GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 24, 2025

Connie Clauson
Leisure Living Mgt of Portage
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390016015
Investigation #: 2025A0581020
Fountain View Ret Vil 0f Port #2

Dear Connie Clauson:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the quality of care 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 (517) 284-9730.

Sincerely,

Cathy Cushman

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL390016015 |
| | |
| **Investigation #:** | 2025A0581020 |
| | |
| **Complaint Receipt Date:** | 03/03/2025 |
| | |
| **Investigation Initiation Date:** | 03/03/2025 |
| | |
| **Report Due Date:** | 05/02/2025 |
| | |
| **Licensee Name:** | Leisure Living Mgt of Portage |
| | |
| **Licensee Address:** | Suite 203<br>3196 Kraft Ave SE<br>Grand Rapids, MI 49512 |
| | |
| **Licensee Telephone #:** | (616) 285-0573 |
| | |
| **Administrator:** | Sara Johnson |
| | |
| **Licensee Designee:** | Connie Clauson |
| | |
| **Name of Facility:** | Fountain View Ret Vil 0f Port #2 |
| | |
| **Facility Address:** | 7818 Kenmure Drive<br>Portage, MI 49024 |
| | |
| **Facility Telephone #:** | (269) 327-9595 |
| | |
| **Original Issuance Date:** | 08/01/1995 |
| | |
| **License Status:** | 1ST PROVISIONAL |
| | |
| **Effective Date:** | 10/08/2024 |
| | |
| **Expiration Date:** | 04/07/2025 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATIONS

| | **Violation Established**? |
|---|---|
| The facility is short staffed. | Yes |
| Direct care staff are not administering medications accurately. | Yes |
| Additional findings | Yes |

**** To maintain the coding consistency of residents across special investigations and renewal reports, the residents in this special investigation report are not identified in sequential order.*

## III. METHODOLOGY

| | |
|---|---|
| 03/03/2025 | Special Investigation Intake - 2025A0581020 |
| 03/03/2025 | APS Referral - No referral necessary. APS denied investigating the allegations. |
| 03/03/2025 | Special Investigation Initiated – Telphone - Interview with Careline nurse practitioner, Angela Copeland |
| 03/03/2025 | Contact – Document Received – Email from Administrator, Sara Johnson. |
| 03/04/2025 | Contact – Telephone call made – Interview with direct care staff, Tandra McKinney. |
| 03/04/2025 | Contact – Telephone call made – Interview with direct care staff, Catherine Ware. |
| 03/04/2025 | Contact – Document Received – Email from Sara Johnson. |
| 03/06/2025 | Referral - Office of Fire Safety |
| 03/07/2025 | Contact – Telephone call made – Interview with direct care staff, Tatiana Reed. |
| 03/14/2025 | Inspection Completed On-site - Conducted fire drill due to staffing concern, observed/interviewed staff. |
| 03/14/2025 | Contact – Telephone call made – Interview with licensee designee, Connie Clauson. |
| 03/20/2025 | Contact - Document Received - Email from Erin Clauson, Operation Development Director. |

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|---|---|
| 03/26/2025 | Contact – Face to face – Interview with Connie Clauson and Sara Johnson at facility. |
| 04/04/2025 | Contact - Document Received - Email from Sara Johnson. |
| 04/15/2025 | Inspection Completed-BCAL Sub. Non-Compliance |
| 04/17/2025 | Contact – Telephone call made – Left voicemail with Licensee Designee, Connie Clauson. |
| 04/17/2025 | Contact – Document Sent – Email to Connie Clauson. |
| 04/21/2025 | Contact – Telephone call made – Left another voicemail with Connie Clauson. |
| 04/21/2025 | Exit conference with Administrator, Sara Johnson, via telephone. |
| 04/22/2025 | Contact – Telephone call made – Interview with direct care staff, Jessica Kellogg. |
| 04/24/2025 | Contact – Document Received – Email from Sara Johnson. |

**ALLEGATION: The facility is short staffed.**

**INVESTIGATION:** On 03/03/2025, I received this complaint through the Bureau of Community Health Systems (BCHS). The complaint alleged the facility does not have sufficient direct care staff on duty at all times for the personal care, supervision, and protection of residents. The complaint alleged the facility's residents are diagnosed with dementia.

