GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 3, 2023

Anne Kesler
Country Woods Assisted Living, LLC
8504 Doe Pass
Lansing, MI 48917

RE: License #: AM230388695
Investigation #: 2023A1029020
Country Woods Assisted Living

Dear Ms. Kesler:

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

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

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

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

Sincerely,

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM230388695
Investigation #:	2023A1029020
Complaint Receipt Date:	02/06/2023
Investigation Initiation Date:	02/06/2023
Report Due Date:	04/07/2023
Licensee Name:	Country Woods Assisted Living, LLC
Licensee Address:	8504 Doe Pass Lansing, MI 48917
Licensee Telephone #:	(517) 224-8300
Administrator:	Anne Kesler
Licensee Designee:	Anne Kesler
Name of Facility:	Country Woods Assisted Living
Facility Address:	7021 Hartel Road, Potterville, MI 48876
Facility Telephone #:	(517) 224-8300
Original Issuance Date:	08/27/2019
License Status:	REGULAR
Effective Date:	02/27/2022
Expiration Date:	02/26/2024
Capacity:	12
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Country Woods Assisted Living does not have enough direct care staff member working to provide care to residents.	No
Resident A was sent to the hospital on February 5, 2023 and she was observed with extensive bruising in all stages of healing on her arms, legs, and head.	No
One direct care staff member caused 12 medication errors and one error resulted in a resident going to the hospital for medical treatment.	No
Licensee designee Anne Kesler saves deceased residents' medications for use in the event that a current resident runs out of medication.	No
Additional findings	Yes

III. METHODOLOGY

02/06/2023	Special Investigation Intake 2023A1029020
02/06/2023	APS Referral - APS is also investigating. Assigned to Carol Stahl, APS Eaton County
02/06/2023	Special Investigation Initiated – Letter to APS Carol Stahl
02/22/2023	Contact - Received Email exchange with Carol Stahl APS
02/24/2023	Contact - Telephone call made to Relative A1
02/24/2023	Contact - Telephone call made to anonymous complainant.
02/28/2023	Inspection Completed On-site – face to face with direct care staff member Ronda Ballman, Resident A and Resident B
03/07/2023	Contact - Document Received Email from Carol Stahl
03/21/2023	Contact – Email to Anne Kesler requesting documentation.
03/22/2023	Contact – Email and telephone call to Anne Kesler.
03/27/2023	Contact – Telephone call to Holt Senior Care and Rehabilitation, LTC Pharmacy Megan Church, former direct care staff member Heather Buffington (Left message), Tina Gaskin (# not in service),

	Alexis Radcliffe (# not in service, sent her an email), Joanna Rodriguez (Left message), Careline Health Group (Stacy Near), email exchange with Ms. Kesler, Lashonta Anderson at Clipboard Health staffing agency, Ebony Sheldon (# not available)
03/29/2023	Contact – Telephone call to Heather Buffington, Left message, Carol Stahl APS, Florene Whitley, hospital social worker at Sparrow Eaton, Joanna Rodriguez
03/29/2023	Exit conference with licensee designee Anne Kesler, left message and sent email.

ALLEGATION:

Country Woods Assisted Living does not have enough direct care staff member working to provide care to residents.

INVESTIGATION:

On February 6, 2023 a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns that Country Woods Assisted Living does not have enough direct care staff members working per shift.

On February 24, 2023, I interviewed Relative A1. Relative A1 stated she did not notice any staffing concerns while she was there. Relative A1 stated they always seemed to have adequate staffing.

On February 24, 2023, I interviewed Complainant who stated she is a medical assistant and "knows what is legal or not and Ms. Kesler gets away with a lot." Complainant stated she is concerned regarding staffing because at one time there were nine residents and there were three direct care staff members working for each day because there is one direct care staff member for each shift. Complainant stated Resident B was blind so she would assume he needed more assistance, but she did not know for sure.

On February 28, 2023, I completed an unannounced onsite investigation at Country Woods Assisted Living and interviewed direct care staff member, whose current role is a home manager, Ronda Ballman. Ms. Ballman stated there were currently eight residents at Country Woods Assisted Living and four direct care staff members who alternate shifts. Ms. Ballman stated one direct care staff member per shift provides enough coverage to meet all the resident needs at this time.

