GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 11, 2023

Kathleen Sparrow-Dinzik
White Oaks, A Randall Residence
300 White Oak Road
Lawton, MI 49065

RE: License #: AL800315841
Investigation #: 2023A1031043
White Oaks Assisted Living - I

Dear Ms. Sparrow-Dinzik:

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 (616) 356-0183.

Sincerely,

KDuda

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL800315841
Investigation #:	2023A1031043
Complaint Receipt Date:	05/25/2023
Investigation Initiation Date:	05/26/2023
Report Due Date:	07/24/2023
Licensee Name:	White Oaks, A Randall Residence
Licensee Address:	300 White Oak Road Lawton, MI 49065
Licensee Telephone #:	(269) 624-4811
Licensee Designee/Administrator:	Kathleen Sparrow-Dinzik
Name of Facility:	White Oaks Assisted Living - I
Facility Address:	300 White Oak Road Lawton, MI 49065
Facility Telephone #:	(269) 624-4811
Original Issuance Date:	04/01/2013
License Status:	REGULAR
Effective Date:	10/03/2021
Expiration Date:	10/02/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Residents are not receiving appropriate personal care and supervision.	No
The home did not inform the designated representative that Resident A had fallen. There was a delay in communicating COVID exposure in the home.	No
Residents are not receiving prescribed medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/25/2023	Special Investigation Intake 2023A1031043
05/26/2023	Special Investigation Initiated – Telephone Interview with Complainant.
05/31/2023	Contact – Document Received.
06/02/2023	Contact - Telephone Interview with Complainant.
06/07/2023	Inspection Completed On-site
06/07/2023	Contact - Face to Face Interviews with Kathleen Sparrow-Dinzik, Cheryl Alford, Staff #1, and Staff #2.
06/08/2023	Contact - Document Sent Email sent to Kathleen Sparrow-Dinzik requesting documentation.
06/09/2023	Contact - Telephone Interview with Laurie Cooper.
06/09/2023	Contact - Telephone Interview with Staff #3, Steve Woltanski, and Emily Miller.
06/14/2023	Contact - Telephone Interview with Staff #4 and Staff #5.
06/16/2023	Contact - Document Received

06/20/2023	Contact - Document Requested from Hometown Pharmacy and ECP.
06/21/2023	Contact - Email exchange with Nichole Shelton.
06/21/2023	Contact - Telephone Interview with Nichole Shelton.
06/22/2023	Contact – Telephone Interview with Complainant.
06/22/2023	Contact – Email Exchange with Complainant.
06/22/2023	Contact - Documents Received from Kathleen Sparrow-Dinzik.
06/22/2023	Contact – Documents Reviewed.
06/23/2023	Contact - Documents Received from Kathleen Sparrow-Dinzik.
06/27/2023	Contact – Telephone Interview with Michael Hoving.
06/28/2023	Contact – Documents Requested.
06/30/2023	Contact – Documents Received.
07/05/2023	Inspection Completed On-Site
07/05/2023	Contact – Face to Face Interviews completed with Cheryl Alford, Debra Stratton, Torrie Sprague, Staff #6, Staff #7, and Staff #8.
07/06/2023	Contact – Documents Reviewed.
07/07/2023	Contact – Documents Requested from Cheryl Alford.
08/10/2023	Exit Conference with Licensee Designee Kathleen Sparrow-Dinzik.

ALLEGATION:

Residents are not receiving appropriate personal care and supervision.

INVESTIGATION:

On 5/25/23, I received a written complaint from Complainant #1 alleging that the home did not provide appropriate personal care for Resident A. Complainant #1 reported Resident A was found on multiple occasions to be sitting in wet and/or soiled briefs or no briefs at all. Complainant #1 reported it appeared Resident A had been left like that for hours due to observing the briefs to either be dried or the brief

being so full there was an odor they could smell before coming in proximity of Resident A. Complainant #1 reported Resident A was left alone in the restroom without assistance for hours although she was not able to adequately care for herself. Complainant #1 reported necessities including toilet paper or towels were often not available. Resident A's bathroom was observed to be dirty, and the floor was sticky from urine. Feces was observed to be dried on the toilet. Complainant #1 reported they arrived at the home on multiple occasions where Resident A was observed to be left at the table after meals, sleeping in her wheelchair in uncomfortable positions, and sliding down in her wheelchair to the point of almost falling out. Resident A was observed to have wet briefs and other residents were observed to be left in their wheelchairs overnight. Complainant #1 reported they have observed residents to be left unsupervised. During these occasions, other residents were observed to have accessed dirty dishes and scraping food off plates to provide to other residents as well accessing the laundry bin and wiping down tables with dirty laundry. Complainant #1 reported they have observed an 18:1 resident to staff ratio while visiting the home. Complainant #1 reported the staff was not able to get the residents dressed, changed, and fed independently.

