GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 21, 2025

Debra Krajewski
SouthWest AFC, L.L.C.
#296
6026 Kalamazoo Ave., SE
Kentwood, MI 49508

RE: License #: AM410285333
Investigation #: 2025A0583018
SouthWest AFC

Dear Ms. Krajewski:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM410285333
Investigation #:	2025A0583018
Complaint Receipt Date:	01/30/2025
Investigation Initiation Date:	02/03/2025
Report Due Date:	03/01/2025
Licensee Name:	SouthWest AFC, L.L.C.
Licensee Address:	6026 Kalamazoo Ave., SE, Suite 296 Kentwood, MI 49508
Licensee Telephone #:	(616) 698-6681
Administrator & Designee:	Debra Krajewski
Name of Facility:	SouthWest AFC
Facility Address:	212 56th St. SW, Wyoming, MI 49548
Facility Telephone #:	(616) 534-5870
Original Issuance Date:	05/01/2007
License Status:	1ST PROVISIONAL
Effective Date:	11/18/2024
Expiration Date:	05/17/2025
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Staff Charlene Thompson documented the administration of Resident A's medication before the medication was scheduled to be dispensed.	Yes
Staff withheld Resident A's personal funds.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/30/2025	Special Investigation Intake 2025A0583018
01/31/2025	APS Referral
02/03/2025	Special Investigation Initiated - Telephone Guadian Cassidy Boensch
02/03/2025	Inspection Completed On-site
02/20/2025	Exit Conference Licensee designee Debra Krajewski

ALLEGATION: Staff Charlene Thompson documented the administration of Resident A's medication before the medication was scheduled to be dispensed.

INVESTIGATION: On 01/30/2025 complaint allegations were received from the LARA-BCHS-Complaints online reporting system. The complaint alleged that "medications are being initialed prior to the present date or med pass time".

On 01/31/2025 I emailed the complaint allegations to Adult Protective Services Centralized Intake.

On 02/03/2025 I interviewed Cassidy Boensch via telephone. Ms. Boensch stated that she is Resident A's legal guardian. Ms. Boensch stated that she visited the facility on 01/29/2025 at approximately 11:00 AM and observed that Resident A's Medication Administration Record (MAR) indicated that Resident A had received her prescribed Vicks VapoRub on 01/29/2025 at "bedtime". Ms. Boensch stated that she spoke to staff Charlene Thompson who stated that she had initialed Resident A's MAR on 01/29/2025 at "bedtime" with an "O" for "other", even though she had not yet administered the medication. Ms. Boensch stated that Ms. Thompson said

Resident A refused the medication the entire month of January 2025 and Ms. Thompson marked “O” on Resident A’s MAR rather than “R” for “refused”. Ms. Boensch stated that she and staff Joyce Smith are the only two staff who dispense medications at the facility and both staff have initialed Resident A’s refusals from 01/01/2025 until current with an “O” for “other”. Ms. Boensch stated that she observed Resident A’s MAR indicated that Resident A did not receive the medication from 01/01/2025 until 01/29/2025 and the MAR is marked with an “O” for the entirety of the month. Ms. Boensch stated that she photographed Resident A’s January 2025 MAR and emailed me a copy of the document. Ms. Boensch stated that she had not been notified that Resident A had been refusing the administration of Vicks VapoRub until her 01/29/2025 visit.

On 02/03/2025 I received an email from Cassidy Boensch. The email contained a photograph of Resident A’s January 2025 MAR. I observed that Resident A’s MAR indicates that Resident A is prescribed Vicks Ointment VapoRub by Dr. Thomas Finn to be applied 1 Gram topically at bedtime to Resident A’s fingernails and toes. I observed that the document indicates that Resident A did not receive the medication from 01/01/2025 until 01/29/2025 and the document is marked with an “O” for “other” daily. I observed that the document has a key which lists the letter “O” for “other and the letter “R” for “refused”. I did not observe details regarding why Resident A refused the medication or if a medication professional was contacted after the refusal. I also did not observe documentation in Resident A’s MAR to indicate the medication had been discontinued.

On 02/03/2025 I completed an unannounced onsite investigation at the facility and interviewed staff Charlene Thompson, licensee designee Debra Krajewski (via telephone), and Resident A.

