactone 25 mg was prescribed and given correctly at 25 mg according to the order. Resident E was not administered her Morphine and/or Ativan as prescribed during the months of December 2021 and January 2022. There are various times noted on Resident E's medication administration record where no explanation is given for Resident E not being provided medication or it's noted that no trained direct care giver was available to pass medication including specifically January 24 and 25, 2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility does not have staff trained in medication administration to administer medications.

INVESTIGATION:

After my review of the direct care staff member schedules for December 2021 and January 2022, there are shifts that do not have a direct care staff member scheduled to administer medications in January 2022. There were no shifts in December 2021 that did not include a direct care staff member trained to administer medications. In January 2022, the following shifts did not include direct care staff member trained in medication administration for third shift 11PM-7AM: January 3, 5, 8, 10, 14, 15, 16, 18, 24, 25, 29, 30, and 31.

Mr. Ramade stated that he had an "on call" direct care staff member trained in medication administration that lived twenty minutes away that could administer medications, however, she was not on the schedule for these days. Mr. Ramade stated the following direct care staff members were trained to administer medications: Staff 3,

Staff 6, Staff 7, Staff 9, Staff 10, and Staff 11. Most of these direct care staff members do not work third shift so unless Staff 7 was scheduled to work 11PM – 7 AM every day in January 2022, there was not someone assigned to administer medications. Mr. Ramade also stated there were dates during January 2022 when no direct care staff member trained in medication administration was working during third shift.

On February 14, 2022, I interviewed direct care staff member, Staff 5. When he worked third shift then he would work with one other person. He was not trained to administer medications when he worked there. He felt that two people were able to perform the third shift duties needed but he was assigned to work with another direct care staff member that was not trained to administer medications if needed on third shift.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (a) Be trained in the proper handling and administration of medication.
ANALYSIS:	The direct care staff member schedule for January 2022 showed thirteen third shifts that did not have an available direct care staff member trained to administer medications working at Margaret's Meadows, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident G did not receive lab readings from the Internalized Normalized Ratio (INR) machine to measure his blood levels for his Coumadin medication.

INVESTIGATION:

On December 27, 2021, a complaint was received via a denied Adult Protective Services referral from Centralized Intake alleging that Resident G did not receive lab readings from the INR machine to properly prescribe his Coumadin medication.

On December 27, 2021, I interviewed Careline Health Physicians NP Lindy Hilding. She stated Resident G had an in home INR machine and licensee designee, Satish Ramade told her the machine was broken. NP Hilding stated there was an active order for Resident G to have a regular lab draw every two weeks using an INR machine at Margaret's Meadows to check Resident G's Coumadin levels.

On January 15, 2022, I received an email form Mr. Ramade confirming there was no lab draws completed for the months of November and December to check Resident G's coumadin levels. Mr. Ramade reported Resident G's INR machine was not working properly and there was an order for a new one placed in November 2021 but since that time Mr. Ramade had not taken any other steps to assure Resident G's blood was drawn as ordered.

On January 21, 2022, I interviewed Resident G at Margaret's Meadows. Resident G was unaware of a INR machine that was used to track his blood levels for his coumadin medication. He stated the staff members at Margaret's Meadows keep track of his medication and do a nice job.

On February 4, 2022, Licensee designee Satish Ramade sent Resident G *Health Care Appraisal,* which was signed by Lindy Hilding, FNP-BC on March 26, 2021. Resident G has PT/INR every two weeks on his treatments ordered section of the *Health Care Appraisal*.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Resident G *Health Care Appraisal* signed by Lindy Hilding, FNP on March 26, 2021, includes documentation that Resident G has PT/INR every two weeks on his treatments ordered section of the *Health Care Appraisal*. According to Mr. Ramade, Resident G has not had any lab work for the months of November and December resulting in his Coumadin medication being held on December 17, 2021. During this time, Mr. Ramade made no attempts to have the lab work done another way such as a walk in clinic or hospital that would have completed this order.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

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

02/25/2022

Jennifer Browning
Licensing Consultant

Date

Approved By:

02/25/2022

Dawn N. Timm
Area Manager

Date