During the onsite investigation, I was able to review the *Resident Register* and all resident records. According to the resident records all residents are fairly independent and needed minimal assistance with personal care tasks. I reviewed all resident records to confirm there were no residents who require the assistance of two direct care

staff members for mobility assistance. I also reviewed the staffing schedule for January 2023 and February 2023 which showed there was always one direct care staff member working each shift.

On February 28, 2023, I interviewed Resident F and Resident C. Neither resident reported having to wait for assistance and both felt like their needs are met timely at Country Woods Assisted Living.

On March 22, 2023, I interviewed licensee designee, Ms. Kesler who stated there are still eight residents and no one requires the assistance of two direct care staff members to assist with mobility. Ms. Kesler stated there are never two direct care staff members on a shift and she has always had one direct care staff member working per shift. Ms. Kesler stated she does not have anyone who requires catheter assistance or Hoyer lifts currently. Ms. Kesler stated her current residents can all ambulate independently.

On March 29, 2023, I interviewed former direct care staff member Joanna Rodriguez. Ms. Rodriguez stated there has been times where they are staffing one person at night because they want them to use a Hoyer by herself and she does not feel like this is the safest. Ms. Rodriguez stated Ms. Kesler told her she was able to use the Hoyer lift with one person. Ms. Rodriguez did not have any further concerns regarding staffing.

APPLICABLE RULE	
R 400.14206	**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:	There is no indication licensee designee Ms. Kesler has not scheduled enough direct care staff members to provide care to the residents at County Woods Assisted Living. I reviewed the resident register, all resident records, and the January and February 2023 direct care staff members schedules which all indicated there was one direct care staff member per shift. Ms. Kesler does not accept residents who need the assistance of two direct care staff members for mobility or ambulation, therefore one direct care staff member is adequate to provide services according to the resident's *Assessment Plan for AFC Residents.*
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was sent to the hospital on February 5, 2023 and she was observed with extensive bruising in all stages of healing on her arms, legs, and head.

INVESTIGATION:

On February 6, 2023, a complaint was received via an assigned adult protective services referral with concerns that Resident A was sent to the hospital with various stages of bruising on her arms, legs, and head. Adult Protective Services (APS) specialist Carol Stahl was assigned to investigate these concerns.

I reviewed an AFC Incident / Accident Report regarding the incident that was completed by direct care staff member, whose role is home manager, Ronda Ballman on February 5, 2023.

> *"Explain what happened: [Resident A] kept throwing herself on the floor, bed, and wall and yelling "help me" while they were assuring her.*
> *Action taken by staff: Staff called 911 per Ms. Kesler's instruction and Ms. Ballman put the portable handrail lift in between the mattress and mats on the floor. [Resident A] was constantly yelling out prior to her falling."*

On February 22, 2022, I received an email from Eaton County Adult Protective Services specialist, Ms. Stahl who was able to see Resident A at Sparrow Hospital. Ms. Stahl stated there was bruising on Resident A but Resident A denied that anyone had hit or harmed her while residing at Country Woods Assisted Living. Ms. Stahl stated Ms. Ballman reported to her she put a moveable rail in her room and told her Resident A "threw herself to the floor."

On February 24, 2023, I interviewed Relative A1. Relative A1 stated there were bruises on Resident A and she was only at Country Woods Assisted Living for four days. She went to pick her up on a Sunday and she was not there because they took her to the hospital. Relative A1 stated she changed her clothes for her two days prior and the bruises were not there. Relative A1 stated Resident A is still at Sparrow Hospital and she does not believe Resident A will return to Country Woods Assisted Living. Relative A1 stated she was upset because Resident A needed to get a feeding tube after this occurred. Relative A1 stated Resident A has never thrown herself on the floor and has never been combative but when asked Resident A does not remember how the bruises occurred. Relative A1 stated Resident A has one bruise on her forehead, her shin, and her leg. Relative A1 stated she did not notice anything concerning when she was at Country Woods Assisted Living. When she went back to the home to get Resident A's belongings, she saw a railing there and a fall pad in her room after she went to the emergency room. Relative A1 stated she was told Resident A threw herself out of bed but she did not think Resident A could do that because she did not have the muscle control to throw herself out of the bed.