Staff Charlene Thompson stated that she would not complete an interview without licensee designee Debra Krajewski present on speaker phone, therefore Ms. Krajewski was placed on speaker phone during the interview. Ms. Thompson stated that she and staff Joyce Smith are the only staff that administer residents’ medications at facility. She stated that she worked at the facility on 01/29/2025 during which time guardian Cassidy Boensch visited the facility at approximately 11:30 AM. Ms. Thompson stated that she provided Ms. Boensch with access to Resident A’s MAR. Ms. Thompson stated that Resident A is prescribed Vicks VapoRub once daily to be applied at “bedtime” at approximately 8:00 PM. Ms. Thompson acknowledged that she had initialed Resident A’s MAR for 01/29/2025 at “bedtime” indicating that the Vicks VapoRub had been refused by Resident A even though it had not yet been offered. Ms. Thompson confirmed that she initialed Resident A’s 01/29/2025 8:00 PM administration as “O” for other. Ms. Thompson stated that it was a “mistake” to initial Resident A’s MAR because she had not yet offered the medication to Resident A because it was not yet bedtime. Ms. Thompson agreed this was a medication documentation error. Ms. Thompson stated that Resident A refused the administration of this medication on multiple dates during January 2025, and Ms. Thompson documented the refusal with the

letter “O” for other. Ms. Thompson acknowledged that during each of these previous refusals, she never contacted a medical professional for guidance. Ms. Thompson stated that the facility maintains Resident A’s medication in stock in the medication cart however I observed that the medication was not located in the medication cart. Ms. Thompson then stated that she had recently observed the medication in the medication cart but could not recall the last date.

Licensee designee Debra Krajewski stated via telephone that Resident A was previously prescribed Vicks VapoRub from Dr. Finn. Mr. Krajewski stated that the medication was discontinued due to refusal. Ms. Krajewski stated that she had obtained a discontinue order and would provide a copy of that order for review.

Resident A stated that she had initially refused the administration of Vicks VapoRub because she was “allergic” to the medication. She further stated that during the month of January 2025 no staff had offered her the medication.

While onsite I observed Resident A’s MAR for the time frame of 01/01/2025 until 01/31/2025. I observed that Resident A is prescribed Vicks VapoRub apply one gram topically every night at bedtime. I observed that from 01/01/2025 until 01/31/2025, the letter “O” for “other is marked for each date. I observed that the document further stated in handwritten ink, “refuse to take/D/C 01-30-25”.

On 02/05/2025 at 1:00 PM I received and reviewed an email from licensee designee Debra Krajewski. The email contained a pdf attachment labeled as “MH DC VICKS”. The document was handwritten on lined paper and appeared to be a discontinuation order for Resident A stating, “please DC Vicks VapoRub by 01/28/2025” “Reason: Refusing”. I observed that the document was written by provider Thomas Finn DNP.

On 02/05/2025 I interviewed licensee designee Debra Krajewski. Ms. Krajewski stated that she could not recall the date she obtained the copy of Resident A’s “DC order” for her prescribed Vicks VapoRub. Ms. Krajewski stated that staff Charlene Thompson had a “low IQ” and was a “DEI hire” but stated that Ms. Thompson had been adequately trained to administer residents’ prescription medications.

On 02/05/2025 I interviewed Nurse Practitioner Thomas Finn via telephone. Mr. Finn stated that he had previously prescribed Resident A with Vicks VapoRub to be applied daily before bed. Mr. Finn stated that on 02/04/2025 he met with licensee designee Debra Krajewski in person and Ms. Krajewski requested that Mr. Finn draft a discontinue order for Resident A’s Vicks VapoRub. Mr. Finn stated that Ms. Krajewski reported that Resident A had been refusing the medication. Mr. Finn stated that Ms. Krajewski specifically requested that the discontinue order be backdated to the reflect a discontinue date of 01/28/2025. Mr. Finn stated that he honored Ms. Krajewski’s request to backdate the discontinue order to 01/28/2025. Mr. Finn confirmed that he had not received any prior communication from Ms. Krajewski or her staff regarding Resident A’s refusal of the Vicks VapoRub before he met with Ms. Krajewski on 02/04/2025.

On 02/06/2025 I interviewed staff Joyce Smith via telephone. Ms. Smith stated that license designee Debra Krajewski would be on speaker phone during the interview. Ms. Smith stated that she and staff Charlene Thompson were the only staff who administered residents' medications January 2025. Ms. Smith stated that she did not administer Resident A's prescribed Vicks VapoRub because Resident A refused to pay for the medication. Ms. Smith stated that she marked Resident A's MAR with the letter "O" for other on multiple dates in January 2025 because Resident A refused it. Ms. Smith stated that she could not recall when she had observed Resident A's Vicks VapoRub in the facility's medication cart.

