RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

February 9, 2018

Carol Dalson
3475 E. Tyler
Twin Lake, MI 49457

RE: License #:	AF610263945
Investigation #:	2018A0356009
	Paul's Place AFC

Dear Ms. Dalson:

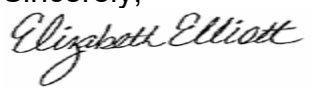
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF610263945
Investigation #:	2018A0356009
Complaint Receipt Date:	12/18/2017
Investigation Initiation Date:	12/18/2017
Report Due Date:	02/16/2018
Licensee Name:	Carol Dalson
Licensee Address:	3475 E. Tyler Twin Lake, MI 49457
Licensee Telephone #:	231-744-5336
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Paul's Place AFC
Facility Address:	3475 E. Tyler Twin Lake, MI 49457
Facility Telephone #:	(231) 744-5336
Original Issuance Date:	04/05/2004
License Status:	REGULAR
Effective Date:	10/05/2016
Expiration Date:	10/04/2018
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's medication is not being administered as prescribed.	Yes
The licensee supplemented an over the counter medication when prescribed medication ran out.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/18/2017	Special Investigation Intake 2018A0356009
12/18/2017	Special Investigation Initiated - Telephone Complainant
12/18/2017	APS Referral-Denied for Investigation
12/27/2017	Contact - Telephone call made Shelly Evans, Health West RN
01/05/2018	Inspection Completed On-site
01/05/2018	Contact - Face to Face Licensee Carol Dalson.
01/05/2018	Contact - Telephone call made Dee Versalle, Legal Guardian for Resident A.
01/05/2018	Exit Conference Licensee Carol Dalson.

ALLEGATION: Resident A's medication is not being administered as prescribed.

INVESTIGATION: On 12/18/2017, I received an Incident Report (IR) from Muskegon County Health West (formerly Muskegon County Community Mental Health). The IR documented the following concerns: *"Health West RN received a call from the provider (Licensee, Carol Dalson) asking for refills on Ativan 0.5 tabs. Current Rx was written 11/7/2017 for #60 tabs. Provider stated that pharmacist had given enough for the weekend to bridge until new Rx could be written. RN called Walgreens and was told that the pharmacy did give a supply to last the weekend without a script. Meds should have lasted until 11/6 (sic, may have meant 12/06/2017). He was to be rechecked in 4 weeks as a med change was made on*

11/7. The provider did make an apt. but not until 12/18. I spoke with Kate (physician) and it was suggested he come in this week. Supports coordinator left a message to reschedule this week and as of today apt (sic) has not been made.' Action taken by staff: 'MAPS was done and showed a few other early fills of Ativan over the past year. I called Walgreens for fill dates and was given dates of fill to be 11/30/2017 #60,11/2/2017 #5,10/5/2017 #30, 7/17/2017 #30,4/23/2017 #30,2/6/2017 #30,11/18/2016 #30. Because this info did not match MAPS I spoke with our pharmacist who also called and was given the fill dates that are listed on MAPS. Pharmacist at Walgreens did admit a weekend supply was given without a script. Dr. Green/Kate aware of indescrepencies and urged that client come in this week for an appointment. I attempted to contact guardian on 12/06 with no answer. Injury: the IR documented no injury to (Resident A)."