On February 28, 2023, I completed an unannounced onsite investigation at Country Woods Assisted Living and interviewed Ms. Ballman. Ms. Ballman stated Resident A had bruising on her and she was acting very agitated so she went to the hospital on February 5, 2023. Ms. Ballman stated she had bruising because she would throw herself down on the floor. Ms. Ballman stated she had a fall mat and a bed guard before she went to the hospital. Ms. Ballman stated direct care staff member Heather Buffington was working when Resident A was sent to the hospital. Ms. Ballman stated Relative A1 did not have concerns of Resident A going to the hospital. Ms. Ballman stated there were no concerns of physical abuse to any of the residents. Ms. Ballman denied she has ever witnessed any of the direct care staff members being rough with any of the residents. Ms. Ballman stated Resident A was constantly yelling for them to "help her" even thought she was lying in bed. Ms. Ballman stated she was not aware Resident A had bruising on her until adult protective services worker, Ms. Stahl came to the home and let her know. Ms. Ballman stated Resident A will not be returning to Country Woods Assisted Living because she now has a feeding tube and they are not equipped to care for a resident with a feeding tube. Ms. Ballman stated Resident A ate very little at Country Woods Assisted Living each time she was offered a meal.

During the onsite investigation, I reviewed Resident A's resident record. According to her *Health Care Appraisal* completed on January 23, 2023, she is diagnosed with diabetes Type 2, GERD, Anemia, History of CVA with right side hemiplegia. According to the *Health Care Appraisal* she utilizes a walker and wheelchair to assist with mobility. I also reviewed the discharge notes from Holt Senior Care and Rehabilitation Center which Resident A expressed fear of falling and stated she required supervision or touching assistance for transferring from "sit to stand" and for "walking 10 feet" and on January 19, 2023, a note indicating she is a "fall risk with history of syncope and dizziness, right sided weakness, and poor safety awareness." According to Resident A's *Assessment Plan for AFC Residents*, she needs help with grooming, dressing, personal hygiene, and walking /mobility, and stand by assistance with toileting.

On February 28, 2023, I interviewed Resident F and Resident C. Neither resident remembered Resident A residing at Country Woods Assisted Living but both reported they were happy living at the facility. Neither resident reported the staff members were rough with them in any way and both reported direct care staff members were attentive to their needs. Resident F and C both stated they felt safe residing at County Woods Assisted Living.

On March 22, 2023, I interviewed licensee designee Ms. Kesler. Ms. Kesler stated she talked to Relative A1 when she signed the paperwork to admit Resident A however Ms. Kesler stated she did not know the full extent of Resident A's condition. Ms. Kesler stated when she went in to do the assessment of her for 10-15 minutes, she also did not see any concerns. Ms. Kesler stated there was no documentation showing that she had dementia or any psychotic episodes. Ms. Kesler stated when she arrived, she started yelling, "Help me, Help me!" when there would be nothing wrong. Ms. Kesler stated she worked one of the first nights after Resident A was admitted and recalled Resident A continuously cried out to help her in her sleep and she also refused food. Relative A1

stated Resident A could be “fussy” about food. Ms. Kesler stated Resident A told her that she was hungry in the middle of the night and she wanted bread with butter and water and when she gave it to her, Resident A took two bites of it and then told her she did not want it. After she did not finish this snack, Ms. Kesler stated Resident A wanted to go back to her room but was also exhibiting anxiety. Ms. Kesler stated she took Resident A back to bed but Resident A got back up again yelling “help me” again and she was up and down most of the night. Ms. Kesler stated Resident A could get into her wheelchair without any problems by herself because she did not want to wait for her. Ms. Kesler stated the following day she was still crying out off and on and refusing to eat full meals, but instead only eat one or two bites. Ms. Kessler stated she was worried about her falling so Ms. Ballman put the pads on the floor and a portable handrail that she could use to assist herself out of bed.

Ms. Kesler stated she spoke with someone at Careline Health Group about whether Resident A would qualify for hospice services, however she ended up at the hospital instead. Ms. Kesler stated the day that she went to the hospital she was throwing herself on the floor so the decision was made to send her to Sparrow Eaton Hospital to be assessed. Ms. Kesler stated it is possible the bruising came from before she entered their facility or when she was throwing herself down on the ground. Ms. Kesler stated she has never had any concerns regarding any of her direct care staff members physically abusing any of the residents or handling them in a manner that would cause bruising.

