GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 8, 2023

Brenda Ice
Loving Care Residential Assisted Living, LLC
27852 Starling Lane
Flat Rock, MI 48134

RE: License #: AS820292538
Investigation #: 2023A0116024
Loving Care Residential Assisted Living

Dear Ms. Ice:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS820292538 |
| | |
| **Investigation #:** | 2023A0116024 |
| | |
| **Complaint Receipt Date:** | 02/03/2023 |
| | |
| **Investigation Initiation Date:** | 02/07/2023 |
| | |
| **Report Due Date:** | 04/04/2023 |
| | |
| **Licensee Name:** | Loving Care Residential Assisted Living, LLC |
| | |
| **Licensee Address:** | 31704 Marigold Dr.<br>Brownstown, MI 48173 |
| | |
| **Licensee Telephone #:** | (734) 348-6006 |
| | |
| **Administrator:** | Brenda Ice |
| | |
| **Licensee Designee:** | Brenda Ice |
| | |
| **Name of Facility:** | Loving Care Residential Assisted Living |
| | |
| **Facility Address:** | 31704 Marigold Dr.<br>Brownstown, MI 48173 |
| | |
| **Facility Telephone #:** | (734) 379-2601 |
| | |
| **Original Issuance Date:** | 02/07/2008 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 09/07/2022 |
| | |
| **Expiration Date:** | 09/06/2024 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| The facility is not allowing Resident A to have visitation with relatives. | Yes |
| Resident A's daughters are in a dispute over guardianship of her. Despite presenting documentation to the facility that a Power of Attorney (POA) is in effect, they refuse to honor it and allow Relative (A) to take Resident A out of the facility to get medical treatment. Resident A is in severe pain and needs to see her doctor but is not being allowed to go. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 02/03/2023 | Special Investigation Intake<br>2023A0116024 |
| 02/03/2023 | APS Referral<br>Received. |
| 02/07/2023 | Special Investigation Initiated - Telephone<br>Left a message for Amy Morse, physical therapist, at Assured Care Home Health. |
| 02/07/2023 | Contact - Telephone call made<br>Interviewed Relative A. |
| 02/07/2023 | Contact - Telephone call made<br>Interviewed Relative (B). |
| 02/07/2023 | Contact - Telephone call made<br>Interviewed licensee designee, Brenda Ice. |
| 02/07/2023 | Contact - Telephone call made<br>Interviewed Ms. Morse. |
| 02/07/2023 | Contact - Document Received<br>Received copy of Relative A's Power of Attorney (POA) for Resident A. |
| 02/09/2023 | Inspection Completed On-site<br>Interviewed Resident A and staff Sade Lindsay. |

| | |
|---|---|
| 02/09/2023 | Contact - Telephone call made<br>Spoke with Relative (A). |
| 02/09/2023 | Contact - Telephone call made<br>Spoke with Relative (B). |
| 02/09/2023 | Contact - Telephone call made<br>Interviewed Adult Protective Services (APS) investigator, Tomea Bean. |
| 02/09/2023 | Contact - Telephone call made<br>Spoke to Ms. Ice. |
| 02/09/2023 | Inspection Completed-BCAL Sub. Compliance |
| 02/23/2023 | Contact - Telephone call received<br>Spoke with Relative A. |
| 03/01/2023 | Contact - Telephone call received<br>Spoke with Ms. Bean, APS. |
| 03/06/2023 | Exit Conference<br>With licensee designee, Brenda Ice. |

**ALLEGATION:**

**The facility is not allowing Resident A to have visitation with relatives.**

**INVESTIGATION:**

On 02/07/23, I interviewed Relative A, and she reported that there is an ongoing feud between she and Relative B. Relative A reported that Resident A revoked Relative B's power of attorney (POA) on or about 12/14/22, and then appointed her as her medical and financial POA. Relative A reported that Relative B petitioned the court for Guardianship and a hearing is scheduled for 02/23/23. Relative A reported that licensee designee, Brenda Ice has taken sides with Relative B and is feeding into all of the negativity. Relative A reported that because of Ms. Ice's bias she has refused to allow her to visit the facility and has had staff call the police on her when she has come to the facility. Relative A reported that although this is a nasty dispute between the family, Ms. Ice should have been neutral in the matter. Relative A reported that she talks to Resident A on the phone, and she has expressed to her that she wants her to visit and would like to go out of the facility to enjoy lunch or

other activities, however, Ms. Ice refuses to let Resident A leave the facility and to date will not allow Relative A to visit. Relative A is hopeful that she will be granted guardianship of Resident A at the hearing on 02/23/23.

