GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 6, 2021

Lisa Rice
Coventry Home, LLC
14901 Coventry
Southgate, MI 48195

RE: License #: AS820394946
Investigation #: 2021A0992016
The Retreat At Northville

Dear Ms. Rice:

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 feel free to 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 (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**
**BUREAU OF COMMUNITY AND HEALTH SYSTEMS**
**SPECIAL INVESTIGATION REPORT**
**"ALL ALLEGATIONS WILL NOT BE ADDRESSED AS THEY ARE NOT RULE RELATED."**

## I. IDENTIFYING INFORMATION

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| **License #:** | AS820394946 |
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| **Investigation #:** | 2021A0992016 |
| | |
| **Complaint Receipt Date:** | 04/09/2021 |
| | |
| **Investigation Initiation Date:** | 04/09/2021 |
| | |
| **Report Due Date:** | 06/08/2021 |
| | |
| **Licensee Name:** | Coventry Home, LLC |
| | |
| **Licensee Address:** | 14901 Coventry<br>Southgate, MI 48195 |
| | |
| **Licensee Telephone #:** | (248) 762-4668 |
| | |
| **Administrator:** | Lisa Rice |
| | |
| **Licensee Designee:** | Lisa Rice |
| | |
| **Name of Facility:** | The Retreat At Northville |
| | |
| **Facility Address:** | 47260 7 Mile Road<br>Northville, MI 48167 |
| | |
| **Facility Telephone #:** | (248) 924-2661 |
| | |
| **Original Issuance Date:** | 05/02/2019 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 11/02/2019 |
| | |
| **Expiration Date:** | 11/01/2021 |
| | |
| **Capacity:** | 6 |
| | |

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| **Program Type:** | AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| • Resident A was rushed to the emergency room with leg pain and slurred speech due to being dehydrated.<br>• Licensee did not cooperate with the family and alert them that Resident A was not drinking enough water for proper hydration.<br>• Complainant witnessed direct care staff use a sarcastic tone when speaking to Resident A and roll her eyes when engaging in conversation with Resident A. | No |
| • Direct care staff confines Resident A to the bed even though resident is not medically assessed to be bed-ridden.<br>• Resident A is not allowed to use the commode for passing bowl movements. | Yes |
| • Complainant is concerned Resident A is receiving CBD gummies/lollipops to treat anxiety without a doctor's prescription.<br>• Resident A is not receiving medication as prescribed. Resident A moved to another facility and the Tylenol PRN is missing. Direct care staff stated it was never refilled after Resident A returned to the home from the rehabilitation facility**.** | No |
| **ADDITIONAL FINDINGS** | Yes |

## III. METHODOLOGY

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|---|---|
| 04/09/2021 | Special Investigation Intake<br>2021A0992016 |
| 04/09/2021 | Special Investigation Initiated - Telephone<br>Complainant |
| 04/16/2021 | Contact - Telephone call made<br>Lisa Rice, licensee designee |
| 04/21/2021 | Contact - Document Received |

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| | Resident A's hospital discharge documents, medication administration records (MARS), home care medical information sheet and health care appraisal. |
| 04/23/2021 | Contact - Telephone call made<br>Complainant, not available; message left. |
| 05/04/2021 | Contact - Telephone call made<br>Tammy Sinelli, direct care staff |
| 05/04/2021 | Contact - Telephone call made<br>Jammie McFalls, home manager |
| 05/11/2021 | Contact - Telephone call made<br>Karen Phillips, Resident A's nurse |
| 05/11/2021 | Contact - Telephone call made<br>Davida, Resident A's physical therapist; not available, message left. |
| 06/03/2021 | Contact - Telephone call made<br>Davida, Resident A's physical therapist; not available, message left. |
| 06/03/2021 | APS Referral |
| 06/07/2021 | Contact - Document Sent<br>Records request sent to St. Mary Mercy Hospital for Resident A. |
| 06/08/2021 | Contact - Document Received<br>Resident A’s records received from St. Mary Mercy Hospital. |
| 06/14/2021 | Contact - Telephone call made<br>Rabab Makki, APS. |
| 06/23/2021 | Contact - Telephone call made<br>Ashley Labrake, Innovative Pharmaceutical Solutions Group |
| 06/23/2021 | Contact - Telephone call made<br>Davida Schlager-Kass |
| 06/23/2021 | Contact - Telephone call made<br>Dr. Andrew Mechigan, Northville Family Foot Specialists |
| 06/23/2021 | Contact - Document Sent |

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| | Letter sent to Dr. Mechigan, in attempt to discuss Resident A Specialists |
| 06/23/2021 | Exit conference<br>Ms. Rice |
| 07/01/2021 | Exit Conference<br>Ms. Rice |

**ALLEGATION:**

- Resident A was rushed to the emergency room with leg pain and slurred speech due to being dehydrated.
- Licensee did not cooperate with the family and alert them that Resident A was not drinking enough water for proper hydration.
- Complainant witnessed direct care staff use a sarcastic tone when speaking to Resident A and roll her eyes when engaging in conversation with Resident A.