On 02/11/2025 I completed a LARA file review for facility AM410285333. I observed that a renewal inspection dated 10/02/2023 indicated that this facility was found to be in violation of R 400.14312 (1) due to staff Joyce Smith documenting the administration of a resident's medication that she later acknowledged she did not actually administer. Furthermore, it was discovered that the medication Ms. Smith documented as having been administered was not in the facility because the facility was out of stock of that medication. The approved Corrective Action Plan stated that the facility's compliance coordinator would monitor Medication Administration records monthly for compliance. I also observed Special Investigation Report 2025A0583002 10/31/2024 indicated that the facility was found to be in violation of R 400.14312 (1) due to staff Charlene Thompson leaving a plastic container of acetaminophen unsecured in Resident A's bedroom and two Advair diskus' were observed unsecured in Resident A's bedroom, and it was unknown whom the Advair diskus' belong to. This Special Investigation Report indicated that the facility was found to be in violation of R 400.14312 (6) due to the Advair Diskus 100 mcg-50 mcg/dose located on Resident A's bedroom floor and one small plastic container of acetaminophen 325 mg and acetaminophen 500 mg located on a dresser. These medications were unsecured and accessible to residents. In response to these findings, licensee designee Debra Krajewski submitted a Corrective Action Plan dated on 11/14/2024 which was approved, and Ms. Krajewski accepted a Provisional license.

On 02/20/2025 I completed an Exit Conference with licensee designee Debra Krajewski via telephone. Ms. Krajewski stated that Resident A's prescribed Vicks VapoRub had been discontinued prior to 01/29/2025. Ms. Krajewski stated that although she did not obtain a discontinue order from Dr. Finn until 02/04/2025, she believed a different physician had discontinued it prior to that date. Ms. Krajewski did not dispute Dr. Finn's report of signing the order on 02/04/2025 and backdating the order to 01/28/2025 at Ms. Krajewski's request. Ms. Krajewski stated that she disputed the finding of a rule violation. She stated that she does not know whether she will accept or contest the recommendation to revoke her license.

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 S333.1101 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:	While on site on 02/03/2024, I observed Resident A's Medication Administration Record for the time frame of 01/01/2025 until 01/31/2025. I observed that Resident A was prescribed Vicks VapoRub apply one gram topically every night at bedtime. I observed that from 01/01/2025 until 01/31/2025, the letter "O" for "other" is marked for each date. I observed that the document further stated, "refuse to take/D/C 01-30-25". Staff Charlene Thompson stated that Resident A is prescribed Vicks VapoRub once daily to be applied at bedtime at approximately 8:00 PM. Ms. Thompson acknowledged that she did initial Resident A's MAR for 01/29/2025 at bedtime, indicating that the Vicks VapoRub had been refused by Resident A even though it had not yet been offered. Ms. Thompson acknowledged that she initialed Resident A's 01/29/2025 8:00 PM administration as "O" for other. Ms. Thompson stated that it was a "mistake" to initial Resident A's MAR because she had not yet offered the medication to Resident A because it was not yet bedtime. While onsite I observed that the facility did not have Resident A's prescribed Vicks VapoRun in stock. Resident A stated that she had initially refused the administration of Vicks VapoRub because she was "allergic" to the medication. She further stated that during the month of January 2025 no staff had offered her the medication. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a repeat violation of the applicable rule. Staff Charlene Thompson acknowledged that she did initial Resident A's MAR for 01/29/2025 at bedtime, indicating that the Vicks VapoRub had been refused by Resident A even though it had not yet been offered. Ms. Thompson stated that it was a "mistake" to initial Resident A's

	MAR because she had not yet offered the medication to Resident A because it was not yet bedtime. Licensee designee Debra Krajewski stated that she had secured a discontinue order prior to the 01/29/2025 incident, however the prescribing Podiatry Nurse Practitioner Thomas Finn indicated that as of 01/29/2025 he had not authorized a discontinuation order and only drafted such an order on 02/04/2025 at Ms. Krajewski' request. Furthermore, during a 02/03/2025 onsite inspection, Resident A's medication was not in stock at the facility.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Renewal Inspection 10/02/2023** **Special Investigation Report 2025A0583002 10/31/2024**

ALLEGATION: Licensee Designee Debra Krajewski increased Resident A's rate without reviewing the increase with Resident A's guardian.

INVESTIGATION: On 01/30/2025 complaint allegations were received from the LARA-BCHS-Complaints online reporting system. The complaint alleged that during the month of January Resident A "was only given $20 out of the $44 of personal spending money given to her".

