



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 11, 2026

Harish Sathri
Elderly Solutions, Inc.
100 Santure Road
Monroe, MI 48162

RE: License #: AS580255782
Investigation #: 2026A0116037
Elderly Solutions, Inc.

Dear Mr. Sathri:

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 (313) 456-0380.

Sincerely,

A handwritten signature in blue ink that reads "Pandrea Robinson".

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS580255782
Investigation #:	2026A0116037
Complaint Receipt Date:	06/29/2026
Investigation Initiation Date:	06/29/2026
Report Due Date:	08/28/2026
Licensee Name:	Elderly Solutions, Inc.
Licensee Address:	100 Santure Road Monroe, MI 48162
Licensee Telephone #:	(734) 240-2374
Administrator:	Harish Sathri
Licensee Designee:	Harish Sathri
Name of Facility:	Elderly Solutions, Inc.
Facility Address:	100 Santure Road Monroe, MI 48162
Facility Telephone #:	(734) 240-2374
Original Issuance Date:	07/11/2003
License Status:	1ST PROVISIONAL
Effective Date:	01/30/2026
Expiration Date:	07/29/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 03/09/26, Resident A had what appeared to be red scratches or blotches on her skin and the following day the area was bruised. On 03/12/26, Resident A's torso was covered with bruises as well as her arm.	No
Additional Findings	Yes

III. METHODOLOGY

06/29/2026	Special Investigation Intake 2026A0116037
06/29/2026	Special Investigation Initiated - Telephone APS supervisor, Jake Ceslick.
06/29/2026	Inspection Completed On-site Director of Operations, Krushna Panda, home manager, Amy South, and review of Resident A's body chart records, and hospital discharge paperwork from March 2026.
06/29/2026	APS Referral Received.
07/17/2026	Contact - Telephone call made Hospice Nurse, Danielle England.
07/20/2026	Inspection Completed On-site Home manager, Amy South, reviewed Resident A's medication administration record (MAR), employee counseling forms, visually observed Resident A and interviewed POA 1.
07/21/2026	Contact - Telephone call made Hospice nurse, Danielle England.
07/22/2026	Inspection Completed On-site Staff, Kaine Scott, home manager, Amy South. Requested to review July 2026 staff schedule, Resident A's Hospice service plan, former staff, Takiyah Mabene, employee records.
07/22/2026	Contact - Document Received

	July 2026 staff schedule.
07/22/2026	Contact - Telephone call made Hospice Nurse, Danielle England. Requested copy of Hospice service plan.
07/22/2026	Contact - Document Received Resident A's hospice service plan from Elara Caring records department.
07/22/2026	Inspection Completed-BCAL Sub. Non-Compliance
07/23/2026	Contact - Telephone call made APS investigator, Tywanda Millender.
08/13/2026	Contact-Telephone call made Clinical Team Manager, Molly Harris, Elara Caring Hospice.
08/19/2026	Contact-Telephone call made Clinical Team Manager, Molly Harris, Elara Caring Hospice.
08/24/2026	Contact-Telephone call made Clinical Team Manager, Molly Harris. Left a message requesting a return call.
08/26/2026	Contact-Telephone call made Area Director of Clinical Operations, Heather Steuber.
08/26/2026	Contact-Document received Resident A's prescription order.
08/26/2026	Contact-Telephone call received Hospice Nurse, Lindsay Barron.
08/26/2026	Contact-Telephone call received Clinical Team Manager, Molly Harris.
08/26/2026	Contact-Telephone call received Hospice Nurse, Brittany Bussell.
08/28/2026	Exit Conference Licensee Designee, Harish Sathri

ALLEGATION:

On 03/09/26, Resident A had what appeared to be red scratches or blotches on her skin and the following day the area was bruised. On 03/12/26, Resident A's torso was covered with bruises as well as her arm.

INVESTIGATION:

On 06/29/26, I interviewed APS supervisor, Jake Ceslick, and he reported that the allegations were not substantiated as there were no findings of abuse or neglect. Mr. Ceslick reported it appeared the allegations may have come from 2 former disgruntled employees.