On March 27, 2023, I contacted Holt Senior Care and Rehabilitation Center where Resident A resided in prior to moving to County Woods Assisted Living and spoke to the administrator, Marie Patrick, RN. RN Patrick stated Resident A was admitted to them January 6, 2023 and she was there for rehabilitation, however when she first arrived, she thought it would be a longer term placement but she was discharged on February 1, 2023. RN Patrick stated Resident A went to the emergency room on January 22, 2023 and she left the facility with Relative A1 once. RN Patrick stated on January 17, 2023 Resident A did have a skin check completed and there are notes she had a blanchable arrhythmia with ankle, shoulder had reddened areas on her feet so there was a foam dressing applied. RN Patrick stated there were no open sores on Resident A however she had a stage one pressure injury on her right ankles. RN Patrick stated while at their facility, Resident A did have COVID-19 and received the Paxlovid treatment. RN Patrick stated she has also noticed in the following weeks after having COVID-19, she has noticed resident’s skin will sometimes look like there is redness or become blotchy and with sores. RN Patrick stated when Resident A left their facility they drew her labs on January 9, 2023, her hemoglobin was low at 9 so that would also make her risk for bruising and would cause bruising to appear easily. RN Patrick stated Resident A had high anxiety when she was in their placement and when she had COVID-19.
RN Patrick stated she did not have any falls when she was at their facility or throw herself down but she was getting Ativan when she first arrived but this medication was discontinued while at this facility. RN Patrick stated they ordered a hospital bed with air mattress due to stage 1 pressure sore. RN Patrick stated there was also documentation Resident A had a mental health history of depression and anxiety due to adjustment

disorder. RN Patrick stated Relative A1 reported to her Resident A has a history of bipolar disorder. RN Patrick stated she was only 104 pounds and she left at 99.6 pounds after she had COVID-19. Relative A1 reported Resident A only eats egg whites, potato chips, and toast while she was at home. According to RN Patrick, Resident A was eating less than 50% of her meals.

On March 27, 2023, I interviewed Careline Health Group practice manager for the nurse practitioners, Stacy Near. Ms. Near stated Resident A is not a previous patient of theirs but Matt Basham, NP is the nurse practitioner who sees patients at Country Woods Assisted Living. Ms. Near stated he was unavailable this week, but she confirmed there were seven current patients he has contact with every two weeks at Country Woods Assisted Living. Ms. Near said they received a referral February 7, 2023, to start services for Resident A from Ms. Kesler however on February 8, 2023, they were told to hold off because the patient would be in the hospital for a while and would not be returning to County Woods Assisted Living. Ms. Nears stated NP Basham has never mentioned any suspicions of abuse or neglect toward any of the residents in the facility.

On March 29, 2023, I contacted Eaton County Adult Protective Services, Carol Stahl. Ms. Stahl stated she will not be substantiating for physical abuse because although Resident A did have bruising, she is on blood thinners and bruises easily.

On March 29, 2023, I interviewed former direct care staff member Joanna Rodriguez. Ms. Rodriguez stated she left her employment before Resident A moved into Country Woods Assisted Living but she was never concerned regarding physical abuse in the facility. Ms. Rodriguez stated sometimes the residents may have frail skin and bruise easily because they were on blood thinners, but she did not have concerns any of the direct care staff members were harming the residents.

APPLICABLE RULE	
R 400.14305	**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 on information obtained, Resident A was treated with dignity and her personal need of protection and safety were attended to at Country Woods Assisted Living. According to RN Patrick, Resident A exhibited a lot of the same anxious behaviors and Resident A was on blood thinners which would cause her to bruise at the time of her admission to this facility. Ms. Near reported there were no concerns of abuse that were reported to her by NP Basham who regularly provides patient care to residents at Country Woods Assisted Living.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

One direct care staff member caused 12 medication errors and one error resulted in a resident going to the hospital for medical treatment.

INVESTIGATION:

On February 6, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns that a direct care staff member at Country Woods Assisted Living caused 12 medication errors including one that sent a resident to the hospital.

On February 24, 2023, I interviewed Relative A1. Relative A1 stated there were no medication errors that she was aware of when Resident A was there but since she was incoherent, Resident A would not know if she was taking her medications correctly. Relative A1 stated there were no medication errors that were brought to her attention during the time Resident A resided there.

On February 24, 2023, I interviewed Complainant who stated she did not know which resident had to go to the hospital because of medication errors. Complainant stated Ms. Ballman would know this information because she is the current home manager. Complainant stated the direct care staff member who made the error is still working there and nothing has happened to correct the situation or prevent it from occurring again.

