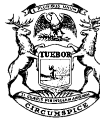

RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

May 2, 2018

Tesie Quiton and Alex Quiton
634 South Whitman
Ada, MI 49301

RE: License #: AS410251218
Investigation #: 2018A0357008
ATL Home Care L.L.C.

Dear Tesie and Alex Quiton:

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,

Arlene B. Smith, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410251218
Investigation #:	2018A0357008
Complaint Receipt Date:	03/08/2018
Investigation Initiation Date:	03/08/2018
Report Due Date:	05/07/2018
Licensee Name:	Tesie Quiton and Alex Quiton
Licensee Address:	634 South Whitman Ada, MI 49301
Licensee Telephone #:	(616) 291-4326
Administrator:	Tesie Quiton
Licensee Designee:	Tesie and Alex Quiton
Name of Facility:	ATL Home Care L.L.C.
Facility Address:	4711 Chalet Lane, SW Wyoming, MI 49519-4911
Facility Telephone #:	(616) 531-9238
Original Issuance Date:	03/18/2003
License Status:	REGULAR
Effective Date:	09/17/2017
Expiration Date:	09/16/2019
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has had a bad cough for weeks and there has not been any medical attention provided.	No
Resident A does not receive assistance putting in his eye drops.	No
Resident A is not allowed to use a heater in his room.	No
Resident A is served hot dogs and cheese sandwiches each day and lacks a nutritional diet.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/08/2018	Special Investigation Intake 2018A0357008
03/08/2018	Special Investigation Initiated - Telephone I telephoned the anonymous complainant and left a message.
03/08/2018	APS Referral
03/08/2018	Contact - Telephone call made To network 180, Recipient Rights.
04/19/2018	Contact – Telephone call made to Resident A.
04/19/2018	Contact – Telephone call made to Resident A's Legal Guardian.
04/23/2018	Inspection completed on site.
04/23/2018	Contact – Face-to-Face conducted an interview with Resident A and direct care staff, Theresa Shaffer.
04/23/2018	Contact Documents received: Menus for three weeks of April 2018, Resident A's assessment plan, Resident Care Agreement and Resident A's Health Care Appraisal.
04/23/2018	Contact-Document reviewed. I reviewed Resident A's file and home documents.
04/26/2018	Inspection completed on site.
04/26/2018	Face-to-face interview with House Manager Ludivico Aragoza.
04/26/2018	Contact-Documents received: April menu, last week of April, Attached orders to the Health Care Appraisal.

04/27/2018	Contact-Telephone Call Received from Tandeum365 Registered Nurse Amy Murell.
05/01/2018	Contact – Document -Received: Documents from Metro Health
05/01/2017	Exit conference by Telephone with Co-Licensee, Tesie Quiton.

ALLEGATION: Resident A has had a bad cough for weeks and there has not been any medical attention provided.

INVESTIGATION: On 03/08/2018, our Department received an anonymous compliant on our OnLine complaint form. The complaint contained concerns related to Resident A's personal belongings that could not be addressed by our department but were referred to Adult Protective Services. The compliant stated further that Resident A has had a bad cough for weeks and there are concerns that he may have the flu but staff will not take him in or call a Doctor. The complaint also alleged that Resident A says he eats hotdogs and cheese sandwiches every day and has a personal heater he uses to stay warm and staff will not allow him to use it due to the electricity usage. It was also alleged that Resident A had cataract surgery and doesn't get any help putting his drops in his eyes and he does not get enough water to drink.

On 04/19/2018, I telephoned Resident A. He stated he previously had a cough and had seen his physician about two weeks ago, but the physician did not help him. He then stated he got rid of the flu. Resident A also stated that he had a legal guardian, but claimed she was not responsive to him.

On 04/19/2018, I conducted a telephone interview with Resident A's guardian. She explained that Adult Protective Services staff had removed Resident A from his previous residence and she had been appointed as his guardian due to Resident A's diagnosis of Alzheimer's disease and his inability to care for himself. She had placed him in the licensed Adult Foster Care home named, ATL Home Care L.L.C. She explained that he needed supervision and personal care. She confirmed that Resident A had been ill with a cough for weeks and had seen his physician. She reported that he had a chest x-ray and had been prescribed medications. She said it took a long time for him to feel better. She also explained that Resident A is seen by a Registered Nurse, from Tandem365. She stated that Resident A's medical needs were attended to in a timely basis. She reported that Resident A does not have a reliable memory and he repeats himself.