On 06/29/26, I conducted an unscheduled onsite inspection and interviewed Hospice Social Worker, Shayla Lieto, Resident A, home manager, Amy South, and Director of Operations, Krushna Panda.

Ms. Lieto reported that she is the hospice social worker with Elara Caring Hospice. She reported that Resident A did not begin receiving hospice services until 05/28/26 and so they would have no knowledge of what may have occurred in March. Ms. Lieto reported they are providing wound care twice per week, bed baths twice per week and will be increasing their days in the home based on Resident A's decline. Ms. Lieto provided the name and contact information for the assigned hospice nurse.

I interviewed Resident A. Resident A was not able to engage in full conversation, however, was able to respond yes or no to questions. Resident A responded in a whisper and would follow up with a head nod. Resident A denied that any of the staff intentionally hurt her, dropped her, hit, or scratched her. Resident A responded yes, when asked if she remembered falling a few months ago. Resident A was unable to provide any details. With the assistance of home manager, Amy South, I was able to observe Resident A's arms, neck, stomach and I did not observe any marks, scratches or bruises on her body.

I interviewed home manager, Amy South, and she reported that Resident A did not have bruising all over her body as alleged. She reported that two disgruntled employees reported these allegations to APS the same day they quit. Ms. South reported that Resident A had an unwitnessed accidental fall in the home on 03/03/26. Ms. South reported that she had fallen out of bed, and they think she may have hit her arm and possibly chest area on the nightstand that is right next to her bed. Ms. South reported that Resident A appeared fine and verbalized that she was okay. Ms. South reported that on 03/07/26, former staff, Kaydence Moore, observed bruises on Resident A's arms and chest and notified her. Ms. South reported that they sent Resident A to the hospital for evaluation and treatment. Ms. South reported that Resident A was released from the hospital on 03/12/26 and reported

she did not sustain any fractures or broken bones from the fall. Ms. South reported it did take a few weeks for the bruises to heal and fade away.

I interviewed, director of operations and owner of the business, Krushna Panda. Ms. Panda reported that she conducted an internal investigation in March 2026 after observing the bruising on Resident A's arm. Ms. Panda reported in March Resident A was still able to fully communicate and so she spoke to her and asked how she sustained the bruises. Ms. Panda reported that Resident A told her that no one harmed her and that she fell attempting to get out of bed and thinks she may have hit the nightstand by her bed, which likely caused the bruising. Ms. Panda further reported that Resident A's Parkinson's disease was progressing which caused her balance and coordination to worsen, and she was also becoming more stiff and rigid. Ms. Panda reported shortly after the fall home manager, Amy South, met with the family to discuss the addition of hospice services as Resident A's Parkinsons was progressing. The family initially did not agree with the recommendation, however, a couple months later agreed to enroll Resident A in hospice care.

On 07/20/26, I interviewed POA 1 while onsite. POA 1 reported that he was aware of the fall and subsequent hospitalization that occurred in March of 2026. He reported that Resident A did not sustain any fractures or broken bones. POA 1 confirmed that in March Resident A was still verbal and able to communicate and did not express any concerns to him or the family during their visits to the home. POA 1 also reported that he spoke to APS and they were unable to substantiate abuse/neglect during their investigation and he was satisfied with the outcome of the investigation.

I reviewed the homes internal body chart forms that documented bruises on Resident A's arms and chest area. I also reviewed Resident A's hospital discharge summary from 03/12/26 documented Resident A's fall. The discharge summary confirms that Resident A sustained some bruises, however, did not have any broken bones or fractures.

