GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 31, 2023

Laura Ardelean
Butternut Hill Family Group Home LLC
4011 Butternut Hill Drive
Troy, MI 48098

RE: License #: AS630394899
Investigation #: 2023A0605036
Butternut Hill Senior Living North

Dear Laura Ardelean:

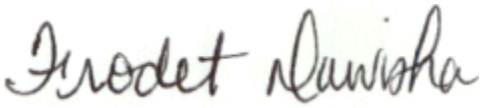
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630394899
Investigation #:	2023A0605036
Complaint Receipt Date:	05/26/2023
Investigation Initiation Date:	05/30/2023
Report Due Date:	07/25/2023
Licensee Name:	Butternut Hill Family Group Home LLC
Licensee Address:	4011 Butternut Hill Drive Troy, MI 48098
Licensee Telephone #:	(248) 930-3492
Administrator:	Gabriel Ardelean
Licensee Designee:	Laura Ardelean
Name of Facility:	Butternut Hill Senior Living North
Facility Address:	4105 Butternut Hill Troy, MI 48098
Facility Telephone #:	(248) 930-3492
Original Issuance Date:	06/28/2019
License Status:	REGULAR
Effective Date:	12/28/2021
Expiration Date:	12/27/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Home is understaffed.	No
On 04/27/2023, Resident A reported the owner, Gabriel Ardelean, stole her body wash and deodorant as he allows other residents to use it. The altercation turned physical; Gabriel pushed Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

05/26/2023	Special Investigation Intake 2023A0605036
05/30/2023	Special Investigation Initiated - Letter Emailed APS worker Heather Stickel the allegations
05/30/2023	APS Referral Adult Protective Services (APS) made referral
05/31/2023	Inspection Completed On-site Conducted unannounced on-site investigation in collaboration with APS worker Heather Stickel
06/22/2023	Contact - Telephone call made Discussed allegations with licensee designees Gabriel Ardelean and Laura Ardelean
07/12/2023	Contact - Document Received Email from Laura Ardelean
07/17/2023	Contact - Telephone call made Discussed allegations with Guardian C and Guardian F
07/17/2023	Exit Conference Conducted with licensee designee Gabriel and Laura Ardelean

ALLEGATION:

Home is understaffed.

INVESTIGATION:

On 05/26/2023, intake #195484 was referred by Adult Protective Services (APS) regarding home understaffed and licensee designee Gabriel Ardelean was in a physical altercation with Resident A who accused Mr. Ardelean of stealing her body wash and deodorant.

On 05/30/2023, I initiated this special investigation via email to APS worker Heather Stickel who was also investigating these allegations.

On 05/31/2023, I along with APS worker Heather Stickel conducted an unannounced on-site investigation. Present were two direct care staff (DCS) Alice Ihalas and Maria Corbos along with Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F. Also present was Resident A's daughter/durable power of attorney (DPOA).

I along with Ms. Stickel interviewed Resident A and her daughter/DPOA regarding the allegations. Resident A stated that there is usually two staff members per shift which includes Mr. Ardelean. Resident A reported that her only complain about staff is that staff speak minimal English, and she has difficulty understanding them. Resident A can ambulate but uses a walker to get around. Resident A had difficulty staying focused and would often talk about unrelated topics. DPOA (A) reported there are always two DCS on shift whenever she visits with her mother. She did not have concerns.

I interviewed Resident B in her bedroom. Resident B was sitting up in bed. She is ambulatory. She has lived here since March 2023 and stated, "I love it here." Resident B advised there are always two DCS on shift and most of the time it's the owner, Gabriel Ardelean working the shift along with his wife Laura Ardelean. Resident B advised there has never been staffing issues as there is always two staff on shift. She reported no concerns.

I attempted to interview Resident C, but she was unable to carry a conversation and I was having difficulty understanding her. She is on hospice and bedbound.

I interviewed Resident D who is ambulatory with a walker. He is hard of hearing in both ears. Resident D has lived here for about one year. He likes living here and reported two DCS on shift always. He too had no concerns to report.