On 04/23/2018, I was at the home and interviewed Resident A. He stated that he was feeling better and he had several appointments with his medical doctor.

On 04/23/2018, I conducted an interview with the Direct Care Staff, Theresa Shaffer who stated that she was the weekend relief staff for the AFC home. She explained

that Resident A had been prescribed Mucinex and they had administered it as prescribed. She showed me Resident A's Medication Administration Record (MAR) for March 2018. The following was recorded: "Mucinex 600 mg ER Tab take 1 or 2 tablets by mouth every 12 hours as needed for cough. 8AM and 8PM." The staff's initials were recorded starting on 03/02/ through 03/09/2018. The MAR then recorded Mucinex for 5 days PRN starting on 03/12/2018. Staff's initials were recorded two times daily through 04/18/2018 and one dose at 8:00 AM on 03/20/2018. Ms. Shaffer reported that Resident A had been to Metro Health and seen the Nurse Practitioner on 03/13/2018 and she had prescribed him Methyl Prednisolone 4mg. The MAR recorded this medication starting on 03/14/2018 through 04/17/2018. Resident A had also been prescribed Azithromycin, also known as Zithromax Z-Pak which was started on 03/14/2018 and the initials on the MAR indicated he received the medication for the prescribed five days.

On 04/26/2018, I conducted an interview with the House Manager, Ludivico Aragoza. He stated that when Resident A started with a cough and he did not get better after a few days that he called the Tandem365 and the registered nurse came out. He stated that Resident A did have appointments with his attending physician and was prescribed medications, which he had written on Resident A's MAR and were administered. He stated that Resident A was cared for medically and he did get better.

On 05/01/2018, I conducted an exit telephone interviewed with Co-licensee, Tessie Quiton, and she agreed with my findings. She reported she was aware of his illness and she knew they had called the nurse to seek medical care.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	It was alleged that Resident A became ill and was not provided with medical attention. Resident A's guardian stated that Resident A did receive proper and timely medical attention for his illness. Mr. Aragoza and Ms. Shaffer both stated that they did seek medical attention for Resident A and he received his medications as prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A does not receive assistance putting in his eye drops.

INVESTIGATION: On 03/08/2018, our Department received an anonymous compliant on our OnLine complaint form. The complaint read as follows: "(Resident A) had cataract surgery and he doesn't get any help putting his drops in his eyes."

On 04/19/2018, I conducted a telephone interview with Resident A's guardian. She explained that Resident A had cataract surgery well over a year ago and his physician had not prescribed a continuation of the eye drops. She explained that when she placed Resident A in the AFC home he did not have a prescription for eye drops. She stated that Resident A has a diagnosis of Alzheimer's and he does not remember details.

On 04/23/2018, I conducted an interview with Resident A in his bedroom of the AFC home. He stated that he had surgery for cataracts and he had eye drops for his eyes, but they do not give him any eye drops.

On 04/23/2018, Ms. Shaffer was invited into Resident A's room and she explained that he did not have any prescribed drops for his eyes. She looked into a box from his closet and there was a small bottle of eye drops for "dry eyes." She explained to Resident A that if he wanted help to put in the drops for dry eyes all he had to do was ask and she or the other staff would do it for him.

On 05/01/2018, I conducted an exit telephone interviewed with Co-licensee, Tessie Quiton, and she agreed with my findings. She stated that she thought the aid who comes in and provides his bath weekly had purchased the over counter dry eye drops for Resident A. She stated she admitted him to the home and he did not have eye drops prescribed upon his admission to the home.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	It was alleged that Resident A did not receive eye drops after cataract surgery.

	Resident A's guardian stated that Resident A does not have a prescription for eye drops.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A is not allowed to use a heater in his room.

INVESTIGATION: On 03/08/2018, our Department received an anonymous compliant on our OnLine complaint form. The complaint read as follows: "(Resident A) has a personal heater he likes to use to stay warm and they will not allow him to use it due to the electricity usage."