On 5/31/23, I received an email from Complainant #1 containing undated pictures of soiled briefs and a reclining chair with a urine-soaked incontinence pad.

On 6/2/23, I interviewed Complainant #1 via telephone. Complainant #1 provided a summary of concerns as identified in the written complaint and supporting documentation initially submitted.

On 6/7/23, I interviewed Staff #1 in the home. Staff #1 reported they have been employed at the home for one week and did not have any information regarding the allegations. Staff #1 reported they have not observed any residents neglected or not cared for appropriately.

On 6/7/23, I interviewed Staff #2 in the home. Staff #2 reported there are currently 14 residents in the home. Staff #2 reported they have worked multiple shifts by themselves. Staff #2 reported it is difficult to care for all the residents as well as prepare meals and complete basic tasks when they are the only staff working. Staff #2 reported there are multiple residents that exhibit behavioral difficulties such as becoming aggressive that require another staff to assist to redirect behaviors. Staff #2 reported there is a medication technician that is scheduled to provide direct care as well to ensure two staff are working. Staff #2 reported the medication technicians do not often assist with providing direct care outside of passing medications. Staff #2 reported they have observed urine and feces in the bathrooms after housekeeping reported to have cleaned them. Staff #2 reported they have not observed residents sit for long periods of times in wet briefs as she completes rounds to ensure their personal needs are met. Staff #2 reported residents do run out of necessities such as toilet paper and paper towel as the home rations supplies for the residents. Staff #2 reported the staff schedule is not accurate as the home will pull staff from other units to assist other units within the facility. For instance, there is currently an

unlicensed area of the facility and one other large group adult foster care licensed unit. Staff #2 reported the leadership team tells staff they will assist with providing direct care when the home is short staffed, but they never help when needed.

On 6/7/23, I interviewed the licensee designee Kathleen Sparrow-Dinzik in the home. Ms. Sparrow-Dinzik reported staff are reminded to complete rounds every two hours to ensure that the residents personal care needs are met. Ms. Sparrow-Dinzik reported she has had conversations with staff for not completing rounds every two hours. Ms. Sparrow-Dinzik reported this requirement was also discussed at staff meetings. Ms. Sparrow-Dinzik reported action is taken with staff who are not completing their job duties and completing rounds. Ms. Sparrow-Dinzik the residents are provided with necessities such as toilet paper and paper towel by housekeeping when their bathrooms are cleaned. Ms. Sparrow-Dinzik reported the home has a housekeeper Monday through Friday that works eight hours per day weekly. Ms. Sparrow-Dinzik reported no concerns regarding the care the residents are receiving by staff. Ms. Sparrow-Dinzik reported they have the necessary staff to meet licensing requirements for the resident to staff ratio of 15:1. Ms. Sparrow-Dinzik reported there are two staff on each day shift which consists of a direct care worker and medication technician. Ms. Sparrow-Dinzik reported the medication technician assists with direct care when they are not passing medications. Ms. Sparrow-Dinzik reported there is one staff schedule during sleeping hours and an additional “float” staff that works on the two units in the home. Ms. Sparrow-Dinzik reported the nurses will assist staff when needed if they are short on staff. Ms. Sparrow-Dinzik reported she assists at times with direct care but not as often as the nurses. Ms. Sparrow-Dinzik reported the staff schedules are accurate and reflect all changes including call offs.

On 6/7/23, I interviewed the Wellness Director Cheryl Alford in the home. Ms. Alford reported she has not observed any of the residents in the home neglected. Ms. Alford reported the home always has two staff scheduled which includes a direct care worker and medication technician. Ms. Alford reported the medication technicians are also responsible for providing direct care when they are not passing medications. Ms. Alford reported when the home is short on staff the leadership team which includes herself, Ms. Sparrow-Dinzik, and Torrie Sprague will provide direct care. Ms. Alford reported she felt two staff was adequate to meet the needs of the residents in the home.

