GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 4, 2022

Carl Schuler
Gladwin Adult Care, LLC
325 Commerce Court
Gladwin, MI 48624

RE: License #: AL260317409
Investigation #: 2022A0572021
The Horizon Senior Living V

Dear Mr. Schuler:

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 (906) 226-4171.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL260317409
Investigation #:	2022A0572021
Complaint Receipt Date:	02/04/2022
Investigation Initiation Date:	02/08/2022
Report Due Date:	04/05/2022
Licensee Name:	Gladwin Adult Care, LLC
Licensee Address:	325 Commerce Court Gladwin, MI 48624
Licensee Telephone #:	(989) 246-1000
Administrator:	Paula Cassiday
Licensee Designee:	Carl Schuler
Name of Facility:	The Horizon Senior Living V
Facility Address:	450 Quarter Street Gladwin, MI 48624
Facility Telephone #:	(989) 246-1000
Original Issuance Date:	11/01/2012
License Status:	REGULAR
Effective Date:	04/30/2021
Expiration Date:	04/29/2023
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is a recent amputee, and she will go 4-5 days without her pain meds. Her meds will run out and staff do not refill on time leaving her without the meds for days.	Yes
Resident A fell out of her wheelchair over a month ago and she is still waiting for her hip x-ray.	No
Cushion for wheelchair was discussed and has not been provided and facility has covid and resident booster shots have not been arranged.	No

III. METHODOLOGY

02/04/2022	Special Investigation Intake 2022A0572021
02/08/2022	Special Investigation Initiated - On Site
02/08/2022	Contact - Face to Face Home Manager, Bo Hammond.
03/31/2022	Contact - Telephone call made Home Manager, Jamie Tate and Staff, Lindsey Lewis.
03/31/2022	Exit Conference Licensee, Carl Schuler.
04/01/2022	Contact - Telephone call made Resident A.
04/01/2022	Exit Conference Licensee, Carl Schuler.
04/01/2022	APS Referral. Referred to APS.
04/04/2022	Contact - Document Received Incident Report.

ALLEGATION:
Resident A is a recent amputee, and she will go 4-5 days without her pain meds. Her meds will run out and staff do not refill on time leaving her without the meds for days.

INVESTIGATION:
On 02/04/2022, the local licensing office received a complaint for investigation. APS was sent a referral for further investigation.

On 02/08/2022, an unannounced onsite was conducted at The Horizon Senior Living, located in Gladwin County, Michigan. Interviewed was Home Manager, Bo Hammond.

On 02/08/2022, I interviewed Home Manager, Bo Hammond regarding an allegation that Resident A will go 4-5 days without her pain meds when her meds run out. Ms. Hammond informed that they do not pick up medications as they are delivered to the facility. Resident A was out of the Narcotics. Due to severer weather, they received an email from the pharmacy informing them that they would not be delivering medications on time. Because they have e-scripts, they do not have the ability to pick up medications.

On 02/08/2022, I reviewed several of the resident's medication sheets and they appeared to be accurate, however; Resident A was out of the Hydrocodone Acetaminophen 325 mg, Gabapentin 300 mg and Midodrine 2.5 mg, Ferrous Sul 325 mg, Eliquis 2.5 mg, Losartan Pot 50 mg, Mag Oxide 400 mg and Metformin 500 mg on 01/31/2022 and 02/01/2022. It is indicated on the Med Sheet when the medication was 'out of inventory.

On 02/08/2022, I reviewed emails from the Pharmacy which indicated that due to weather conditions, they will not be doing deliveries of medications.

On 03/31/2022, I interviewed Home Manager, Jamie Tate regarding an allegation that Resident A will go 4-5 days without her pain meds when her meds run out. Ms. Tate informed that this is not true. There was a major ice storm so the pharmacy emailed them, informing them that they will not be delivering medications for a couple days. The pharmacy is in Flint, Michigan, so its approximately two hours one way, but she had offered to pick them up because she did not want Resident A to be without her medications. Since the medications were narcotics, the pharmacy would not allow her to pick them up. This was discussed with Resident A's daughter, but she was still upset with the facility.

On 03/31/2022, I interviewed Staff, Lindsey Lewis regarding an allegation that Resident A will go 4-5 days without her pain meds when her meds run out. She informed that there are no residents going without medications for 4-5 days and not sure why this allegation would be made. She wasn't aware of the ice storm which may have caused for the meds not to be delivered on time.

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:	A narcotic that Resident A is prescribed was not delivered timely by the pharmacy and it was indicated in the Med Sheet that they were out. Emails indicating that the meds will not be delivered due to weather were reviewed. Home manager offered to pickup the medications, but the pharmacy denied the request because they were narcotics. Resident A was without several of her medications on 01/31/2022 and 02/01/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
Resident A fell out of her wheelchair over a month ago and she is still waiting for her hip x-ray.