On February 28, 2023, I completed an unannounced onsite investigation at Country Woods Assisted Living and interviewed Ronda Ballman. Ms. Ballman stated she has had a lot of medication errors lately and they are all done by one employee Heather Buffington. Ms. Ballman stated she has talked to her several times, had her complete another medication training, but there are still issues. Ms. Ballman stated Ms. Buffington is now the assistant manager alongside herself and Ms. Ballman did not feel this was necessary. Ms. Ballman stated the medication administration records (MAR) will show the medications were given correctly but there were times a direct care staff member or herself would find a medication on the floor or in a resident bedroom thus

demonstrating a resident medication was not given as prescribed. Ms. Ballman stated it was assumed Ms. Buffington was the one that caused the medication to fall to the floor because she worked the shift prior but there is no information how long the medication was on the floor.

Ms. Ballman stated there was one time there was a medication error and Resident B ended up in the hospital because he had a seizure. Ms. Buffington missed his medication on November 16, 2022 and he was in the Sparrow Emergency on November 17, 2022 because he had a breakthrough seizure (HCC). Ms. Ballman stated Resident B does have a history of seizures which is why he is on medication to control them.

During the onsite investigation, I reviewed Resident B's after visit summary from November 17, 2022 which stated he was seen for a breakthrough seizure at Sparrow emergency by Katherine Peterson, MD. There was nothing indicated on the *After Visit Summary* that this seizure was due to a missed medication and under *Instructions* it stated the following*: "Pt was given his second dose of divalproex today in the ED. He still will need his night medications when he returns home. He should be taking 500 mg three times daily per previous notes. Dr. Peterson ordered a Valproic Acid test which would show his Depakote level and the reference range for this was 50-125 ug/ML and Resident B's value was 49."* Ms. Ballman stated this was due to a missed medication caused by Ms. Buffington but according to the *Resident Register,* Resident B did not move into Country Woods until November 18, 2022.

I also reviewed Resident B's current medications from LTC Pharmacy and confirmed that all of Resident B's current medications were at the facility. I was able to confirm all of the medications matched up with the medication blister and instructions on the MAR. All of Resident B's medications were given as prescribed for the month of February 2023.

Ms. Ballman produced the following *AFC Incident / Accident Report* regarding medication errors:

All the following *AFC Incident / Accident Reports* were submitted by Ms. Ballman.

- February 5, 2023 [Resident I] did not get medications in the AM. Action taken by staff was "talked to her and this cannot happen or will have to give days off and take the medication class again." Corrective measures were to put reminders in front of binder to be sure and document all medications on MAR.
- February 6, 2023 [Resident H] missed medication (Metoprolol) at 8 am and when third shift came in she noticed it was not given but the other medications were. 4th warning. Talked with Heather Buffington again about missed medication pass.
- February 6, 2023 Tina from 3rd shift was cleaning the main area and found a pill when she swept. Talked with Heather Buffington and gave a 5th warning.

Management shadowed her on the medication pass. (AFC Incident / Accident Report does not indicate which resident the medication was for.)

- February 13, 2023, [Resident E] was not given all medication at bedtime staff found her medication in bed when changing her sheets. Warning completed on medication errors to Heather Buffington. Management will supervise when giving medications.

On March 22, 2023, I interviewed licensee designee Ms. Kesler. Ms. Kesler stated she "does not know 100% that there were medication errors happening because there were recently some internal issues going on between Ms. Buffington and Ms. Ballman." Ms. Kesler stated Ms. Buffington was recently promoted to Assistant Manager because Ms. Kessler needed more assistance and Ms. Ballman was upset when this occurred. Ms. Kesler stated she kept Ms. Buffington on as the assistant manager and Ms. Ballman was the manager until Ms. Buffington left her employment in the beginning of March 2023. Ms. Kesler stated Ms. Buffington noticed the "medication errors" first and was trying to get Ms. Ballman in trouble. After that happened, Ms. Ballman stated "noticing" medication errors in order to get Ms. Buffington in trouble. Ms. Kesler stated she even offered to give them both an evening out to help them to get along with each other and neither one of them were interested in working it out. Ms. Kesler does not think there were medication errors because when she has reviewed the medication administration records, all medications were documented as given correctly. Ms. Kesler stated all *AFC Incident / Accident Reports* that were done regarding medication errors were all written by Ms. Ballman stating the error was with Ms. Buffington. Ms. Kesler stated when there is a medication error, they write up an *AFC Incident / Accident Report* and then she lets the pharmacy know of the error. Ms. Kesler stated she will let the pharmacy know of the error but sometimes Ms. Ballman will do it.