Upon review of the facility's electronic record, the facility is licensed to provide personal care, supervision and protection to the aged populations and/or individuals with Alzheimer's disease with a maximum capacity of 20 residents. The facility is identified as the "Memory Care" facility. My review determined the facility is approximately 40 feet away from a neighboring facility, identified as the "Assisted Living" facility, which is also owned and operated by the licensee.

On 03/03/2025, I conducted an unannounced inspection at the facility regarding a separate special investigation. Direct care staff, Jessica Kellogg, provided me with a copy of the facility's staff schedule for 02/14-02/17. Jessica Kellogg identified 02/16 as a date whereas she was requested to come into work by direct care staff, Melvina Higgins, because scheduled staff either did not come or they called off work; therefore, leaving the facility insufficiently staffed.

I reviewed the schedule provided by Jessica Kellogg. I determined on 02/15, one direct care staff was scheduled to work 1st and 2nd shift, while two staff were scheduled to work 3rd shift. I was unable to determine which staff were scheduled to work in the facility on 02/16 because the staff schedule did not identify any specific staff assigned to the facility. Rather, the staff schedules identified how many staff were assigned to work in both the facility and the Assisted Living facility for 1st, 2nd and 3rd shifts. Due to the confusion of the staff schedule, I requested the facility's Administrator, Sara Johnson, provide me copies of the licensee's Paycor timesheets for clarification.

On 03/03/2025, I interviewed Careline Hospice nurse practitioner, Angela Copeland, who stated Resident K and Resident R reported to her direct care staff do not assist them as needed. Angela Copeland stated for example, Resident K contacted Careline Hospice agency on 02/15 and reported direct care staff had not transferred him out bed because the facility was short staffed. Angela Copeland stated Resident K required a Hoyer lift for transferring; however, she was unable to report the number of staff required to safely operate a Hoyer lift. Angela Copeland was unable to provide specific examples of how Resident R was not receiving care from staff.

On 03/04/2025, I interviewed direct care staff, Tandra McKinney, who stated there were multiple instances where she was working alone in the facility despite two staff scheduled to work. She stated if staff left early, arrived late, or failed to show up then the facility was insufficiently staffed. She denied one staff working in the facility for hours at a time, but stated it was not unusual for one staff to be left working alone for approximately 30 minutes to 1.5 hours at a time. Tandra McKinney stated on 02/15 she worked alone for approximately 30 minutes when direct care staff, Brooklyn Rybarczyk, showed up approximately 30 minutes late.

Tandra McKinney stated staff address resident needs, but stated staff may not immediately address a resident's request or need if staff are engaged in another task. She stated staff also transfer Resident K out of bed; however, it was usually at the direction of Resident K. She stated Resident K does not always want to get out of bed even when staff offer their assistance or encourage him.

Tandra McKinney stated a cook is not always available to prepare meals in the facility; therefore, she or other direct care staff prepare and serve meals to the residents, in addition to providing care to them. She stated as a result, it takes staff longer to complete tasks in the facility. She stated she was aware of resident's diets and supervision requirements while eating. She stated multiple residents require a Hoyer lift to transfer, which two direct care staff are needed to operate safely, but one staff will operate, if needed.

Tandra McKinney stated she recalled participating in a fire drill, but it was over a year ago and it took approximately 20 minutes despite two staff participating along with the assistance of the maintenance person. Tandra McKinney stated two direct

care staff are assigned to work in the facility for all shifts, including the overnight shift; however, she stated she believed three staff were needed to evacuate all the residents safely. She stated increased staffing was needed because multiple residents are combative, and multiple residents require physical assistance from staff.

On 03/04/2025, I interviewed direct care staff, Catherine “Cat” Ware, whose statement was consistent with Tandra McKinney’s statement; however, she did not identify any concerns the facility was insufficiently staffed and denied being left to work alone in the facility. She stated despite working in the facility for over three years, she could not recall the last time she completed a practice fire drill; therefore, she had no information regarding the time or the efficiency of staff evacuating residents from the facility in the event of an emergency.

On 03/03/2025 and 03/04/2025, the facility’s Administrator, Sara Johnson, emailed me copies of staff’s Paycor timesheets for 02/14-02/17, 02/21-02/24, 02/28-03/03, and 03/06-03/08. I was unable to determine the specific facilities staff worked in based on the timesheets alone, except handwritten notes were inputted next to the hours worked by staff assigning staff to either working in the Memory Care facility, Assisted Living facility or both.

