GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2022

Shannon Aldrich
Ashley Court Of Brighton Inc.
7400 Challis Road
Brighton, MI 48116

RE: License #: AL470092982
Investigation #: 2022A1033031
Ashley Court -Bldg # 4

Dear Ms. Aldrich:

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,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL470092982
Investigation #:	2022A1033031
Complaint Receipt Date:	09/01/2022
Investigation Initiation Date:	09/02/2022
Report Due Date:	10/31/2022
Licensee Name:	Ashley Court Of Brighton Inc.
Licensee Address:	7400 Challis Road Brighton, MI 48116
Licensee Telephone #:	(734) 622-0074
Administrator:	Shannon Aldrich
Licensee Designee:	Shannon Aldrich
Name of Facility:	Ashley Court -Bldg # 4
Facility Address:	7400 Challis Road Brighton, MI 48116
Facility Telephone #:	(734) 622-0074
Original Issuance Date:	08/30/2000
License **Status:**	REGULAR
Effective Date:	11/08/2021
Expiration Date:	11/07/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility does not have adequate staffing.	No
The facility did not provide for the personal care of Former Resident A by not emptying her catheter bag and not turning/repositioning the resident on a consistent basis.	No
The direct care staff are not trained to administer medications.	No
The temperature in the facility, especially Former Resident A's room, was too hot.	No
Former Resident A's morphine was not administered correctly.	No
Additional Findings	Yes

III. METHODOLOGY

09/01/2022	Special Investigation Intake 2022A1033031
09/02/2022	Special Investigation Initiated - Telephone Telephone call made to Complainant. Message left.
09/06/2022	Contact - Telephone call received Interview with Complainant via telephone.
09/08/2022	Inspection Completed On-site Interview with Licensee Designee, Shannon Aldrich, facility nurse, Lori Napier. Review of resident record, employee schedules, employee trainings, and facility walk through completed.
09/30/2022	Contact - Telephone call made Interview with Citizen 1 via telephone.
09/30/2022	Contact - Telephone call made Attempt to interview, Promedica Hospice Staff, Citizen 2. Citizen 2 was paged to call consultant. Awaiting a call back.
10/07/2022	Contact - Telephone call made Attempt to interview direct care staff, Shawna Kuehnel. Voicemail message left.
10/07/2022	Contact - Telephone call made

	Attempt to interview direct care staff, Jaclyn Zrenchik. Voicemail message left.
10/07/2022	Contact - Telephone call made Attempt to interview direct care staff, Darla Warden. Voicemail message left.
10/07/2022	Contact - Telephone call made Attempt to interview direct care staff, Dalisa Clinton. Voicemail message left.
10/07/2022	Inspection Completed-BCAL Sub. Compliance
10/10/2022	Contact – Telephone call received Interview with direct care staff, Darla Warden, via telephone.
10/10/2022	Contact – Telephone call received Interview with direct care staff, Shawna Kuehnel, via telephone.
10/11/2022	Contact – Telephone call made Interview with direct care staff, Jaclyn Zrenchik, via telephone.
10/11/2022	Contact – Document Sent Email to Licensee Designee, Shannon Aldrich, requesting further documentation.
10/25/2022	Exit Conference conducted via telephone with Licensee Designee, Shannon Aldrich, voicemail message left.

ALLEGATION:

The facility does not have adequate staffing.

INVESTIGATION:

On 9/1/22 I received an online complaint regarding the Ashley Court Bldg #4 adult foster care facility (the facility). The complaint alleged that the facility is not adequately staffed to provide for resident care needs. On 9/6/22 I interviewed Complainant via telephone. Complainant reported Former Resident A was admitted to the facility on 8/22/22 and expired on 8/27/22. Complainant reported Former Resident A had been cared for by hospice services through Promedica Hospice. Complainant reported that the facility appeared to be understaffed and it was difficult to find staff to assist with care. Complainant reported Former Resident A would go hours without a direct care staff member coming into her room to provide for basic care needs, such as repositioning the resident and emptying her catheter bag.

