GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 3, 2024

James Pilot
Bay Human Services, Inc.
P O Box 741
Standish, MI 48658

RE: License #:	AS090395688
Investigation #:	2024A0123037
	Rose Home

Dear James Pilot:

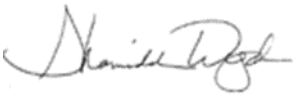
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090395688
Investigation #:	2024A0123037
Complaint Receipt Date:	05/17/2024
Investigation Initiation Date:	05/17/2024
Report Due Date:	07/16/2024
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Tammy Unger
Licensee Designee:	James Pilot
Name of Facility:	Rose Home
Facility Address:	308 Ireland Auburn, MI 48611
Facility Telephone #:	(989) 662-4595
Original Issuance Date:	10/01/2018
License Status:	REGULAR
Effective Date:	04/01/2023
Expiration Date:	03/31/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 04/23/2024, home manager Robin Lintern was asked to have Resident A's helmet repaired/replaced. Resident A was seen on 04/23/2024 sneezing and the helmet flew off Resident A's head. As of 05/16/2024, the helmet was not repaired or replaced.	Yes
On 05/12/2024, Resident B was reported as having excoriated skin on the buttocks and peri-area due to poor care/neglect while wearing an adult brief. Resident A was sent to a hospital emergency room and was prescribed medication.	Yes
As of 05/15/2024, only one of Resident B's antibiotics were secured by the Staff Robin Lintern, despite her being provided with a directive from the home's nurse to seek out other pharmacies to obtain the second antibiotic.	Yes

III. METHODOLOGY

05/17/2024	Special Investigation Intake 2024A0123037
05/17/2024	Special Investigation Initiated - Telephone I spoke with Melissa Prusi from Recipient Rights.
05/20/2024	Inspection Completed On-site I conducted an unannounced on-site with Melissa Prusi of Recipient Rights.
06/04/2024	APS Referral APS referrals completed.
06/05/2024	Contact - Telephone call made I left a voicemail requesting a return call from nurse Barb Guerin.
06/05/2024	Contact - Telephone call made I spoke with case manager Amy Ricker via phone.
06/05/2024	Contact - Telephone call received I received a voicemail from nurse Barb Guerin.
06/05/2024	Contact - Telephone call made

	I spoke with Barb Guerin, RN via phone.
06/06/2024	Contact - Telephone call made I left a voicemail requesting a return call from staff Robin Lintern.
06/06/2024	Contact - Telephone call made I left a voicemail requesting a return call from staff Kristina Ertel.
06/06/2024	Contact - Telephone call made I interviewed staff Paradise Russell via phone.
06/07/2024	Contact - Telephone call received I interviewed staff Robin Lintern via phone.
06/13/2024	Contact- Telephone call made I left a voicemail requesting a return call from Resident B's public guardian.
06/17/2024	Contact - Telephone call made I left a voicemail requesting a return call from staff Tina Anderson.
06/17/2024	Contact - Telephone call made I left a voicemail requesting a return call from staff Christina Salo.
06/26/2024	Contact- Telephone call made I made a second attempted call to staff Christina Salo.
06/26/2024	Contact- Telephone call made I interviewed staff Kristina Ertel.
06/26/2024	Contact- Telephone call made I made an attempted call to Resident B's public guardian's office.
06/28/2024	Inspection Completed On-site I conducted a follow-up on site at the facility.
07/01/2024	Exit Conference I spoke with administrator/designated person Tammy Unger via phone.

ALLEGATION: On 04/23/2024, home manager Robin Lintern was asked to have Resident A's helmet repaired/replaced. Resident A was seen on 04/23/2024 sneezing and the helmet flew off Resident A's head. As of 05/16/2024, the helmet was not repaired or replaced.

INVESTIGATION: On 05/17/2024, I spoke with Melissa Prusi of recipient rights. She stated that home manager Robin Lintern was removed from the schedule due to alleged neglect. We agreed to conduct an on-site investigation on 05/20/2024.