Ms. Kesler was able to send me text messages from January 9, 2023 written between herself, Ms. Buffington, and Ms. Ballman where she tried to address the concerns between the two direct care staff members and telling them to be honest with one another. There was also another one from November 22, 2022 written to Ms. Ballman where Ms. Kesler was discussing her attitude toward other direct care staff members and reminding her to work as a team.

On March 27, 2023, I contacted LTC Pharmacy and spoke with Megan Church. Ms. Church stated Ms. Kesler from Country Woods Assisted Living has great communication with the pharmacy and she has not experienced any issues or concerns. Ms. Church stated anytime there is a medication change they send it to them and they fix it in the medication administration record (MAR) for them. Ms. Church stated they do the electronic MAR through Quick MAR and provide this to the facility. Ms. Church stated she has not noticed any medication errors for them but if there was then Ms. Kesler would report the error to them.

On March 27, 2023, I interviewed Careline Health Group practice manager, Ms. Near. Ms. Near stated NP Basham is the nurse practitioner who oversees resident care at Country Woods Assisted Living but he was unavailable. Ms. Near stated NP Basham

has not mentioned medication errors to her. Ms. Near stated most facilities will fax a document in writing showing an issue has occurred in the facility with a missed medication. Ms. Near stated Resident B is their patient however she was not aware of any medication error because they did not receive his referral for care until November 21, 2022 because he did not move into Country Woods Assisted Living until November 18, 2022, which was after a seizure on November 17, 2022 because his family was not providing his medication regularly and he could no longer live alone. Ms. Near stated Resident B does have a history of monthly seizures and is on medication for a known seizure disorder.

Licensee designee Ms. Kesler sent documentation of Heather Buffington's training for "Basics of Medication Management" which was completed on January 18, 2023. There was also documentation "intake of medications" and "ordering" was discussed during staff meetings on January 17, 2023 and February 22, 2023.

On March 29, 2023, I interviewed former direct care staff member Joanna Rodriguez. Ms. Rodriguez stated there were not medication errors on a regular basis but she stated there were times when the day shift direct care staff members, Ms. Ballman and Ms. Buffington would just set the medication in a cup on the table in front of the resident and not watch them take the medication. Ms. Rodriguez stated she has never noticed the residents knocking the medications on the floor when this occurred.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Licensee designee Ms. Kesler stated she was not positive medication errors were occurring at Country Woods due to some disputes between two of her direct care staff member Ms. Buffington and Ms. Ballman. I was also not able to verify medication errors were occurring at this time. The *AFC Incident / Accident Report's* I reviewed indicated medications fell on the floor but there is no information how long they were on the floor or who dropped the medication. According to the interview with Ms. Near Careline Health Group Resident B was not residing at Country Woods Assisting Living when he had his seizure on November 17, 2022. I was also able to confirm on the *Resident Register* that Resident B did not move into the facility until November 18, 2022. Ms. Near also reported NP Basham did not have any documented medication errors for the residents at Country Woods Assisted Living.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Licensee designee Anne Kesler saves deceased residents' medications for use in the event that a current resident runs out of medication.

INVESTIGATION:

On February 6, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns licensee designee Anne Kesler keeps the residents' expired medications to use after they pass away.

On February 24, 2023, I interviewed the complainant who stated the old medications were kept in the back office and Ms. Kesler would take them out to use them if a medication ran out or did not get ordered for a different resident.

On February 28, 2023, I completed an unannounced onsite investigation at Country Woods Assisted Living and interviewed Ms. Ballman. Ms. Ballman provided the Resident Register which documented the last residents who passed away were Resident J on November 19, 2022, Resident K on October 12, 2022, and Resident L on September 20, 2022. Ms. Ballman showed me the medication cabinet in the back office and there were no resident medications for residents who have passed away.

Ms. Ballman stated when someone is deceased, she goes through all the expired medications and sends them back to the pharmacy. Ms. Ballman stated there is a drawer of medications that says "D/C" which is where the medications will go if she is waiting for the pharmacy to come pick them up. Ms. Ballman stated the medications are in a lock box and the only one that has the key is Ms. Buffington, Ms. Kesler, and herself.

On March 22, 2023, I interviewed licensee designee Ms. Kesler. Ms. Kesler stated she has never given a deceased resident's medication to a current resident.