I was unable to interview Resident E as she was sleeping and did not wake easily after I called out her name several times.

I was unable to interview Resident F as she does not speak English only Chinese.

I interviewed DCS Alice Ihalas regarding the allegations. Ms. Ihalas has been working for this corporation for about four years. She reported there is always two DCS on shift in the morning and one DCS at night; 7AM-8PM and 8PM-7AM. Ms. Ihalas stated that whenever there is an issue with staffing, the owners Gabriel and Laura Ardelean works those shifts. Ms. Ihalas stated that DCS Maria helps her with the residents when needed, but that Maria's primary role is to cook and clean. She reported there are no concerns regarding this home being understaffed. Ms. Ihalas did not have a staff schedule to provide during this visit.

I interviewed DCS Maria Corbos. Ms. Corbos spoke very minimal English. She works everyday except for Sundays. According to Ms. Corbos she is only responsible for cooking and housekeeping. Ms. Corbos stated she does not help Alice with the residents. I was unable to gather any further information.

On 06/22/2023, I contacted both licensee designees Gabriel and Laura Ardelean and discussed the allegations. Mr. and Mrs. Ardelean reported that there are no residents that require a one-on-one staff according to their assessment plans. Mrs. Ardelean will email me the assessment plans for review and the staff schedule for May and June 2023. Mrs. Ardelean reported that both DCS Alice Ihalas and Maria Corbos have completed all required training by the department. She stated that Ms. Corbos does mainly focus on cooking and cleaning, but that she will assist Ms. Ihalas if needed; however, she does not administer any medications. Mrs. Ardelean advised that all residents are ambulatory even though some are in a wheelchair. The residents can stand and pivot except for Resident C who is bedbound. In her case, DCS use the Hoyer lift to transfer her if needed. Mrs. Ardelean advised that when she and Mr. Ardelean were out of the country from 05/30/2023-06/09/2023, DCS Alice Ihalas stayed overnight with DCS Maria Corbos at the home. Although Ms. Ihalas was sleeping during the night shift, she was available if Ms. Corbos needed her as standby. Mrs. Ardelean advised she is still looking to hire additional staff but has been having difficulty finding appropriate staffing for the home. Both she and Mr. Ardelean work many shifts to ensure that residents' needs are being met. They live nearby so whenever staff need them, they are available.

On 06/28/2023, I reviewed Residents A, B, C, D, E, and F assessment plans and there are no residents that require a one-on-one staff. I also reviewed the staff schedule for May and June 2023 and there are days where there is only one staff per shift, but according to Mr. and Mrs. Ardelean, they live nearby this home and assist whenever needed.

On 07/17/2023, I interviewed DPOA (C) regarding the allegations via telephone. DPOA (C) advised whenever they visit their mother at this home, there is always a minimum of two DCS on shift. DPOA (C) stated that she always sees Mr. or Mrs. Ardelean working at this home with one of the DCS if there are not two DCS working that day. She reported no concerns.

On 07/17/2023, I interviewed DPOA (F) via telephone regarding the allegations. DPOA (F) stated whenever he visits with his mother at this home, there is a minimum of two if not three staff members on shift. He stated that he always sees either Mr. or Mrs. Ardelean working at the home with other staff. He too had no concerns to report.

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:	Based on my investigation, there is sufficient staff on shift for the supervision, personal care, and protection of Residents A, B, C, D, E, and F. All the residents except for Resident C who is bedbound can ambulate with a walker or if in a wheelchair, can stand and pivot. The DCS are fully trained in using the Hoyer lift on the residents when needed. Also, licensee designees Gabriel and Laura Ardelean are both staffed at this home and live close if DCS require their assistance.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

On 04/27/2023, Resident A reported the owner, Gabriel Ardelean, stole her body wash and deodorant as he allows other residents to use it. The altercation turned physical; Gabriel pushed Resident A.