On 05/20/2024, I conducted an unannounced on-site inspection with recipient rights investigator Melissa Prusi. During this on-site, I observed Resident A's helmet. The helmet did not have a strap. Resident A was observed lying in bed. Resident A was not interviewed due to being non-verbal. Other residents were observed during this on-site to be clean and appropriately dressed.

Staff Amanda Black was interviewed and stated that the strap has been missing for about four months.

Staff Lisa Corrion stated that she started working in the home in October 2023, and at that time Resident A did not have a helmet strap.

On 06/05/2024, I spoke with Resident A's Bay Arenac Behavioral Health case manager Amy Ricker via phone. She stated the issue regarding Resident A's helmet was never resolved. Resident A was recently medically discharged from the home and is currently in the hospital. She stated that the home managers were not doing follow up with instructions given to them. Amy Ricker stated that Resident A's helmet flew off Resident A's head after sneezing. There was never any follow-up from home manager Robin Lintern regarding the helmet. She stated that she sent Staff Lintern an email on 05/08/2024, and the response was that staff took Resident A to a doctor's appointment but forgot to ask about the helmet and strap. She stated that she does not know how long Resident A's strap was missing.

On 06/05/2024, I spoke with Resident A's Bay Arenac Behavioral Health nurse Barb Guerin. Nurse Guerin stated that case manager Amy Ricker informed her about the missing helmet strap. She stated that she was told that the strap was ordered, and that Staff Black took Resident A to an appointment at Oakland Orthopedic, but Oakland Orthopedic told Staff Black they did not have a helmet, strap, or an order for Resident A. Nurse Guerin stated that she then provided staff with an order for the equipment to take to Oakland Orthopedic. She stated that they had waited for it, but she is not sure if Staff Robin Lintern ever sent the order to Oakland Orthopedic. Nurse Guerin stated that Resident A is still using the old helmet.

On 06/06/2024, I spoke with staff Paradise Russell via phone. Staff Russell stated that she has worked in the facility since April 2024, and primarily works third shift. Staff Russell stated that she was unaware Resident A's helmet had a missing strap.

Resident A does not wear the helmet while in bed but does wear the helmet during transfers to the living room.

On 06/07/2024, I interviewed staff Robin Lintern via phone. She stated that she has worked at the facility for two months. She stated that Resident A's file has a script for just a helmet. She stated that she does not know if the strap was ordered with the original helmet, because someone handwrote the word "strap" on the electronic script. She stated that Resident A sneezed one day, and the helmet popped off Resident A's head in front of Resident A's case manager Amy Ricker. She stated that the helmet needing a strap was not brought to her attention until the sneezing incident Resident A had, and that it was a longstanding issue before she came aboard. She stated that case manager Amy Ricker instructed the home to obtain a strap for the helmet. She stated that staff took Resident A in for a doctor's appointment but forgot to ask for a script for the helmet strap. She stated that she called to inquiry about it and left a message with the receptionist at the doctor's office.

On 06/26/2024, I interviewed staff Kristina Ertel via phone. Staff Ertel stated that she has worked in the facility since February 2024. She stated that she has never seen a strap for Resident A's helmet. She stated that she thinks when the previous home manager (prior to home manager Robin Lintern) was present, staff were informed that Resident A was supposed to have a strap for their helmet, and that it would be ordered. She stated that when Staff Lintern started as home manager, there was no discussion about the helmet strap. Staff Ertel stated that she has never seen Resident A's helmet come off, but towards the end Resident A was flailing and their coordination was off, and it would knock the helmet off when Resident A would be sitting down.

On 06/28/2024, I conducted a follow-up on-site at the facility. I obtained a copy of an order dated 05/21/2024, signed by Dr. Sefako Phala M.D. The order is for a safety helmet for Resident A due to recurrent falls.