On 9/8/22 I completed an on-site investigation at the facility. I interviewed Licensee Designee, Shannon Aldrich. Ms. Aldrich reported the facility did care for Former Resident A from 8/22/22 through 8/27/22. Ms. Aldrich reported direct care staff provided for Former Resident A's care needs, and they had adequate staffing to be able to care for all residents. Ms. Aldrich reported direct care staff turn and reposition their bedbound residents every two hours. Ms. Aldrich reported Former Resident A arrived at the facility on 8/22/22 as requiring assistance to a transfer to a chair. She reported that after about three days she became weaker and was unable to get out of bed. Ms. Aldrich reported facility nurse/direct care staff, Lori Napier, was also in and out of Former Resident A's room, frequently, checking on her needs. Ms. Aldrich reported Former Resident A was a new admission to their facility and admitted to hospice care when she arrived at the facility. Ms. Aldrich reported direct care staff made sure to empty Former Resident A's catheter bag and she has no recollection of ever seeing the bag go without being tended to.

During on-site investigation, on 9/8/22, I interviewed nurse/direct care staff member Ms. Napier. Ms. Napier reported she did provide for Former Resident A's care needs by making regular checks on her while she was a resident of the facility. She reported direct care staff provided for every two-hour repositioning and regular personal care services. Ms. Napier reported Former Resident A's catheter bag was emptied and maintained while Former Resident A was residing in the facility.

During on-site investigation I reviewed the facility staff schedule for the dates of 8/22/22 through 8/27/22. I found the following staff patterns:

- 8/22/22, 7am – 7pm, 4 scheduled direct care staff.
- 8/22/22, 7pm – 7am, 2 scheduled direct care staff.
- 8/23/22, 7am – 7pm, 4 scheduled direct care staff.
- 8/23/22, 7pm – 7am, 2 scheduled direct care staff.
- 8/24/22, 7am – 7pm, 4 scheduled direct care staff.
- 8/24/22, 7pm – 7am, 2 scheduled direct care staff.
- 8/25/22, 7am – 7pm, 4 scheduled direct care staff.
- 8/25/22, 7pm – 7am, 2 scheduled direct care staff.

- 8/26/22, 7am – 7pm, 4 scheduled direct care staff.
- 8/26/22, 7pm – 7am, 2 scheduled direct care staff.
- 8/27/22, 7am – 7pm, 2 scheduled direct care staff.
- 8/27/22, 7pm – 7am, 2 scheduled direct care staff.

During on-site investigation, on 9/8/22, I reviewed the *Assessment Plan for AFC Residents* form for Former Resident A, dated 8/22/22. Under section *II. Self Care Skill Assessment*, subsections *B. Toileting, C. Bathing, D. Grooming, E. Dressing, F. Personal Hygiene*, it states, "Requires total care with see ADL's." I reviewed the facility, *ADL Sheets* form, dated August 2022, for Former Resident A. The form has sections to document food intake, bowel movements (BM's) and bladder output. Under the section for "Food Intake", there was documentation for the dates 8/22/22 through 8/26/22. The section, "BM's", had notations for the dates, 8/22/22 through 8/24/22. The section, "Bladder", had notations for the dates, 8/22/22 through 8/24/22.

On 9/30/22 I interviewed Citizen 1 via telephone. Citizen 1 reported that she is a family member of Former Resident A. Citizen 1 reported she visited the facility, daily, sometimes twice a day. Citizen 1 reported she had concerns that the staffing at the facility was not adequate. She reported that it was difficult to find staff, especially when she visited in the evening. Citizen 1 reported that when she was with Former Resident A for multiple hours, she did not see a direct care staff come into the room to check on the resident. Citizen 1 reported she discussed this concern with the facility and was told staff were giving the family privacy while they visited. Citizen 1 reported that she never saw the staff provide personal care or tend to Former Resident A's catheter bag, while she was visiting. Citizen 1 reported she never witnessed the catheter bag being overfilled with urine while she visited the facility.

On 9/30/22 I attempted to interview the on-call hospice nurse with Promedica Hospice, Citizen 2. The Promedica office noted that Citizen 2 works evening hours and they would page him to contact me. I did not receive a response from Citizen 2.

On 10/10/22 I interviewed direct care staff, Darla Warden, via telephone. Ms. Warden reported she has worked for the facility for about 13 years. Ms. Warden reported she works as a supervisor at the facility and provides direct care. She reported she recalls Former Resident A and did provide for her direct care needs while she was scheduled to work. Ms. Warden reported that the facility uses a log that hangs on the resident door where staff document when they reposition a bedbound resident. Ms. Warden reported that she feels the facility is sufficiently staffed and has no concerns about staffing.