On 02/03/2025 I interviewed Cassidy Boensch via telephone. Ms. Boensch stated that at the beginning of January 2025, she sent licensee designee Debra Krajewski one check (#9007) in the amount of $1100.00. Ms. Boensch stated that Resident A's rent is $1056.50 per month and the remainder of $43.50 should be provided to Resident A for spending money. Ms. Boensch stated that Ms. Krajewski cashed the $1100.00 check but provided Resident A with only $20.00 in personal spending money. Ms. Boensch stated that she was aware that a social security rate increase had been approved by the federal government however, Ms. Krajewski did not review the rate increase with Ms. Boensch. Ms. Boensch stated that Ms. Krajewski further failed to provide Ms. Boensch with a new resident care agreement to sign in order to increase Resident A's rate.

On 02/05/2025 I received an email from licensee designee Debra Krajewski. The email contained Resident A's Resident Funds Part II form which indicates that Resident A was provided $20.00 in personal spending money on 01/15/2025.

On 02/06/2025 I received an email from licensee designee Debra Krajewski. The email contained Resident A's Resident Care Agreement, signed 05/30/2024. The document does not include a specific amount of money for the agreed basic fee. The document states "st. pay" as the agreed upon basic fee.

On 02/06/2025 I interviewed licensee designee Debra Krajewski via telephone. Ms. Krajewski stated that she received check #9007 in the amount of $1100.00 from guardian Cassidy Boensch. Ms. Krajewski stated that she cashed the check and kept $1080.00 of the funds to pay Resident A's January 2025 rent. Ms. Krajewski stated that she gave staff Joyce Smith $20.00 in cash and Ms. Smith provided the cash to Resident A on 01/15/2025 for her personal spending money. Ms. Krajewski stated that Resident A's social security had been increased January of 2025 and therefore Resident A's rent was also increased. Ms. Krajewski acknowledged that she did not send Ms. Boensch an updated Resident Care Agreement form to review and sign regarding an increase of Resident A's rent starting January 2025.

On 02/20/2025 I completed an Exit Conference with licensee designee Debra Krajewski via telephone. Ms. Krajewski stated that she doesn't agree that a rule violation occurred because Resident A's Resident Care Agreement states the agreed upon rate is the "state rate". Ms. Krajewski stated that she has completed Resident Care Agreements in this manner "for years". Furthermore, Ms. Krajewski stated that it is the responsibility of a guardian to know what the state rate is and that it changes yearly. Ms. Krajewski stated that moving forward, she will add a fee amount to all Resident Care Agreements.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(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:	Guardian Cassidy Boensch stated that at the beginning of January 2025, she sent licensee designee Debra Krajewski one check (#9007) in the amount of $1100.00. Ms. Boensch stated that Resident A's rent was $1056.50 per month and the remainder of $43.50 should be provided to Resident A for spending money. Ms. Boensch stated that Ms. Krajewski cashed the $1100.00 check but provided Resident A with only $20.00 in personal spending money. Resident A stated that staff Joyce Smith provided her with $20.00 personal spending money for January 2025. Resident A stated that she believed she was entitled to approximately $44.00 however she was told by Ms. Smith that Resident A would only receive $20.00.

	Licensee designee Debra Krajewski stated that she received check #9007 in the amount of $1100.00 from guardian Cassidy Boensch. Ms. Krajewski stated that she cashed the check and kept $1080.00 of the funds to pay Resident A's January 2025 rent. Ms. Krajewski stated that she gave staff Joyce Smith $20.00 in cash and Ms. Smith provided the cash to Resident A on 01/15/2025 for her personal spending money. Ms. Krajewski stated that Resident A's social security had been increased in January of 2025 and therefore Resident A's rent was also increased. Ms. Krajewski acknowledged that she did not send Ms. Boensch an updated Resident Care Agreement reflecting an increase in Resident A's rent. Resident A's Resident Funds Part II form indicates that Resident A was provided $20.00 in personal spending money on 1/15/25. Resident A's Resident Care Agreement, signed 05/30/2024, does not include a specific amount of money for the agreed basic fee. The document states "st. pay" as the agreed upon basic fee. A preponderance of evidence was discovered to substantiate a violation of the applicable rule. Licensee designee Debra Krajewski provided Resident A with $20.00 of the $43.50 in personal spending cash that guardian Cassidy Boensch sent to Ms. Krajewski in check #9007. Ms. Krajewski charged Resident A an extra $23.50 in rent despite acknowledging that she had not provided Ms. Boensch, with an updated Resident Care Agreement that reflects an increase in the agreed basic fee.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Licensee Designee Debra Krajewski failed to document the agreed upon fee in Resident A's Resident Care Agreement.