On 07/01/2024, I conducted an exit conference with administrator/designated person Tammy Unger. I informed her of the findings and conclusions. Tammy Unger reported that Resident A's helmet was ordered prior to Resident A being discharged from the facility. Resident A had a helmet fitting completed on 06/20/2024, and is currently awaiting delivery of the helmet. Staff Robin Lintern was suspended on 05/14/2024 in part for not ordering Resident A's helmet. Staff Lintern was terminated on 06/07/2024 following the outcome of the recipient rights investigation.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to

	such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	On 05/20/2024, I conducted an unannounced on-site at the facility. I observed Resident A's helmet, which was not equipped with a strap. Staff Amanda Black and Staff Lisa Corrion were interviewed and reported that Resident A did not have a helmet strap. On 06/05/2024, I spoke with Resident A's case manager Amy Ricker via phone. Amy Ricker stated that the home managers did not follow up with the request she made for Resident A to have a helmet strap. Bay Arenac Behavioral Health nurse Barb Guerin stated that she provided staff with an order for the new equipment, but she was not sure that Staff Robin Lintern ever sent the order in, and that Resident A was still using the old helmet. On 06/07/2024, I interviewed home manager Robin Lintern via phone. Staff Lintern stated that the missing strap was a long-standing issue before she became home manager. She stated that staff took Resident A for a doctor's appointment but forgot to ask for a script for the helmet strap. On 06/26/2024, I interviewed staff Kristina Ertel who stated that the home manager prior to Staff Lintern had mentioned that Resident A needed a helmet strap, which corroborates what Staff Lintern said about it being a longstanding issue. There is a preponderance of evidence to substantiate a rule violation in regard to staff not following the instructions and recommendations of a health care professional in regard to Resident A obtaining a helmet strap.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **On 05/12/2024, Resident B was reported as having excoriated skin on the buttocks and peri-area due to poor care/neglect while wearing an adult brief. Resident B was sent to a hospital emergency room and was prescribed medication.**

- **As of 05/15/2024, only one of the antibiotics were secured by the Staff Robin Lintern, despite her being provided with a directive from the home's nurse to seek out other pharmacies to obtain the second antibiotic.**

INVESTIGATION: On 05/17/2024, I spoke with Melissa Prusi of recipient rights. She stated that home manager Robin Lintern was removed from the schedule due to alleged neglect. We agreed to conduct an on-site investigation on 05/20/2024.

On 05/20/2024, I conducted an unannounced on-site inspection with recipient rights investigator Melissa Prusi. During this on-site, Resident B was observed in their bedroom. Resident B could not be interviewed due to being non-verbal.

Regional manager Tabatha Barnes stated that she thinks Resident B's recliner chair was cleaned with a chemical but is not sure. She stated that the home manager is responsible for training staff on the use of chemicals.

Assistant home manager Amanda Black was interviewed and stated that she thinks Resident B's issue may be a chemical burn. She stated that someone may have put something on Resident B's chair, and that Resident B's private area and buttocks were affected. She stated that the Resident B's skin is currently purple/red but it looked worse.

Resident C was interviewed. Resident C stated that they have witnessed Resident B's recliner chair cleaned by staff before with a carpet cleaner machine. Resident C was shown four different bottles of cleaner and pointed out bottle of Great Value Pine-Scent Multi-Purpose Cleaner that Resident C has witnessed staff cleaning Resident B's chair with. The label states "*New 2X concentrated formula*."

On 05/20/2024, requested documentation was obtained during this on-site. A Bay Human Services *Skin Audit* form was obtained. It is dated 05/12/2024 signed by staff Amanda Black. Staff Black's comments state "*Complete breakdown on [Resident B's] bottom. Bruise on left leg*." Action taken notes "*Cream/powder monitor area keep clean*."

A copy of Resident B's electronic medication administration records (MAR) for May 2024 were obtained. Resident B had the following medications noted on the MAR:

1. Cephalexin 500 MG capsule- script date: 05/12/2024 start date: 05/14/2024 at 4:00 pm
2. SMZ-TMP Tab 400-800 MG (Bactrim SS)- script date 05/12/2024 start date: 05/14/2024 8:00 pm
3. Desitin CRE 13%- script date: 05/15/2024 start date: 05/15/2024 6:00 pm
4. SSD CRE 1%- script date: 05/14/2024 start date: 05/14/2024 8:00 pm

Resident B's hospital discharge paperwork was obtained. The discharge paperwork from MyMichigan Health Park Bay is dated 05/12/2024. It notes that Resident B was seen for a wound check and diagnosed with "*skin breakdown and pressure injury of skin of sacral region, unspecific injury stage*." Resident B was prescribed cephalexin (Keflex) and sulfamethoxazole-trimethoprim (*Bactrim*). The discharge paperwork also notes to follow up with David Mulder, P.A., and the Wound Treatment Center on 05/13/2024, and to pick up the medications at Anderson Pharmacy.