On 04/19/2018, I conducted a telephone interview with Resident A's guardian. She explained that Resident A previously resided in a trailer and she witnessed him sitting in his chair in only his underwear in front of a heater, while he watched television. She stated that when he was admitted to the AFC home he wanted to do the same thing, but she had explained to him that he had to be dressed every day and he had to come out of his room for exercise and to eat his meals. She stated that he likes his room really hot. She stated that Resident A's bedroom is warm enough but because he has been used to sitting right in front of his heater he was having difficulty adjusting to not having the heater directly in front of him.

On 04/23/2018, I conducted an interview with Resident A in his bedroom and the heater was unplugged and not in use. Resident A explained that he likes the heater on. I found the room warm, but it was warm outside.

On 04/26/2018, I conducted an interview with Ms. Shaffer and Mr. Aragoza and they both reported that when they go to his bedroom and they open his door the heat is overwhelming. They both expressed concern with how hot it is in his room. They both stated that Resident A's bedroom was not cold.

On 05/01/2018, I conducted an exit telephone interviewed with Co-licensee Tessie Quiton and she stated that she was unsure of the use of the electrical heater, but Resident A's guardian wanted him to have the heater and to use it. She acknowledged that she should have checked with her Licensing Consultant first.

APPLICABLE RULE	
R 400.14406	**Room temperature.**
	All resident-occupied rooms of a home shall be heated at a temperature range between 68 and 72 degrees Fahrenheit during non-sleeping hours. Precautions shall be taken to prevent prolonged resident exposure to stale, noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations from the requirements of

	this rule shall be based upon a resident's health care appraisal and shall be addressed in the resident's written assessment plan. The resident care agreement shall address the resident's preferences for variations from the temperatures and requirements specified in this rule.
ANALYSIS:	It was alleged that Resident A was not allowed to use his electrical heater in his room. According to the two staff Resident A has been using his electrical heater and his bedroom has not been cold. Resident A's guardian expressed her opinion that Resident A's room was adequately heated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A is served hot dogs and cheese sandwiches each day and lacks a nutritional diet.

INVESTIGATION: On 03/08/2018, our Department received an anonymous compliant on our OnLine complaint form. The complaint read as follows: "(Resident A) does not receive healthy meals-says he eats hotdogs and cheese sandwiches every day. He does not get enough water to drink."

On 04/19/2018, I conducted a telephone interview with Resident A's guardian. She stated that when she has been in the home she had not noticed that Resident A was served hotdogs and cheese sandwiches. She stated that Resident A does not have a good memory due to his diagnosis and she reported that on occasion he can be unreliable in reporting reality.

On 04/23/2018, I attempted to interview Resident B about the food including the repeated use of hot dogs and grilled cheese sandwiches. He said that there was not repeated use of hot dogs or grilled cheese sandwiches. I asked the same question of Resident C and he said it was true that there was repeated servings of hot dogs and grilled cheese sandwiches. Neither resident elaborated any more on the food served in the home.

On 04/23/2018, I was in the AFC home and I observed the menus. The staff Theresa Shaffer provide the menus for the first three weeks of April. Ms. Shaffer reported that she usually does not follow the menus in the home because she does not feel they are adequate, so she provides her own foods for the days she works. She stated she does not record any of her food substitutions. She reported that the home does not have enough fresh fruits and vegetables. I reviewed the menus. I found hot dogs recorded twice on the menus one at supper time 04/09/2018 and

once for breakfast on 04/12/2018. I observed Ms. Shaffer, provide a hot dog for a resident as he walked through the kitchen. I observed grilled cheese sandwich on the menus for three days for lunch. The word "Fruits" were recorded on 33 times for lunch and/or supper for the three weeks in April. Bananas were recorded three times and two apples were recorded. For the three weeks of April green beans were recorded four times and the same for corn. Mashed potatoes were recorded on the menu twice in three weeks. Salad mix was recorded three times. At the bottom of the menu was recorded: "Snack, and cookies." On the week of 04/15-21/2018, "Donut" was recorded on 04/17/2018. For breakfast each day, "2% Milk and Coffee," was recorded. Breakfast was recorded for 04/08/2018-04/14/2018: "Scrambled eggs toast/ bread /butter, cereal, toast bread, butter, oatmeal /boiled eggs, Pancake/ syrup/sausages, cereal/hot dog, waffles/syrup sausages, cereal/toast/Bagel with cream cheese. Lunch: "2% Milk /Water." For supper it recorded "2% milk." The menu for 04/08-14/2018 Tuna fish sandwiches with chips and Fruits, Ramen noodles with crackers/ Banana, Grilled cheese with tortilla chips and fruits, Tomato soup with crackers/Fruits, Ham sandwich/chips/Fruits, Ramen noodles/Crackers/Fruits, boiled eggs sandwich chips/Fruits. Supper: Chicken Bar-B-Que Mix/ Rice/ Green beans/Fruits, Hot dogs/chips/Fruits, Pork Chops Mashed Potatoes/Green Beans/Fruits, Fish filet/ Macaroni and cheese/corn, Ham burger/Tortilla chips/Fruits, Spaghetti' Garlic bread/Fruits and Tacos/Salad Mix/Fruits"