On 10/10/22 I interviewed direct care staff, Shawna Kuehnel. Ms. Kuehnel reported she has worked for the facility for about five years in the capacity of a medication passer and direct care staff member. Ms. Kuehnel reported that Former Resident A

was repositioned every two hours. She reported that there was a “turn schedule” on her door that the staff would sign. She further reported direct care staff cared for Former Resident A’s catheter and regularly checked this bag and emptied the urine. Ms. Kuehnel reported the facility is adequately staffed, and she feels there is always, day and night, appropriate staffing. Ms. Kuehnel reported that there is a medication passer scheduled for each shift.

On 10/11/22 I interviewed direct care staff, Jaclyn Zrenchik, via telephone. Ms. Zrenchik reported she has worked for the facility for around 13 years and her current title is Medication Passer. Ms. Zrenchik reported that Former Resident A was not at the facility for a long period of time. She reported that days after her admission she became bedbound. Ms. Zrenchik reported that the staff would provide for her care by repositioning Former Resident A every two hours. She reported that when there is a bedbound resident the facility uses a log that hangs on the door of the resident’s room that they initial when they reposition the resident. Ms. Zrenchik could not recall whether this log was present on Former Resident A’s door. Ms. Zrenchik reported direct care staff also provided for Former Resident A’s catheter care on a regular basis when they checked on her toileting needs every two hours. Ms. Zrenchik reported that medication passers are available on each shift worked. She reported that she feels the facility is adequately staffed and she has no concerns about staffing patterns. Ms. Zrenchik reported that she feels Former Resident A’s care needs were attended to by the facility.

APPLICABLE RULE	
R 400.15206	**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 upon interviews with Ms. Aldrich, Ms. Napier, Complainant, Citizen 1, Ms. Zrenchik, Ms. Warden, Ms. Kuehnel, as well as review of Former Resident A's record, review of daily schedules for 8/22/22 through 8/27/22, and observations from on-site inspection, the facility is maintaining adequate staffing levels. The facility reported having two to four direct care staff working the day shift, from 7am to 7pm, and two direct care staff working the evening shift from 7pm to 7am which was confirmed via review of the schedule. The direct care staff reported adequate staffing patterns to be able to provide for resident care needs outlined in Former Resident A's *Assessment Plan for AFC Residents* form.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not provide for the personal care of Former Resident A by not emptying her catheter bag and not turning/repositioning the resident on a consistent basis.

INVESTIGATION:

On 9/1/22 I received an online complaint which alleged facility direct care staff members did not provide for Former Resident A's personal care needs by not emptying her catheter bag and not turning/repositioning the resident on a consistent basis. On 9/6/22 I interviewed Complainant via telephone. Complainant reported that Former Resident A admitted to the facility on 8/22/22 and expired on 8/27/22. Complainant reported Former Resident A had been cared for by hospice services through Promedica Hospice. Complainant reported the facility appeared to be understaffed and it was difficult to find staff to assist with care. Complainant reported Former Resident A would go hours without a direct care staff member coming into her room to provide for basic care needs, such as repositioning the resident and emptying her catheter bag.

On 9/7/22 Complainant emailed a photograph of Former Resident A lying in her hospital bed at the facility. In the photograph the resident was sleeping, uncovered, wearing a t-shirt and an incontinence brief. From this picture I was not able to

observe if the brief was soiled and could not view the resident's catheter bag to determine whether it had been attended to by direct care staff. The sheets and blankets on the bed did not appear to be soiled in this photograph.

On 9/8/22 I completed an on-site investigation at the facility. I interviewed Licensee Designee, Shannon Aldrich. Ms. Aldrich reported that the facility did care for Former Resident A from 8/22/22 through 8/27/22. Ms. Aldrich reported direct care staff provided for Former Resident A's care needs, and they had adequate staffing to be able to care for all residents. Ms. Aldrich reported direct care staff turn and reposition their bedbound residents every two hours. Ms. Aldrich reported Former Resident A arrived at the facility on 8/22/22 as needing assistance to transfer to a chair. She reported that after about three days she became weaker and was then unable to get out of bed. Ms. Aldrich reported facility nurse/direct care staff, Lori Napier, was also in and out of Former Resident A's room, frequently, checking on her needs. Ms. Aldrich reported that Former Resident A was a new admission to their facility and admitted to hospice care when she arrived at the facility. Ms. Aldrich reported direct care staff made sure to empty Former Resident A's catheter bag and she has no recollection of ever seeing the bag go without being tended to.

