GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 20, 2023

Mary Marzolo
Cherry Suite AFC, LLC
10774 US-31 S
Williamsburg, MI 49690

RE: License #: AM050320275
Investigation #: 2023A0009018
Cherry Suite

Dear Ms. Marzolo:

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 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,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
701 S. Elmwood, Suite 11
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM050320275
Investigation #:	2023A0009018
Complaint Receipt Date:	02/13/2023
Investigation Initiation Date:	02/13/2023
Report Due Date:	04/14/2023
Licensee Name:	Cherry Suite AFC, LLC
Licensee Address:	10774 US-31 S Williamsburg, MI 49690
Licensee Telephone #:	(586) 242-7709
Administrator:	Mary Marzolo
Licensee Designee:	Mary Marzolo, Designee
Name of Facility:	Cherry Suite
Facility Address:	10774 US-31 S Williamsburg, MI 49690
Facility Telephone #:	(231) 498-2233
Original Issuance Date:	09/24/2013
License Status:	REGULAR
Effective Date:	03/24/2022
Expiration Date:	03/23/2024
Capacity:	11
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is prescribed Dilaudin but is not receiving this medication, instead she is given another medication. Resident A is also not given her prescribed medication that helps her urinate (Bumex/Bumetanide).	Yes
Additional Finding	Yes

III. METHODOLOGY

02/13/2023	Special Investigation Intake 2023A0009018
02/13/2023	APS Referral
02/13/2023	Special Investigation Initiated - On Site Joint site visit with adult protective services (APS) worker Ms. Jacqueline Muzyl Interviews with Resident A, direct care worker Ms. Tracy Smith and Resident A's Family Member
02/14/2023	Contact – Documents received from licensee designee Ms. Mary Marzolo
03/07/2023	Contact – Telephone call made to APS worker Ms. Jacqueline Muzyl
03/08/2023	Contact – Documents sent to APS worker Ms. Jacqueline Muzyl
03/08/2023	Contact – Telephone call received from APS worker Ms. Jacqueline Muzyl
03/09/2023	Contact – Telephone call made to hospice nurse Taylor Beal, Promedica Hospice, left message
03/09/2023	Inspection Completed – On Site Interview with licensee designee/administrator Mary Marzolo Face to face and discussion with Resident A
03/09/2023	Contact – Telephone call made to APS worker Ms. Jacqueline Muzyl

03/10/2023	Contact – Document (email) received from APS worker Ms. Jacqueline Muzyl
03/10/2023	Contact – Telephone call made to hospice supervisor Barbara MacGregor and nurse Chelsea Vandenbosch, Promedica Hospice
03/10/2023	Contact – Telephone call made to APS worker Ms. Jacqueline Muzyl, left message
03/10/2023	Contact – Telephone call made to licensee designee/administrator Mary Marzolo
03/10/2023	Contact – Telephone call made to Resident A's Power of Attorney
03/11/2023	Contact – Document (email) received from licensee designee/administrator Mary Marzolo
03/13/2023	Contact – Telephone call made to hospice nurse Taylor Beal, Promedica Hospice, left message
03/14/2023	Contact – Telephone call received from hospice nurse Taylor Beal and supervisor Barbara MacGregor, Promedica Hospice
03/14/2023	Contact – Telephone call made to direct care worker Tracy Smith
03/14/2023	Contact – Telephone call made to direct care worker Kimberly Harris
03/15/2023	Contact – Documents received from licensee designee/administrator Mary Marzolo
03/16/2023	Contact – Telephone call received from hospice nurse Taylor Beal and supervisor Barbara MacGregor, Promedica Hospice
03/17/2023	Contact – Telephone call made to home manager Julie Yaroch
03/17/2023	Contact – Telephone call made to licensee designee/administer Mary Marzolo
03/17/2023	Exit conference with licensee designee/administer Mary Marzolo

ALLEGATION: Resident A is prescribed Dilaudin but is not receiving this medication, instead she is given another medication. Resident A is also not given her prescribed medication that helps her urinate (Bumex/Bumetanide).

INVESTIGATION: I conducted a site visit at the Cherry Suite adult foster care home on February 13, 2023. I met adult protective services (APS) worker Jacqueline Muzyl there who was also conducting an investigation into the matter. We were met at the door by direct care worker Tracy Smith who was cooperative and allowed us into the home. Ms. Muzyl and I met with Resident A at that time. Ms. Muzyl attempted to interview Resident A. Resident A did not present as being oriented to time and place at the time of the interview. We did not believe that she would be able to accurately answer questions regarding her medication so we did not pursue that line of questioning. Resident A did seem well-cared for and comfortable during the time of the site visit. After the interview, Ms. Muzyl reported that Resident A has a diagnosis of Alzheimer's disease which was consistent with her presentation.