Based on this information and reviewing the licensee’s “Summarized Census Report” for February and March, I determined one direct care staff was working in the facility for 19 residents on 02/15 from 6:15 am until 6:45 am, 02/15 from 2:15 pm until 3 pm, and 02/16 from 6:15 am until 8 am and one direct care staff was working in the facility for 17 residents on 03/01 from 6:30 am until 7:15 am.

Additionally, there were nine timeframes on the timesheets where staff were identified as working in both the Memory Care and Assisted Living facilities, which indicated staff were floating between the two facilities. Consequently, it is reasonable to believe the facility was not sufficiently staffed for 19 residents on 02/14 from 1:45 pm until 6:15 am, 02/15 from 3 pm until 6:15 am, and 02/16 from 2 pm until 6 am or sufficiently staffed for 17 residents on 03/01 from 6 am until 10:30 pm, 03/01 from 2:45 pm until 6 am, 03/02 from 9:45 pm until 3:15 pm, 03/06 from 2:30 pm until 6 am, 03/06 from 4:45 pm until 4 am , and 03/07 from 2 pm until 6 am.

On 03/06/2025, I contacted Bureau of Fire Services inspector, Ken Howe, to report my concerns the facility was insufficiently staffed for an emergency or fire. We agreed to conduct an unannounced 3rd shift fire drill to determine if the facility was sufficiently staffed to safely evacuate residents.

On 03/07/2025, I interviewed direct care staff, Tatiana Reed, via telephone. Her statement to me was also consistent with Tandra McKinney’s statement. She stated in addition to multiple residents requiring Hoyer lifts, there were also multiple residents on hospice. Tatianna Reed identified the facility being insufficiently staffed during a shift change on 03/06/2025. She stated staff, Cat Ware, left the facility at

10:15 pm without waiting for another staff to replace her. Tatiana Reed stated there were three staff between the facility and the Assisted Living facility from approximately 11 pm until 2:15 am, which corroborates the Paycor timesheets dated 03/06-03/07. Tatiana Reed stated there are multiple times per month where staff go between the buildings to provide assistance and to help one another when needed or requested.

Tatiana Reed stated despite working in the facility for approximately two years, she denied ever participating in a fire drill or receiving instruction on evacuating residents requiring special assistance.

On 03/14/2025, I conducted an unannounced inspection at the facility with BFS inspector, Ken Howe, to simulate an unannounced 3rd shift fire drill. Upon arriving to the facility at approximately 3 pm, there was only one staff, Brittany Middleton, working in the facility with 17 residents. She stated she had been alone in the facility since staff, Tandra McKinney, left at 2:45 pm. Brittany Middleton stated a temporary agency staff had been requested from Interim Staffing agency to replace Tandra McKinney; however, this temporary agency staff was running late. Also present in the facility during the inspection were an outside agency worker who was providing an activity to residents for an upcoming holiday, a kitchen staff, Sharron Moore, and the facility's maintenance director, Dan Foster. Both Sharron Moore and Dan Foster stated they were not trained in providing direct care work. Dan Foster stated he was only expected to work until 3 pm, but requested to be present for the practice fire drill.

Direct care staff, Melvina Higgins, arrived at the facility at approximately 3:45 pm to assist Brittany Middleton in the fire drill despite her being assigned to work in the Assisted Living facility. The majority of the residents were located in the facility's common area because of the holiday activity; therefore, Melvina Higgins and Brittany Middleton were instructed to assist residents back to their bedrooms as this would likely be their location during a 3rd shift emergency or fire. Additionally, I observed Resident B, G, K, and P already in wheelchairs, which a later review of their assessment plans documented these residents require Hoyer lifts for transferring. Melvina Higgins and Brittany Middleton did not transfer these residents into their wheelchairs for the start of the fire drill.

Dan Foster initiated the drill by verbally alerting staff and residents of the fire drill and setting off the alarm. The outside agency worker was instructed not to participate in or assist residents in any way during the drill. It took in excess of 10 minutes for Melvina Higgins and Brittany Middleton to evacuate 12 residents out of the facility. Melvina Higgins stated she was unable to assist with evacuating any more residents because Resident D, F, and N needed additional monitoring because she identified them as "wanderers". Brittany Middleton stated she was unable to transfer the remaining residents in the building by herself without the assistance of a second staff.

The facility's front door malfunctioned throughout the practice fire drill. Rather than the door automatically unlocking when the fire alarm was activated the door remained locked, which required staff to enter in the door code each time they entered or exited the facility.