On 6/7/23, I conducted an unannounced visit to the home. The home was observed to have two staff working. I went into each residents’ bedroom and bathroom. The home, bedrooms and bathrooms were observed to be generally clean. There were three bathrooms that had sticky floors and a small amount of feces or urine on the floor and toilet. Housekeeping was also observed to be cleaning the home and bathrooms. I did not observe any residents to be unkept or sitting in soiled clothing.

On 6/8/23, I requested staff schedules and the assessment plans for randomly selected residents in the home.

On 6/9/23, I interviewed Resident A's previous hospice nurse Laurie Cooper. Ms. Cooper reported she could not provide information relating to the allegations.

On 6/9/23, I interviewed Staff #3 via telephone. Staff #3 reported there are staffing issues in the home that include the home either being understaffed or overstaffed. Staff #3 reported there are typically two staff scheduled to work in the home. Staff #3 reported they have not observed residents sitting in soiled briefs or clothes for extended periods of times. Staff #3 reported they ensure residents are changed and clean when they are working. Staff #3 reported the bathrooms can get dirty at times, but housekeeping cleans the bathrooms. Staff #3 reported residents are provided with necessities such as toilet paper and paper towel. Staff #3 reported residents will run out of briefs because the families of the residents are responsible for providing briefs for their family members. Staff #3 reported the home does have some briefs to provide residents when needed if they run out and families do not provide the items.

On 6/14/23, I interviewed Staff #4 via telephone. Staff #4 reported the home is supposed to have three staff due to the residents needs but there is typically one or two staff working. Staff #4 reported the leadership team does not assist when the home is short staffed. Staff #4 reported they have not observed any of the residents in the home to be neglected or sitting in soiled briefs or clothing for long periods of time. Staff #4 reported they ensure all their personal care needs are met when they are working. Staff #4 reported housekeeping is responsive to requests made by staff to clean bathrooms or areas of the home that need to be cleaned. Staff #4 reported the home provides residents with necessities such as toilet paper and paper towel. Staff #4 reported the resident's families are responsible for providing briefs, but the home will provide them if a resident runs out.

On 6/14/23, I interviewed Staff #5 via telephone. Staff #5 reported they got moved to a different unit within the facility and was not able to provide current information regarding staffing concerns. Staff #5 reported when they did work in the home there were issues with short staffing. Staff #5 reported the leadership team did not help that often. Staff #5 reported they did not observe any residents neglected while working in the home.

On 6/22/23, I reviewed SIR #2022A1031012 dated 6/14/22 and Corrective Action Plan dated 7/5/22 in the licensing file. The investigation report read "10/12 resident files reviewed did not have assessment plans completed to reflect current needs for the home to properly assess the necessary number of staff needed to provide care". The Statement of Correction dated 8/12/22 verified the implementation of a tracking system to ensure initial resident assessments and annual assessments are completed timely. The document confirmed that all resident care agreements had been updated.

On 7/5/23, I reviewed 8 out of 14 resident assessment plans for current residents residing in the home:

- Resident M – Assessment dated 4/8/21 and not signed by resident or designated representative.

- Resident N – Assessment dated 8/13/19.

- Resident O – Assessment dated 10/11/22, not signed by resident/designated representative.

- Resident P – Assessment not available for review.

- Resident Q – Assessment not dated, signed by previous licensee designee, and incomplete.

- Resident R – Assessment dated 5/17/23, incomplete and not signed by resident/designated representative or licensee designee.

- Resident S - Assessment not available for review.

- Resident T - Assessment not available for review.

On 7/5/23, I reviewed 8 out of 14 resident care agreements for current residents residing in the home:

- Resident M – Agreement dated 3/7/22.

- Resident N – Agreement dated 1/29/22.

- Resident O – Agreement dated 1/26/21 and only signed by licensee designee.

- Resident P – Agreement not available for review.

- Resident Q – Agreement dated 1/26/21 and only signed by licensee designee.

- Resident R – Agreement dated 1/26/21 and only signed by licensee designee.

- Resident S - Agreement not available for review.

- Resident T - Agreement not available for review.

On 7/7/23, I reviewed the staff schedules from April 2023 through June 2023. The schedules reflect that the home had two to three staff scheduled in the home from 6a-2pm and 2pm-10pm and one to two staff scheduled from 10pm-6am.

On 7/5/23, I interviewed Staff #6 in the home. Staff #6 reported they have been working in the home for almost one year. Staff #6 reported they do not have any concerns regarding having enough staff in the home. Staff #6 reported they feel there is adequate staff and resident needs are being met.