On 07/23/26, I interviewed APS investigator, Tywanda Millender, and she reported that she closed the APS case on 06/26/26 and reported there was no evidence to substantiate abuse or neglect. Ms. Millender reported that APS received the complaint on 05/30/26, more than two months after the fall. She reported that face to face contact was made with Resident A on the evening of 05/30/26 and again on 06/24/26. Ms. Millender reported that Resident A did not have any marks or bruises on her body on the two occasions APS saw her. Ms. Millender reported during her interview with Resident A on 06/24/26 she was alert but spoke in a whisper. She reported that Resident A reported feeling safe and denied being hurt by anyone in the facility. Ms. Millender reported that the on-call APS investigator who made the initial face to face with Resident A on 05/30/26 reported Resident A reported feeling safe and denied that anyone had hurt her. The on-call staff reported that Resident A complained of some soreness caused by a wound on her buttock. Ms. Millender reported Resident A had just enrolled in hospice care and they were going to be

providing wound care. Ms. Millender further reported that she spoke with POA1 and Resident A's sister and neither reported any concerns at the time regarding the care the staff was providing to Resident A.

On 08/28/26, I conducted the exit conference with licensee designee, Harish Sathri, and informed him of the findings of the investigation. Mr. Sathri agreed with the findings.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on the findings of the investigation, which included interviews with home manager, Amy South, director of operations, Krushna Panda, Resident A, POA1, and APS investigator, Tywanda Millendar, there is not a preponderance of evidence to substantiate the allegations. Resident A had an unwitnessed fall on 03/03/2026, that resulted in her sustaining some bruising to her arms and chest area. Resident A was later sent to the hospital for evaluation and treatment. Resident A did not sustain any injuries. Resident A reported that she was safe in the home and denied being hurt by anyone. Neither APS nor I observed any marks or bruises on Resident A. This violation is not established as Resident A was treated with dignity and respect, free from exploitation, and protected and safe.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/17/26, I interviewed Hospice Nurse, Danielle England, with Elara Caring Hospice. Nurse England reported that she is a registered nurse and has been Resident A's hospice nurse since 05/28/26. Nurse England reported that she initially was going to the home twice per week to provide wound care for Resident A. She reported that due to Resident A's decline and progression of the wound she or

another nurse was going to the home daily as of 07/06/26 to provide wound care and “by your side” care. Nurse England reported that “by your side” care is a part of Elara Caring’s end of life program that provides more support to the patient, with their team being at the home more often and having nurse visits daily.

Nurse England reported she was the primary nurse providing care to Resident A, however, there were three or four occasions when another nurse would fill in for her.

Nurse England reported that she trained Ms. South in proper wound care for Resident A so that she could train her staff, however, Ms. South reported that she would be the only one in the home providing the wound care.

Nurse England reported that prior to 07/06/26, Resident A’s wound care was completed by her or another hospice nurse two days per week and the remaining 5 days, home manager, Amy South, was changing Resident A’s dressings and doing the wound care regimen. Nurse England reported beginning 07/06/26 she and another hospice nurse were providing daily wound care, and Ms. South would only need to provide additional wound care if Resident A defecated and/or if the wound was leaking/oozing and required cleaning re-packing and re-dressing.

Nurse England reported that when Resident A’s wound was measured on 05/28/26 the size of the wound was 1.8cm x 2.4cm x 0cm and when she measured it on 07/17/26 it was 10.6cm x 4.7cm x 2cm. Nurse England reported that she attributed some of progression of the wound to Resident A not being changed regularly, improper wound care in her absence, and Resident A not being repositioned every two hours. Nurse England reported that the wound progressed in a short period of time. She reported that she provided an abundance of education to the staff and really worked with them providing in-depth training, addressing issues as soon as they arose, and availing herself as needed to answer questions or provide additional education. Nurse England reported that she informed home manager, Amy South, as well as the other staff who were on shift during her visits to the home, the importance of Resident A’s brief being changed regularly for proper wound healing and to prevent infection.

Nurse England reported that Resident A has a foley catheter that drains her urine, but reported she requires brief changes if she defecates and due to the wound leaking/draining. Nurse England reported that during her visits on 07/05/26 and 07/08/26 she removed Resident A’s brief to provide wound care and observed partially dried feces in her brief. She reported this was an indication to her that she had been sitting in it for a while. Nurse England reported that she addressed it with home manager, Amy South, who in turn reported that she would be addressing this with all staff.