Discharge paperwork from MyMichigan Health Park Bay dated 05/14/2024 was obtained as well. The reason for visit is noted to be for a wound check, and the diagnosis is noted to be a burn. Resident B was prescribed silver sulfadiazine (Silvadene) to be picked up at McLaren LTC Pharmacy. Resident B was also given a Wound Clinic referral, and instructed to follow up again with David Mulder, PA.

Documentation from MyMichigan Health shows that Resident B was seen on 05/17/2024 for wound treatment by Nichola Jardas, PA-C, CWS. The documentation notes "*pressure ulcer of right buttock, stage 3, pressure ulcer of left buttock, stage 3, and diaper dermatitis*. *Debrided*."

An *AFC Licensing Division- Incident/Accident Report* dated 05/12/2024 at 10:00 am signed by regional manager Kelly Surles notes:

"*While assisting [Resident B] with a shower it was noticed [Resident B] had some breakdown on both sides of [their] bottom. [Resident B] was taken to MyMichiganHealth. Staff to follow all discharge instructions. Antibiotics were prescribed*."

An *AFC Licensing Division- Incident/Accident Report* dated 05/12/2024 at 1:30 pm signed by staff Amanda Black and staff Robin Lintern notes:

"Gave resident a shower in small bathroom. Staff discovered open sores and redness on consumers bottom. Called Nurse Barb (Guerin) and notified supervisor (home manager). Staff put cream and powder on open wound. Nurse directed consumer to go to ER. I will be reminding staff about all brief changes and change of positions to prevent sores."

An *AFC Licensing Division- Incident/Accident Report* dated 05/14/2024 at 2:30 pm signed by staff Tabatha Barnes notes the following:

"*Consumer has rash/breakdown on bottom and back of thighs. Was treated in ER Sunday- ER gave oral treatment but no topical treatment. Nurse Barb gave verbal order to take to walk in for eval and topical treatment orders. Taken to walk in clinic to obtain further orders. Nurse directed staff to attempt to keep pants/bottom on as tolerated to help prevent irritation. Oral antibiotic, taken to walk in for further treatment attempt to cover bottom with clothing*."

On 06/05/2024, I spoke with Resident B's Bay Arenac Behavioral Health nurse Barb Guerin. She stated that the incident started on 05/12/2024. She received a call from assistant home manager Amanda Black. Staff Black informed Nurse Guerin that she took Resident B to the bathroom, saw Resident B's skin, and that Resident B was not like this at the end of the last shift Staff Black worked. Nurse Guerin gave instruction to take Resident B to the emergency room. She stated that she told Staff Black to call Staff Lintern to come in, so Resident B could go to the hospital, but she cannot verify when Staff Lintern reported to the home so Resident B could be transported to the emergency room. Later, Staff Lintern reported to Nurse Guerin that two antibiotics were ordered and Nurse Guerin stated that she gave Staff Lintern directions for care. Nurse Guerin stated that by 5/14/2024, the antibiotics had not been started. She reached out to program manager Tabatha Barnes for assistance, the meds got to the facility, and were started after that. Resident B had another emergency room visit on 05/14/2024, and hospital staff at that time told the facility's staff it looked like Resident B had a chemical burn. Silvadene cream was ordered. Nurse Guerin stated that the thought initially was that Resident B may have sat in diarrhea for an extended period of time. She stated that she made a call the following day (05/15/2024) and spoke with second shift staff Tina Anderson, who reported to Nurse Guerin that she worked on Saturday from 7:00 pm to 7:00 am, and at 6:00 am brief change, noticed a red gallon sized bottle of clean on Resident B's dresser, and that the bottle label noted the cleaner was corrosive.