We then spoke with direct care worker Tracy Smith. She said that she typically is not the one who gives residents their prescribed medication but does sometimes. When she does pass medication, she always gives them their medication as prescribed by their physician and never deviates from the prescription instructions. Any medication that she administers to a resident, she records in the resident's individual medication log. Ms. Smith said that Resident A had been receiving in-home hospice services since October 8, 2022. The hospice agency had recently changed. She did know that the previous hospice nurse a disagreement with licensee designee Mary Marzolo and Ms. Marzolo's daughter Julie Yaroch. Ms. Marzolo and Ms. Yaroch believed that the hospice nurse was trying to hasten Resident A's death by the choice of medications she was prescribed. Ms. Smith said that she was aware that Resident A was sometimes given Tylenol instead of her prescribed Dilaudid but did not know the details of why that would happen. We asked if there were any other times that Resident A was not given medication as prescribed. She said that in early January of 2023, Resident A was ill and seemed as if she might be close to passing away. They did discontinue some of her medication at that time. She did not know if Ms. Marzolo had discontinued those medications herself or if they were discontinued by a nurse or doctor. Ms. Smith showed us Resident A's individual medication log for January of 2023. It showed that one dose of her Levothyroxine had not been administered on January 7, 8 and 9 of 2023. The other dose had continued to be administered during that time according to the log. Her Celexa was administered during the month of January 2023 except for January 6 through January 9. It appeared that her Celexa was also not administered during that time. Ms. Smith agreed that this might have been the time-period when her medication had temporarily been discontinued. Ms. Smith did know that the hospice nurse was visiting Resident A several times per week and that she often left behind medication orders. We asked if we could have copies of those orders. Ms. Smith looked for those orders but was only able to provide one copy, dated December 30, 2022. She said that she was unaware of where the others might be located. Ms. Smith was able to provide us with Resident A's individual

medication logs for December of 2022 and January of 2023 but was unable to provide a log for February of 2023 thus far.

We asked Ms. Smith about Resident A receiving morphine. She retrieved Resident A's prescribed medication and showed us what Resident A is prescribed. We noted that Resident A is prescribed hydromorphone, a type of morphine. Resident A's medication log showed that she had been given a dose of hydromorphone on January 3, January 6 and January 31, 2023. The bottle of hydromorphone was nearly full and did appear as if the three aforementioned doses were missing from the bottle. The hydromorphone was prescribed as-needed, given up to every four hours or as scheduled by the hospice nurse.

Ms. Muzyl and I spoke with Resident A's Family Member who was visiting his mother at the time of our site visit. He said that he did not have any concerns regarding his mother's care at the facility. Resident A's Family Member said that he believed that his mother was being well-cared for there and he felt staff at the facility do a good job with her. He said that he visits her often due to living nearby.

I reviewed the Medical Practioner's Orders dated December 30, 2022, that was provided by direct care worker Tracy Smith. The order was signed by Taylor Beal, RN. In regards to Bumex, it ordered, 'Initiate (1) Bumex 0.5 mg. tablet: take 1 tablet in a.m. by mouth every 2 days for edema.'

I reviewed Resident A's individual medication log for December of 2022. It showed that Resident A had been given a dose of 0.5 of Bumetande on December 30, 2022 and possibly on December 31, 2022. Bumetanide is the generic form of Bumex.

On February 14, I received nine pages of medication orders for Resident A from Cherry Suite. Most of the orders were from hospice nurses with Promedica Hospice. The orders began on October 17, 2022 with the last order dated February 9, 2023. An order dated December 13, 2022, stated, 'Initiate Bumex 0.5 mg tablet. Take 1 tablet daily for 5 days.' I noted on Resident A's medication log that initials were placed on the row above Bumetande for five days starting on December 15 through December 19, 2022.

I reviewed an order dated December 30, 2022. It ordered, 'Bumex 0.5 tablet: Take 1 tablet (a.m.) by mouth every 2 days.' I checked Resident A's medication log. There were times placed in the Bumetande row on December 30 and December 31, 2022 that indicated 6pm and 9am respectively. On Resident A's January 2023 medication log it showed that Bumetande had been administered to Resident A roughly every two days except for January 4 through January 8, 2023 when it was not administered. It showed that it had been administered back-to-back on January 22 and January 23.

An order dated December 31, 2022, stated, 'Use hydromorphone as ordered for labored breathing.' A further order on January 6, 2023, stated 'Hydromorphone

1mg/ml liquid: Give 0.5 ml as needed for pain, grimacing, difficulty breathing or agitation.' I reviewed Resident A's medication logs regarding Hydromorphone/Dilaudin. It indicated that Resident A had been administered Hydromorphone/Dilaudin on January 3, January 6 and January 31 of 2023. Tylenol 500mg. had been administered to Resident A on January 6, January 12 and January 13 of 2023.

I provided the above-mentioned records to APS worker Jacqueline Muzyl. On March 9, 2023, she reported that she had looked over the records I had provided as well as the records we had already obtained. She said that she did not see any obvious deviations regarding Resident A's medication administration. Ms. Muzyl said that she still needed to speak with Ms. Marzolo about the allegations and would get back with me about her findings.