On 02/07/23, I received and reviewed the current POA document which appoints Relative A as the medical and financial POA upon Resident A's inability to make decisions on her own. The document is dated 01/23/23.

On 02/07/23, I interviewed Relative B and she reported that all of the allegations are lies are a result of the feud between she and Relative A. Relative B reported that Relative A and Resident A had a violent and unhealthy past growing up and now that she is trying to make sure Resident A is safe and her needs are met, Relative A shows up acting like she cares about Resident A, when it's really about Resident A's money. Relative B reported that she does not think it is healthy that Relative A and Resident A spend any time together, and she is glad that Ms. Ice has prohibited it. Relative B confirmed that Resident A revoked her as POA in December of '22 and reported that she has since petitioned the court for guardianship of Resident A as she believes that Resident A is in the beginning stages of Dementia.

On 02/07/23, I interviewed licensee designee, Brenda Ice, and she reported that there has been an ongoing dispute between the family of Resident A. Ms. Ice reported that initially Relative B was the POA for Resident A and was making decisions on her behalf. Ms. Ice reported then some way Resident A had the POA revoked and named Relative A as her POA.

Ms. Ice reported that Relative B did not want Relative A to visit or take Resident A out of the facility and reported that she honored her request. I informed Ms. Ice that the POA is for medical and financial decisions at the time that it has been determined by a medical professional that Resident A is unable to make decisions for herself. I informed Ms. Ice that she should not have been restricting Relative A from visiting Resident A or from taking her out of the facility. I informed Ms. Ice that it is Resident A's right to have contact with relatives and friends and to receive visitors in the home. I informed Ms. Ice that at the present Resident A is her own guardian and is able to make decisions regarding visitors coming to the facility and leaving the facility with family if she desires. Ms. Ice reported an understanding and reported that she would notify Relative A and inform her that she can visit and take Resident A out of the facility if they decide to do so.

On 02/09/23, I conducted an unscheduled onsite inspection and interviewed staff, Sade Lindsay and Resident A. Ms. Lindsay reported that Resident A has only been in the facility a few months and reported that there has been an ongoing feud between Relative A and Relative B and reported that the staff are in the middle of it. Ms. Lindsay reported at the instruction of Ms. Ice, the staff have not allowed Relative A to visit or to take Resident A out of the facility. Ms. Lindsay reported that the staff don't know which relative to believe and they all want to do what they can to make sure Resident A is safe.

I interviewed Resident A and she reported that she is unhappy living in the facility and reported she feels like she is a prisoner. Resident A reported that she does not wish to have a relationship with or visit with Relative B, however, reported that she wants Relative A to visit her and take her out of the facility from time to time. Resident A reported that Ms. Ice is punishing her because of what Relative B has told her. Resident A reported that she is of sound mind and that she wants to see Relative A. I informed Resident A that I had spoken with Ms. Ice and informed her that she could not restrict her from having family and friends visit. I informed her that she could contact Relative A and inform her that she could start visiting. Resident A was happy and thanked me for coming to speak with her**.**

On 02/09/23 I spoke with Relative A and informed her that I had spoken with Ms. Ice and Resident A regarding visitation. I informed Relative A that Ms. Ice is aware and has informed the staff to allow her entry onto the facility to visit. I informed Relative A that as the current POA, she does not have any authority to restrict Relative B from visiting, if Resident A wishes to visit with her. Relative A reported an understanding.

On 02/09/23, I spoke to Relative B and informed her that if she wishes to visit with Resident A and Resident A wants to visit with her then they can set it up as they please. I informed Relative B that although Relative A is the current POA she does not have the authority to restrict visitation. Relative B reported an understanding.

On 02/23/23, I spoke to Relative A and she reported that the court granted temporary guardianship to a public guardian, Family Options, and the court ordered some things be completed prior to the next court hearing which is in April. Relative A reported that it's a sad day for all involved and unfortunate that it has come to this. Relative A is hopeful that at the next hearing things will get sorted out and that she will be able to obtain guardianship of Resident A.