Upon ending of the practice fire drill, I determined Resident E, H, J, L, and O, had not been evacuated from the facility. Melvina Higgins, Brittany Middleton and Dan Foster stated Resident E and Resident O refused to participate in the fire drill. Melvina Higgins stated Resident O screamed at her and gave her "a hard time". Dan Foster stated Resident H was on hospice and "actively dying"; therefore, neither he nor staff felt it was appropriate for him to participate in the fire drill. Subsequently, staff shut his bedroom door and placed a pillow in front of it as a signal to emergency personnel. Upon completion of the drill, I observed Resident H in his bed, awake and actively making gestures and sounds. Resident J's bedroom door was also shut with a pillow placed outside the door. I observed Resident J awake in bed, alert and engaged in conversation. Throughout the fire drill, I observed Resident L wandering about the facility in and out of resident bedrooms. At the conclusion of the drill, staff did not initially account for Resident L in the facility until I discovered her laying in another resident's bed and asked staff to identify her.

Regarding recent fire drills, Dan Foster stated he supervised three practice fire drills in the facility, dated 01/31/2025, 03/10/2025 and 03/13/2025 and provided the corresponding documentation. The 01/31 practice fire drill was conducted at 9:45 am and took 8 minutes to complete with 17 residents in the building. There were no staff signatures on the fire drill documentation acknowledging which staff participated in the drill.

The 03/10 practice fire was conducted at 2:32 pm and took six minutes to complete with 16 residents in the facility. The copy of the drill documented four residents stayed in their bedrooms with "Pillow" documented by their room number. No additional information was provided. Direct care staff, Brittany Middleton and Brooklyn Demark, the facility's kitchen staff, Sharron Moore and a Careline Hospice aide were documented as participants in the fire drill.

The 03/13 practice fire drill was conducted at 5:12 am and took nine minutes to complete with 16 residents in the facility. The copy of the drill documented Resident B, G, J, K, and P were left in their bedrooms with towels outside their rooms with the documentation "Proper Placement of Towels in Front of Door!!". Though the documentation identified two direct care staff participating in the practice drill, I was unable to identify the names of these specific staff due to their signatures being illegible.

There were no additional staff or temporary agency staff in the facility when I left the facility at approximately 5 pm.

Upon leaving the facility, I contacted the facility's licensee designee, Connie Clauson, to report a practice fire drill had been completed with BFS, with the outcome determined unacceptable. I informed Connie Clauson that due to the facility being on a provisional and the impractical evacuation time of the fire drill there was supporting evidence the facility was insufficiently staff. Consequently, I informed Connie Clauson my recommendation would be revocation of the facility's license. I informed Connie Clauson that in the interim she needed to ensure the facility was safe for residents. She stated she would review resident's assessment plan and attempt to reduce census.

On 03/20/2025, I reviewed resident assessment plans, which were identified as "Resident Evaluations" for all 17 residents residing in the facility on 03/14/2025. Upon review of these assessment plans, I determined the following:

- Eight residents received hospice care services.

- Six residents required either two-person assistance with transferring or transfer assistance using a mechanical/Hoyer lift.

- Eight residents were identified as wandering risks.

- Twelve residents were diagnosed with dementia or Alzheimer's or were identified as experiencing confusion, disorientation or memory loss.

- Six residents were identified as having severe difficulty in expressing ideas or needs, required maximal assistance or guessing by a listener, or speech was limited to single words or short phrases.

- Three residents were identified as experiencing aggressive type behaviors.

- Nine residents were either identified as incontinent, requiring two staff for bathroom assistance, or required regular staff assistance with bladder/bowel care.

- Nine residents required either two persons or required at least physical assistance from staff with activities of daily living (ADL's) like dressing or grooming.

- Two residents were identified as exhibiting sexually inappropriate behaviors.

- Six residents were identified as either unable to eat independently, required monitoring while eating, needed physical assistance from staff with eating, had difficulty swallowing or had a special diet identified such as pureed or finger foods.

- Six residents were identified as being dependent on staff for a shower/bath.

- Ten residents were identified as either being “bedbound” or required an assistive device such as a cane, walker, Broda chair or wheelchair for mobility assistance.

I also reviewed the facility’s written evacuation procedure; however, residents who required special assistance were not identified in this procedure. Additionally, I reviewed the licensee’s policy on mechanical lifts, which documented two direct care staff are needed to operate a mechanical lift.