I made a site visit at Cherry Suite on March 9, 2023 and spoke with licensee designee/administrator Mary Marzolo at that time. I asked her for Resident A's individual medication log for February of 2023. Ms. Marzolo provided that. She confirmed that what they had listed as Bumetande was Resident A's Bumex/Bumetanide. Resident A's medication log showed that Resident A had been administered Bumex every day, February 2 through February 6 on one row. It was recorded as having been administered on February 10, 2023, on a second row. It showed that Bumex had been administered on February 7 through February 9 and February 11 through February 20 on a third row. The medication was then discontinued on February 20, 2023. Ms. Marzolo showed me the prescription bottle for Resident A's Bumex which was filled on February 2, 2023. The bottle indicated that she was to be administered the Bumex daily. The bottle indicated that 14 pills were filled at that time. I noted that there were still pills in the bottle. I asked Ms. Marzolo to count the pills at that time. She counted out 14 pills in front of me. I asked her why the 14 pills remained in the bottle. Ms. Marzolo stated that possibly her daughter had combined pills from another bottle into that one. I asked her why the medication was stopped. Ms. Marzolo said that the new hospice nurse did not believe that Resident A needed the Bumex any longer and discontinued it at that time. Ms. Marzolo provided me with a hand-written order from Resident A's new hospice provider, Hospice of Michigan. It was dated February 20, 2023, and ordered, 'Stop Bumex. Please monitor for swelling/shortness of breath.'

I asked Ms. Marzolo about the past medication log which had been provided to me earlier. I explained that the order dated December 30, 2022, indicated that the Bumex should be administered once every two days but that the log indicated that she received Bumex on December 30 and then also on December 31, 2022. There were no initials on those dates, only times 6pm and what looked like 9am respectively. She agreed that it looked like times instead of initials but did not have an explanation for the consecutive administrations. Ms. Marzolo explained that Resident A had been sick with Covid-19 at the time. They had been talking with the hospice nurse Taylor Beal during that time and it is possible that she told them to give her an extra does which would explain the consecutive administrations. I

showed Ms. Marzolo my copy of Resident A's medication record for January 2023. I asked her why it appeared that Resident A had not received her prescribed Bumex on January 4 through January 8. I pointed out that it looked as if initials on those dates had been whited-out. She said that she did not know why. Ms. Marzolo said that Resident A had continued to be sick and weak during this time-frame. Resident A was very weak and unable to swallow during that time and they were not always able to administer her medication. They were only able to administer the medication when she was alert and able to swallow pills or take them in apple sauce. I asked Ms. Marzolo about the initials on the medication record for Bumex dated January 20 and January 22 which were circled. She said that when the initials are circled that meant that the medication was not actually given. Ms. Marzolo said that she did not have an explanation for that discrepancy either.

I asked Ms. Marzolo about the complaint that Resident A was not given her Dilaudin. She confirmed that Hydromorphone is the generic version of Dilaudin. That is how it is recorded in Resident A's medication log. It was prescribed by her hospice doctor due to Resident A having kidney failure. Ms. Marzolo stated that it is a much stronger pain medication than what they typically give residents there. I asked Ms. Marzolo about the complaint that she was refusing to give Resident A her Dilaudin. She replied that she has no problem giving it to her if it is "for the right reason". She said that if Resident A shows signs of pain, distress or rapid breathing it will be administered. She said that the first time she gave Resident A the Dilaudin it "knocked her out for a day and a half". She said that she asked the hospice nurse if she could give her half of a dose after that. I asked Ms. Marzolo if they had only administered the Dilaudin three times as reflected in the January of 2023 medication record. She said that the hospice nurse gave it to Resident A at least once when she was present. The nurse did not record those administrations in the medication record. I told Ms. Marzolo that it was not the nurse's responsibility to record the administration of the medication, it was their responsibility to record it. I asked her more about the complaint of them not giving Resident A the Dilaudin. Ms. Marzolo stated that there was never a time when Resident A was in obvious pain or distress that they did not give it to her.

I received an email message from APS worker Jacqueline Muzyl on March 10, 2023. She wrote, *"Hi Adam – I spoke with owner Mary Marzolo yesterday after you and I ended our telephone call. I ended up interviewing Mary in full because Mary is leaving on Sunday for Florida to see her spouse for a week. This is the response to the question I asked her: APS asked, do you know why Promedica Hospice discontinued services. Mary stated I wasn't told anything; I didn't even know we were investigated until today; I called them (Promedica Hospice) to find out why all this happened, they (Promedica Hospice) confiscated all our medications, locked everything up; they came in and took the meds, they (Promedica Hospice) sent people out and locked up the medications in the lock box and said we are not allowed to give out medication; I called the hospice nurse Taylor who had been on the case and she would not respond to me or take my call; I called the company and talked to the head of nursing and she didn't have anything to tell me; (Resident A's*

Power of Attorney) said that protective services are coming out on you and I don't know why; I asked the son (Resident A's Family Member) and he didn't seem to know why. APS asked, do you know the name of the person from Promedica Hospice who came and confiscated Marjorie's hospice meds? Mary stated, I think it was somebody named Amy; somebody came at night; that's what my notes say. Mary said she did not receive a phone call from the hospice staff of Promedica Hospice. I will be going to have a home call/F2F contact with (Resident A) on Monday and will proceed to close out the case when I find time to write the report – no substantiation of neglect in the APS case".