On 03/06/23, I conducted the exit conference with licensee designee, Brenda Ice, and informed her of the findings of the investigation. Ms. Ice reported an understanding and reported that she was just trying to do the right thing. Ms. Ice reported that she has decided to close the facility. Ms. Ice reported she has been looking to sell for quite some time and things have not worked. To date, Ms. Ice reported that Resident A is the only Resident in the facility. Ms. Ice reported she has provided Family Options with notice that the facility will close on 03/25/23 and reported that she is helping them find placement for Resident A. Ms. Ice reported that Family Options thinks that a nursing home would best suit Resident A.

| APPLICABLE RULE | |
|---|---|
| **R 400.14304** | **Resident rights; licensee responsibilities.** |
| | **(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:**<br>**(k) The right to have contact with relatives and friends and receive visitors in the home at a reasonable time. Exceptions shall be covered in the resident's assessment plan. Special consideration shall be given to visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.** |
| **ANALYSIS:** | This violation is established as Ms. Ice prevented Resident A from having contact with relatives by refusing to allow Relative A into the home.<br><br>Ms. Ice admitted that she refused to allow Relative A to visit because of some things Relative B shared with her about the past relationship between the two of them. Ms. Ice also believed that at the time Relative B placed Resident A in the home, she was the POA and had the authority to say who was allowed to visit. I informed Ms. Ice that the POA that was in place for Resident A was specific to medical and financial only. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Resident A's daughters are in a dispute over guardianship of her. Despite presenting documentation to the facility that a Power of Attorney (POA) is in effect, they refuse to honor it and allow Relative A to take Resident A out of the facility to get medical treatment. Resident A is in severe pain and needs to see her doctor but is not being allowed to go.**

**INVESTIGATION:**

On 02/07/23, I interviewed Relative A and she reported that Resident A has been complaining of pain in her shoulder area, however, the facility will not allow her to

take Resident A to the doctor to have it looked at. Relative A reported that she had an appointment scheduled and the staff refused her entry into the home to pick Resident A up.

On 02/07/23, I interviewed Relative B and she reported that when she was the POA she placed her mother in the facility in November ’22. Relative B reported that she signed the paperwork and agreed for Resident A to be seen by the house doctor and Resident A agreed to that. Relative B reported that Resident A had been seen several times by the house doctor and reported she had recently been prescribed some ointment for the pain in her shoulder. Relative B reported that the shoulder pain had been an ongoing issue and that Resident A was prescribed pain medication to take as needed, however, reported that Resident A prefers a holistic approach to things and was refusing to take the pain medication. Relative B reported that Resident A was also receiving physical therapy but believes that has ended as it was determined based on her age, that the shoulder is not going to get better, and that ointments and pain medications would be the only things to offer relief. Relative B reported that Resident A was receiving great care in the home, and she has no concerns. Relative B reported this is another attempt by Relative A to cause trouble for the facility.

On 02/07/23, I interviewed licensee designee, Brenda Ice, and she reported that Resident A is receiving medical treatment by the house doctor and reported that he sees all of the residents monthly. Ms. Ice reported that Resident A was admitted at the end November ‘22. Ms. Ice reported that Dr. Pierce saw Resident A on 01/02/23 and again on 02/15/23. Ms. Ice reported due to Resident A’s ongoing shoulder issues, her constant complaints of pain and refusal to take her PRN pain medications, on 02/03/23, Dr. Pierce prescribed Voltaren 1% gel to be applied to Resident A’s shoulder three times per day as needed. Ms. Ice reported that on 02/15/23, Dr. Pierce saw Resident A to follow up on her shoulder and to see and treat her for a sore she had on her buttocks.

Ms. Ice reported that Resident A is prescribed PRNs for Tramadol and a medication for muscle spasms. Ms. Ice reported that most times Resident A will refuse her medications, however, reported that the staff are doing their job by attempting to administer her medication to her when she verbalizes that she is having shoulder pain. Ms. Ice reported that she and the staff have informed Resident A that she has to keep the pain medication in her system in order for it to be effective, however, Resident A continues to refuse the medication when offered or will not request it, even when she has verbalized that her shoulder is hurting.

On 02/07/23, I interviewed Amy Morse and she reported that she was the physical therapist for Resident A. Ms. Morse reported that the family dispute going on is concerning to her and she wants to ensure that it does not impact the care of Resident A. Ms. Morse reported that Resident A is in pain and reported that it was her understanding that Relative A had a scheduled appointment with Resident A’s

doctor on or about 02/02/23, and Ms. Ice and her staff refused to allow Relative A in the home to take Resident A.

Ms. Morse reported that her services have concluded as Resident A's condition will not improve, however, she reported that Resident A would benefit from pain management so that she is not constantly hurting. Ms. Morse reported that she contacted the house doctor, Dr. Pierce's office and left a message with her concerns. Ms. Morse reported to date she has not heard from Dr. Pierce or his staff.