On 06/06/2024, I spoke with staff Paradise Russell via phone. Staff Russell stated that she has worked in the facility since April 2024, and primarily works third shift. She stated that one night she noticed that Resident B's bottom was bloodshot red. She stated that she passed this information to the medication passer that was on shift. She stated that on the next shift when she reported to work, she was informed that Resident B had burns. She stated that she was initially told that it may have been because Resident B scoots across the floor. Resident B also takes off their brief when it is wet. Staff Russell stated that she was told that a bottle of floor cleaner was found left on Resident B's dresser. She stated that they do not clean the bedrooms on third shift, and that she does not know who left the chemicals in Resident B's bedroom.

On 06/07/2024, I interviewed staff Robin Lintern via phone. She stated that staff Amanda Black text her on 05/12/2024 (Sunday, Mother's Day) that the home's nurse wanted Resident B to go to the emergency room. She stated that she reported to the facility so staff could take Resident B to the emergency room. She stated that later that day, she called Nurse Guerin to get permission to pass medication and food to Resident B. She stated that Resident B's scripts were sent to Anderson Pharmacy, which is closed on Sundays. She stated that on the following day, staff and residents had to evacuate the home due to a bed bug treatment that was taking place. She stated that she received a call from Nurse Guerin regarding the medications for Resident B, and she told Nurse Guerin she would follow up later that day due to the bed bug situation. Staff Lintern stated that had the McLaren Pharmacy received the script, the home would not have received the delivery because no one was at the

home that day to receive the medication. She stated that the following morning she spoke with staff Amanda Black and staff Christina Salo to follow up with the medication. She stated that she does not know if regional manager Tabitha Barnes had the pharmacy switched, but the medication was delivered 05/14/2024 from the McLaren Pharmacy. She stated that she thinks that Nurse Guerin was upset that she (Staff Lintern) was not fast enough at acquiring the medications. She stated that she is not sure if it was one or two antibiotic medications that were prescribed, and she was not in the home when the scripts were obtained, as she was already on suspension pending investigation. She stated that due to COVID-19, Resident B's recliner was in the bedroom. Staff Barnes informed Staff Lintern that a staff person may have cleaned the recliner chair with cleaning solution, and the recliner may not have dried completely. Staff Lintern stated that Resident B strips out of their clothing and briefs, and that when Resident B is in their room, staff don't check that Resident B stays dressed. Staff Lintern stated that this is due to Resident B being in their own room and having privacy. She stated that staff are quick to redress Resident B when Resident B is in the common area of the home. She stated that she was not able to find out who worked that weekend and what happened.

On 06/13/2024 and 06/26/2024, attempted phone calls were made to Resident B's public guardian.

On 06/26/2024, I interviewed staff Kristina Ertel via phone. Staff Ertel worked with staff Christina Salo on 05/11/2024 at 7:00 am to 7:00 pm per the staff schedule. Staff Ertel stated that she and Staff Salo had put Resident B in a bubble bath. They did not see anything abnormal with Resident B's skin. She stated that while providing Resident A with personal care (on 05/12/2024), she had found open sores and notified assistant home manager Amanda Black. Staff Ertel stated that she wrote an incident report. Staff Ertell stated that she took Resident B to the emergency room on 05/12/2024, and the hospital could not figure out what was wrong. She stated that the hospital prescribed an ointment for Resident B, and that she does not recall any oral treatment being prescribed. She stated that nothing abnormal happened on her shift, and as the days went on there was just speculation. Staff Ertel stated that a staff person had found a bottle of cleaner in Resident B's bedroom. She stated that third shift does the deep cleaning in the home. She stated that she was told that a staff person had used the cleaner to clean Resident B's chair. She stated that the red cleaner bottle was found in Resident B's room about three days after she had worked.

On 06/28/2024, I conducted a follow-up on-site at the facility. I spoke with regional manager Kelly Surles. She stated that she wrote an incident report because there was no incident report written. She stated that Resident B looked like they had a chemical burn. She stated that she thinks staff may have cleaned Resident B's floor with a chemical. She stated that they have since stopped using the chemical. She stated that a physician, as well as Nurse Guerin also noted that it was a chemical burn. She stated that it could have happened on any shift.