I spoke with Promedica Hospice supervisor Barbara MacGregor by phone on March 10, 2023. She reported that nurse Taylor Beal was unavailable but she, herself, would tell me what she knew regarding Cherry Suite and Resident A. Ms. MacGregor said they did not believe that Ms. Marzolo was following doctor's orders regarding Resident A's prescription medication. Ms. Marzolo changed dosages and gave Resident A over-the-counter medication. Ms. Marzolo had made a comment that she did not want to hasten Resident A's demise because she did not want an empty bed at the facility. She said that she could not lose Resident A for financial reasons. Ms. Marzolo was told that the medications Resident A is prescribed would not hasten Resident A's demise. Ms. Marzolo only wanted to provide half of the dose of Dilaudin to Resident A. Resident A's family had initiated hospice services because they wanted their mother to be comfortable. Ms. Marzolo was not cooperating with their services as a hospice agency. Ms. Marzolo seemed to believe that the pain medication would hasten Resident A's death. Ms. MacGregor went on to say that on January 6, 2023, their hospice nurse saw that Resident A was in obvious pain. Ms. Marzolo's daughter, Julie Waroch, said that she did not want to give Resident A her prescribed Dilaudin but instead wanted to give her Tylenol and see how she did. Hospice nurse Chelsea Vandenbosch entered the interview with supervisor Barb MacGregor at that point. Ms. Vandenbosch stated that she had been present with nurse Taylor Beal when some of the issues had arisen at Cherry Suite. She said that they had locked Resident A's care medications on-site because of their concerns. They did this to try to ensure that the medications were administered as ordered. Ms. Vandenbosch stated that they observed Resident A's legs were swollen and her lungs consistently sounding wet during their visits. They believed that this was from her retaining liquid. The Bumex/Bumentanide had previously been prescribed to help her shed liquid, but it seemed to them that Resident A was not receiving this medication. She said that they counted pills left in the prescription bottles and noted that there were several more pills than should have remained. As a result, they believed that Resident A was not receiving her Bumex as prescribed. Ms. MacGregor added that the other nurse involved, Taylor Beal, was not available at that time but that I should also speak with her.

On March 10, 2023, I left a voicemail message for APS worker Jacqueline Muzyl to report what the Promedica supervisor and nurse had shared.

On March 10, 2023, I spoke with licensee designee/administrator Mary Marzolo by phone. I told her that the Promedica Hospice staff reported that they had not believed that Resident A was receiving her Bumex/Bumetanide as prescribed. Ms. Marzolo stated that she wanted me to know that she had a very good relationship with them until right at the end. She maintained that they gave the medication as prescribed except for the time that she had previously discussed with me. She said that she believed that the full bottle of Bumex/Bumentanide pills I observed during my visit were combined by her daughter, Julie Yaroch, with pills from other bottle(s). 1 mg. of Bumex was given each day for 5 days in early February followed by 0.5 mg. of Bumex each day until February 20, 2023, when it was discontinued.

I spoke with Resident A's Power of Attorney (POA) by phone on March 10, 2023. She said that she had been in total support of Promedica Hospice while they were involved. They were in close contact with her and she did believe that their concerns regarding the medication were legitimate, although she had no way to confirm it. She was told by nurses at Promedica Hospice that her mother was not receiving her medication as prescribed. They shared with her what they were seeing in her mother's condition which they believed was an indication of her not receiving her prescribed medication. Resident A's POA said that although she believed them, Ms. Marzolo reported to her that her mother was receiving her medication as prescribed. Last month, Resident A's POA was contacted late at night by a nurse at Promedica suggesting she move her mother immediately from Cherry Suite. This was because they continued to believe that Resident A was not receiving her prescribed medication and could be in danger because of that. Resident A's POA said that she considered it but it was very sudden and ultimately felt it best for her mother to stay at Cherry Suite. Her brother also supported this who lives nearby the facility and often visits. Resident A seemed comfortable and well-cared for by her and her brother who sees her several times a week.

On March 11, 2023, I received an email message from Ms. Marzolo that she wished to mail me (overnight on the next business day) a package of documents which would, she hoped, clear up some of the questions I had which she had not been able to answer previously. She said that I should receive these documents at my office on March 14, 2023.