On 04/02/2025, I interviewed direct care staff, Brooklyn Rybarczyk, via telephone. Her statement to me regarding the needs of the residents in the facility was consistent with Tandra McKinney’s and Tatianna Reed’s statements. Brooklyn Rybarczyk stated she worked in the facility from approximately November 2024 through the end of February 2025. She stated she did not participate in any fire drills during that time.

On 04/21/2025, I interviewed Administrator, Sara Johnson. She stated there were currently 16 residents in the facility. She stated Resident E was discharged at the end of March 2025, Resident H passed away on 03/15, and Resident T, who requires a Hoyer lift, was admitted to the facility from the Assisted Living facility. Sara Johnson stated two staff continued to be assigned to the facility; however, she intended to assign a dedicated floater staff to be utilized Monday through Friday from approximately 10 am until 7 pm. She stated the floater would work at both facilities to reduce staffing issues. I informed Sara Johnson the floater staff could not be counted in the staffing ratio, which she acknowledged she understood. She stated Sharron Moore was no longer working in the facility, but she hired a Food Service Director who was not expected to start until 05/01. Currently, Sara Johnson stated she and other staff are preparing meals in advance; however, she stated she also intended to hire two cooks. She stated staff continue to adhere to resident dietary needs and special diet requirements. Sara Johnson also stated staff are expected to sign the fire drills acknowledging their participation. I informed Sara Johnson staff signatures were not documented on the January fire drill and other signatures were illegible. I encouraged her to have staff both print and sign their names on fire drills.

According to SIR # 2022A0581011, dated 02/04/2022, the facility was in violation of Adult Foster Care administrative Rule 400.15206(1) when it was determined only two direct care staff were working between the facility and the Assisted Living facility on 12/03/2021 from approximately 4:30 pm until 6:50 pm when 16 residents resided in the facility during waking hours.

The facility’s approved Corrective Action Plan (CAP), dated 03/01/2022, documented the staffing would be one direct care staff to 15 residents during waking hours and one direct care staff to twenty residents during sleeping hours. The CAP documented if any resident required the assistance of two caregivers for transfers or care then two direct care staff shall always be on duty in the facility. The CAP

documented the facility's staff schedule would adequately reflect all direct care hours as worked, and the staff schedule shall be updated routinely to adequately record the location and hours of all personnel providing direct care.

According to SIR # 2022A0581011, dated 02/04/2022, the facility was also in violation of Adult Foster Care administrative Rule 400.15206(2) when it was determined there was insufficient staff working in the facility to meet the needs of the facility's 16 residents from 12/01/2021 through 12/09/2021. The investigation determined nine residents required the use of a wheelchair, walker and/or cane to ambulate, 12 residents had a diagnosis of dementia and/or Alzheimer's, five residents had a history of wandering or exit seeking behaviors, and at least half of the residents required assistance from staff in completing ADL's. Additionally, the investigation determined staff were being utilized at both the facility and the Assisted Living facility, when completing the facility's fire drills and providing direct care services. Subsequently, it was determined the licensee was utilizing floating or roaming staff between the two facilities.

The facility's approved Corrective Action Plan (CAP), dated 03/01/2022, documented the facility's staffing levels and care needs would meet the needs of the current residents. The CAP documented the staffing levels would be reviewed any time there was a change in the facility's census due to a significant change in a resident's condition, or due to a significant change to a resident's service plan. It also documented the facility's Administrator would implement a new call-in procedure to ensure adequate staffing was provided to meet the needs of all residents in the event a staff did not come in for a scheduled shift.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15206** | **Staffing requirements.** |
| | **(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.** |

| | |
|---|---|
| **ANALYSIS:** | During my unannounced inspection on 03/14/2025, direct care staff, Brittany Middleton, was the sole staff working in the facility providing protection, supervision and personal care to 17 residents from approximately 2:45 pm until 3:45 pm. Additionally, upon review of the licensee's Paycor timesheets, I determined the facility was staffed with one direct care staff for 19 residents on 02/15 from 6:15 am until 6:45 am, 02/15 from 2:15 pm until 3 pm, 02/16 from 6:15 am until 8 am and one direct care staff for 17 residents on 03/01 from 6:30 am until 7:15 am.<br><br>Consequently, the ratio of direct care staff to residents did not meet the minimum requirement of 1 staff to 15 residents for these dates and timeframes. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br><br>**SEE SIR# 2022A0581011, DATED 02/04/2022, CAP DATED 03/01/2022** |

| **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:** | Based upon the total care needs of the facility's population, the simulated 3rd shift fire drill, and a review of relevant facility documents pertinent to the allegation, there is substantial evidence supporting the facility does not have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of the residents. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br><br>**SEE SIR# 2022A0581011, DATED 02/04/2022, CAP DATED 03/01/2022** |

**ALLEGATION: Direct care staff are not administering medications accurately.**

**INVESTIGATION:**

The complaint provided no additional information other than what was identified in the allegations.