INVESTIGATION:
On 02/08/2022, I interviewed Home Manager, Bo Hammond regarding an allegation that Resident A fell out of her wheelchair over a month ago and she is still waiting for her hip x-ray. Ms. Hammond informed that they never had an order for an x-ray. Home Manager Ms. Tate had spoken with Resident A and she never expressed any concerns with regards to her fall, but the daughter was upset and was screaming at Ms. Tate. The fall occurred before Ms. Tate was working there, so she did not even know about a fall and there was never an order for an x-ray.

On 02/08/2022, I reviewed Resident A file and there is no indication that she is a fall risk. An Incident Report was completed for her fall.

On 03/31/2022, I interviewed Home Manager, Jamie Tate regarding an allegation that Resident A fell out of her wheelchair over a month ago and she is still waiting for her hip x-ray. Ms. Tate informed that she was not even aware of the fall as she was not working for the company at the time. The day that the daughter complained to her, she reached out to the doctor and the doctor to get the x-rays done. Resident A never complained of pain, so she never knew that there was an issue as the fall was

prior to her employment. The x-rays were negative and believe that the daughter just wanted x-rays done because she had a fall. There was never a order for one, prior to her contacting the doctor.

On 03/31/2022, I interviewed Staff, Lindsey Lewis regarding an allegation that Resident A fell out of her wheelchair over a month ago and she is still waiting for her hip x-ray. She does not know anything about Resident A needing an x-ray. She informed that if one is ordered, the facility is very good with making sure that it gets taken care of.

On 04/01/2022, I spoke with Resident A, via FaceTime. She informed that she likes her home and it's getting better. She does not have any concerns at this time.

On 04/04/2022, I reviewed the Incident Report regarding Resident A's fall. It indicated that staff heard Resident A calling for help from the kitchen. Staff ran down the hall and Resident A was laying on the floor by the TV. Resident A stated, "I forgot I was missing my right leg. How silly is that?" Staff assisted her back into bed. The physician was called as she received a bump on the back of her head. She was reassured that this is common to forget about missing a limb when being a new amputee. Resident A is on 2-hour checks but will be checked more frequently and will ensure that call light is always on her.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Resident A had a fall and there were no x-rays ordered. The current manager was not employed with the facility at the time of the fall and did not find out about the fall until approximately a month and a half later. There were no orders for an x-ray. The Home Manager contacted the doctor so that x-rays can be done.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Cushion for wheelchair was discussed and has not been provided and facility has covid and resident booster shots have not been arranged.

INVESTIGATION:
On 02/08/2022, I interviewed Home Manager, Bo Hammond regarding allegations that a cushion for a wheelchair was discussed and has not been provided and the facility has covid and resident booster shots have not been arranged. Ms.

Hammond informed that she is not aware of anything regarding an order of a cushion for a wheelchair because she is the Home Manager for the other building. She believes that with these allegations, there is the assumption that they can just provide things to the residents which is not the case. In regard to the Booster Shots, the National Guard administered the initial vaccinations, but won't conduct the boosters due to the amount of covid cases they have had at their facility.

On 03/31/2022, I interviewed Home Manager, Jamie Tate regarding allegations that a cushion for a wheelchair was discussed and has not been provided and the facility has covid and resident booster shots have not been arranged. When she started her employment at the facility, the vaccinations were completed, but the booster shots were not setup. She reached out to an organization to get these completed but was unable to because they did not administer the original shots. They are waiting on the Health Department to come to the facility to administer the boosters, however; they will not come out due to the covid cases at the facility. In regard to the cushion for the wheelchair, until the daughter questioned her about this. She spoke with the doctor on the same day that she talked with the daughter and was told that the cushion would have to be ordered by the physical therapist. She is working with the physical therapist to get the cushion but informed that there is no guarantee that the physical therapist will write the order. But she made the request just so that the daughter would not be upset.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The booster shots had been scheduled several times, but due to multiple covid cases at the facility, they have not been able to get this completed for the residents. There was no order for a cushion for Resident A's wheelchair. As soon as Ms. Tate became aware that the daughter wanted one for Resident A, she spoke with the doctor, who then referred her to the Physical Therapist, who she eventually made the request to.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 03/31/2022, an Exit Conference was held with Licensee, Carl Shuler regarding the allegations and the results of the investigation.

On 04/01/2022, another Exit Conference was held with Licensee, Carl Shuler regarding the allegations and the results of the investigation. He was informed that there would be a rule violation due to the missed med pass.

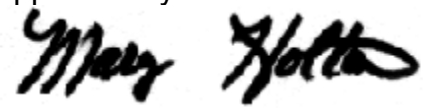
IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this large adult foster care group home (Capacity 1-20).

04/04/2022

Anthony Humphrey Date
Licensing Consultant

Approved By:



04/04/2022

Mary E Holton Date
Area Manager