**INVESTIGATION:**

On 4/09/2021, I contacted the Complainant and proceeded to discuss the allegations, in which the Complainant confirmed. The Complainant further stated Resident A was transported to the hospital due to leg pain and at the time she was severely dehydrated. The Complainant said when it was brought to the attention of Lisa Rice, licensee designee, she said Resident A had not been drinking many fluids. The Complainant said Resident A's family was never notified and uncertain how long this behavior had been going on. Prior to discussing the remaining allegations, the Complainant stated she couldn't discuss the rest of the allegations at this time and agreed to call back at a later date.

On 4/16/2021, I contacted Lisa Rice, licensee designee, and interviewed her regarding the allegations, in which she denied. Ms. Rice further denied having any knowledge of Resident A being dehydrated when she was admitted into the hospital; she said Resident A would drink plenty fluids regularly. Ms. Rice said Resident A was actually transported to the hospital due to her complaining of leg pain. She said Resident A was examined and when she was ready for discharge, Relative A (whom is her Power of Attorney) was contacted. Ms. Rice said when staff asked Relative A about discharge papers, she provided the home with a portion of the discharge documents but not the full printout; Ms. Rice agreed to provide me with a copy of what she received. She said although Resident A was a resident in the home, Relative A played a very intricate role in Resident A's care. Ms. Rice said historically, Resident A often complained of leg pain and when Relative A was notified, she refused to allow Resident A to have pain medication.

She said Resident A also suffered from severe anxiety and Relative A refused to allow her to receive any form of treatment or medication for it. Ms. Rice said Resident A was well cared for, never neglected or mistreated. Ms. Rice denied witnessing any of the direct care staff use a sarcastic tone when speaking to Resident A or any eye rolling when engaging in conversation with her. I requested contact information including names and telephone numbers for her direct care staff (DCS), in which she provided. Ms. Rice also agreed to provide me with a copy of Resident A's home care medical information sheet and health care appraisal. Ms. Rice said she was not aware of Resident A's current whereabouts once Relative A removed her from the home. Regarding Resident A's ability to be interviewed, she said Resident A is in the early stages of Dementia and has bouts of confusion but can possibly be interviewed.

On 4/21/2021, I received a portion of Resident A's hospital discharge documents which only outlined prescribed medications, no discharge instructions. I received a copy of Resident A's home care medical information sheet, which included the name and telephone number for her nurse, physical therapist, home doctor, podiatrist, and a copy of her health care appraisal. I reviewed the received documents to determine Resident A's health history and/or current diagnosis. Based on Resident A's health care appraisal it is noted that Resident A is legally blind, and has mental and physical limitations including depression, bilateral extremity weakness, decline in function in the past six month and requires a two-person assist. Resident A also has a history of urinary tract infections (UTIs). The documentation received didn't state Resident A was dehydrated.

On 5/04/2021, I interviewed Tammy Sinelli, direct care staff regarding the allegations. Prior to addressing the allegations, Ms. Sinelli offered history as it pertains to Resident A. She said Resident A was in the home for approximately a year and during that time she recalls her going to the hospital twice, once for leg pain and the other for an appendicitis. Ms. Sinelli said Relative A requested to be notified any time Resident A needed pain medication or any other form of treatment, which was agreed. However, Ms. Sinelli said Relative A was a very difficult person to get in contact with. She said she recalls the time Resident A was sent to the hospital due to leg pain, staff called Relative A several times and left messages letting her know Resident A was in pain and they were considering sending her to the hospital. Ms. Sinelli said staff texted and continuously called until contact was made with Relative A, and once she was made aware of the situation, she declined Resident A be transported to the hospital. Ms. Sinelli said Resident A was experiencing pain for a couple days, until finally staff called the ambulance because Resident A appeared to be in extreme pain at that point. As it pertains to the allegations, Ms. Sinelli denied having any knowledge of Resident A being dehydrated. In fact, Ms. Sinelli said Resident A couldn't have been dehydrated because she had plenty fluids on a regular basis. She said she constantly drank cranberry juice and water. Ms. Sinelli denied being sarcastic with Resident A or witnessing any of the other staff being sarcastic with her. She said Resident A had a call button that she would ring every ten minutes, she said she had all the staffs

undivided attention. She said Resident A was well cared for, she was not neglected, and she was not pleased when Relative A removed her from the home.