I interviewed multiple staff; however, none of them identified any concerns with administering medications to any specific residents. Subsequently, I requested to review each resident's electronic March 2025 Medication Administration Record (eMAR). I was provided with 15 out of 17 eMARs and upon their review, I determined the following eight residents did not receive their medication, as required, because the medications were documented not being in the facility.

According to the documentation on Resident B's generated March eMAR, he was prescribed the following medications, but the eMAR notation of "Temp out" indicated the medication was not administered:

- Senna plus tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident B on 03/06, 03/07, 03/08, 03/09, 03/10, 03/11, or 03/12.

- Acetaminophen 325 mg tablet, to be administered by giving two tablets by mouth every 6 hours. This medication was not administered to Resident B on 03/13 at 12 am.

According to documentation on Resident D's generated March eMAR, she was prescribed the following medications, but the eMAR notation of "Temp out" indicated the medication was not administered:

- Levothyroxine 75 mcg tablet, to be administered by giving 1 tablet by mouth once daily on an empty stomach This medication was not administered to Resident D on 03/13, 03/16, 03/17, 03/21, 03/22, 3/23, 03/24, 03/25, 03/26 or 03/27.

- Atorvastatin 40 mg tablet, to be administered by giving 1 tablet by mouth at bedtime. This medication was not administered to Resident D on 03/14 or 03/17.

According to documentation on Resident I's generated March eMAR, she was prescribed the following medications, but the eMAR notation of "Temp out" indicated the medication was not administered:

- Citalopram Hbr 20 mg tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident I on 03/06 or 03/11.

- Hydrocodone - APAP 5-325 mg tab, to be administered by giving 1 tablet by mouth three times daily and every 6 hours as needed for pain. This medication

was not administered to Resident I on 03/14 at 8 am, 03/14 at 2 pm or 03/14 at 8 pm.

- Senna Plus Tablet, to be administered by giving two tablets by mouth twice daily. This medication was not administered to Resident I on 03/06 at 8 am or 03/11 at 8 am.

- Lorazepam 1 mg tablet, to be administered by giving 1 tablet by mouth twice weekly on shower days with the additional instruction to administer 1 hour before shower. This medication was not administered to Resident I on 03/19, 03/24, 03/26 or 03/31.

According to documentation on Resident L's generated March eMAR, she was prescribed the following medications, but the eMAR notation of "Temp out" indicated the medication was not administered:

- Vitamin B-12 500 mcg tablet, to be administered by giving 1 tablet by mouth once daily. This medication was only administered to Resident L on 03/01 and 03/15

- Acetaminophen 325 mg tablet, to be administered by giving 2 tablets by mouth three times daily. This medication was not administered to Resident L on 03/02 at 2 pm or 8 pm, 03/03 at 8 am, 2 pm or 8 pm, 03/04 at 8 am, 2 pm or 8 pm, 03/05 at 8 am, 2 pm or 8 pm, 03/06 at 8 am, 2 pm, or 8 pm, 03/07 at 8 am, 2 pm and 8 pm, 03/08 at 8 am or 2 pm, 03/09 at 8 am, 2 pm, or 8 pm, 03/10 at 8 am, 03/20 at 8 am, 03/23 at 8 am, 2 pm or 8 pm, 03/24 at 8 am or 8 pm, 03/25 at 8 am or 2 pm, 03/26 at 8 am or 2 pm, 03/27 at 8 am or 2 pm, 03/28 at 8 am or 8 pm, 03/29 at 8 am or 2 pm, 03/30 at 8 am or 8 pm or 03/31 at 8 am or 2 pm

According to documentation on Resident M's generated March eMAR, he was prescribed the following medications, but the eMAR notation of "Temp out" indicated the medication was not administered:

- Thiamine (B1) 100 mg tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident M on 03/01 or 03/12.

- Olanzapine 2.5 mg tablet, to be given 1 tablet by mouth every night. This medication was not administered to Resident M on 03/12.