During this on-site, I followed-up with assistant home manager Amanda Black who stated that she does not know what happened to Resident B, and that she just knows the last shift she worked that Resident B did not look like that, and that she took Resident B to the emergency room on Mother's Day (05/12/2024).

On 07/01/2024, I conducted an exit conference with administrator/designated person Tammy Unger via phone. I informed her of the findings and conclusions. Tammy Unger reported that regional manager Tabatha Barnes completed a medication in-service (including ordering of new meds) with staff on 06/27/2024. Staff Robin Lintern was suspended on 05/14/2024 in part for failing to obtain Resident B's prescriptions. Staff Lintern was fired on 06/07/2024 following the outcome of the recipient rights investigation.

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:	On 05/20/2024, I conducted an unannounced on-site at the facility. Staff Tabatha Barnes stated that she thinks staff cleaned Resident B's recliner chair with a chemical. Staff Black stated that she thinks someone put something on Resident B's chair. Resident C was interviewed and stated that they have witnessed staff clean Resident B's recliner chair with chemicals. I observed Resident B in the facility during this on-site. Resident B could not be interviewed due to being non-verbal. On 06/07/2024, I interviewed home manager Robin Lintern who stated that she was informed by staff Tabatha Barnes that a staff may have cleaned the recliner chair with a cleaning solution, and the recliner may have not dried all the way. Documentation was obtained during this on-site. A Bay Human Services *Skin Audit* form dated 05/12/2024 notes that Resident B was observed to have a complete skin breakdown, and a bruise. Emergency room discharge paperwork from MyMichigan Health Park dated 05/12/2024 notes that Resident A was diagnosed with a "*skin breakdown and pressure injury of skin of sacral region, unspecific injury stage."* Discharge paperwork dated 05/14/2024 notes that Resident A was diagnosed with a burn.

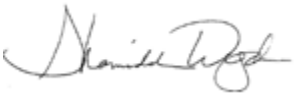
	Documentation dated 05/17/2024, notes that Resident B was seen by Nichola Jardas, PA-C, CWS for wound treatment follow-up. Phone call attempts were made on 06/13/2024 and 06/26/2024 to Resident A's public guardian's office. During the course of this investigation, staff Paradise Russell, Staff Kristina Ertel, and Nurse Guerin were interviewed and reported that they were told that a bottle of cleaner was left in Resident B's bedroom. Nurse Guerin reported being told it was left on Resident B's dresser. There is a preponderance of evidence to substantiate a rule violation. On 05/12/2024 and 05/14/2024, Resident B was taken to the emergency room and was diagnosed with skin breakdown and then diagnosed with a burn.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications**
ANALYSIS:	On 05/20/2024, I conducted an unannounced on-site at the facility. I obtained a copy of Resident B's medication administration records for May 2024. The documentation shows that Resident B was prescribed Cephalexin 500 mg and SMZ-TMP Tab 400-800 MG (Bactrim) on 05/12/2024. The medications were not started until 05/14/2024 at 4:00 pm and 05/14/2024 at 8:00 pm respectively. On 06/05/2024, I spoke with Bay Arenac Behavioral Health nurse Barb Guerin. She stated that there was a delay in obtaining Resident B's scripts. She stated that she reached out to staff Tabatha Barnes for assistance, and the medications were started after that. Prior to this, she followed up with home manager Robin Lintern about the scripts. On 06/06/2024, I spoke with home manager Robin Lintern. She stated that Resident B's scripts were sent to Anderson

	Pharmacy which is closed on Sundays. She stated that she thinks Nurse Guerin was upset that she was not fast enough at acquiring Resident B's prescriptions. There is a preponderance of evidence to substantiate a rule violation. Resident B was prescribed medication at the emergency room on 05/12/2024. The prescriptions were not obtained and started until the evening of 05/14/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group license (capacity 1-6).



07/03/2024

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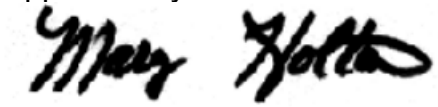
Shamidah Wyden Date
Licensing Consultant

Approved By:



07/03/2024

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Mary E. Holton Date
Area Manager