GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 9, 2023

Carl Schuler
Suthern Adult Care, LLC
617 Riverview Ct.
Gladwin, MI 48624

RE: License #: AL650308159
Investigation #: 2023A0360019
The Horizon Senior Living III

Dear Mr. Schuler:

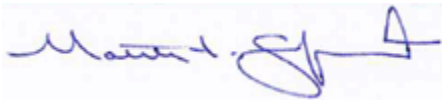
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

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

If you desire technical assistance in addressing these issues, please 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 (866) 865-0006.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS COMPLAINT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL650308159
Investigation #:	2023A0360019
Complaint Receipt Date:	03/14/2023
Investigation Initiation Date:	03/16/2023
Report Due Date:	05/13/2023
Licensee Name:	Suthern Adult Care, LLC
Licensee Address:	617 Riverview Ct. Gladwin, MI 48624
Licensee Telephone #:	(989) 343-9404
Administrator:	Paula Cassiday
Licensee Designee:	Carl Schuler
Name of Facility:	The Horizon Senior Living III
Facility Address:	613 Progress St. West Branch, MI 48661
Facility Telephone #:	(989) 343-9404
Original Issuance Date:	02/11/2011
License Status:	REGULAR
Effective Date:	09/16/2021
Expiration Date:	09/15/2023
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident B was cussed at by staff.	Yes
Resident A was not administered pain medication as prescribed leaving her in pain unnecessarily.	No
Resident A's family was not provided a refund after Resident A's death.	No
Additional Findings	No

III. METHODOLOGY

03/14/2023	Special Investigation Intake 2023A0360019
03/16/2023	Special Investigation Initiated - Letter
03/16/2023	APS Referral online
03/17/2023	Inspection Completed On-site home manager Chasity Garno, Resident B
04/10/2023	Contact - Telephone call made Relative 1-A
05/08/2023	Contact - Telephone call made Helen Bowen, Compassus Hospice
05/08/2023	Contact - Telephone call made Guardian 1-B
05/08/2023	Contact - Telephone call made Chasity Garno, Home Manager
05/08/2023	Contact - Telephone call made DCS Nellie Kleinert
05/09/2023	Contact - Telephone call made DCS Hannah Hathcock
05/09/2023	Exit Conference With Administrator Paula Cassiday

ALLEGATION: Resident B was cussed at by staff.

INVESTIGATION: On 3/14/2023 I was assigned a complaint from the LARA online complaint system.

On 3/16/2023 I completed an adult protective services referral.

On 3/17/2023 I conducted an unannounced onsite inspection at the facility. The home manager Chasity Garno stated that it was brought to her attention that on 2/13/2023 direct care staff Nellie Kleinert and Hannah Heathcock had been in an argument with Resident B. She stated she reviewed the video surveillance footage of the incident and witnessed both staff interacting with Resident B. She stated Ms. Kleinart stated to her that Resident B attempted to punch her and that she told Resident B, “What the fuck” and then walked away. She stated that Ms. Heathcock stated she then went over to Resident B and asked him if he tries to hit his wife like that? Ms. Garno stated both staff were written up for the incident and Ms. Kleinert was suspended for two days. She stated she discussed the incident with Resident B’s guardian, Guardian 1-B. Guardian 1-B was satisfied with the corrective action.

3/17/2023 I attempted to interview Resident B, but his verbal abilities were very limited and he could not answer basic questions.

On 4/10/2023 I contacted Relative 1-A. Relative 1-A stated that he and his wife were at the facility on 2/13/2023 visiting their family member and his wife witnessed the incident between both direct care staff and Resident B.

On 5/08/2023 I contacted Guardian 1-B. Guardian 1-B stated the facility contacted him about the incident between the direct care staff and his father on 2/13/2023. He stated Resident B can be very combative, he does not have any concerns and he stated that the home manager Chasity Garno handled everything appropriately.

On 5/08/2023 I contacted direct care staff Nellie Kleinert. Ms. Kleinert stated on 2/13/2023 she went to give Resident B his medications and he got upset and tried to hit her in the head. She stated she walked away and stated, “what the fuck.” She stated direct care staff Hannah Hathcock then went over to Resident B and asked him if he hits his wife like that? Ms. Kleinert stated she received a several day suspension for the incident.

On 5/08/2023 I contacted direct care staff Hannah Hathcock but was unable to leave a message.