On March 14, 2023, I spoke with supervisor Barbara MacGregor and nurse Taylor Beal of Promedica Hospice by phone on March 14, 2023. Ms. Beal was the nurse who worked mostly with Resident A during their involvement with her. She said that her first concern was that the facility gave Resident A over-the-counter medication which was not ordered by the doctor. Over-the-counter medications must be ordered by the doctor who ensures it will not react with the other medications prescribed. They were giving Resident A Tylenol instead of Dilaudin which is what had been prescribed to Resident A for pain. The Tylenol was not ordered by her doctor. Ms. Beal went on to say that she was at the facility on January 6, 2023 and observed that Resident A was in pain. She was going to give Resident A a prescribed dosage of Dilaudin but Ms. Yaroch did not want Resident A to have the

Dilaudin. She wanted to give her a Tylenol instead. Ms. Beal said that she left and spoke with other professionals about the situation. She went back later in the day and observed that Resident A's pain was still "unmanaged". She said that she gave Resident A her Dilaudin at that time. I referred to Resident A's medication record at that time. It showed that Resident A received a Tylenol 500 mg. pill on that day. What looked like the initials "JY" were placed on the row for "Tylenol 500 mg." In the row for Hydromorphone (Dilaudin) on that day it showed what looked like "2pm". Ms. Beal confirmed that she was there the second time around 2 p.m. on that day when she administered the Dilaudin. This probably reflected her administering the medication at that time.

Ms. Beal also reported that Resident A was prescribed Bumex/Bumetanide because of her retaining fluid. She was experiencing "fluid overload". During most of their time with her, Resident A was prescribed 0.5 of Bumex every two days. When they thought that Resident A was getting her Bumex, her swelling decreased and the crackling or wet sound in her lungs decreased. The swelling would seem to be under control but then they would notice that her arms and legs were swelling again and that her lungs sounded wet. Ms. Marzolo disagreed with their assessment that Resident A was retaining fluid. She seemed to believe that she could disregard the doctor's orders for the medication. Ms. Marzolo told Ms. Beal that she would only give the Bumex every three days or hold the medication altogether based on her, Ms. Marzolo's, own assessment. Ms. Beal explained that Ms. Marzolo has reported that she is a licensed nurse herself and seemed to think it is her role to diagnose and treat Resident A herself. Both Ms. Beal and her supervisor said that was not appropriate. They explained that only the doctor can prescribe and order medication. Ms. Beal said that every time Ms. Marzolo admitted she was not giving the medication as prescribed, Ms. Beal would explain to her that only the doctor can change the medication order. After Ms. Marzolo admitted that she had not given Resident A the medication as prescribed, Ms. Beal would observe swelling in Resident A's arms and legs and crackling in her lungs. Ms. Marzolo believed that Resident A was fatigued from getting up to use the bathroom so much after taking the medication. Ms. Beal said that she believed that Resident A was fatigued because she was having trouble breathing due to the fluid in her lungs. She went on to say that it is not within Ms. Marzolo's scope to assess and treat Resident A. Promedica Hospice has a 24/7 phone number to call and a nurse can be on-site within two hours if Ms. Marzolo or other staff believe a medication change needs to occur. It is the nurse's role to assess and report what they are seeing to the doctor. Ms. Beal felt that Ms. Marzolo was always trying to influence what she, Ms. Beal, reported to the doctor. In early February of 2023, the doctor increased the Bumex to 1 mg. once a day for 5 days due to Resident A still holding fluid. On February 6, 2023, Ms. Beal went to see Resident A and Ms. Marzolo told her that Resident A had "dried out". Ms. Beal said that she still observed that Resident A was holding fluid. She instructed Ms. Marzolo to continue administering 0.5 mg. of Bumex as prescribed. When Ms. Beal returned on February 9, 2023, she did not believe that Resident A had been given her Bumex. She was swollen and had crackling in her lungs. Ms. Beal said that she checked Resident A's medication record. Ms. Marzolo

had written “STOP” on the line for Bumex and the medication had been crossed off. Then it had been written in below, the same medication and dosage. I asked Ms. Beal why she thought that had been done. She replied that she believed that Ms. Marzolo had stopped giving Resident A her medication and then written the same exact thing in below and initialed it to seem as if she was actually giving the medication. Ms. Beal said that she counted the Bumex medication on February 9, 2023. She counted 18 0.5 mg. pills at that time. She and the other nurse believed that there should only be 12 pills remaining instead of 18. I asked what, specifically, made them believe that the count was “off”. Ms. MacGregor said that they compared Resident A’s pharmacy report, the medication record on-site with the pill count. Ms. MacGregor reported that the pharmacy report listed two dates, February 2 and February 8, that 14 pills of 0.5 mg. Bumex was picked up. She said that the numbers did not match up at that time. Ms. MacGregor said that she did not know if she could provide the pharmacy report to me but would check and get back with me.

On March 15, 2023, I received a package of documents sent from Ms. Marzolo containing medication administration records for Resident A, most of which I had already gathered. Ms. Marzolo had highlighted areas of the records which she wanted to bring to my attention as well as tagging some areas which I had previously asked her about. Ms. Marzolo also provided the corresponding medication orders for each month. I had previously asked Ms. Marzolo about a period in early January of 2023 when Resident A’s medication log had shown she was not administered all of her medication. Ms. Marzolo had tagged this area and written in, “Very ill – not taking in liquids”. She had referenced an order dated January 6, 2023, and written on an attached note, “(Resident A) very ill at this time period per staff. Mary Marzolo not at AFC”. On the February 2023 medication record and regarding the three rows for “Bumatande”, Ms. Marzolo indicated that it had been written in multiple times in error. She noted that the hospice nurse had administered the Bumex/Bumentanide on one occasion and that her staff had administered it the other times as directed. Ms. Marzolo attempted to show that the medication administration records did reflect what had been ordered by the physician.