On 04/26/2018, I conducted an interview with the House Manger, Ludivico Aragoza. He stated that he encourages Resident A to drink water. He provided the menu for 04/22/2018 through 04/28/2018. He stated that the Co-Licenses do the shopping for the food items recorded on the menus. He reported that occasionally he goes to the store to pick up some food items. I asked about fresh fruits and vegetables and he showed me 5 or 6 apples, 8 small oranges and one large orange. This was Friday and he reported they shop on Monday. He also had some cabbage and a small bag of raw carrots. He provided the menu for the last week of April and this menu had juice recorded in three places and green beans were recorded as ½ cup for three times. The other three-week menus did not have juice recorded or any measurements for green beans. Green beans were served three times for supper for the last week of April. A baked potato was noted on 04/24/2018 with ½ cup of sweet corn. On 04/26/2018, recorded was ¾ cup of mix vegetables and on 04/28/2018 it recorded ¾ cup of French fries. The menus for the month of April lacked fruits and vegetables, on a daily basis. For the week of 04/01-07/2018, the menu indicated they served corn twice and one serving of green beans. Therefore, for the entire week only three vegetables were served. Ramen noodles were served with crackers. For the week of 04/01-07/2018, chips were served seven times. For the week of 04/14-21/2018, recorded on the menu were one serving of mashed potatoes, one serving of green beans and one serving of corn. I could not determine the amount of fruits served since the menu recorded "fruits." The menu items contained numerous food items high in sodium such as pizza, canned soups,

hamburgers, Tacos, Ramen noodles and spaghetti. There were many repeated foods. The salad mix recorded did not contain the type of salad it contained.

On 04/30/2018, I reviewed the "Recommended Dietary Allowances contained in the publication entitled "Basic Nutrition Facts." This document requires a minimum of six servings for vegetables and fruits daily. A serving is ½ cup of vegetables cooked or raw and ½ cup of canned or raw fruit. Under the food group of Bread and Cereal the recommendations are a minimum of five servings. Under milk and cheese the minimum servings are two. Under the foods of Meat/ poultry/Fish Beans the minimum servings are 2 ½ servings with a serving being two oz(s) so a total of five ounces a day. I was not able to determine from the printed menus if the recommended daily allowances were provided to the residents.

On 05/01/2018, I conducted an exit telephone interviewed with Co-licensee, Tesie Quiton, and she agreed with my findings and she stated she would 'fix the menus."

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	The allegation was that the home does not serve healthy meals. The food items recorded on the menus for the month of April 2018 only contained a small number of vegetables and the word fruits did not define the type of fruits. The menus had food items that were high in sodium.
CONCLUSION:	**VIOLATION ESTABLISHED**
APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(2) Meals shall meet the nutritional allowances recommended under the "Suggested Daily Eating Guide" section, which is adapted from the "United States Department of Agriculture's Daily Food Guide (1979)," and based upon the "Recommended Dietary Allowances (1980)." And contained in the publication entitled "Basic Nutrition Facts," pages 28 and 29, Michigan department of public health publication no. H-808, 1980. This publication