On 07/14/26, Nurse England reported she was at the home providing wound care to Resident A and due to her concerns/suspicions that Resident A’s brief was not being changed regularly she placed a small “X” in an inconspicuous area on the brief. She

reported when she returned 24 hours later, Resident A was still in the same brief. When she opened the brief, she observed leakage from the wound. Nurse England reported that she addressed the matter with home manager, Amy South, who assured her that she would be addressing the matter again with all the staff. Nurse England reported she and Ms. South have both reiterated the importance of regular brief changes. Nurse England reported that she told the staff that even if Resident A does not defecate, her brief should be checked and changed often, minimally at every shift change, and that is only if there is no leakage/draining from her wound.

Nurse England further reported that she informed home manager, Amy South, and trained her on how to properly reposition Resident A, always focusing on keeping her off her buttocks. Nurse England reported that Ms. South took videos and pictures during the training so that she could reference when training the staff. Nurse England reported she recommended that Ms. South create a spread sheet to use and have staff sign off to track and confirm that Resident A was being repositioned every two hours. Nurse England reported that Ms. South never created the spreadsheet or any other document for this purpose.

On 07/20/26, I conducted an unscheduled onsite inspection and interviewed home manager, Amy South, POA 1 and visually observed Resident A. Ms. South reported that she was trained by Nurse England on wound care and repositioning of Resident A. Ms. South reported that she was the only person in the home that did the wound care on the days Nurse England did not come. She reported she came in on her days off or even after hours when staff contacted her to let her know that Resident A needed the wound cleaned and re-dressed after she defecated or if the wound was leaking. Ms. South reported that she wanted to make sure that the wound care was done correctly and didn't want to delegate that responsibility to any of the other staff. Ms. South reported that although the wound progressed and would not heal, she attributed that to Resident A's rapid health decline and reduced caloric intake. I recommended that Ms. South train at least one other staff, in the event she was unable to get to the home timely, to ensure there was no delay in wound care for Resident A. Ms. South reported that she would.

Ms. South admitted that there have been a couple of instances brought to her attention by Nurse England, specifically finding Resident A in soiled briefs. Ms. South reported that she immediately addressed the matter with staff and reiterated the importance of ensuring that she is checked and changed regularly. Ms. South also reported that she was on shift the morning Nurse England came and observed that Resident A had been in the same brief for over 24 hours. She reported that Nurse England showed her the "X" she had placed on the brief the day prior. Ms. South reported that she provided written counseling to both staff who were on shift during 16 of those 24 hours and did not change her brief. I observed both employee counseling records for staff, Nicole Bashaw, and former staff, Takiyah Mabene. Ms.

Bashaw worked from 3:00 p.m. to 11:00 p.m. and Ms. Mabene worked from 11:00 p.m. to 7:00 a.m.

Ms. South reported with regard to repositioning Resident A, she and the staff would do so every two hours. Ms. South reported that Nurse England informed her that this is necessary to keep pressure off the wound that is on Resident A's tailbone. Ms. South reported that repositioning every two hours was something that they did anyway for Resident A and other residents who had pressure/bed sores. Ms. South reported that she trained all the staff on how to reposition Resident A and to her knowledge the staff was doing so. Ms. South reported that she did not have any documentation that I could review verifying that staff were repositioning Resident A every two hours.

Ms. South reported that Nurse England was very helpful to her and staff. Ms. South reported that although Nurse England addressed concerns she observed during some of her visits, she never voiced that she felt she or her staff were not properly caring for the wound or that the wound was progressing due to their lack of proper care. Ms. South reported that Nurse England gave her positive feedback about their overall care.

I interviewed POA 1 while onsite and he reported that Resident A is actively transitioning and the family has been coming to the home daily.

POA 1 reported that he was not informed by staff or the hospice nurse, of the incidents where Resident A was found in soiled briefs or that her brief had not been changed for over 24 hours. POA 1 reported that is concerning.