INVESTIGATION:

On 05/31/2023, I interviewed Resident A and her daughter/DPOA (A) regarding the allegations. Resident A reported that the owner Gabriel, “cares a lot about people,” but that he is “tight with the buck.” She could not find her body wash and deodorant but then found them in the bathroom. Resident A denied she was pushed by Mr. Ardelean and stated she did not feel threatened by him and felt safe at this home. Resident A began talking about her disabled daughter and then changed the topic to heavy rain and then said, “I can’t prove anything.” I was having extreme difficulty following as Resident A kept changing topics before I can ask any follow-up questions. I did observe bruising on Resident A’s left side of her mouth and left side of her cheek. Resident A reported she fell in the bathroom after she went to the toilet. She advised she can toilet herself without assistance, but that she was soiled and needed to change her briefs so as she went to change her briefs, she fell. She stated DCS Alice was working that shift.

On 05/31/23023, I interviewed Resident B and Resident D who both stated that they have never had to share anyone else's body wash or deodorant and that none of their personal items have gone missing. Resident B has never seen Mr. Ardelean push or hit Resident A or any other resident. Resident D stated he has never seen Mr. Ardelean push or hit Resident A or any other resident too.

On 05/31/2023, I interviewed DCS Alice Ihalas regarding the allegations. Ms. Ihalas stated that Resident A's items have never been taken from Resident A and given to other residents to use. She reported that Resident A has dementia and forgets a lot so Resident A believes things were taken from her but were not. Ms. Ihalas has never witnessed Mr. Ardelean yell, argue, or push Resident A or any other resident. Mr. Ardelean cares about these residents and would never hurt them. Ms. Ihalas reported no falls that she is aware of regarding Resident A. She was not present when Resident A fell in the bathroom and does not know how Resident A sustained her injuries. Resident A never told Ms. Ihalas she fell.

On 06/22/2023, I interviewed Mr. and Mrs. Ardelean regarding the allegations. Resident A has dementia and "thinks her stuff are being stolen and given to other residents." Mr. Ardelean denied taking Resident A's body wash and deodorant and denied yelling, arguing, or pushing Resident A. Mrs. Ardelean reported that APS have investigated in the past regarding allegations made by Resident A, but the allegations were never substantiated. Both reported they were told by the previous facility where Resident A was at that Resident A called 911 over 10 times reporting that "her stuff was stolen," which was false.

Mrs. Ardelean was not aware that Resident A fell because if the staff or she and Mr. Ardelean were aware of a fall, then Resident A would have been taken to the hospital. Mrs. Ardelean advised that according to DPOA (A), Resident A is on blood thinners and bruises easily especially when she scratches her face at night. Resident A is on Eliquis, which is a blood thinner that was verified by reviewing Resident A's medication log.

On 07/17/2023, I interviewed DPOA (C) regarding the allegations. DPOA (C) has never witnessed Gabriel Ardelean yell or be aggressive towards Resident C or any other resident at this home. DPOA (C) visits regularly and has only observed staff including Mr. and Mrs. Ardelean go above and beyond providing great care to Resident C and the other residents. DPOA (C) advised they would report any abuse or neglect if it was happening to Resident C or any other resident in this home.

On 07/17/2023, I interviewed DPOA (F) regarding the allegations. DPOA (F) visits Resident (F) regularly and has never witnessed Gabriel Ardelean or any other staff member yell or become aggressive towards Resident F or any other resident at this home. DPOA (F) stated whenever he visits Resident F, she is always clean, fed, and very comfortable. He too would report any concerns if he had observed anything at the home regarding Resident F or any other resident.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on my investigation, licensee designee Gabriel Ardelean did not use any form of physical force towards Resident A. Resident A reported she had her body wash and deodorant missing but then found them in the bathroom. Resident A denied she was pushed by Mr. Ardelean and reported that Mr. Ardelean "cares about people." I interviewed Resident B and Resident D who denied witnessing Mr. Ardelean yell or push Resident A. DCS Alice Ihalas also denied witnessing Mr. Ardelean push or yell at Resident A. Resident A had some bruising to the right side of her face and cheek, but she reported she fell although no one witnessed her fall. Resident A stated she felt safe at this home with Mr. Ardelean.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the unannounced on-site investigation on 05/31/2023, while I was interviewing Resident B in her bedroom, I observed a cup sitting on a table near her bed full of pills. I reviewed Resident B's medications and medication logs to verify that the pills in the cup were prescribed to Resident B. I confirmed the pills in the cup were prescribed to Resident B; however, upon reviewing Resident B's medications and medication logs, I found the following errors:

- Resident B's **Nitrofurantoin Mono/Mac 100MG** was discontinued in April 2023 by the prescribing physician, but the medication was still in the medication basket and not disposed of properly.
- Resident B's **Budesonide Formoterol 80-4.5** was in the medication basket, but not on the medication log for May 2023. The prescription label states, "Inhale two puffs into lungs twice daily." According to DCS Alice Ihalas, Resident B's daughter brought this medication to the home and the staff has been administering this medication on an "as needed" basis. Ms. Ihalas further stated that staff do not put the medications on the medication logs unless the medications are prescribed by the doctor.

- Resident B's **Melatonin**- over the counter was brought in by the family without a script from a licensed physician. This medication was also not on the medication log for May 2023. DCS Alice Ihalas stated she was informed by licensee designee Gabriel Ardelean to administer ½ of the pill to Resident B.
- Resident B's **Oxycodone** was prescribed on an "as needed" basis, but Resident B has been receiving this medication twice daily at 8AM and 8PM from 05/01/2023-05/31/2023, but the physician was not contacted for the prolonged use of this as needed medication.
- Resident B's **Hydrocodone 325MG** was prescribed as an "as needed," medication but Resident B was receiving this medication daily at 8AM from 05/01/2023-05/31/2023.

I then reviewed Resident A's, Resident C's, Resident D's, Resident E's, and Resident F's medication logs and found the following errors:

- Resident A's 8AM medications **Lisinopril 40MG**, **Levetiracetam 250MG**, **Vitamin D3 5000 IU**, **Eliquis 2.5MG**, **Donepezil 15MG**, **Acetaminophen 500MG**, **Simethicone 125MG**, **Timolol 0.5%, Depakote 125MG**, **Alprazolam 0.25MG**, **Metoprolol 25MG** and **Quetiapine 25MG** were administered by staff did not initial the medication log on 05/31/2023.
- Resident C's **Hydrocodone 325MG**: take one tablet every eight hours for pain as needed was given daily at 8AM from 05/01/2023-02/31/2023.
- Resident C's **Divalproex Dr 125MG**, **Quetiapine 25MG**, were passed at 8AM but staff did not initial the medication log on 05/31/2023.
- Resident D's 8AM medications **Loratadine 10MG**, **Famotidine 20MG**, **Aspirin 81MG**, **Vitamin B12 1000MG**, **Senna Plus 8.6-50** were administered but staff did not initial the medication logs on 05/31/2023.
- Resident E's 8AM medications **Sertraline HCL 50MG**, **Sertraline HCL 25MG**, **Quetiapine 50MG**, **Risperidone 0.5MG**, **Divalproex 250MG**, **Sulfasalazine 500MG**, were passed at 8AM but staff did not initial the medication log on 05/31/2023.
- Resident E's **Clonazepam 0.1MG**: take ½ tablet by mouth three times daily as needed was given three times daily; 8AM, 2PM, and 5PM from 05/01/2023-05/30/2023.
- Resident F's **Quetiapine 25MG**, **Vitamin D3 1000 IU**, **Advair Hfa**, **Fluoxetine 20MG**, **Metformin 500MG**, **Loratadine 10MG**, **Diltiazem 120MG**, **Certavite**, **Alprazolam 0.25MG**, **Acetaminophen 500MG** were given at 8AM but staff did not initial the medication log on 05/31/2023.
- Resident F's **Alprazolam 0.25MG**: take one tablet by mouth three times daily was given at 2PM and at 8PM, but staff did not initial the medication log from 05/01/2023-05/31/2023.