On 7/5/23, I interviewed Staff #7 in the home. Staff #7 reported the home has adequate staffing and there are no concerns with resident needs being met.

On 7/5/23, I interviewed Staff #8 in the home. Staff #8 reported the home is supposed to have three staff scheduled due to the behavioral needs of the residents. Staff #8 reported she has worked shifts where there is only one or two staff and it is difficult to complete basic job duties and redirect difficult behaviors. Staff #8 reported the leadership team does not provide direct care if the home is short staffed.

APPLICABLE RULE	
R 400.15206	**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:	When I conducted an unannounced visit to the home on 6/7/23 and 7/5/23, I did not observe any residents to be unkempt or in soiled clothing or briefs. The home was observed to be clean, and bathrooms were stocked with necessary toiletries. Although the staff schedules reflect that at least two staff are scheduled to work, I was not able to properly assess whether the home has adequate staffing to meet the resident’s needs. Assessment plans and resident care agreements were either not available for review, outdated and/or incomplete. It is unclear if the home has enough staff to ensure proper supervision, personal care, and protection of the residents as specified in the resident care agreements and assessment plans.

	While four of the eight staff interviewed indicated inconsistent or lack of adequate staffing, I could not determine with certainty that this was so.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The home did not inform the designated representative that Resident A had fallen.

There was a delay in communicating COVID exposure in the home.

INVESTIGATION:

Complainant #1 reported they did not receive communication from the home regarding the presence of COVID in the home. Complainant #1 reported a family member arrived at the home on 10/25/22 to visit Resident A and they were denied access due to the home implementing quarantine due to positive COVID cases. Complainant #1 reported they did not receive communication from the home regarding positive COVID cases until 10/27/23. Complainant #1 reported Resident A fell on multiple occasions while residing in the home and was hospitalized and they were rarely informed. Complainant #1 reported they have not received any incident reports pertaining to Resident A while she was living in the home. Complainant #1 reported they were Resident A's guardian and should have received better communication from the home while Resident A was in their care.

Ms. Sparrow-Dinzik reported she is responsible for submitting incident reports and communicating with the resident's designated representatives if they have one. Ms. Sparrow-Dinzik reported she maintains contact with the families regarding concerns relating to the home or residents. Ms. Sparrow-Dinzik reported she submits incident reports to required parties electronically. Ms. Sparrow-Dinzik was asked if there were any incident reports completed for medication refusals or residents not receiving medications. Ms. Sparrow-Dinzik referred to Ms. Alford as she was not sure if incident reports were completed for medication concerns.

Ms. Alford reported staff provide her with incident reports if there are any concerns or issues related to the residents. Ms. Alford reported she reviews the incident reports and provides them to Ms. Sparrow-Dinzik to review and submit to the necessary individuals. Ms. Alford reported Ms. Sparrow-Dinzik communicates any concerns the home has with designated representatives.

On 7/5/23, I interviewed the business office coordinator Torrie Sprague in the home. Ms. Sprague reported Ms. Sparrow-Dinzik maintains communication with families

and contacts designated representatives when needed for incidents involving residents.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(a) Unexpected or unnatural death of a resident.** **(b) Unexpected and preventable inpatient hospital admission.** **(c) Physical hostility or self-inflicted harm or harm to others resulting in injury that requires outside medical attention or law enforcement involvement.** **(d) Natural disaster or fire that results in evacuation of residents or discontinuation of services greater than 24 hours.** **(e) Elopement from the home if the resident's whereabouts is unknown.**
ANALYSIS:	There is not sufficient evidence to support that the home is not reporting incidents to resident representatives. Complainant #1 reported the home did not report COVID exposures timely and when Resident A had fallen. However, the home is not required to report incidents that are not identified within this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not receiving prescribed medications.

INVESTIGATION:

Complainant #1 reported when they moved Resident A into the home their medications were not present and had not been ordered for the first week. Complainant #1 reported Resident A was complaining about not receiving heartburn medication because it was out of stock and had been out for approximately two weeks. Complainant #1 was informed by the home that Resident A was out of seven other medications. Complainant #1 contacted Ms. Sparrow-Dinzik and reported a chronic issue with Resident A running out of medications. Complainant #1 reported she was informed by Ms. Sparrow-Dinzik that the pharmacy was the reason Resident A ran out of medication and did not take responsibility for the issues.