On 02/09/23, I conducted an unscheduled onsite inspection and interviewed staff Sade Lindsay and Resident A. Ms. Lindsay reported that today is her first day back to work in over a week and she is not aware of what happened the past week. Ms. Lindsay reported that Resident A only has four or five prescribed medications, and they are all PRNs and are for pain and one is a sleep aid. Ms. Lindsay reported that most times Resident A refuses to take her medication when it is offered even when she has expressed that her shoulder is hurting.

I interviewed Resident A and she reported that her shoulder constantly hurts, and Ms. Ice prevented Relative A from taking her to be seen by a doctor. Resident A reported that the house doctor prescribed her an ointment to apply to her shoulder last week and reported that it has helped. I asked Resident A if she had informed staff that she was having some pain and if she had requested some pain medication. Resident A reported that she knows she has pain medication but reported that she doesn't trust Ms. Ice or any of the staff and she doesn't trust what they may be trying to give her. I informed Resident A that the only way she would get some relief from her pain was to take the prescribed pain medication that was in the home.

I reviewed Resident A's medication administration log and observed that she was recently prescribed (02/03/23) Voltaren 1% gel to be applied as needed for pain. Resident A is also prescribed Cyclobenzaprine HCL 50mg for muscle spasms to be taken every eight hours as needed, Tramadol HCL 50mg to be taken every six hours as needed for pain. There was also a prn for Trazodone 50mg for insomnia and Benzonatate 200mg capsule to be taken as needed for cough.

On 02/09/23, I interviewed Tomea Bean, assigned APS investigator. Ms. Bean reported that she is only investigating allegations of financial exploitation of Resident A that is alleged to have occurred prior to her placement in AFC. Ms. Bean reported the other allegations reported were not assigned for investigation as they were referred to licensing. Ms. Bean reported she is still investigating the financial exploitation and has not made a finding to date.

On 02/09/23, I spoke with Relative A and she reported that she has a doctor's appointment for Resident A with her primary care doctor on 02/13/23.

On 02/23/23, I spoke with Relative A and she reported that when she took Resident A to her appointment on 02/13/23, Resident A's doctor told her that he could only

see her for one matter that day and that she would need another appointment to address the shoulder pain. Relative A reported that an appointment was scheduled for 02/27/23 for Resident A's shoulder pain. Relative A reported that the appointment would likely be cancelled as the court appointed a public guardian through Family Options and that they would be responsible to ensure her medical needs are being met. Relative A was unaware that the house doctor, Dr. Pierce had prescribed some ointment for Resident A's shoulder. Relative A was however aware that Resident A had been refusing to take her prescribed pain medication.

On 03/01/23, I spoke to Ms. Bean (APS) and she reported that she will be keeping her investigation open at least until the next guardianship court hearing, which is scheduled for some time in April. Ms. Bean reported that the court ordered an individualized medical evaluation of Resident A to determine competency amongst other things. Ms. Bean confirmed that the court granted temporary guardianship to Family Options and granted temporary conservatorship to attorney Allen May.

On 03/06/23, I conducted the exit conference with licensee designee, Brenda Ice, and informed her of the findings of the investigation. Ms. Ice agreed with the findings. Ms. Ice also informed me that Resident A was placed at Symphony Applewood Nursing home on Saturday, 03/04/23 and that she would be updating her initial closure letter so that the facility could be closed sooner.

| **APPLICABLE RULE** | |
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| **R 400.14310** | **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:** | This violation is not established as the group home obtained needed care for Resident A.<br><br>Ms. Ice reported that although Resident A was prescribed pain medication and a medication for muscle spasms that she refused to take, the house doctor, Dr. Pierce saw her on 02/03/23, and prescribed the topical ointment Voltaren for Resident A to help ease the pain in her shoulder.<br><br>Relative B reported that Resident A had been seen by Dr. Pierce several times and was prescribed pain medication for her shoulder pain. Relative B reported that Resident A was refusing to take the medication. Relative B also reported that the shoulder pain has been an ongoing ailment that will not get better. Relative B reported that the pain medication and ointments are what will help ease the pain if Resident A will take/apply them.<br><br>Relative A reported that Resident A's shoulder pain has been an ongoing issue and she reported that Resident A does refuse to take the prescribed pain medication. Relative A reported that she had an appointment scheduled for 02/27/23, with Resident A's primary doctor, however reported that appointment was cancelled due to the court appointing a temporary public guardian for Resident A.<br><br>Ms. Morse confirmed that the shoulder issue that Resident A is having will not get better due to her age. Ms. Morse reported she just wanted to make sure that Resident A was getting medical care to address and manage the pain. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 02/09/23, I conducted an unscheduled onsite inspection and interviewed Resident A and staff, Sade Lindsay. During my interview of Resident A, I observed her Voltaren 1% gel ointment on the seat of her walker. I asked Resident A why the medication was in her bedroom and not locked up. Resident A reported that it had been in her possession since it was prescribed to her on 02/04/23. Resident A reported that she had been applying it to her shoulder for pain and reported that the