INVESTIGATION: On 02/06/2025 I received an email from licensee designee Debra Krajewski. The email contained Resident A's Resident Care Agreement, signed 05/30/2024. The document does not include a specific amount of money for the agreed basic fee. The document only notes "st. pay" as the agreed upon basic fee.

On 02/06/2025 I interviewed licensee designee Debra Krajewski via telephone. Ms. Krajewski acknowledged that she did not document a specific fee amount on Resident A's Resident Care Agreement form, signed 05/30/2024. Ms. Krajeski stated that she wrote "st. pay" on Resident A's Resident Care Agreement as the agreed upon rate.

On 02/20/2025 I completed an Exit Conference with licensee designee Debra Krajewski via telephone. Ms. Krajewski stated that she doesn't agree that a rule violation occurred because Resident A's Resident Care Agreement states the agreed upon rate is the "state rate". Ms. Krajewski stated that she has completed Resident Care Agreements in this manner for years. Furthermore, Ms. Krajewski stated that it is the responsibility of a guardian to know what the state rate is and that it changes yearly. Ms. Krajewski stated that moving forward, she will add a fee amount to all Resident Care Agreements.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: (b) A description of services to be provided and the fee for the service.
ANALYSIS:	Resident A's Resident Care Agreement, signed 05/30/2024, does not include a specific amount of money for the agreed basic fee. The document only notes "st. pay" as the agreed upon basic fee. Licensee designee Debra Krajewski acknowledged that she did not add a specific fee amount to Resident A's Resident Care Agreement form, signed 05/30/2024. Ms. Krajeski stated that she wrote "st. pay" in Resident A's Resident Care Agreement as the agreed upon rate. A preponderance of evidence was discovered to substantiate a violation of the applicable rule. Licensee designee Debra Krajewski failed to document a specific fee in Resident A's Resident Care Agreement signed 05/30/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Staff Charlene Thompson failed to document the administration of residents' medications.

INVESTIGATION: On 02/03/2025 at approximately 2:15 PM, I completed an unannounced onsite investigation at the facility and interviewed staff Charlene Thompson. Licensee designee Debra Krajewski participated in the phone conversation via three-way calling per Ms. Thompson's request. Ms. Thompson stated that she has worked at the facility independently from 02/01/2025 until current. Ms. Thompson stated that she has administered all resident medications during this timeframe but failed to document the administration of residents' medications into their respective Medication Administration Records (MAR). Ms. Thompson provided an unopened manila envelope for my review and stated that all residents' February 2025 MARs were in the unopened envelope. Ms. Thompson stated that she has not yet placed the February 2025 MARs into their respective residents' MARs because she had "messed them up" in the past. Ms. Thompson stated that although she did not document the administration of residents' medications from 02/01/2025 until current; "everyone got their meds".

While onsite, I observed Ms. Thompson open the manila envelope labeled as "PAPER MAR" RX 125053 from Pioneer Pharmacy "01/24/25". The envelope contained the February 2025 MARS of Residents A, B, C, D, E, F, G and H. Each resident was prescribed the following medications to be administered from 02/01/2025 until 02/03/2025 at 2:31 PM.

Resident A: Aspirin 81 MG once daily, CALC antacid 500 MG every morning, FAMOTIDINE 20 milligram every morning, Lisinopril 10 MG once daily, One A D tab once daily, Pantoprazole 40 MG once daily, vitamin D3 25 MCG once daily, Calcium+D3 600/400 twice daily, Buspirone 7.5 MG twice daily, Divalproex 125 MG twice daily, Divalproex 250 MG twice daily, and Clozapine 100 MG at bedtime.

Resident B: Cetirizine 10 MG once daily, B-12 Tab 500 MCG once daily, Desitin 13% cream once daily, Fluticasone spray 50 MCG every morning, Folic Acid tab 1000 MCG once daily, and Sertraline tab 50 MG daily

Resident C: Alendronate 10 MG every morning, Atorvastatin 10 MG once daily, Donepezil 10 MG once daily, Losartan/HCT 100-25 MG once daily, and Vitamin D3 50 MCG once daily.