Ms. Marzolo also provided the pharmacy report for Resident A that Promedica supervisor Barbara MacGregor had referenced. The pharmacy report indicated that 5 Bumex pills were filled on December 13, 2022. Resident A’s medication record indicated that she was given those pills December 15 through December 19. The pharmacy report indicated that 8 Bumex pills were filled on December 30, 2022 and 8 again on January 12, 2023. These were reportedly administered December 30, 2022 through January 31, 2023. It is difficult to know how many were administered due to some areas that look to be whited-out and two dates with initials being circled which Ms. Marzolo reported meant that they were not actually given. If all of these pills had been administered as ordered, there should have been none left over. If the whited-out areas and circles indicated that the pills were not given, there would have been 5 tablets left over. The pharmacy report indicated that five 1 mg. tablets were filled on February 2, 2023. The medication report shows that these were

administered February 2 through February 6. The pharmacy report indicates that 14 0.5 Bumex tablets were filled on February 2 and another 14 0.5 Bumex tablets on February 8. Resident A's medication record showed that she was given 14 tablets 0.5 Bumex tablets between February 7 and February 20. The Bumex was discontinued on February 20, 2023. I counted 14 0.5 Bumex pills on-site with Ms. Marzolo on March 9, 2023. From my calculation of these records, this is what should have been left-over if Resident A had been given the medication as prescribed and if the records reflected accurate administration of the medication.

I spoke again with Promedica supervisor Barbara MacGregor and nurse Taylor Beal by phone on March 16, 2023. I reported that I had received the pharmacy report for Resident A that they had referenced and wanted to compare that to Ms. Beal's pill count at the facility. Ms. Beal had believed that there were too many Bumex tablets at the facility on February 9, 2023. She had counted 18 pills at that time and she and the other nurse from her agency had believed that there should only be 12 pills. This fact, along with comments from Ms. Marzolo that she was withholding the medication caused their concern at that time. Ms. Beal was also concerned that Resident A was not receiving the Bumex based on her observations that Resident A seemed to be holding liquid. I reported that from comparing the pharmacy report to the medication logs the Bumex count was fairly close as far as I could determine. The extra pills that they counted at that time could have reflected what I was told regarding Resident A being weak with illness and not being able to swallow some of her medication in late December of 2022 and early January of 2023. They agreed that sometimes a resident can be too weak to take medication. Ms. Beal wanted me to know that another concern they had was that one of the 14 dose prescriptions had been provided by the pharmacy in a bubble-pack which she and the other nurse had not seen on February 9, 2023. That had caused some of the concern. I said that it was possible some of those pills had been removed from the bubble pack and combined in a pill bottle which is not allowed by licensing rules but may have occurred. I explained that what I saw regarding the pharmacy report compared with the medication logs and pill counts was close to what they should have been. They agreed with me that the medication log did seem to indicate that the medication that was provided by the pharmacy was given as directed if the medication logs reflected what had actually been administered.

I spoke with home manager and daughter of the owner, Julie Yaroch, by phone on March 17, 2023. I asked her about the complaint that Resident A had not received all of her medications as ordered by her physician. Ms. Yaroch replied that she is not always present during the weekdays. She said that a lot of the discussions regarding Resident A's medications occurred between her mother, nurse Taylor Beal and direct care worker Tracy Smith. In regard to the Bumex, Ms. Yaroch said that she knows it is prescribed to Resident A to help her shed liquid. Ms. Yaroch said that Resident A was often saturated in the morning when she was taking it. She remembered giving Resident A the Bumex but wanted me to know that January of 2023 was a very hectic month at the facility. If the administration of her Bumex was somehow missed during that time-frame it would not have been intentional.

Otherwise, it was given as prescribed. I asked her about days in the row for Bumex that were whited-out and had circles around some of the initials. Ms. Yaroch said that she could not explain it. She said that she believed that possibly some of the direct care workers might have done that. Ms. Yaroch agreed with me that the medication administration record needs to reflect what was actually administered. I asked Ms. Yaroch about Resident A being prescribed Dilaudin. She replied that Resident A had not displayed signs of being in pain since she had lived with them. Resident A did have some bronchial issues that necessitated being given the Dilaudin. She was given it on a few occasions. Nurse Taylor Beal was reportedly telling them that she was seeing signs that Resident A was in pain but they were not seeing that. I asked Ms. Yaroch specifically about January 6, 2023, when Ms. Beal said she observed Resident A to be in pain. Ms. Yaroch said that they did give Resident A a Tylenol at that time. Ms. Beal later came back and gave Resident A some of her Dilaudin. I asked Ms. Yaroch if they had a doctor's order to be able to give Resident A Tylenol. She replied that Resident A might not have a current order for Tylenol. She believed that Resident A originally had a doctor's order for Tylenol but admitted that the hospice doctor probably did not continue the order.