During on-site investigation, on 9/8/22, I interviewed Ms. Napier. Ms. Napier reported that she did provide for Former Resident A's care needs by making regular checks on her while she was a resident of the facility. She reported that the staff provided for every two-hour repositioning and regular personal care services. Ms. Napier reported that the catheter bag was emptied and maintained while Former Resident A was residing at the facility.

During on-site investigation, on 9/8/22, I reviewed the *Assessment Plan for AFC Residents* form for Former Resident A, dated 8/22/22. Under section *II. Self Care Skill Assessment*, subsections *B. Toileting, C. Bathing, D. Grooming, E. Dressing, F. Personal Hygiene*, it states, "Requires total care with see ADL's." I reviewed the facility, *ADL Sheets* form, dated August 2022, for Former Resident A. The form has sections to document food intake, bowel movements (BM's) and bladder output. Under the section for "Food Intake", there was documentation for the dates 8/22/22 through 8/26/22. The section, "BM's", had notations for the dates, 8/22/22 through 8/24/22. The section, "Bladder", had notations for the dates, 8/22/22 through 8/24/22.

On 9/30/22 I interviewed Citizen 1 via telephone. Citizen 1 reported that she is a family member of Former Resident A. Citizen 1 reported that she visited the facility, daily, sometimes twice a day. Citizen 1 reported she had concerns that the staffing at the facility was not adequate. She reported it was difficult to find staff, especially when she would visit in the evening. Citizen 1 reported she was with Former Resident A for multiple hours and did not see a direct care staff come into the room to check on the resident. Citizen 1 reported she discussed this concern with the facility and was told the staff were giving the family privacy while they visited. Citizen 1 reported she never saw the staff provide personal care or tend to Former Resident

A's catheter bag, while visiting. Citizen 1 reported she never witnessed the catheter bag being overfilled with urine while she was visiting the facility.

On 9/30/22 I attempted to interview the on-call hospice nurse with Promedica Hospice, Citizen 2. The Promedica office noted that Citizen 2 works evening hours and they would page him to contact me. I did not receive a response from Citizen 2.

On 10/10/22 I interviewed direct care staff, Darla Warden, via telephone. Ms. Warden reported that she has worked for the facility for about 13 years. Ms. Warden reported that she works as a supervisor at the facility and provides direct care. She reported that she recalls Former Resident A and did provide for her direct care needs while she was scheduled to work. Ms. Warden reported that the facility uses a log that hangs on the resident door where staff document when they reposition a bedbound resident. Ms. Warden reported that she does not recall if Former Resident A had a catheter. Ms. Warden reported that it was a stressful time for the family as Former Resident A was on hospice services and did experience a steady decline after her admission. Ms. Warden reported that she did not receive any direct complaints from family regarding the care Former Resident A received.

On 10/10/22 I interviewed direct care staff, Shawna Kuehnel. Ms. Kuehnel reported that she has worked for the facility for about five years in the capacity of a medication passer and direct care staff member. Ms. Kuehnel reported that Former Resident A was repositioned every two hours. She reported that there was a "turn schedule" on her door that the staff would sign. She further reported that the direct care staff cared for Former Resident A's catheter and regularly checked the catheter bag and emptied the urine.

On 10/11/22 I interviewed direct care staff, Jaclyn Zrenchik, via telephone. Ms. Zrenchik reported she has worked for the facility for around 13 years and her current title is Medication Passer. Ms. Zrenchik reported that Former Resident A was not at the facility for a long period of time. She reported that days after her admission she became bedbound. Ms. Zrenchik reported that the staff would provide for her care by repositioning Former Resident A every two hours. She reported that when there is a bedbound resident the facility uses a log that hangs on the door of the resident's room that the staff initial when they reposition the resident. Ms. Zrenchik could not recall whether this log was present on Former Resident A's door. Ms. Zrenchik reported that the direct care staff also provided for Former Resident A's catheter care on a regular basis when they checked on her toileting needs every two hours. Ms. Zrenchik reported that she feels Former Resident A's care needs were attended to by the facility.