Complainant #1 requested Resident A's medication administration records (MAR) and discovered Resident A was out of multiple medications for days and weeks at a time for at least a three-month period.

On 5/31/23, I reviewed Resident A's MAR for July through October 2022:

July 2022
Resident A was out of one or more medications on 7/1, 7/2, 7/3, 7/4, 7/5, 7/6, 7/7, 7/8, 7/9, 7/10, 7/11, 7/12, 7/13, 7/14, 7/15, 7/16, 7/18, 7/19, 7/20, 7/21, 7/24, and 7/25.

August 2022
Resident A was out of one or more medications on 8/3, 8/4, 8/8, 8/13, 8/14, 8/15, 8/16, 8/17, 8/18, 8/19, 8/20, 8/21, 8/22, 8/24, 8/25, 8/26, 8/27, 8/28, 8/29, 8/30, and 8/31.

September 2022
Resident A was out of one or more medications 9/1, 9/2, 9/3, 9/4, 9/5, 9/6, 9/7, 9/8, 9/9, 9/11, 9/12, 9/13, 9/14, 9/15, 9/16, 9/17, 9/18, 9/19, 9/20, 9/21, and 9/22.

October 2022
Resident A was out of one or more medications 10/1, 10/9, 10/11, 10/12, 10/13, 10/14, 10/15, 10/16, 10/17, and 10/24.

Staff #2 reported there were previously issues with residents' medications being refilled. Staff #2 reported there were many times multiple residents were out of medications and did not receive their prescribed medications. Staff #2 reported staff would document in the system when a resident was running low on medications and submit a refill request. Staff #2 reported she believed Ms. Alford was responsible for checking and refilling medications.

Ms. Sparrow-Dinzik reported there were no issues regarding residents receiving their prescribed medications. Ms. Sparrow-Dinzik was informed that a MAR was reviewed that showed consistent issues with a resident being without medication. Ms. Sparrow-Dinzik then reported the home did previously have issues with Hometown Pharmacy refilling prescriptions due to having software issues with ECP. Ms. Sparrow-Dinzik reported the ECP system they use was supposed to notify staff when a resident had seven days left of medications. Ms. Sparrow-Dinzik reported staff were to push the "refill" button and the prescription was supposed to be filled by the pharmacy. Ms. Sparrow-Dinzik reported she reached out to Hometown Pharmacy to address her concerns regarding the software system not notifying the pharmacy that a prescription needed to be refilled. Ms. Sparrow-Dinzik reported Hometown Pharmacy was not able to fix the issue. Ms. Sparrow-Dinzik reported they stopped using the refill option within the system and started manually

requesting refills via fax to the pharmacy. Ms. Sparrow-Dinzik was asked if multiple residents were impacted by the systematic issue and not receiving their medications. Ms. Sparrow-Dinzik reported “not to the extent of Resident A”. Ms. Sparrow-Dinzik reported she contacted Hometown Pharmacy multiple times and had meetings to discuss the issues, but the pharmacy was never able to resolve the issue. Ms. Sparrow-Dinzik reported there was also issues with residents receiving medications due to Hometown Pharmacy only delivering medications in the middle of the night. Ms. Sparrow-Dinzik reported they “fired” Hometown Pharmacy and started using a new system in January 2023 and have not had any issues with medication refills. Ms. Sparrow-Dinzik reported she did not contact the residents’ healthcare professional for assistance when residents ran out of medications as she addressed her concerns directly with the pharmacy.

Ms. Alford reported there have not been any issues regarding residents receiving their medications since they started using a new system in January 2023. Ms. Alford reported staff were submitting refill requests through ECP for her to approve when a resident had seven days left of their medication. Ms. Alford reported she would approve the refill request and Hometown Pharmacy was supposed to refill the medications. Ms. Alford reported she would follow-up with the pharmacy within two days if the prescription had not been refilled. Ms. Alford reported she contacted Hometown Pharmacy and was informed by the pharmacy that they would have to order the medication from another pharmacy, or they would put in order in for medications. Ms. Alford reported she continuously called the pharmacy to request refills. Ms. Alford reported she did not document her attempts made to get medications refilled for residents that were out of medications. Ms. Alford reported she did not contact the residents’ healthcare providers for assistance in refilling the medications. Ms. Alford reported this was a consistent issue in the home and approximately “40” residents between the two units were impacted by running out of medications. Ms. Alford reported she and Ms. Sparrow-Dinzik had meetings with Hometown Pharmacy, and they were not able to rectify the issue. Ms. Alford reported this is when they decided to change pharmacies.