POA 1 reported that he and his wife started to see some decline in care being provided by the staff, as there has been a lot of staff turnover and ownership changes. POA 1 reported that prior to these incidents, he had been satisfied with the care provided.

I visually observed Resident A, she was asleep.

On 07/22/26, I completed an unscheduled onsite and spoke with staff, Kaine South. Shortly after my arrival, home manager, Amy South, arrived. I requested to review Resident A's hospice service plan and assessment plan. Mr. South provided the Hospice binder to me. Upon review I observed that there was not a hospice service plan in the binder for Resident A. Mr. South was not able to provide an explanation as to where it was or why it was not in the binder.

I interviewed Ms. South and asked her if she could provide the hospice service plan for my review. Ms. South went through the hospice binder and could not locate it. I informed Ms. South that the hospice service plan should be in the home and readily accessible to her and staff to ensure they are following the plan so Resident A's additional needs are met. I then requested to review Resident A's assessment plan to see if it documented Resident A's decline and current needs. I reviewed the plan

and observed that it was completed September 1, 2025. A new/updated assessment plan had not been completed documenting Resident A's decline, that she was under hospice care or receiving wound care by a hospice nurse and staff.

Ms. South reported that she is a new manager and was not aware that the assessment plan needed to be updated more than annually or that the hospice service plan was required to serve as an addendum to the assessment plan. I explained to Ms. South that if the resident needs change the assessment plan and/or hospice service plan reflect the changes to ensure the personal care, supervision, and protection as well as the services, skills and physical accommodations required by the resident is available in the home. Ms. South reported an understanding and admitted that it made sense to her.

Ms. South informed me that Resident passed and was pronounced by hospice nurse, Donna Lomas, this morning at 1:07 a.m.

On 08/26/26, I interviewed Hospice Nurse, Lindsay Barron. Nurse Barron reported that she provided wound care to Resident A on 07/19/26. Nurse Barron reported that during her visit Resident A was unresponsive and had shallow breathing. She reported after completing the wound care she repositioned Resident A and did not document any concerns.

On 08/26/26, I interviewed Clinical Team Manager, Molly Harris. Nurse Harris reported that she conducted a visit to the home on the evening of 07/21/26. Nurse Harris reported that she did not provide wound care, however, observed that Resident A's skin was thin and breaking down, she observed "boning" (prominent visualization of the patient's skeletal structure) due to near end of life. Nurse Harris reported Resident A looked comfortable and she did not have any concerns.

On 08/26/26, I interviewed Hospice Nurse, Britany Bussell. Nurse Bussell reported that she provided wound care to Resident A on 07/18/26 and 07/19/26. Nurse Bussell reported that 07/18/26 was a "by your side visit" and reported Resident A was not alert and family was present bedside. She reported that she did not have any concerns. Nurse Bussell reported that the 07/19/26 visit was a "PRN" visit, after receiving a call from one of the facility staff, at the recommendation of the family. Nurse Bussell reported that the family was worried about Resident A's breathing, so she went to the facility to assess Resident A. Nurse Bussell could not recall the name of staff person who called her. Nurse Bussell reported she provided wound

care to Resident A and adjusted/repositioned her in bed. Nurse Bussell reported she did not have any concerns.

On 08/28/26, I conducted the exit conference with licensee designee, Harish Sathri and informed him of the findings of the investigation and the specific rule cited. Mr. Sathri reported an understanding.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on the findings of the investigation, which included interviews with hospice nurse, Danielle England, home manager, Amy South, POA 1, Hospice Nurse, Lindsay Barron, Clinical Team Manager, Molly Harris, Hospice Nurse, Brittany Bussell, and my observation, there is a preponderance of evidence to substantiate that the staff did not provide supervision, protection and personal care to Resident A as specified in Resident A's assessment plan. Nurse England, observed on two separate occasions 07/05/26 and 07/08/26, Resident A in briefs soiled with her own feces that had begun to harden and dry out. Nurse England also marked an "X" on the brief Resident A was wearing before leaving the home on 07/14/26. The following day (07/15/26) when Nurse England returned to the home Resident A was still wearing the same brief and it contained leakage from her wound. Additionally, the licensee designee, did not have or ensure that Resident A's hospice service plan was in the home and included as an addendum to her assessment plan and maintained with the assessment plan in her record, therefore this violation is established.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