On 10/11/22 I emailed Licensee Designee, Shannon Aldrich, to request documentation of the rotation log that was noted to hang on Former Resident A's door, by Ms. Zrenchik, Ms. Warden, and Ms. Kuehnel. Ms. Aldrich responded to this request and provided documentation of two daily logs, the *Building 4 Assignment Sheet* and the *Resident Monitoring Log, Building 4* for the dates of 8/22/22 through

8/27/22. I reviewed the provided forms. It was noted that the resident monitoring logs were labeled for day shift and night shift. The logs had times noted of 9am, 11am, 1pm, 3pm, 5pm, 7pm, 9pm, 11pm, 1am, 3am, 5am, 7am. Each time slot had a place to initial that care was provided for resident toileting. On Former Resident A's resident monitoring logs, for the dates of 8/22/22 through 8/27/22, each of these time slots were completed and initialed by a direct care staff member, up through 8/27/22 at 11am.

I reviewed the *Building 4 Assignment Sheets* for Former Resident A. The assignment sheets were labeled for day shift and night shift as well. The assignment sheets reviewed were for the dates 8/22/22 through 8/27/22. Each day shift assignment sheet had a check mark or a direct care staff members initials indicating, "Check and change residents every two hours" and "Complete all morning ADL's (brush hair and teeth)." Each night shift assignment sheet had either a check mark or a direct care staff members initials indicating, "check and change residents every two hours" had been completed.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based upon interviews with Complainant, Ms. Aldrich, Ms. Napier, Ms. Warden, Ms. Kuehnel, Ms. Zrenchik, & Citizen 1, as well as review of Former Resident A's resident record, and review of the *Building 4 Assignment Sheets* & *Resident Monitoring Logs,* the direct care staff did provide for Former Resident A's personal care and protection at the facility including turning/repositioning Resident A and emptying the catheter bag.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The direct care staff are not trained to administer medications.

INVESTIGATION:

On 9/1/22 I received an online complaint alleging direct care staff are not trained to properly administer medications. On 9/6/22 I interviewed Complainant regarding these allegations. Complainant reported direct care staff members were questioned

about their training and reported that they did not have schooling or medication training to be able to administer medications in a facility. Complainant reported there were concerns that Former Resident A's medications were not being administered correctly.

On 9/8/22 I completed an on-site investigation at the facility. I interviewed Ms. Aldrich regarding the allegations. Ms. Aldrich reported that the facility has dedicated "med passers" on each shift. Ms. Aldrich reported that these medication passers have received training to be able to administer resident medications. Ms. Aldrich reported that Ms. Napier provides the medication training for the "med passers", and this is documented in their employee files.

On 9/8/22, during on-site investigation, I interviewed Ms. Napier. Ms. Napier reported that she provides medication administration training to the "med passers" at the facility. Ms. Napier reported medications that were administered to Former Resident A were administered by trained medication passers.

During on-site investigation I reviewed the Medication Administration Record (MAR) for Former Resident A for the month of August 2022. The following staff documented administering medications to Former Resident A:

- Shawna Kuehnel
- Lisa Vanderhoof
- Jaclyn Zrenchik
- Darla Warden
- Dalisa Clinton

I reviewed the direct care staff training records for these employees. The following staff had documentation of medication training in their employee files:

- Shawna Kuehnel
- Lisa Vanderhoof
- Darla Warden
- Dalisa Clinton

Direct care staff, Jaclyn Zrenchik, did not have medication training in her employee file at the time of the on-site investigation.

On 9/8/22 I received an email from Ms. Aldrich regarding the medication training for Ms. Zrenchik. The email contained an attachment of a letter that was signed by Ms. Napier and dated for 9/8/22, which stated, "I Lori Napier, Wellness Director for Ashley Court of Brighton have observed Jaclyn Zrenchik complete a medication pass and have given approval for her to be a medication technician. I have found her to be competent in the area of medication administration."

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:	Based upon interviews with Complainant, Ms. Aldrich, Ms. Napier, review of employee files and Former Resident A's MAR, the direct care staff, who administered medications to Former Resident A, were trained in medication administration.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The temperature in the facility, especially Former Resident A's room, was too hot.

INVESTIGATION:

On 9/1/22 I received an on-line complaint alleging Former Resident A's bedroom, at the facility was too hot and rather uncomfortable. On 9/6/22 I interviewed Complainant. Complainant reported that while family members were at the facility, they noted Former Resident A's room to be unbearably hot and uncomfortable. Complainant reported that there was no thermostat in Former Resident A's room to confirm the temperature.