Resident D: Rosuvastatin 20 MG every night, Vicks VapoRub every night, EarWax Sol drops twice daily, Fish Oil 1000 MG twice daily, Oxybutynin 5 MG twice daily, Clozalpin 100 MG at bedtime, Haloperidol 10 MG every evening, Melatonin 3 MG at bedtime, Metamucil 5.8 G once daily, Metformin 500 MG once daily, Omeprazole 40 MG every morning, Venlafaxine 75 MG daily, Calcium+D3 600/400 twice daily, Docusate 100 MG twice daily, Benztropine 1 MG once daily, Ciclopirox sus .77% once daily, Clonazepam .5 MG every morning, Fluticasone
Spray 50 MCG once daily, Folic Acid 1000 MCG once daily, and Levothyroxine 50 MCG once daily.

Resident E: Austedo 6 MG one tablet by mouth every morning and 12 MG every night at bedtime, Escitalopram 10 MG once daily, Fluticasone spray 10 MCG 1 spray in each nostril once daily, Jardiance 10 MG once daily, loratadine 10 MG once daily, nicotine transdermal patch once daily omeprazole 40MG once daily, Spironolactone 25 Mg once daily, Torsemide 10MG once daily, Westab Plus 20-1 MG once daily, Clonidine .1 MG twice daily, metformin 500 MG twice daily, Oxycarbazepin 600 MG twice daily, Symbicort inhaler twice daily, lorazepam 1 MG twice daily, Prazosin 5 MG every night at bedtime, and Quetiapine 400 MG every night at bedtime.

Resident F: Atorvastatin 40 MG once daily, Desvenlafax 50 MG every morning, Ear Drops DRO 6.5% once daily, Loratadine 10 MG every morning, Metamucil Fiber every morning, Montelukast 10 MG once daily, Senna 8.6 MG twice daily, Sucralfate sus 1 GM/10 ML twice daily, Divalproex 500 MG at bedtime, Melatonin 3 MG at bedtime, Olanzapine 7.5 Mg at bedtime, Polyeth Glyc Pow 3350 once daily, Venlafaxine 75 MG once daily, Vitamin D3 50 MCG once daily, Metformin 100 MG twice daily, Docusate 100 MG twice daily, and Pantoprazole 40 MG twice daily,
Resident G: Levothyroxine 50 MCG every morning, Lidocaine Pad 4 % at bedtime, Loratadine 10 MG once daily, Meloxicam 7.5 MG every morning, Olanzapine 10 MG once daily, Omeprazole 20 MG once daily, Poly Glyc Pow 3350 once daily, TAB-A-Vite once daily, Trihexyphen 2 MG once daily, Acitretin 10 MG twice daily, Biofreeze gel 4% twice daily, Fish Oil 1000 MG twice daily, Olazapine 15 MG every night, and Vicks VapoRub every night.

Resident H: Aspirin 81 MG once daily, Atorvastatin 20 MG once daily, Desmopressin .2 MG once daily, Fluticasone Spray 50 MCG once daily, Levothyroxin 50 MCG once daily, Myrbetriq 50 MG once daily, Acetaminophen 500 MG four times daily, Calcium/VIT D3 600 MG/5MCG twice daily, Fiber-Lax 625 MG twice daily, Fish oil 1000 MG twice daily, Omeprazole 20 MG twice daily, Polyeth Glyc 3350 twice daily, Topiramate 50 MG twice daily, Triamcinolone cream .1% twice daily, Urea cream 40% once daily, Vicks VapoRub twice daily, Clozapine 100 MG once daily, Pantoprazole 4 MG once daily before breakfast, Therapeutic TAB once daily, Vitamin B12 1000 MCG once daily, Vitamin D3 2000 unit every morning, and Vitamin E 400 unit once daily.

Resident A and Resident B each stated that to their knowledge, they have received all of their prescribed medications from Ms. Thompson from 02/01/2025 until current.

On 02/07/2025 licensee designee Debra Krajewski stated that Resident I's MARs are maintained by a sperate pharmacy and therefore Resident I's MARs were not located in the manila envelope observed while onsite on 02/03/2025. Ms. Krajeski stated that staff Charlene Thompson worked at the facility the morning of 02/01/2025 and would have dispensed medications that morning because she was the only staff working.

On 02/20/2025 I completed an Exit Conference with licensee designee Debra Krajewski via telephone. Ms. Krajewski stated that she does not dispute that a rule violation occurred. Ms. Krajewski stated that it was a "bad paperwork error" on staff Charlene Thompson's part. Ms. Krajewski stated that she has verified that all residents had received their medications from 02/01/2025 until 02/03/2025.