On 07/17/26, I interviewed Hospice Nurse, Danielle England, Nurse England reported that on 07/14/26, after providing wound care to Resident A and assessing her, she received the verbal order from the hospice doctor, Dr. Sumali Tamhaney, to discontinue all of Resident A's daily prescription medications. Nurse England reported she then completed the written order, while still in the home, to begin administering 0.5ml morphine concentrate to Resident A every four hours by mouth for pain and shortness of breath.

Nurse England reported that on 07/15/26, she returned to the home to provide wound care to Resident A. She reported she checked Resident A's MAR to make sure all doses of the morphine were administered. Nurse England reported observing the 11:30 p.m. on 07/14/26 and 3:30 a.m. on 07/15/26 boxes blank. Nurse England informed Ms. South of her observations and Ms. South admitted that the midnight staff, Takiyah Mabene, worked 11:00 p.m. to 7:00 a.m. on 07/14/26, and did not administer the two prescribed doses of morphine. Nurse England reported that Ms. South put her initials in both boxes, after being fully aware that the medication was not administered and said, "states [sic] going to be coming in soon and we can't have any open spots on the MARs, we got in trouble for that last time she was here." Nurse England reported that she documented the incident in her notes and stressed again to Ms. South the importance of administering the medications as prescribed to ensure Resident A is not suffering as she transitions.

On 07/20/26, I conducted an unscheduled onsite inspection and reviewed Resident A's MARs and interviewed home manager, Amy South. I observed the initials "AS" on the MAR on 07/14/26 as the person who administered the morphine at 11:30 p.m. and the initials "AS" for the 3:30 a.m. dose on 7/15/26. I also observed the initials "AS" with a circle around the initials on 07/16/26 for the 11:30 p.m. and 3:30 a.m. dose on 07/17/26 and a note on the back of the MAR that documented that on 07/16/26, Takiyah Mabene, did not pass the 11:30 p.m. or 3:30 a.m. dose. Ms. South reported that the medication error occurred on 07/16/26, and that she terminated Ms. Mabene. I informed Ms. South that initials on the MAR signify that the medication was administered. I advised moving forward, if there is a medication error such as a medication not being administered, not to initial the MAR, but provide an explanation on the MAR as to what occurred. Ms. South reported an understanding.

Ms. South provided me with the homes internal medication incident report, that describes the type of medication error, who was responsible for the error, and the action taken. The report documents that the date of occurrence was 07/14/26 and the date the incident was discovered as 07/15/26. The report states that Resident A was not given her scheduled morphine at 11:30 p.m. and 3:30 a.m. The staff person listed is Takiyah Mabene, and it documented that her medication passing privileges are revoked, and further medication training is needed. When asked about the date, Ms. South was adamant that the medication error occurred on 07/16/26 and she

came in on 07/17/26 and discovered the error. Ms. South reported that she needed to fix the dates on the medication incident report to reflect 07/16/26 instead of 07/14/26 and reported the MAR is accurate.

Ms. South reported on the night of 07/19/26, a different hospice nurse, later determined to be Brittany Bussell, was at the home and obtained a new verbal order from the hospice doctor, increasing the frequency the morphine is to be given. The new order was for the morphine to be given every hour as of 10:00 p.m. 07/19/26. Prior to leaving the home, I took a picture of the MAR reflecting the change. The time stamp on the picture I took during my onsite inspection is 9:30 a.m. While reviewing some of the pictures a day later, I observed that the 9:00 a.m. dose of morphine had not been administered as no initials were documented on the MAR.

On 07/20/26, I interviewed POA 1 while onsite. POA 1 reported that he was never notified by staff or Nurse England, of any missed doses of morphine. POA 1 again reported noticing the decline in care provided in the home and attributed it to staff turnover and new ownership.