	may be obtained without charge from Nutrition Services, Bureau of Personal Health Services, Michigan Department of Public Health P.O. Box 30035, Lansing Michigan 48909.
ANALYSIS:	Upon review of the menus for the month of April 2018, the Licensee's failed to provide the Recommended Daily Allowances for the residents of the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 04/26/2018, I reviewed Resident A's Health Care Appraisal which was signed by Eryn C. Quinn, DO on 09/11/2017. The Diagnoses' recorded were "Dementia, DM II (Diabetic Mellitus), HTN (Hypertension), CAD (Coronary Artery Disease)." Under the section of Special Dietary Instructions and Recommended Caloric Intake was written "DM (Diabetic Mellitus) diet, Low salt." I also reviewed the Metro Health, University of Michigan Health, After Visit Summary dated 04/11/2018. "The following issues were addressed: Uncontrolled type 2 diabetes mellitus with complication, without long-term current use of insulin, CKD (chronic kidney disease) stage 3,…Coronary artery disease involving native coronary artery of native heart without angina pectoris, Prostate cancer, Alzheimer's dementia without behavioral disturbances, unspecified timing of dementia onset, Hyperlipidemia… Essential hypertension, Cerebrovascular accident (CVA)…Edema, unspecified type."

On 04/23 and 04/26/2018 I reviewed the home's menus. Mr. Aragoza stated that he had written the menus. He acknowledged that he had not written a special menu for Resident A's prescribed diet He stated that he did not give Resident A sweets. He acknowledged that he did not have any documentation that would indicate that he had provided a Dietetic or low salt diet.

On 05/01/2018, I conducted an exit telephone interviewed Co-licensee, Tesie Quiton, and she stated she agreed with my findings. She stated they have started to put the measurements of the food on the menus.

APPLICABLE RULE	
R 400.1313	**Resident nutrition**
	(3) Special diets shall be prescribed only by a physician. A resident who has a special diet prescribed by a physician shall be provided such a diet.

ANALYSIS:	Resident A's Health Care Appraisal signed by his attending physician had prescribed a Diabetic diet and a low salt diet. The House Manager was not able to provide documentation for these prescribed diets.
CONCLUSION:	**VILOLATION ESTABLISHED**

INVESTIGATION: On 04/23/2018, I was at the AFC home and I interviewed Resident A in his bedroom. I observed a free-standing heater in his room. His guardian, the two direct care staff, and Resident A all acknowledged that Resident A has had the heater since his admission to the AFC home in September 2017. They all acknowledged that Resident A had and currently uses the electrical heater.

On 05/01/2018, I conducted an exit telephone interviewed Co-licensee, Tessie Quiton, and she stated she agreed with my findings. She stated that they have the thermostat locked at 73 degrees to keep Resident A warm. She stated that she questioned if the heater was allowed when he moved in, but his guardian wanted it. She said, "I want it safe for everybody."

APPLICABLE RULE	
R 400. 14510	**Heating equipment generally**
	(2) A furnace, water heater, heating appliances, pipes, wood-burning stoves or furnaces and other flame- or heat-producing equipment shall be installed in a fixed or permanent manner and in accordance with a manufacturer's instructions and shall be maintained in a safe condition.
ANALYSIS:	On 04/23/2018, I observed a free standing electrical heater in Resident A's bedroom. This heating appliance used by Resident A is not allowed in the AFC home.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 04/23/2018, I was at the AFC home and I interviewed Ms. Shaffer (staff). She acknowledged that the menu for the last week of April was not available or posted. She also acknowledged that she provides different foods than what is recorded on the menus for the two days she works, and she did not complete a substitution list.

On 05/01/2018, I conducted an exit telephone interviewed Co-licensee, Tesie Quiton, and she stated that Ms. Shaffer should have known to use a substitution list and she should have put the foods she had chosen to serve on the list. She stated the menu should have been posted.

APPLICABLE RULE	
R 400. 14313	**Resident nutrition**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any changes or substitution shall be noted and considered as part of the original menus.
ANALYSIS:	The staff Ms. Shaffer acknowledged that the home did not have the last week of April's menus available or posted. She also acknowledged that she did not record the foods she prepared and served to the residents when she worked in the home
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 04/19/2018, I conducted a telephone interview with Resident A's guardian. She reported that Resident A was a diabetic and she had taken this blood testing supplies and three brand new glucometers to the AFC home. She anticipated that the home would be taking Resident A 's blood sugars.