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.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	On 02/03/2025 I observed that Residents A, B, C, D, E, F, G and H's February 2025 Medication Administration Records lacked any staff initials or subsequent documentation which would indicate that they received their respective medications from 02/01/2025 until 02/03/2025 at 2:15 PM. Staff Charlene Thompson stated that she is the only staff who has worked at the facility from 02/01/2025 until 02/03/2024 at 2:15 PM. Ms. Thompson stated that she administered all required resident medications during this timeframe but acknowledged that she failed to document the administration of residents' medications on their respective Medication Administration Records. A preponderance of evidence was discovered to substantiate a violation of the applicable rule. Staff Charlene Thompson stated that she administered all required medications from 02/01/2025 until 02/03/2025 at 2:15 PM; but acknowledged that she failed to document each medication on their respective MAR. A review of the facility's Medication Administration Records from 02/01/2025 until 02/03/2025 confirmed that the documents

	lacked any staff initials or documentation which would indicate that residents' medications were administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Facility staff failed to contact an appropriate health care professional after Resident A refused her prescribed medication.

INVESTIGATION: On 02/03/2025 I received an email from Resident A's guardian, Cassidy Boensch. The email contained a photograph of Resident A's January 2025 Medication Administration Record. Resident A's MAR indicates that Resident A is prescribed Vicks Ointment VapoRub by Dr. Thomas Finn to be applied 1 Gram topically at bedtime to Resident A's fingernails and toes. The document states that Resident A did not receive the medication from 01/01/2025 until 01/29/2025 and is marked with an "O" for "other" daily. The document has a key which lists the letter "O" for "other and the letter "R" for "refused".

On 02/03/2025 while onsite, I interviewed staff Charlene Thompson. Licensee designee Debra Krajewski participated in the phone conversation via three way calling per Ms. Thompson's request. Ms. Thompson stated that she and staff Joyce Smith are the only staff who administer residents' medications at the facility. Ms. Thompson stated that Resident A is prescribed Vicks VapoRub once daily to be applied at "bedtime". Ms. Thompson stated that on multiple dates during January 2025, Resident A refused the administration of the medication. Ms. Thompson acknowledged that after each January 2025 refusal, she never contacted a medical professional for guidance.

While onsite I observed Resident A's MAR for the time frame of 01/01/2025 until 01/31/2025. I observed that Resident A is prescribed Vicks VapoRub apply one gram topically every night at bedtime. I observed that from 01/01/2025 until 01/31/2025, the letter "O" for "other is marked for each date. I observed that the document further stated, "refuse to take/D/C 01-30-25".

On 02/05/2025 I interviewed Nurse Practitioner Thomas Finn via telephone. Mr. Finn stated that he had previously prescribed Resident A with Vicks VapoRub to be applied daily before bed. Mr. Finn stated that on 02/04/2025 he met with licensee designee Debra Krajewski in person and Ms. Krajewski requested that Mr. Finn draft a discontinue order for Resident A's Vicks VapoRub because Resident A had been refusing the medication. Mr. Finn stated that Ms. Krajewski specifically requested that the discontinue order be backdated to the reflect a discontinue date of 01/28/2025. Mr. Finn stated that he honored Ms. Krajewski's request to backdate the discontinue order to 01/08/2025. Mr. Finn stated that he had not received any prior communication from Ms. Krajewski or her staff regarding Resident A's refusal of the Vicks VapoRub before he met with Ms. Krajewski on 02/04/2025.

On 02/06/2025 I interviewed staff Joyce Smith via telephone. Licensee designee Debra Krajewski participated in the phone conversation via three way calling per Ms. Smith's request. Ms. Smith stated that she and staff Charlene Thompson were the only staff who administered residents' medications January 2025. Ms. Smith stated that on multiple occasions during the month of January 2025, Resident A refused her prescribed Vicks VapoRub. Ms. Smith stated that the medication was not in stock at the facility, and she could not recall the last time she administered Resident A's Vicks VapoRub. Ms. Smith stated that she marked Resident A's refusal with an "O" for "other" rather than an "R" for "refused". Ms. Smith acknowledged that after each January 2025 refusal, Ms. Smith did not contact Resident A's prescriber or any other medical professional and therefore she did not record further instructions. Ms. Smith stated she would not "waste" her "time" contacting a medical professional to discuss Resident A's refusal because "it's not important".

On 02/20/2025 I completed an Exit Conference with licensee designee Debra Krajewski via telephone. Ms. Krajewski stated that she does not dispute that a rule violation occurred however she said that contacting a medical professional regarding Resident A refusing Vicks VapoRub was a "low priority".