On 12/27/2017, I interviewed Shelly Evans, RN at HealthWest via telephone. Ms. Evans stated Resident A came in to HealthWest on 11/07/2017 due to increased agitation and Resident A's Ativan prescription was increased from 0.5 mg 1x PRN (as needed) to 0.5mg 2x daily and a Rx(prescription) was written for 60 tabs. Ms. Evans reported Resident A was to return to HealthWest for a med review in 4 weeks (which would have been on or about 12/05/2017) due to the change in medication. Ms. Evans stated on 12/01/2017, the pharmacy "bridged a script" for Ativan for the weekend without a prescription and gave Ms. Dalson 5 Ativan pills to last the weekend for Resident A. Ms. Evans reported then, on 12/04/2017, Ms. Dalson called HealthWest and reported Resident A was out of medications and according to Ms. Evans, those medications should have lasted until 12/06/2017. Ms. Evans stated Ms. Dalson reported the pharmacy is not giving enough of the medication because HealthWest was not writing the prescription properly. Ms. Evans stated she is not sure if it's the pharmacy or Ms. Dalson that is incorrect so, the HealthWest nursing staff requested Resident A see Dr. Kate Jackson at HealthWest so all prescriptions of this medication can be closely monitored. Ms. Evans reported Ms. Dalson agreed and Resident A is now seeing Dr. Jackson at HealthWest. Ms. Evans stated Dr. Jackson wanted to see Resident A the week of 12/04/2017 but instead Ms. Dalson made the appointment for 12/18/2017. Ms. Evans stated they were able to work Resident A in on 12/13/2017 and Ms. Dalson brought him in for a med review. Ms. Evans stated from 12/04/2017 through 12/13/2017, Resident A probably did not get his prescribed Ativan. Ms. Evans stated as far as she knows, there are no other concerns with Resident A's other medications, just the Ativan.

On 01/05/2018, I conducted an unannounced inspection at the facility and interviewed Ms. Dalson. Ms. Dalson stated Resident A was on Ativan as a PRN (as needed) medication, 0.5mg until 11/07/2017 when the prescription was changed to 0.5mg 2x daily by HealthWest due to Resident A experiencing increased agitation. Ms. Dalson acknowledged due to the change in the prescription from a PRN to a twice daily dose, the Ativan ran out because the script was only good until the next appointment which was the beginning of December 2017. Ms. Dalson stated she had been given a card by HealthWest documenting that she had to call and make an appointment for Resident A to be seen. Ms. Dalson stated she mistakenly thought

she could call in a refill but realized Resident A had to be seen in the HealthWest office. Given those two oversights, Ms. Dalson acknowledged she failed to get Resident A's refill on time so the pharmacist gave extra Ativan medication to "bridge" the gap of time until she could get him into HealthWest for an appointment. Ms. Dalson stated she ended up making an appointment for Resident A for 12/18/2018 because she could not get in any sooner and acknowledged that Resident A ran out of Ativan causing Resident A to miss 7 days of the medication on 12/06, 12/07, 12/08, 12/09, 12/10, 12/11 and 12/12/2017. Ms. Dalson reported HealthWest was able to get them in for an appointment on 12/13/2017 where a new prescription was written.

On 01/05/2018, I conducted an Exit Conference with Ms. Dalson. Ms. Dalson stated she understood the information, analysis and conclusion of this applicable rule violation.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(1) Prescription medication, including tranquilizers, sedatives, dietary supplements, or individual special medical procedures, shall be given or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy container which shall be labeled for the specific resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being (33.1101 et. seq. of the Michigan Compiled Laws.
ANALYSIS:	Ms. Dalson acknowledged that Resident A was out of the prescribed medication Ativan 0.5 mg. to be administered 2x daily every day and was out of the medication for 7 days beginning 12/06/2017-12/12/2017. Ms. Dalson failed to give Resident A prescribed medication from his physician and therefore; a violation of this applicable has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The licensee supplemented an over the counter medication when prescribed medication ran out.

INVESTIGATION: On 12/18/2017, I received an Incident Report (IR) from Muskegon County Health West (formerly Muskegon County Community Mental Health). The IR documented the following concerns: *"Supports coordinator called Provider to make an appointment and was told that because she could not get Ativan for (Resident A) she had been giving him "happy camper stress reliever" and*

a miller lite. She (Ms. Dalson) told Karen (supports coordinator) that the stand-by guardian was ok with this. Supports coordinator asked that an appointment be made this week. Home provider state that he (Resident A) was doing well with "happy camper and miller lite" and that she would just keep the appointment she had and would call sooner if issues. I was able to inform the guardian today and she stated that she was not aware he was being given the "happy camper/miller lite" combination.' Injury: the IR documented no injury to (Resident A)."