On 6/9/23, I interviewed the Hometown Pharmacy manager Steve Woltanski and the operations manager Emily Miller via telephone. They reported the home never reported issues regarding the software system refilling medications or not receiving residents’ medications. They reported if the home had reached out, they would have sent a technician immediately to the home to repair the software issues they were experiencing as they take these issues very seriously. They reported they never attended any meetings with anyone at the home to address the medication concerns.

Staff #4 reported there was a period where there were issues with residents not receiving their medications. Staff #4 reported multiple residents in the home were impacted by this issue. Staff #4 reported direct care staff were responsible for entering in notes in the computer to state medications were running low or medications were out. Staff #4 reported Ms. Alford was responsible for following up

and ensuring medications were refilled for the residents. Staff #4 reported the leadership team did not prioritize the medication issue and it was “rough” for a while with resident’s medication issues. Staff #4 reported “things are getting better” with the new computer system.

Staff #5 reported they were concerned due to residents not receiving their medications. Staff #5 reported multiple residents were impacted over a period of time. Staff #5 reported residents were negatively impacted by this especially those that demonstrated behavioral difficulties. Staff #5 reported there are still issues with residents receiving medications due to staff misplacing medications and staff not being able to locate the medication which results in a “no pass”.

On 6/21/23, I interviewed ECP senior compliance officer Nichole Shelton. Ms. Shelton reported the ECP system offers different functions and options for the home to tailor to their needs. Ms. Shelton reported the system can track medication inventory and offers a “reorder” function if the home chooses to use this feature. Ms. Shelton reported medication refills are put in a “reorder que” and the request is sent to the pharmacy to refill. Ms. Shelton reported if a home has issues with the ECP system, they are to contact the pharmacy or ECP directly to rectify the issue and a technician is sent to repair the issues. Ms. Shelton reported the company offers training packages and ongoing resources to ensure users can adequately utilize the system. Ms. Shelton was not able to confirm whether the home utilized offered trainings or reported any issues with the ECP system.

On 6/22/23, I reviewed randomly selected MARs for residents that resided in the home from July to October 2022:

- Resident B was out of one on more medications 19 days in July, 20 days in August, 17 days in September, and 11 days in October.

- Resident C was out of one or more medications 8 days in July, 7 days in August, 16 days in September, and 2 days in October.

- Resident D was out of one or more medications 18 days in July, 24 days in August, 9 days in September, and 19 days in October.

- Resident E was out of one or more medications 4 days in July, 2 days “no pass – other problems” documented – unclear if resident was out of medication, in hospital in September and discharged from home 10/7/22.

- Resident F was out of one or more medications 6 days in July, 14 days in August, 10 days in September, and 1 day in October.

- Resident G was out of one or more medications 2 days in July, 4 days in August, 7 days in September, and 14 days in October.

On 6/27/23, I interviewed the director of long-term sales through Hometown Pharmacy Michael Hoving. Mr. Hoving reported he was not informed by the home that multiple residents were experiencing issues with not receiving their medications through Hometown Pharmacy. Mr. Hoving reported Hometown Pharmacy provides a courtesy service to assist with refilling medications for their clients. Mr. Hoving reported it is ultimately the responsibility of the home to contact the pharmacy and/or the healthcare provider to ensure medications are sent to the pharmacy and refilled. Mr. Hoving reported he did have a conversation with the home regarding additional training needs to learn how to use the software system better. Mr. Hoving reported a Medication Pass Workshop and additional trainings and resources were provided to the home. Mr. Hoving reported the home did not attend any of the offered trainings or workshops offered to them.

Staff #6 reported there were previously issues with residents receiving their medications for a brief period of time. Staff #6 reported they are now a trained medication technician and there has not been anymore issues with residents receiving medications.

Staff #7 reported they were not in the current position last year as they worked in the kitchen. Staff #7 reported they were unaware of any concerns related to residents receiving medications.