I spoke with licensee designee/administrator Ms. Marzolo by phone on March 17, 2023. She said that she was gone from the facility in Florida for three weeks in January of 2023 and was also sick with Covid-19 during that time. She was aware that some things that shouldn't have happened might have occurred in her absence. She agreed that she is responsible for everything that occurs at the facility whether she is there or not. I asked her about the complaint that Resident A was not receiving all her prescribed medication. Ms. Marzolo said that when she got back from Florida, Resident A's arm and leg was swollen. Hospice nurse Taylor Beal wanted to increase the frequency of the Bumex at that time. 1 mg. of Bumex was given for five days and then 0.5 mg. of Bumex every day after that. It was given as directed. Before that time, the Bumex was given every other day. She did not know why it was given consecutively on December 30 and December 31, 2022. It may have been a "verbal order" to administer it that way. Ms. Marzolo said that she could not explain what looked to be whited-out areas on the Bumex row. She did say that this was during the time that Resident A was very sick and not able to swallow anything. I asked her about the circles around some of the initials on the Bumex row reminding her that she had told me that meant it wasn't actually given. Ms. Marzolo said that she couldn't say, only that during her previous experience as a medical professional when something is circled it meant to hold it and not administer it. In regard to the Bumex having three different rows on the February medication log, Ms. Marzolo said that it was an error and someone must not have seen that it was already written in on the log. Ms. Marzolo said that it was given as directed, though, and that was why she provided me with the information she had to try to show that. I asked Ms. Marzolo about them giving Resident A Tylenol when it wasn't not ordered at the time it was given. Ms. Marzolo said that Resident A came in with a lot of medication when she was admitted. She said that she knew that a hospice doctor will change prescriptions and evaluate what is needed at that time a patient is admitted to hospice. She admitted that she didn't see that it is still ordered after

Resident A started receiving hospice services. I asked Ms. Marzolo about Resident A's Dilaudin. She said that she did give it on a few occasions when Resident A was having trouble breathing. Ms. Marzolo did ask Ms. Beal if they could cut the dosage of the Dilaudin in half. Ms. Beal said she would ask the doctor but never got back to them on that. She said that she thought that she was able to evaluate when someone was in pain and Resident A did not exhibit signs that she was in pain to them.

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:	It was confirmed through this investigation that Resident A was given Tylenol for pain instead of her prescribed Dilaudin/Hydromorphone. There was no order from a licensed physician which allowed for her to be given Tylenol during the time it was administered to her.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	There was concern regarding Resident A not receiving her Bumex/Bumentanide. The hospice nurse assigned to Resident A reported that she believed that Resident A was retaining liquid which should not have happened if she was being given her Bumex. Staff at the facility maintained that they did give Resident A her Bumex as prescribed except for a time when she was ill and not able to swallow anything. I checked the pharmacy report against the medication logs and according to

	the logs, the medication was given as prescribed. A hospice nurse had reported that on February 9, 2023, she counted 18 Bumex pills when she believed there should have only been 12 remaining. This might be explained by the facility's report that Resident A was not given medication during a time when she was ill with Covid-19. The evidence is not conclusive to conclude that Resident A was not given her Bumex as prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

During my site visit to the Cherry Suite facility on March 9, 2023, direct care worker Tracy Smith reported that medication was being set up beforehand for staff by Julie Yaroch. Ms. Smith said that she knew this was a violation of licensing rules. At that time, I told licensee designee/administrator Mary Marzolo that setting up medication beforehand was not allowed by licensing rules and that they needed to discontinue that practice immediately.

I spoke with direct care worker Tracy Smith again by phone on March 14, 2023. She said that Ms. Julie Yaroch sets up the residents' medication for other staff to administer later in the evening. This includes her putting the pills into cups marked with the resident's name. Ms. Yaroch also measures out liquid medication and leaves it sitting in the medication cabinet as well as crushes pills and puts them in applesauce for each resident who takes their medication in that fashion. The liquid medication and applesauce is left sitting out, sometimes for hours, in the medication cabinet. The other staff are not allowed to initial themselves in the medication record after administering the medication. Ms. Yaroch will later initial that the medication was administered. Ms. Smith said that she has told Ms. Marzolo and Ms. Yaroch that she will administer the residents' medication herself since she knows from experience this is a licensing requirement. She also initials the medication record herself against their wishes. I asked Ms. Smith if this practice of setting up of the medication beforehand has continued even after I told Ms. Marzolo it was not allowed. She stated that it had. She has spoken to another direct care worker, Ms. Kimberly Harris, who works the night shift who is also concerned about it. She has also mentioned that it is still happening.