On 08/26/26, I interviewed Area Director of Clinical Operations for Elara Caring Hospice, Heather Steuber. I requested a copy of the written prescription order, from 07/19/26, when the hospice doctor increased the frequency, the sublingual morphine was to be given. Ms. Steuber reported that the written order is dated 07/21/26, but Hospice Nurse, Brittany Bussell, obtained the verbal order the night of 07/19/26 after assessing Resident A.

On 08/26/26, I received and reviewed the written order documenting that the morphine 100mg/5ml concentrate oral solution frequency was increased to hourly on 07/19/26. The previous morphine 100mg/5ml concentrate that was to be given every four hours as of 07/14/26 was discontinued.

On 08/26/26, I interviewed Hospice Nurse, Brittany Bussell. Nurse Bussell reported that during her visit to the home on 07/19/26, she assessed Resident A and observed her to have shallow breathing and terminal secretions. Nurse Bussell reported that she contacted the on-call hospice doctor, Dr. Tahir Alvi, and obtained a verbal order to increase the frequency of the sublingual morphine 100mg/5ml concentrate from every four hours to hourly. She reported the family was present and in agreeance with the change.

On 08/28/26, I conducted the exit conference with licensee designee, Harish Sathri, and informed him of the findings of the investigation and the specific rules cited. Mr. Sathri reported an understanding. He reported that he has conducted multiple in-service trainings with staff as well as stressed the importance of initialing the MAR during their staff meetings and while in the facility. He voiced his frustrations regarding the staff failures pertaining to the administration of the medication as well as properly documenting/initialing at the time of administration.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based on the findings of the investigation, which included interviews with Hospice Nurse, Danielle England, home manager, Amy South, Hospice Nurse, Brittany Bussell, my review of Resident A's MAR, prescription orders, and the homes internal medication incident report, there is a preponderance of evidence to substantiate that Resident A's medication was not given as prescribed by hospice physicians, Dr. Sunali Tamhaney and Dr. Tahir Alvi. On 07/14/26 at 11:30 p.m., 07/15/26 at 3:30 a.m., and 07/20/26 9:00 a.m. staff did not administer Resident A's morphine medication as prescribed. Repeat violation established; LSR dated 01/16/24, CAP dated 01/30/24. Previous rule 312 (1) new rule 675(1) promulgated 11/03/25.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.675	Resident medications.
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: (b) Complete an individual medication log that contains all of the following: (i) Medication name. (ii) Dosage. (iii) Label instructions for use. (iv) Time to be administered. (v) Initials of the individual who administered the medication at the time given. (vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.

ANALYSIS:	Based on the findings of the investigation, which included interviews with Hospice Nurse, Danielle England, home manager, Amy South, and my review of Resident A's MAR, the July 2026 staff schedule and former staff, Takiyah Mabene's medication incident report there is a preponderance of evidence to substantiate that home manager, Amy South, initialed the MAR attesting that she was the individual who administered Resident A's 11:30 p.m. dose of morphine on 07/14/26 and 3:30 a.m. dose on 07/15/26. According to Nurse England, Ms. South admitted that the medication was not administered, however she still initialed the MAR to avoid being cited by the department. According to the staff schedule, Ms. South did not work on 07/14/26. Former staff, Takiyah Mabene worked from 11:00 p.m. to 7:00 a.m. on 07/14/26. Although Ms. South reported that the medication error occurred on 07/16/26 and was discovered on 07/17/26, her internal medication incident report and employee counseling forms document that the medication error occurred on 07/14/26 and discovered on 07/15/26, further, the employee counseling records documents that Ms. Mabene was removed from the schedule on 07/15/26, after the medication error and for not changing Resident A's brief during her shift on 07/14/26. Repeat violation established; LSR dated 01/27/26, CAP dated 02/11/26.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

I recommend revocation of the license.



Pandrea Robinson
Licensing Consultant

08/28/26
Date

Approved By:



Ardra Hunter
Area Manager

09/04/26

Date