On 9/8/22 I completed an on-site investigation at the facility. I interviewed Ms. Aldrich regarding the allegation. Ms. Aldrich reported that the facility is only air conditioned in the main living areas, such as family room, hallways, kitchen, and dining room areas. Ms. Aldrich reported that residents and their family members are told that the resident rooms are not air conditioned and it would be the responsibility of the resident and/or their family member to provide a window unit air conditioner. Ms. Aldrich reported she does not have the resident or their guardians sign anything acknowledging this information.

During on-site investigation I observed the thermostats in the main area of the facility. There are two thermostats, and both read 70 degrees during this visit. I did tour Former Resident A's room and noted that it did feel warmer than the hallway, but it did not feel uncomfortable on this date.

On 9/30/22 I interviewed Citizen 1 via telephone. Citizen 1 reported that she would visit the facility daily to see Former Resident A. Citizen 1 reported that Former Resident A's room "was hot." She reported one of the staff found her a fan for the room and later she went and purchased her own fan. She reported Former Resident A did not appear to be bothered by the heat. Citizen 1 reported she was not told, upon admission, that there is not air conditioning in the resident bedrooms. She reported that they could not open the window in the room as the direct care staff would smoke outside the window and this would make Former Resident A's room smell of cigarette smoke. Citizen 1 reported that it felt like 90 degrees in the room. She further reported she did not have a thermometer to check this temperature for accuracy.

On 10/10/22 I interviewed Ms. Warden via telephone. Ms. Warden reported she does not recall the temperature of Former Resident A's room due to the time that has lapsed since her admission/discharge. Ms. Warden reported she never received a complaint from the family regarding the temperature of the room.

On 10/10/22, I interviewed Ms. Kuehnel, via telephone. Ms. Kuehnel reported that the temperature of Former Resident A's room was not reported to her as a problem. She reported that residents are made aware that the central air conditioning is only available in the main areas of the facility. Ms. Kuehnel reported that it was explained to Former Resident A's family that they would need to bring in a fan or a window air conditioner.

On 10/11/22, I interviewed Ms. Zrenchik, via telephone. Ms. Zrenchik reported some of the resident rooms can be warm depending on which side of the building they are on and where the sun is at during the day. Ms. Zrenchik reported Former Resident A's room temperatures is unknow to her at this time. Ms. Zrenchik reported that residents and their guardians are informed that the rooms are not air conditioned and they will need to accommodate this need on their own.

APPLICABLE RULE	
R 400.15406	**Room temperature.**
	All resident-occupied rooms of a home shall be heated at a temperature range between 68 and 72 degrees Fahrenheit during non-sleeping hours. Precautions shall be taken to prevent prolonged resident exposure to stale, noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations from the requirements of this rule shall be based upon a resident's health care appraisal and shall be addressed in the resident's written assessment plan. The resident care agreement shall

	address the resident's preferences for variations from the temperatures and requirements specified in this rule.
ANALYSIS:	Based upon interviews with Ms. Aldrich, Ms. Zrenchik, Ms. Warden, Ms. Kuehnel, Complainant, and Citizen 1 as well as observations from on-site investigation, the facility is maintaining a temperature between 68 and 72 degrees. Precautions were taken to prevent exceedingly high temperatures by having fans available in Resident A's resident room.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Former Resident A's morphine was not administered correctly.

INVESTIGATION:

On 9/1/22 I received an online complaint alleging that Former Resident A's morphine was not administered correctly while she was at the facility. On 9/6/22 I interviewed Complainant. Complainant reported direct care staff were not administering the proper dosage of morphine. Complainant noted Former Resident A's hospice team had changed the dosage of morphine and the direct care staff were still administering the initial dosage, not the changed dose.

On 9/8/22 I completed an on-site investigation at the facility. I interviewed Ms. Aldrich regarding the allegation. Ms. Aldrich reported that there was a family friend, who appeared to have been hired by the family, to sit with Former Resident A. Ms. Aldrich noted that this individual had asked for more morphine to be administered than what was ordered on Former Resident A's MAR. Ms. Aldrich reported that they had conversation with this individual about this order and noted that Former Resident A's plan of care could only be discussed with family members due to HIPPA. Ms. Aldrich reported that if the hospice team were to change the dosage of morphine, their team is responsible to communicate this to the pharmacy and the pharmacy then updates the MAR immediately. Ms. Aldrich reported facility direct care staff member administered the morphine to Former Resident A as it was prescribed and written on the MAR.