On 5/08/2023 I contacted the home manager Chasity Garno. Ms. Garno stated Hannah Hathcock no longer works at the facility.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	The complaint alleged Resident B was cussed at by staff. Direct care staff Nellie Kleinert and Hannah Heathcock were involved in an incident on 2/13/2023 in which Ms. Kleinert admitted to saying, “what the fuck” to Resident B after he attempted to hit her. Resident B was not able to be interviewed due to limited verbal abilities. The home manager stated both direct care staff were written up for the incident. Resident B’s Guardian, Guardian 1-B stated he was contacted when the incident occurred and is satisfied with the outcome. There is a preponderance of evidence that Resident B was not treated with dignity and that his personal needs, including protection and safety were not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was not administered pain medication as prescribed leaving her in pain unnecessarily.

INVESTIGATION: On 3/16/2023 I conducted an unannounced onsite inspection at the facility.

The home manager Chasity Garno stated Resident A was admitted to the facility on 2/13/2023 with hospice services and died on 2/20/2023. She stated that while she was at the facility, she received the maximum dosage of morphine that hospice had prescribed. She stated the family was wanting them to administer more morphine, so they contacted Hospice Compassus, and the morphine dosage was increased. She stated that Hospice staff was at the facility every day. She provided me with medication administration records for Resident A as well as orders from Hospice Compassus increasing the morphine dosages on 2/18/2023 and 2/19/2023.

On 4/10/2023 I contacted Relative 1-A. Relative 1-A stated each day he came to the facility to visit Resident A she was experiencing breakout pain and appeared to be suffering. He stated he asked the staff to administer more morphine, but they stated they needed to contact the home manager before they can administer more pain medication. He stated that he contacted hospice, and they stated the facility was not administering the maximum dosage of Morphine.

On 5/08/2023 I contacted Helen Bowen from Hospice Compassus. Ms. Bowen stated the facility was administering the maximum doses of pain medications for Resident A. She stated she was in the facility each day and reconciled all the medications. She stated the facility requested increased dosages of morphine which were ordered on 2/18/2023 and 2/19/2023. She stated the facility did a wonderful job trying to meet Resident A's needs and had no concerns about Resident A's care and medications administration.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	The complaint alleged Resident A was not administered pain medication as prescribed leaving her in pain unnecessarily. The home manager stated the facility administered Resident A the maximum dosage of Morphine to help control her pain and requested increases twice from Hospice on 2/18/2023 and 2/19/2023. Relative 1-A stated Resident A was in pain, flopping around and the staff refused to administer more medications. Helen Bowen from Hospice Compassus stated Resident A was administered Morphine as prescribed and the facility requested and received dosage increases on 2/18/2023 and 2/19/2023. She stated she reconciled all medications for Resident A and the facility administered the medications as prescribed.

	There is not a preponderance of evidence that Resident A did not receive her medications as prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A's family was not provided a refund after Resident A's death.

INVESTIGATION: On 3/16/2023 I conducted an unannounced onsite inspection at the facility. The home manager Chasity Garno stated she has been trying to contact Resident A's family to send them a refund check. She showed me an envelope and refund check that had been returned to the facility undeliverable. She stated once the family gives her an updated address, she will mail the refund or they can pick up the check from the facility.

On 4/10/2023 I contacted Relative 1-A. Relative 1-A stated the refund check issue has been resolved and they have received it.

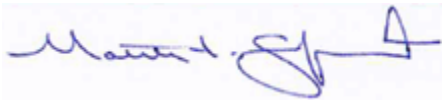
APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(14) A licensee shall have a written refund agreement with the resident or his or her designated representative. The agreement shall state under what conditions a refund of the unused portion of the monthly charge that is paid to the home shall be returned to the resident or his or her designated representative. The refund agreement shall provide for, at a minimum, refunds under any of the following conditions: **(a) When an emergency discharge from the home occurs as described in R400.15302.** **(b) When a resident has been determined to be at risk pursuant to the provisions of sections 11 and 11a to 11f of Act No. 280 of the Public Acts of 1939, as amended, being {{400.11 and 400.11a to 400.11f of the Michigan Compiled Laws.** **(c) When a resident has been determined to be at risk due to substantial noncompliance with these licensing rules which results in the department taking action to issue a provisional license or to revoke or summarily suspend, or refuse to renew, a license and the resident relocates. The amount of the monthly charge that is returned to the resident shall be based upon the written refund agreement and shall be prorated based on the number of days that the resident lived in the home during that month.**

ANALYSIS:	The complaint alleged Resident A's family was not provided a refund after Resident A's death. The home manager Chasity Garno stated the facility issued a refund check to the family however it was returned to the facility. Relative 1-A stated the refund check has been received and the issue is resolved. There is not a preponderance of evidence that the facility did not comply with the refund policy.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 05/09/2023 I conducted an exit conference with the administrator Paula Cassiday. Ms. Cassiday concurred with the findings.

IV. RECOMMENDATION

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



05/09/2023

Matthew Soderquist Date
Licensing Consultant

Approved By:

05/09/2023

Jerry Hendrick Date
Area Manager