On March 27, 2023, I contacted LTC Pharmacy and spoke with Megan Church. Ms. Church stated she has not had any concerns regarding Ms. Kesler and stated they will regularly fax them when a medication runs out. Ms. Church did not report any concerns regarding Ms. Kesler using old medications.

On March 27, 2023, I interviewed Careline Health Group practice manager, Ms. Near. Ms. Near stated NP Basham has not reported any concerns that Ms. Kesler is using medications that are left from deceased residents. Ms. Near stated when someone passed away the facility or family will take care of the left-over medications because Careline Health Group does not take medications when a patient is deceased.

On March 29, 2023, I interviewed former direct care staff member Joanna Rodriguez. Ms. Rodriguez stated she has never observed medications from a former resident administered to a current resident.

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:	On February 28, 2023, I looked through the office file cabinet/medication cabinet in the back office and confirmed there was no remaining medications belonging to residents who were now deceased. On March 22, 2023, I interviewed licensee designee Ms. Kesler who stated she has never given a deceased resident medication to a current resident. There was no evidence residents are receiving medications prescribed to another resident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On February 7, 2023, I interviewed adult foster care licensing consultant, Jana Lipps. Ms. Lipps confirmed she did not receive an *AFC Incident / Accident Report* regarding Resident A going to the hospital on February 5, 2023.

I reviewed the licensing department facility record for Country Woods Assisted Living and the *AFC Incident / Accident Report* for Resident A going to Sparrow Eaton Hospital was not in their file.

On March 29, 2023, I contacted Eaton County Adult Protective Services, Carol Stahl. Ms. Stahl stated she asked Ms. Kesler why a report was not done and sent to licensing and Ms. Kesler forwarded the report to her. Ms. Stahl received the *AFC Incident / Accident Report* from licensee designee Ms. Kesler by email on February 28, 2023 and forwarded it to my attention on March 7, 2023.

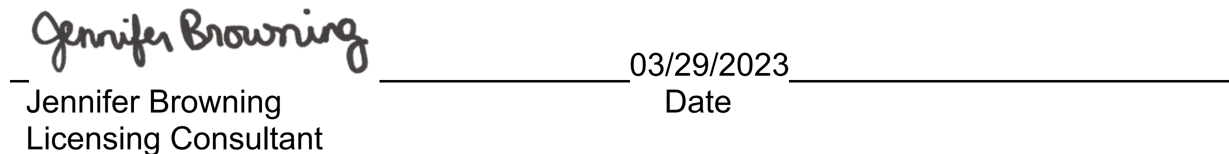
I reviewed the *AFC Incident / Accident Report* and it was signed by Ms. Ballman on February 5, 2023 but not signed by Ms. Kesler until February 17, 2023 and not sent to the licensing department within 48 hours of the incident.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a

	written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(ii) Hospitalization.**
ANALYSIS:	I reviewed the facility record for Country Woods Assisted Living and the *AFC Incident / Accident Report* for Resident A going to Sparrow Eaton Hospital was not in their file. On March 29, 2023, I contacted Eaton County Adult Protective Services, Carol Stahl. Ms. Stahl stated she received the *AFC Incident / Accident Report* from licensee designee Ms. Kesler by email on February 28, 2023 and Ms. Stahl forwarded it to my attention on March 7, 2023. I reviewed the *AFC Incident / Accident Report* and it was signed by Ms. Ballman on February 5, 2023 but not signed by Ms. Kesler until February 17, 2023 and not sent to the licensing department within 48 hours of the incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

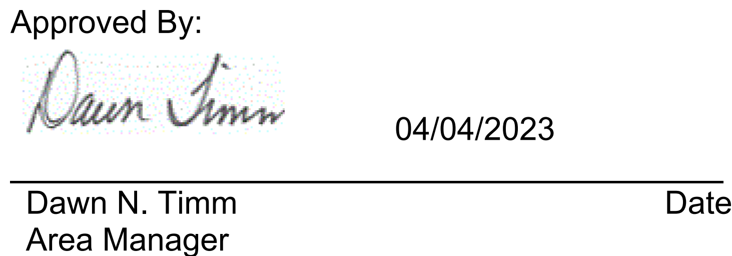
Upon receipt of an approved corrective action plan, I recommend no change in the license status.



03/29/2023

Jennifer Browning — Date
Licensing Consultant

Approved By:



04/04/2023

Dawn N. Timm — Date
Area Manager