During on-site investigation, on 9/8/22, I reviewed Former Resident A's MAR. I found the following orders for morphine written on Former Resident A's MAR:

- Morphine Sul Sol 20MG/ML Color, Give 0.25ML (5MG) by mouth every 4 hours as needed for pain/dyspnea. Prescribed by James Gee. Written on 8/23/22 and discontinued on 8/26/22
- Morphine Sul Sol 20MG/ML Color, Give 0.25ML (5MG) by mouth three times daily. Prescribed by James Gee. Written on 8/26/22 and discontinued on 8/27/22.
- Morphine Sul Sol 20MG/ML Color, Give 0.25ML (5MG) by mouth every 4 hours as needed for pain. Prescribed by James Gee. Written on 8/26/22 and discontinued on 8/27/22.
- Morphine Sul Sol 20MG/ML Color, Give 0.5ML sublingually every 4 hours. Prescribed by Michael Allison. Written on 8/27/22 and discontinued on 8/27/22.

I reviewed the MAR for doses administered. All morphine doses were recorded as administered as ordered on Former Resident A's MAR for August 2022.

During on-site investigation, on 9/8/22, I reviewed the *Hospice IDG Comprehensive Assessment and Plan of care Update Report*, from Promedica Hospice for Former Resident A. This report was dated 8/30/22 and contained hospice staff plan of care for the dates, 8/22/22 through 8/27/22. The report contained the following information pertaining to the morphine ordered for Former Resident A:

- 8/26/22 ("Order Date") "Roxanol 20MG/ML 5MG PO TID". 8/28/22 ("Effective Date"), 8/26/22 ("Approved Date").
- 8/26/22 ("Order Date") "Morphine 20MG/ML Give 10 MG SL Q 4 Hrs Scheduled." 8/29/22 ("Approved Date").
- 8/26/22 ("Order Date") Morphine 20MG/ML 5-20 MG SL Q 1 HR PRN. 8/29/22 ("Approved Date").

On 9/30/22 I interviewed Citizen 1 regarding Former Resident A's medications. Citizen 1 reported she was not at the facility very often when medications were being administered. Citizen 1 reported she was not aware of any medication concerns, and she did not have any medications concerns when she was visiting Former Resident A.

On 9/30/22 I attempted to interview the on-call hospice nurse with Promedica Hospice, Citizen 2. The Promedica office noted that Citizen 2 works evening hours and they would page him to contact me. I did not receive a response from Citizen 2.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon interviews with Ms. Aldrich, Complainant, & Citizen 1 in addition to review of Former Resident A's MAR for August 2022 and the *Hospice IDG Comprehensive Assessment and Plan of care Update Report,* direct care staff members administered Former Resident A's morphine as it was prescribed and as the prescriptions were ordered and the order was sent to the pharmacy by hospice team members.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During on-site investigation on 9/8/22 I reviewed Former Resident A's MAR for the month of August 2022. Direct care staff, Lisa Vanderhoof, was listed on the MAR as administering medication to Former Resident A on the following dates and times:

- 8/26/22, 7:55pm, Morphine Sul Sol 20 MG/ML Color 100MG/5ML Sol.
- 8/26/22, 8:45pm, Morphine Sul Sol 20 MG/ML Color 100MG/5ML Sol.
- 8/27/22, 1:08am, Lorazepam Tab 1MG
- 8/27/22, 1:08am, Hyoscyamine Sub 0.125 MG Subl
- 8/27/22, 1:08am, Morphine Sul Sol 20 MG/ML Color 100MG/5ML Sol.
- 8/27/22, 5:17am, Hyoscyamine Sub 0.125 MG Subl
- 8/27/22, 5:17am, Morphine Sul Sol 20 MG/ML Color 100MG/5ML Sol.
- 8/27/22, 5:17am, Lorazepam Tab 1MG

I reviewed Ms. Vanderhoof's employee file. The employee file contained documentation of medication administration training. The file did not contain documentation of the following required trainings for direct care staff members:

- Reporting requirements.
- First aid.
- Cardiopulmonary resuscitation.
- Personal care, supervision, and protection.
- Resident rights.
- Safety and fire prevention.
- Prevention and containment of communicable

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Based upon review of Former Resident A's MAR and Ms. Vanderhoof's employee file. Ms. Vanderhoof is missing documentation of required trainings for direct care staff and was administering medications to Former Resident A without completing required trainings.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

10/25/2022

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Jana Lipps Date
Licensing Consultant

Approved By:

10/25/2022

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Dawn N. Timm Date
Area Manager