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: (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:	Resident A's Medication Administration Record indicates that Resident A is prescribed Vicks VapoRub apply one gram topically every night at bedtime and that from 01/01/2025 until 01/31/2025 Resident A did not receive the medication. Staff Charlene Thompson stated that on multiple dates during January 2025 Resident A refused the administration of Vicks VapoRub. Ms. Thompson acknowledged that during each refusal she never contacted a medical professional for guidance. Staff Joyce Smith stated that she and staff Charlene Thompson were the only staff who administered residents' medications in January 2025. Ms. Smith stated that on multiple occasions Resident A refused her prescribed Vicks VapoRub. Ms. Smith acknowledged that after each January 2025 refusal, Ms. Smith

	did not contact Resident A's prescriber or other medical professional and therefore did not record further instructions. A preponderance of evidence was discovered to substantiate a violation of the applicable rule. Resident A's Medication Administration Record demonstrates that Resident A refused the administration of her prescribed Vick VapoRub the duration of January 2025 and staff Charlene Thompson and Joyce Smith did not contact a medical professional after each refusal.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: On 02/03/2025 prescribed medications were observed as unsecured at the facility.

INVESTIGATION: While onsite on 02/03/2025, I observed Resident C's Polyethylene Glycol PRN prescribed by Dr. A. Sylvester unsecured on the facility's medication cart located in the communal dining room. I further observed Resident B's Hydrocortisone 2.5 % cream prescribed by Dr. J. Stevens was located unsecured in Resident B's bedroom on a nightstand. I observed that Resident B's medication was prescribed to be administered topically twice daily until resolved and was to be discarded after 09/30/2024.

Staff Charlene Thompson stated that she had forgotten to secure Resident C's Polyethylene Glycol in the locked medication cart. Ms. Thompson stated that she was unaware that Resident B had prescribed hydrocortisone cream unsecured in her bedroom.

Resident B stated that she was given the Hydrocortisone in the past by a staff whose name she could not recall. Resident B stated that she had stored the medication in her bedroom for a long period of time and continues to self-administer the medication occasionally when she had irritated skin.

On 02/11/2025 I completed a LARA file review for facility AM410285333. I observed Special Investigation Report 2025A0583002 (10/31/2024) indicated that the facility was found to be in violation of R 400.14312 (6) due to staff Charlene Thompson leaving a plastic container of acetaminophen unsecured in Resident A's bedroom and two Advair diskus' were observed unsecured in Resident A's bedroom, and it is unknown whom the Advair diskus' belong to. These medications were unsecured and accessible to residents. Licensee designee Debra Krajewski submitted a Corrective Action Plan dated 11/14/2024 which was approved, and Ms. Krajewski accepted a Provisional license.

On 02/20/2025 I completed an Exit Conference with licensee designee Debra Krajewski via telephone. Ms. Krajewski stated that she does not dispute nor accept

that a rule violation occurred. She stated that staff Charlene Thompson said that Resident C's Polyethylene Glycol was unsecured because she was getting ready to administer the medication. Ms. Krajewski stated that the Hydrocortisone 2.5 % cream observed in Resident B's bedroom was "empty".

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	On While onsite I observed Resident C's Polyethylene Glycol PRN prescribed by Dr. A. Sylvester unsecured on the facility's medication cart located in the communal dining room. I further observed Resident B's Hydrocortisone 2.5 % cream prescribed by Dr. J. Stevens was located unsecured in Resident B' bedroom on a nightstand. Staff Charlene Thompson stated that she had forgotten to secure Resident C's Polyethylene Glycol in the locked medication cart. Ms. Thompson stated that she was unaware that Resident B had prescribed hydrocortisone cream unsecured in her bedroom. Resident B stated that she was given the Hydrocortisone in the past by a staff whose name she could not recall. A preponderance of evidence was discovered to substantiate a violation of the applicable rule. Staff Charlene Thompson left Resident C's Polyethylene Glycol unsecured on the facility's medication cart located in the community dining room. Additionally, Resident B's prescribed and expired hydrocortisone 2.5 % cream was observed as unsecured in Resident B's bedroom.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation Report 2025A0583002 10/31/2024**

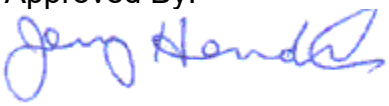
IV. RECOMMENDATION

I recommend the revocation of the license as a result of the above-cited quality-of-care violations, the noted repeat violations, and the fact that the home is currently operating with a Provisional license as a result of previous substantiated licensing rule violations.

02/20/2025

Toya Zylstra Date
Licensing Consultant

Approved By:



02/21/2025

Jerry Hendrick Date
Area Manager