staff were aware. I informed Resident A that all medications have to be locked up and applied and/or given by the staff. Resident A reported understanding.

I interviewed staff, Ms. Lindsay and she reported that she was not aware that the ointment was in Resident A's room and reported that today was her first day working since the previous Saturday (02/04/23). Ms. Lindsay reported that all staff know that medications are to be locked and applied or administered by staff. Ms. Lindsay placed the medication in the locked medication cabinet.

On 02/09/23, I interviewed licensee designee, Brenda Ice, and informed her of my observations during the onsite inspection. Ms. Ice reported that all staff are fully trained and know better. Ms. Ice reported that she would be calling all staff to address the matter.

On 03/06/23, I conducted the exit conference and advised Ms. Ice of the findings of the investigation. Ms. Ice reported an understanding.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | **(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.** |
| **ANALYSIS:** | This violation is established as Resident A's prescription Voltaren 1% gel ointment was not locked and was in her possession at the time of my onsite. Further, Resident A reported that the medication had been in her bedroom with her since 02/04/23. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| APPLICABLE RULE | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | **(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.** |
| **ANALYSIS:** | This violation is established as Resident A reported that she had been applying her prescribed Voltaren 1% gel to her shoulder as needed for pain. Relative A reported that the staff were aware that it was in her room and failed to apply the medication for her. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

On 02/09/23, I interviewed Resident A and during the interview I observed a spray bottle of Lotrimin Antifungal Spray on Resident A's dresser. I asked Resident A about the medication, and she reported that the medication belonged to a resident that use to live in the facility. I reviewed the label and confirmed that the medication was not prescribed to Resident A. Resident A reported that she found the medication under the bathroom sink and had been using it on an area on her buttocks. I informed Resident A that I would be giving the medication to the staff so that it could be properly disposed of.

I interviewed staff Ms. Lindsay, and she reported not being aware that the medication was in Resident A's bedroom and reported that Ms. Ice is the person that discards medication when a resident no longer needs it or no longer resides in the facility. I gave Ms. Lindsay the medication and she locked it up and reported she would inform Ms. Ice of its location and need for disposal.

On 02/09/23, I interviewed Ms. Ice and informed her of my observations during the onsite inspection. Ms. Ice was surprised and reported that all medications are required to be locked up and reported that when residents pass away or move out of the home the medications are properly disposed of or given to the family. Ms. Ice reported she is unaware of how this medication got into Resident A's room and even more surprised that staff saw it and failed to remove it from her bedroom. Ms. Ice reported that she will immediately contact all the staff to address this issue.

On 03/06/23, I conducted the exit conference with licensee designee, Brenda Ice, and informed her of the findings of the investigation. Ms. Ice reported an

understanding and stated that in lieu of a corrective action plan she would be sending an updated closure letter as she is closing the license. Ms. Ice reported that Resident A was the last resident left at the facility and reported she was moved on 03/04/23 by Family Options (Public Guardian) to a nursing home.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | **(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.** |
| **ANALYSIS:** | This violation is established as the licensee designee and her staff failed to take precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.<br><br>Resident A had access to and was using a topical anti-fungal spray (Lotrimin AF) that was prescribed to a resident that was no longer residing in the home. The medication was in her bedroom. Resident A reported that she found the medication under the sink in the bathroom. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **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:** | This violation is established as Resident A found and was using a topical antifungal spray that belonged to a resident that was no longer living in the home. The medication was not properly disposed of and was no longer required once the previous resident moved out of the home. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of the signed closure letter, in lieu of the corrective action plan, I recommend closure of the license as requested by the licensee designee. The licensee designee reported that she has been attempting to sell the business for the past few years with no luck. Presently, she has decided to close the license and sell the house.

03/07/23

Pandrea Robinson — Date
Licensing Consultant

Approved By:

03/08/23

Ardra Hunter — Date
Area Manager