On 04/26/2018, I reviewed Resident A's Health Care Appraisal which was signed by Eryn C. Quinn, DO on 09/11/2017. The Diagnoses' recorded were "Dementia, DM II (Diabetic Mellitus)…"

On 04/26/2018, I reviewed a Metro Health University of Michigan Health, After Visit Summary, dated 03/13/2018 with instructions from Cheryl L Kruithof, NP. Attached was Resident A's medication list as of 03/13/2018. Recorded were Blood-Glucose Meter, Disc Type Kit, Diabetic Supplies, Lancet Device, Glucose blood VI test strips and Insulin needles. I reviewed an "After Visit Summary" dated 04/11/2018 by Eryn C Quinn DO which stated: "Uncontrolled type 2 diabetes mellitus with complication, without long-term current use of insulin." Attached was Resident A's medication. This list contained the same diabetic items as the list from 03/13/2018.

On 04/23/2018, I conducted a face-to-face interview with the staff Theresa Shaffer. She stated that they had not been taking Resident A's blood sugars because they did not have a glucometer or the supplies to take them because the guardian would not pay for the supplies.

On 04/26/2018, I conducted a face-to-face interview with the house manager, Mr. Aragorza. He explained that Resident A's guardian had supplied many boxes of expired test strips when Resident A was admitted on 09/202017. He said they could not use expired test strips. He also stated that the pharmacy had delivered the glucometer (date unknow) and he sent it back because the guardian would not pay for it. He had no written evidence that he had taken Resident A's blood sugars since he has been in the AFC home on 09/20/2017.

On 04/27/2018, I conducted a telephone interview with the Registered Nurse, Amy Muller, from Tandeum356. She explained that she had ordered the glucometer and the supplies for Resident A's blood sugars to be taken. She did not provide the date.

On 05/01/2018, I received a call from Metro Health, Angalena M. Green, RMA (Registered Medical Assistant) 358and she stated that they had prescribed on 09/20/2017, to take Resident A's blood sugars daily. She stated that the nurse, Ms. Muller, had asked them to order all of the blood sugar equipment for Resident A's blood sugars to be taken. Ms. Green said they sent the prescriptions to the pharmacy with Resident A's insurance information, so it would have cost nothing or very little. She stated that as of 09/20/2017, the staff were to take Resident A's blood sugars daily.

On 05/01/2018, I received a fax from Dr. Quinn's office. It read: "Amy RN from Tandum365 asking if Dr. Quinn would like staff tests pts. Blood sugar levels. If so, please send new order for test strips and glucometer, Pharmacy Life Care Pharmacy with the telephone number. I received a faxed copy of the order dated 09/20/2017, which read: "Check blood sugars once daily." Also, she sent all of the orders for the glucose monitoring kit (FREESTYLE) and all of the supplies, all dated 09/20/2017. The notes to pharmacy stated: "Please dispense brand that pars with pt. Insurance."

On 05/01/2018, I conducted an exit telephone interviewed Co-licensee, Tesie Quiton, and she stated Resident A's guardian had brought the test strips to the AFC home, but the staff had discovered that they had all expired. She reported that the guardian had stated that Resident A had enough test strips for 14 months and she said she would not pay for any more. Ms. Quiton stated that the guardian had sent her an email on 11/12/2017, that she would not pay for the blood glucose equipment. Ms. Quiton stated that the pharmacy had sent Resident A's guardian a bill for the supplies. Ms. Quiton stated that there was confusion between the Nurse, the guardian and the pharmacy. She did acknowledge that Resident A did need his blood sugars checked.

APPLICABLE RULE	
R 400. 143.14312	**Resident medication.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Complied Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Resident A's Health Care Appraisal signed by his attending physician indicated his diagnosis included Diabetic Mellitus type II. On 09/20/2017, Resident A's physician had prescribed a glucometer, along with all of the required supplies to take the blood sugars and had ordered Resident A's blood sugars to be taken daily. Ms. Shaffer and Mr. Aragoza, both acknowledged that they had not taken Resident A's blood sugars daily since he had been admitted to the home on 09/20/2017. Mr. Aragoza acknowledged he had send the glucometer back to the pharmacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action, I recommend the status of the license remain unchanged.

Arlene B. Smith 05/02/2018

Arlene B. Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 05/02/2018

Jerry Hendrick Date
Area Manager