On 12/27/2017, I interviewed Ms. Evans via telephone. Ms. Evans stated Ms. Dalson acknowledged to her that she was supplementing Resident A's Ativan with Happy Camper Stress Reliever and a Miller lite. Ms. Evans stated she and the HealthWest staff do not agree with supplementing a medication such as Ativan with Happy Camper and a Miller Lite.

On 01/05/2018, I interviewed Ms. Dalson while conducting an unannounced inspection. Ms. Dalson stated she ran out of Resident A's Ativan and purchased an over the counter product from a Health Food store called Happy Camper Stress Reliever which is an all-natural stress reliever. Ms. Dalson acknowledged she gave Resident A the Happy Camper Stress Reliever and allowed Resident A to "hold a Miller Lite" and stated Resident A only drank one Miller Lite out of the 5 days she gave him the beer. Ms. Dalson stated she gave Resident A the Happy Camper Stress Reliever and Miller Lite combo in lieu of the prescribed Ativan on 12/06/2017, 12/07/2017, 12/08/2017, 12/09/2017 and 12/10/2017. Ms. Dalson stated on 12/06/2017, she spoke to Resident A's legal guardian Dee Versalle who agreed with this modification of Resident A's medications. Ms. Dalson stated the Happy Camper Stress Reliever seemed to work well for Resident A and he did not have any negative side effects that she noted.

On 01/05/2018, I interviewed Ms. Versalle via telephone while at Ms. Dalson's home. Ms. Versalle stated she was made aware by Ms. Dalson on 12/06/2017 that Resident A ran out of the prescribed Ativan and that Ms. Dalson purchased Happy Camper Stress Reliever from the Health Food store. Ms. Versalle stated she did not oppose this as a temporary option for Resident A.

On 01/05/2018, I conducted an Exit Conference with Ms. Dalson. Ms. Dalson stated she understood the information, analysis and conclusion of this applicable rule violation.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: (b) Not adjust or modify a resident's prescription medication

	without agreement and instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record in writing any adjustments or modifications of a resident's prescription medication.
ANALYSIS:	Ms. Dalson acknowledged that she ran out of Resident A's prescription Ativan on 12/06/2017 and while waiting for an appointment with Resident A's doctor, Ms. Dalson used Happy Camper Stress Reliever and a Miller Lite to control Resident A's agitation in lieu of Resident A's prescribed medication Ativan. Consequently, a violation of this applicable rule has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

INVESTIGATION: On 01/05/2018, I interviewed Ms. Dalson while conducting an unannounced inspection. I requested Resident A's Medication Administration Records (MAR) for review. Ms. Dalson produced a MAR for the month of September 2016. The MAR for Resident A documents, Lorazepam (Ativan) 0.5mg PRN, as needed and Sertraline (Zoloft) 100mg 3 tabs, 1x daily at 8:00AM. Ms. Dalson acknowledged that she has not maintained Resident A's MAR or documented the administration of Resident A's two medications since September 2016.

On 01/05/2018, I conducted an Exit Conference with Ms. Dalson. Ms. Dalson stated she understood the information, analysis and conclusion of this applicable rule violation.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: (a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.
ANALYSIS:	Ms. Dalson acknowledged that she failed to maintain Resident A's MAR including the time and amount of Resident A's prescribed medications Lorazepam (Ativan) and Sertraline (Zoloft) since September 2016. A violation of this applicable rule has been established.

CONCLUSION:	VIOLATION ESTABLISHED

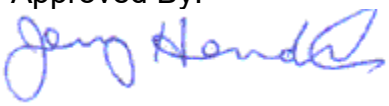
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

02/09/2018

Elizabeth Elliott — Date
Licensing Consultant

Approved By:



02/09/2018

Jerry Hendrick — Date
Area Manager