Staff #8 reported they were not aware of any current concerns regarding medications because they are not allowed to pass medications. Staff #8 reported only medication technicians can pass medications.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on interviews and the review of supporting documentation, the home did not ensure that residents were receiving their medications pursuant to label instructions. Medication administration records revealed multiple residents were chronically out of medications for multiple days and weeks for at least four months. The home did not appropriately address and prioritize the issue and consistently blamed the pharmacy for residents not receiving medications. The home reported they did not contact any healthcare providers in efforts to rectify the alleged issues they were experiencing with the pharmacy. The home was not able to provide any documentation to support their claims that meetings were held with the pharmacy. The

	pharmacy reported the home never informed them of any issues with residents running out of medications or issues with the ECP medication system which could have been resolved if they were notified.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

SIR #2022A1031012 dated 6/14/22 indicated 10 out of 12 resident files reviewed did not have assessment plans completed. The CAP dated 7/5/22 identified that the Wellness Director Ms. Alford had been trained and oriented in her position and had made catching up assessments a priority. The CAP read that the home implemented a spreadsheet system to track when assessments and care plans are due to be updated annually and to ensure initial assessments are completed timely. The Statement of Correction dated 8/12/22 verified assessment plans were updated and the implementation of a tracking system to ensure initial assessments and annual assessments are completed.

On 6/22/23, I reviewed the renewal licensing report dated 10/21/21. The home received a licensing violation for not having a resident assessment plan available for review. The CAP indicates the home implemented a tracking system to electronically flag a resident's account to notify the home that an annual review is due.

On 6/22/23, Complainant #1 reported they never participated in the completion of Resident A's assessment plan and did not receive a copy of any assessment plans.

I reviewed 8 out of 14 resident assessment plans for current residents residing in the home:

- Resident M – Assessment dated 4/8/21 and not signed by resident or designated representative.
- Resident N – Assessment dated 8/13/19.
- Resident O – Assessment dated 10/11/22, not signed by resident/designated representative.
- Resident P – Assessment not available for review.
- Resident Q – Assessment not dated, signed by previous licensee designee, and incomplete.

- Resident R – Assessment dated 5/17/23, incomplete and not signed by resident/designated representative or licensee designee.

- Resident S - Assessment not available for review.

- Resident T - Assessment not available for review.

On 7/5/23, Ms. Alford reported she is not utilizing a spreadsheet tracking system for resident assessment plans.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on the review of resident assessment plans, it has been determined that the home is not completing assessment plans as required by this rule. Eight resident assessments reviewed revealed the home is not completing assessments at least annually, obtaining required signatures to verify the assessments are being completed with the resident/designated representative, or they are not being completed at all. The home has not utilized a tracking system as identified in two previous corrective action plans to ensure assessment plans are being completed and to remain in compliance with this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference licensing study report (LSR) dated 10/21/21 and corrective action plan (CAP) dated 10/19/21.**

INVESTIGATION:

I reviewed 8 out of 14 resident care agreements for current residents residing in the home. The home is not consistently using the department approved resident

agreement form. The home provided a copy of an “Admission Agreement” packet that is being used instead of the department’s resident care agreement form.

On 7/6/23, I reviewed the licensing file and did not locate an approved variance to utilize a substitute form.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident care agreement.**
	(7) A department resident care agreement form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department. A resident shall be provided the care and services as stated in the written resident care agreement.
ANALYSIS:	The home is not consistently using the department approved resident agreement form. Multiple resident files did not have resident care agreements available for review. The home provided a copy of an “Admission Agreement” packet that is being used instead of the department’s resident care agreement form.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I reviewed eight out of 14 resident care agreements for current residents residing in the home:

- Resident M – Agreement dated 3/7/22.
- Resident N – Agreement dated 1/29/22.
- Resident O – Agreement dated 1/26/21 and only signed by licensee designee.
- Resident P – Agreement not available for review.
- Resident Q – Agreement dated 1/26/21 and only signed by licensee designee.
- Resident R – Agreement dated 1/26/21 and only signed by licensee designee.

- Resident S - Agreement not available for review.
- Resident T - Agreement not available for review.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident care agreement.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.
ANALYSIS:	Based on the review of documentation, it has been determined that the home is not completing the resident care agreements as required by this rule. Eight resident care agreements reviewed revealed the home is not completing the resident care agreements annually and some occasions, not at all.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I reviewed eight out of 14 resident health care appraisals for current residents residing in the home:

Resident M – Health appraisal not available for review.

Resident N – Health appraisal dated 8/11/20.

Resident O – Health appraisal current.

Resident P – Health appraisal not available for review.

Resident Q – Health appraisal dated 9/10/21.

Resident R – Health appraisal current.

Resident S - Health appraisal not available for review.