On 5/04/2021, I contacted Jammie McFalls, home manager, and interviewed her regarding the allegations. Ms. McFalls made me aware that she was hired in 3/2021 and her first day was 3/10/2021, she said Resident A returned to the home on 3/18/2021 from Novi Lakes Rehabilitation. She said she doesn't have any knowledge of Resident A's behaviors or conditions such as being dehydrated prior to her being admitted into the hospital because she was not employed at the home at that time. Ms. McFalls denied Resident A was treated unfairly. She said she was provided with great care, and she cried as Relative A removed her from the home because she didn't want to leave.

On 6/08/2021, I received Resident A's records from St. Mary Hospital. Based on the hospital records, Resident A arrived at St. Mary Mercy Hospital on 1/25/2021, presenting with leg pain. She was examined and her primary discharge diagnosis was atrial fibrillation with rapid ventricular rate status post Albation (irregular heartbeat). Resident A's secondary discharge diagnosis was diverticulosis (infection or inflammation of pouches that can form in the intestines) and proctocolitis (inflammation in the rectum and colon). The hospital course summary and discharge instruction were as follows:

> *"Patient is 83-year-old woman with PMH atrial fibrillation not currently on anticoagulation, legally blind, pacemaker placement 2/2 SSS, muscular dystrophy, anxiety who presents with chief complaint of bilateral leg pain. Patient found to be in Afib RVR and placed on Cardizem drip discontinued after ablation. She was found to have abnormal appendix on CT and other abnormal findings on CT scan. General surgery stated surgery not indicated at this time. Cardiology following. GI recommends continued antibiotics and flex sigmoidoscopy if family allows, and MRI dedicated to the liver outpatient as patient has a pacemaker. AV nodal ablation on 1/29. Barium esophagram for concern of dysphagia was unremarkable. Flex sig done 2/2/21, biopsy taken and pending. Patient was discharged to Novi Lakes Rehab with 3 days of keflex and flagyl to complete 7-day course of antibiotics for proctocolitis."*

Based on the hospital records, I was unable to determine Resident A was severely dehydrated on 1/25/2021 when she was examined at St. Mary Mercy Hospital. In fact, as it pertains to Resident A's nutrition status it indicates no malnutrition diagnosis at this time.

On 5/11/2021, I contacted Karen Phillips, Resident A's nurse regarding the reported allegations. Ms. Phillips explained that she's been assigned as Resident A's nurse for approximately five years but visited with her at this home three times for forty-five minutes each visit, prior to her relocating. Ms. Phillips said during her visits with Resident A she appeared to be well groomed and cared for while she was there. She said she taught the staff how to properly dress Resident A's pressure wounds

and they were doing a fantastic job taking care of her. Ms. Phillips said she always observed Resident A with water and snacks. Ms. Phillips denied having any concerns for the level of care Resident A was receiving at the home.

On 6/14/2021, I received a telephone call from Rabab Makki, Adult Protective Services (APS). Ms. Makki stated she interviewed all involved parties except for Resident A. She stated Resident A was observed sleeping and was not interviewed. She said Resident A experiences bouts of confusion, so there was no need to wake her. Ms. Makki said Resident A appeared to be clean and well-groomed. She said she also spoke with Relative A and she is pleased with Resident A's current home and care.

On 6/23/202, I contacted Davida Schlager-Kass, Resident A's physical therapist regarding the allegations. Ms. Kass explained that she was not Resident A's initial assigned PT, she said she was filling-in for someone. Ms. Kass said she visited with Resident A a couple times at the home and every time she appeared to be comfortable, well-kept, clean, and well-groomed. She said the staff was very attentive and took good care of her. Ms. Kass said she never observed Resident A disheveled or unkept. She said she doesn't think the staff were neglectful.