- Trazodone 50 mg tablet, to be given 1 "half tablet" by mouth at bedtime. This medication was not administered on 03/12.

According to documentation on Resident O's generated March eMAR, he was prescribed the following medications, but the eMAR notation of "Temp out" indicated the medication was not administered:

- Aspirin EC 81 mg tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident O on 03/01, 03/03, 03/04, 03/05, 03/06, 03/07, 03/08, 03/09, 03/10, 03/11, or 03/12

According to documentation on Resident P's generated March eMAR, he was prescribed the following medications, but the eMAR notation of "Temp out" indicated the medication was not administered:

- Baclofen 10 mg tablet, to be administered by giving 1 tablet by mouth twice daily. This medication was not administered to Resident P on 03/16 at 8 am

- Ciprofloxacin 500 mg tablet, to be administered by giving 1 tablet my mouth twice daily. This medication was not administered to Resident P on 03/16 at 8 am.

- Tramadol Hcl 50 mg, to be administered by giving 1 tablet by mouth every 6 hours. This medication was not administered to Resident P on 03/13 at 12 am.

According to documentation on Resident R's generated March eMAR, he was prescribed the following medications, but the eMAR notation of "Temp out" indicated the medication was not administered:

- Tramadol HCL 50 mg tablet, to be administered by giving 1 tablet by mouth twice daily. This medication was not administered to Resident R on 03/25 at 8 am, 03/27 at 8 am or 8 pm, or 03/28 at 8 am or 8 pm.

On 04/22/2025, Sara Johnson stated the majority of residents receive their medications through Hometown Pharmacy in blister packs. I confirmed with Sara Johnson these blister packs are customized pouches containing resident medications based upon the time of day and date the medication should be administered. For example, all of a resident's morning medications would in one blister pack labeled with the resident's name, the date and time the medication should be administered, the medication list on the front of the package containing the medication and dosage, and description of each pill. Sara Johnson stated she was not aware of any medication issues in the facility. She stated if a resident's medication was running low or had run out then the expectation would be for the facility's Resident Care Managers (RCM) to contact Hometown Pharmacy, request refills or report any issues. She stated staff are also trained on contacting Hometown Pharmacy and following up regarding medications.

On 04/22/2025, Jessica Kellogg, who is also identified as one the facility's RCMs, stated if the notation of "temp out" was documented on the eMAR then it was because the medication was not in the facility and unable to be administered. She stated there could be several reasons a medication would not in the facility such as the pharmacy did not packet it in the blister packs, the pharmacy did not fill it because a new prescription was needed from the physician, or it was not refilled in a timely manner. Jessica Kellogg stated it was the expectation of staff to contact the

pharmacy and request refills in a timely manner however, she stated this process could be delayed for reasons like medications running out on the weekends and the pharmacy not being opened or waiting on a new physician's order.

| **APPLICABLE RULE** | |
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| **R 400.15312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.** |
| **ANALYSIS:** | Based on my review of resident electronic *Medication Administration Records* for March 2025, eight out of 15 residents did not receive all of their medications as prescribed because their medications were not in the facility to administer. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS**

**INVESTIGATION:**

During the investigation, I reviewed the facility's staffing schedule from 02/16-03/01 and 03/02-03/15. Upon review of the schedules, I determined one schedule was being created for both the Memory Care facility and Assisted Living facility. The staff schedules included the names of staff assigned to work across both facilities rather than assigning staff to a specific facility. Additionally, an "X" or an "O" was inputted by each staff's name identifying the staff as either a "MED TECH" or "THE CAREGIVER". Consequently, I was unable to determine who was assigned to work in either facility on any given day or shift.

Additionally, the facility's staff schedule was neither updated to accurately reflect who worked in the facility nor the hours worked. For example, when I conducted my inspection on 03/14, the facility's staff schedule identified four staff working across the Memory Care and Assisted Living facilities; however, there was only one staff working in each facility at the time of my inspection. Direct care staff, Brittany Middleton, stated she worked 1st shift, but was mandated to work 2nd shift as well; however, this was not reflected on the staff schedule. Direct care staff, Melvina Higgins, was documented as working 1st shift; however, she was not identified as working the 2nd shift despite getting mandated to do so. The only way to accurately determine the number of hours worked by a staff was to review the licensee's Paycor timesheets.

Direct care staff, Tammie Ward and Melvina Higgins, both stated the facility's staff schedule was created to decrease staffing issues at the start of each shift. They both stated due to staffing issues and shortages, staff could be reassigned to a different facility at the start of a shift depending on which facility staff were needed.