Resident T - Health appraisal not available for review.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Based on the review of documentation, the home is not ensuring that health care appraisals are being completed as required by this rule. Multiple residents did not have health care appraisals available for review or they were completed one to two years ago.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Alford reported incident reports are not in the residents' files. Ms. Alford reported she provides the incident reports to Ms. Sparrow-Dinzik, and she does not know where they are kept.

On 7/6/23, I requested the home's incident reports while conducting an onsite inspection. The home provided incident reports for the month of June 2023. The incident reports were completed on an internal form and not on a department approved form. The home was not able to locate other incident reports prior to June 2023.

I reviewed the licensing file and did not locate an approved variance to utilize a substitute form.

APPLICABLE RULE	
R 400.15311	**Incident notification, incident records.**
	(3) An incident must be recorded on a department-approved form and kept in the home for a period of not less than 2 years.

ANALYSIS:	The home is not using a department approved incident form and was not able to provide incident reports prior to June 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Complainant #1 reported she noticed on the MAR that “refused” was frequently documented as a reason Resident A did not receive their medication. Complainant #1 reported she was informed by the home that “refused” could be documented due to a resident sleeping, being out of the building, or showering. Complainant #1 reported they were informed by the home that staff are not correctly documenting in the MAR reasons residents are not receiving medications and needed to be trained better.

Ms. Sparrow-Dinzik reported Ms. Alford would be able to answer questions related to improper medication documentation in MAR. Ms. Sparrow-Dinzik reported she was not aware of any issues related to staff not documenting information in the MAR correctly.

Ms. Alford reported she and Ms. Sparrow-Dinzik were aware of issues and inconsistencies regarding staff not properly documenting information within the MAR. Ms. Alford reported there were issues where staff would document a resident refused medication when the home did not have the medication in stock. Ms. Alford reported the home discussed the concerns with staff at a meeting and had them complete a short quiz. Ms. Alford reported staff were not provided with a formal training to learn how to properly document issues related to medication within the MAR.

Multiple MAR records for residents reviewed did not have complete notations and/or had inaccurate notations as to why residents did not receive their medications as prescribed. The MAR often reflects “No Pass Reason: Other Problems” and there is no supporting comment as to why a “No Pass” occurred. Multiple records also reflect “Resident Refusal” although on the same date or the date before and after, it is noted residents were out of medications.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4)(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.**
ANALYSIS:	The home did not properly complete the resident's medication logs. Ms. Alford acknowledged discrepancies within the medication records as staff were not documenting correctly. The home did not document reasons why residents had a "no pass". The MARs reviewed were inconsistent as there were multiple comments stating residents refused medications when they were out of medications. The home did not provide training to ensure that medication logs were being completed accurately by staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Sparrow-Dinzik reported if residents refuse medications, the home documents the refusal, Ms. Alford then contacts the appropriate healthcare provider. Ms. Sparrow-Dinzik reported Ms. Alford then documents and implements what is recommended by the healthcare professional.

Ms. Alford reported she has not contacted any healthcare providers when residents refuse medication, a medication error occurs, or residents are out of medications. Ms. Alford reported she was not aware that she was supposed to contact the appropriate health care professional when these incidents occur.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4)(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.

ANALYSIS:	Ms. Sparrow-Dinzik reported Ms. Alford is responsible for contacting the appropriate health care professional if a medication error occurs or when residents refuse prescribed medications. Ms. Alford reported she has not contacted any healthcare providers when residents refuse medication, a medication error occurs, or residents are out of medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Six out of eight resident files reviewed did not have a Resident Funds I form available for review which included Resident M, Resident N, Resident O, Resident P, Resident S, and Resident T.

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Six out of eight resident files reviewed did not have a Resident Funds I form available for review.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/10/23, I completed an exit conference with Ms. Sparrow-Dinzik via telephone. Ms. Sparrow-Dinzik reported she did not agree with the findings involving residents not receiving medications. Ms. Sparrow-Dinzik reported this was no fault of the home and the pharmacy failed to provide the prescribed medications. Ms. Sparrow-Dinzik acknowledged that the home was using internal forms not approved by the department and acknowledged that resident files were not complete as the required forms were not available for review.

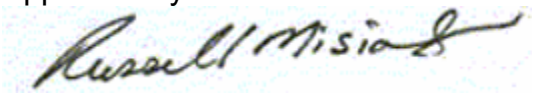
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional.

8/11/23

Kristy Duda Date
Licensing Consultant

Approved By:



8/11/23

Russell B. Misiak Date
Area Manager