I interviewed DCS Ms. Ihalas regarding the medication errors and she stated, "I pass everyone's medications and then later I sign the book. During mornings, I have lots to do." Ms. Ihalas does not initial the medication logs at the time she passes the medications. Ms. Ihalas stated that Resident B is not supervised when she gets her medications. She stated that Resident B prefers to take her own medication at her own

time, even though there is nothing in writing from Resident B's prescribing physician stating that Resident B can take her own medications without staff supervision. In addition, I observed Ms. Ihalas complete a simulated medication pass. Ms. Ihalas does not follow the five rights of medication administration even though she informed me, she completed medication administration training. Ms. Ihalas stated, "I pop all the pills, put them in the cups for each person with their names on it and then I hand them the cups after breakfast, and they take the pills." She does not verify the medications with the medication logs.

On 06/22/2023, I discussed the medication errors with both Mr. and Mrs. Ardelean. Mrs. Ardelean stated that DCS Alice Ihalas has completed medication training and did email me a copy of her training that was completed on 12/08/2019. Ms. Ardelean stated that Resident B does not have dementia and can make her own decisions; therefore, they believed she can take her own medications. Resident B's prescribing physician has not provided the home with a written statement indicating that Resident B can take her own medication without supervision. Mr. and Mrs. Ardelean stated that they will be addressing all the medication errors to ensure that staff are passing medications following the five rights and initialing at the time they are administering the medication.

On 07/17/2023, I conducted the exit conference with licensee designee Laura Ardelean regarding my findings. Ms. Ardelean stated she is currently addressing all the issues regarding the rule violations. She is also working on the corrective action plan and will be conducting an in-service training on medication administration with DCS Alice Ihalas to ensure that medications are being administered properly to all the residents.

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:	During the on-site investigation on 05/31/2023, I observed Resident B's medications sitting in a cup on the table next to her bed. The pills were not kept in the original pharmacy-supplied container. I confirmed that the pills in the cup were prescribed to Resident B by reviewing her medications. Resident B's **Melatonin** - over the counter was brought in by the family and was not prescribed by a licensed physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	During the on-site investigation on 05/31/2023, I reviewed Residents B, C, and E medication logs and found the following errors: • Resident B's **Oxycodone** was prescribed on an "as needed" basis, but Resident B has been receiving this medication twice daily at 8AM and 8PM from 05/01/2023-05/31/2023, but the physician was not contacted for the prolonged use of this as needed medication. • Resident B's **Hydrocodone 325MG** was prescribed as an "as needed," medication but Resident B was receiving this medication daily at 8AM from 05/01/2023-05/31/2023. • Resident C's **Hydrocodone 325MG**: take one tablet every eight hours for pain as needed was given daily at 8AM from 05/01/2023-02/31/2023. • Resident E's **Clonazepam 0.1MG**: take ½ tablet by mouth three times daily as needed was given three times daily; 8AM, 2PM, and 5PM from 05/01/2023-05/30/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:

	(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.**
ANALYSIS:	During the on-site investigation on 05/31/2023, I reviewed Residents A, B, C, D, E, and F medication logs and found the following errors: • Resident A's 8AM medications **Lisinopril 40MG**, **Levetiracetam 250MG**, **Vitamin D3 5000 IU**, **Eliquis 2.5MG**, **Donepezil 15MG**, **Acetaminophen 500MG**, **Simethicone 125MG**, **Timolol 0.5%, Depakote 125MG**, **Alprazolam 0.25MG**, **Metoprolol 25MG** and **Quetiapine 25MG** were administered by staff did not initial the medication log on 05/31/2023. • Resident B's **Budesonide Formoterol 80-4.5** was in the medication basket, but not on the medication log for May 2023. The prescription label states, "Inhale two puffs into lungs twice daily." According to DCS Alice Ihalas, Resident B's daughter brought this medication to the home and the staff has been administering this medication on an "as needed" basis. Ms. Ihalas further stated that staff do not put the medications on the medication logs unless the medications are prescribed by the doctor. • Resident B's **Melatonin**- over the counter was brought in by the family without a script from a licensed physician. This medication was also not on the medication log for May 2023. DCS Alice Ihalas stated she was informed by licensee designee Gabriel Ardelean to administer ½ of the pill to Resident B. • Resident C's **Divalproex Dr 125MG**, **Quetiapine 25MG**, were passed at 8AM but staff did not initial the medication log on 05/31/2023. • Resident D's 8AM medications **Loratadine 10MG**, **Famotidine 20MG**, **Aspirin 81MG**, **Vitamin B12 1000MG**, **Senna Plus 8.6-50** were administered but staff did not initial the medication logs on 05/31/2023. • Resident E's 8AM medications **Sertraline HCL 50MG**, **Sertraline HCL 25MG**, **Quetiapine 50MG**, **Risperidone 0.5MG**, **Divalproex 250MG**, **Sulfasalazine 500MG**, were

	passed at 8AM but staff did not initial the medication log on 05/31/2023. • Resident F's **Quetiapine 25MG**, **Vitamin D3 1000 IU**, **Advair Hfa**, **Fluoxetine 20MG**, **Metformin 500MG**, **Loratadine 10MG**, **Diltiazem 120MG**, **Certavite**, **Alprazolam 0.25MG**, **Acetaminophen 500MG** were given at 8AM but staff did not initial the medication log on 05/31/2023. • Resident F's **Alprazolam 0.25MG**: take one tablet by mouth three times daily was given at 2PM and at 8PM, but staff did not initial the medication log from 05/01/2023-05/31/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	During my on-site investigation on 05/31/2023, I observed Resident B's 8AM medications sitting in a cup next to her bed. Resident B stated she takes her own medications without staff supervising her. DCS Alice Ihalas stated that she places Resident B's medications in the cup and then places the cup on the table next to Resident B's bed. Ms. Ihalas does not supervise Resident B taking the medication. Ms. Ihalas stated that Resident B's prescribing physician has not provided any written statement stating that Resident B can take her medication unsupervised.
CONCLUSION:	**VIOLATION ESTABLISHED**

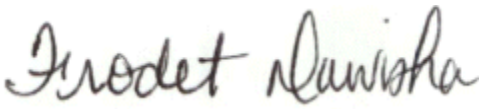
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged**

	use of a medication that is prescribed on an as needed basis. The review process shall include the resident's prescribing physician, the resident or his or her designated representative, and the responsible agency.
ANALYSIS:	During the on-site investigation on 05/31/2023, I reviewed Resident B's and Resident E's medication logs and found the following errors: • Resident B's **Oxycodone** was prescribed on an "as needed" basis, but Resident B has been receiving this medication twice daily at 8AM and 8PM from 05/01/2023-05/31/2023, but the physician was not contacted for the prolonged use of this as needed medication. • Resident B's **Hydrocodone 325MG** was prescribed as an "as needed," medication but Resident B was receiving this medication daily at 8AM from 05/01/2023-05/31/2023, but the physician was not contacted for the prolonged use of this as needed medication. • Resident E's **Clonazepam 0.1MG**: take ½ tablet by mouth three times daily as needed was given three times daily; 8AM, 2PM, and 5PM from 05/01/2023-05/30/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	Resident B's **Nitrofurantoin Mono/Mac 100MG** was discontinued in April 2023 by the prescribing physician, but the medication was still in the medication basket and not disposed of properly.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

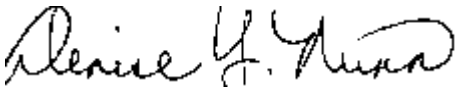
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



07/27/2023

Frodet Dawisha Date
Licensing Consultant

Approved By:



07/31/2023

Denise Y. Nunn Date
Area Manager