Additionally, the staff schedule for 02/16 was not consistent with the licensee's Paycor timesheets of who worked in the facility. The Paycor timesheets documented staff, Jessica Kellogg, worked in the Memory Care facility from 8 am – 3 pm; however, she was not identified on the staff schedule as working during that time.

On 04/21/2025, Sara Johnson stated the licensee was implementing the OnShift platform starting 04/28/2025 to address the issues with the facility's current staffing schedule. She stated the OnShift platform would be both web based and available as an application for cell phones so staff could see both their assigned shifts and open shifts. Sara Johnson stated staff would receive alerts via text message when shifts became available. She stated OnShift would be monitored and managed by herself and two other facility's managers. She also stated shifts would continue to be mandated; however, she stated she hoped OnShift would decrease the need for mandated staff.

According to SIR # 2022A0581011, dated 02/04/2022, the facility was in violation of Adult Foster Care administrative Rule 400.15208(3) when it was determined the licensee was not updating staffing schedules to reflect the actual staff working at the facility or documenting any scheduling changes, as required.

The facility's approved CAP, dated 03/01/2022, documented the staff schedule would be updated regularly to include all direct care hours as worked and would include the location where staff worked.

| **APPLICABLE RULE** | |
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| **R 400.15208** | **Direct care staff and employee records.** |
| | **(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information:**<br>**(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.**<br>**(b) Job titles.**<br>**(c) Hours or shifts worked.**<br>**(d) Date of schedule.**<br>**(e) Any scheduling changes.** |

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| **ANALYSIS:** | Upon my review of the facility's staffing schedules, the licensee is not maintaining a staff schedule of advance work assignments, as required. The licensee is creating one schedule for two facilities and assigning staff to specific buildings at the beginning of a shift based on the needs of either facility. Additionally, the staff schedule does not accurately reflect the hours staff worked. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br><br>**SEE SIR# 2022A0581011, DATED 02/04/2022, CAP DATED 03/01/2022** |

**INVESTIGATION:**

During the simulated 3rd fire shift fire drill, I observed multiple residents who were non ambulatory and required both the assistance of staff and assistive devices to safely evacuate the facility. Additionally, upon review of the resident's assessment plans, I determined all 17 residents required special assistance because they were identified as having either a physical, emotional, or cognitive impairment. I established eight residents received hospice care services, six residents required either two-person assistance with transferring or transfer assistance using a mechanical/Hoyer lift, eight residents were identified as wandering risks, twelve residents were diagnosed with dementia or Alzheimer's or were identified as experiencing confusion, disorientation or memory loss, six residents were identified as having severe difficulty in expressing ideas or needs, required maximal assistance or guessing by a listener, or their speech was limited to single words or short phrases, three residents were identified as experiencing aggressive type behaviors, and ten residents were identified as either being "bedbound" or required an assistive device such as a cane, walker, Broda chair or wheelchair for mobility assistance.

On 03/20/2025, I reviewed the facility's "Fire Alarm Response Procedure/Evacuation Plan"; however, residents requiring special assistance were not identified or addressed in this plan.

On 04/21/2025, Sara Johnson stated the facility's Maintenance Director, Dan Foster was updating the evacuation plan to incorporate and identify the residents who required special assistance during an emergency.

| **APPLICABLE RULE** | |
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| **R 400.15318** | **Emergency preparedness; evacuation plan; emergency transportation.** |
| | **(1) A licensee shall have a written emergency procedure and evacuation plan to be followed in case of fire, medical,** |

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| | **or severe weather emergencies. The evacuation plan shall be prominently posted in the home. Residents who require special assistance shall be identified in the written procedure.** |
| **ANALYSIS:** | The facility's written emergency procedure is not updated to accurately reflect resident needs and/or populations served by the home, as required. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 04/21/2025, I conducted the exit conference with Administrator, Sara Johnson, via telephone after being unable to contact the licensee designee, Connie Clauson, via telephone or email on 04/17 or 04/21. I explained my findings and recommendation to Sara Johnson, which she acknowledged understanding.

## IV. RECOMMENDATION

Due to the continued quality of care and repeat violations, I recommend revocation of the license as recommended in Special Investigation Report # 2025A0581017.

04/23/2025

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Cathy Cushman Date
Licensing Consultant

Approved By:

04/24/2025

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Dawn N. Timm Date
Area Manager