I then spoke with direct care worker Kimberly Harris by phone on March 14, 2023. She said that she works the late shift, from 6:30 p.m. to 8:00 a.m. She has been working at Cherry Suite for a year and a half to two years. Ms. Harris said that when she comes into work, Ms. Yaroch has already set up the medication or is in the process of setting up the medication for the night. The pills are placed in cups labeled with each resident's name. She does not even know what is in each cup, she just gives it to each resident as labeled. Some of the residents receive their

medication in apple sauce. Ms. Yaroch will crush the medication, place it in the applesauce and leave it out. She confirmed that the applesauce is sitting in the medication cabinet, unrefrigerated, until Ms. Harris administers it. The applesauce can be sitting out for up to three hours before she administers it to the resident. Four residents receive their medication in applesauce. Ms. Harris said that she has been told that she is not to write anything in the residents' medication record. She has been told that they do not want "too many people in there". Ms. Yaroch later initials the medication records, herself, to indicate it was administered. Ms. Harris went on to say that even when she gives a resident an unscheduled "as-needed" medication, she has been instructed to just write that on a scrap piece of paper and leave it in the medication cabinet. I asked if she would be willing to send pictures of what was set-up for her when she came in for her shift.

Later on March 14, 2023, I received two photographs of what looked like the inside of a medication cabinet. The photos showed several plastic cups marked with residents' names. Some of the semi-transparent cups seemed to contain pills while two cups appeared to contain applesauce with two plastic spoons sticking out of the top.

I spoke with hospice nurse Taylor Beal by phone on March 16, 2023. She said that she was aware that medication was being prepared by Ms. Marzolo and Ms. Yaroch beforehand for the other staff. Ms. Beal said that she had seen it sitting in cups marked with the residents' names for later administration by direct care staff. She said that she had seen applesauce with crushed medication sitting in the medication cabinet. She believed that the applesauce was sitting out all day sometimes waiting to be administered later. Ms. Beal said that she was also aware that some staff who administered medication were told not to initial the medication records and that Ms. Marzolo or Ms. Yaroch would later initial the log themselves.

I was able to confirm that the medication logs for Resident A almost exclusively had either a "MM" for Mary Marzolo or "JY" for Julie Yaroch initialed for each medication administration. There were, less frequently, some "TS" initials documented by Tracy Smith.

I asked home manager Julie Yaroch about her setting up medications beforehand for other staff to administer later. Ms. Yaroch admitted they did employ this practice but wanted me to know that it only started in November of 2022. Ms. Smith had come into work and told them that she was injured and could not lift her arm. Ms. Yaroch said that she started setting up medication beforehand to help Ms. Smith out. It was easier for Ms. Smith to have it all ready for her to give to the residents. When Ms. Smith got better, Ms. Yaroch said that she continued to set up the medication beforehand because she was used to doing it that way. I asked about her doing it for other staff as well. Ms. Yaroch said that it became part of her "muscle memory" so she just kept doing it for other staff as well. She said that she thought if it was prepared beforehand and then locked up it was fine. Ms. Yaroch said that she was usually in the facility when the other staff administered the medication but

not always. She admitted that she did not always observe the giving of the medication but did initial in the log for it having been given. I asked Ms. Yaroch why she had continued to set up medication beforehand even when I told her mother the week before that they needed to stop that practice immediately. Ms. Yaroch said that she had stopped doing it after my visit with the APS worker in February of 2023. I explained the rules regarding medication administration and Ms. Yaroch said that she understood.

I spoke with licensee designee/administrator Mary Marzolo by phone on March 17, 2023. I asked her about the medication continuing to be prepared beforehand for other staff to administer to the residents. Ms. Marzolo said she apologized for that. She said that it started in October of 2022 when direct care worker Tracy Smith told them she couldn't lift her arm. They started the practice to try to help her. I asked her why it has continued even after I told her that she needed to discontinue that practice the week before. Ms. Marzolo said that she did tell everyone that they couldn't do that anymore. I asked Ms. Marzolo if she had told her daughter that because I had reason to believe that Ms. Yaroch continued the practice. She said that she thought that she had spoken to her daughter about it. She said that her daughter works with the staff who work the night shift and it might have continued then. I went over licensing rules regarding the administration of medication with Ms. Marzolo and she was able to demonstrate that she knew the required elements of the rule.

APPLICABLE RULE	
R 400.14312	**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. (b) Complete an individual medication log that contains all of the following information: (i) The medication. (ii) The dosage. (iii) Label instructions for use. (iv) Time to be administered. (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. (vi) A resident's refusal to accept prescribed medication or procedures. (c) Record the reason for each administration of medication that is prescribed on an as needed basis.

ANALYSIS:	Information was discovered through this investigation that medication was set up beforehand by one staff and then administered by another staff. The individual medication log was later initialed by someone other than the staff who administered the medication. Resident A's individual medication log contained areas that appeared to have been whited-out on three dates and two initials with circles around them on two other dates. There was no explanation or corresponding notes for these discrepancies.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee designee/administrator Mary Marzolo by phone on March 17, 2023. I told her the findings of my investigation and gave her the opportunity to ask questions. We spoke about the proper administration of medication and about the accurate logging of those administrations. Ms. Marzolo agreed that the practice of setting up medication beforehand would stop immediately.

IV. RECOMMENDATION

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

03/20/2023

Adam Robarge — Date
Licensing Consultant

Approved By:

03/20/2023

Jerry Hendrick — Date
Area Manager