On 6/23/2021, I conducted an exit conference with Ms. Rice and individually address the allegations. I explained that upon completion of the investigation, I was unable to determine Resident A was not treated with dignity or that her personal needs weren't met as it pertains to being severely dehydrated or addressed in a demeaning and/or sarcastic manner. Due to insufficient evidence the allegation is unsubstantiated. Ms. Rice denied having any questions.

| **APPLICABLE RULE** | |
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| **R 400.14305** | **Resident protection.** |
| | **(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.** |

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| **ANALYSIS:** | During this investigation, I interviewed Lisa Rice, licensee designee, Jammie McFalls, home manager; Tammy Sinelli, direct care staff; Karen Phillips, Resident A's nurse; Davida Schlager-Kass, Resident A's physical therapist; and the Complainant regarding the allegations. Resident A has bouts of confusion and was not interviewed regarding the allegations.<br><br>Upon review of the hospital records, I am unable to determine Resident A was severely dehydrated on 1/25/2021 when she was examined at St. Mary Mercy Hospital.<br><br>I am further unable to determine that Tammy Sinelli or any of the direct care staff failed to treat Resident A with dignity.<br><br>Based on the investigative findings, there is insufficient evidence to support the allegations that Resident A was not treated with dignity, therefore, the allegation is unsubstantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

- **Direct care staff confines Resident A to the bed even though resident is not medically assessed to be bedridden.**
- **Resident A is not allowed to use the commode for passing bowl movements.**

**INVESTIGATION:**

On 4/09/2021, I contacted the Complainant and proceeded to discuss the allegations, in which the Complainant confirmed. The Complainant explained that Resident A returned from Novi Lakes Rehabilitation with pressure wounds on her foot. She said initially the home staff would transfer Resident A from her bed to her recliner but at some point, staff stopped transferring her altogether and said she was bedridden; the Complainant denied Resident A is bedridden. The Complainant further stated that there was an instance when Resident A needed to have a bowel movement and staff refused to transfer her to the bathroom and suggested she utilize incontinence briefs. She said Resident A was very upset.

On 4/16/2021, I contacted Lisa Rice, licensee designee, and interviewed her regarding the allegations, in which she denied Ms. Rice explained that Resident A returned from the rehabilitation facility with five pressure wounds on her foot. Ms. Rice said per Resident A's medical team, she was unable to apply any form of

pressure on her foot or it would risk further injury; Ms. Rice said Relative A was fully aware of Resident A's injury and her limitations. She said Resident A wore incontinence briefs and it was nothing out of the norm for her to toilet in her briefs. Ms. Rice said she recalls one instance when Resident A wanted to go to the bathroom but due to the pressure wounds, she was unable to apply pressure on her foot and it wasn't safe to transfer her per her medical team. She said it was suggested she go in her incontinence briefs, which was not abnormal for her. Ms. Rice also agreed to provide me with a copy of Resident A's home care medical information sheet and suggested I contact her medical staff to confirm Resident A's physical limitations and/or bedridden state.

On 5/04/2021, I interviewed Tammy Sinelli, direct care staff, regarding the allegations. Ms. Sinelli explained when Resident A returned from the rehabilitation center, she required a two-person assist. She said initially Resident A was being transferred from her bed to her recliner and she had a portable commode chair in her room and she was transferred to and from. However, Ms. Sinelli said Davida, Resident A's physical therapist (PT), asked them to stop transferring her because of the ulcers on her foot, her ankle was completely inverted, and she has neuropathy. Ms. Sinelli said PT was afraid that due to her neuropathy even with a two-person assist, she wouldn't be aware of how much pressure she's applying on her foot, which risks further injury and/or possibly breaking her ankle. Ms. Sinelli confirmed Resident A was encouraged to have a bowel movement in her incontinence brief because PT told them not to transfer her. However, she said when PT explained the risk of transferring her and the possibility of further injuring her foot; PT requested staff stop transferring her. Ms. Sinelli said PT had only been in the home for approximately two weeks before Relative A removed her from the home.

On 5/04/2021, I contacted Jammie McFalls, home manager, and interviewed her regarding the allegations. Ms. McFalls said the PT requested staff stop transferring Resident A due to the risk of further injuring her ankle. Ms. McFalls explained that Resident A suffered from an inverted left ankle, neuropathy and pressure wounds on her left foot. She said there were instances when Resident A's leg would turn black due to the lack of circulation. Ms. McFalls further explained that there were three weeks in between the time Resident A was discharged from Novi Lakes Rehabilitation facility to the time Relative A removed her from the home. She said within the first two weeks of her returning to the home, staff was transferring her to-and-from the portable commode and to-and-from the recliner. However, she said at the two week point the PT requested staff stop transferring her. As far as Resident A being encouraged to have a bowel movement in her incontinence briefs, Ms. McFalls said she's not sure she was encouraged, but said Resident A had bowel movement issues periodically and she was prescribed stool softeners and laxatives because of these issues. So, it wasn't uncommon for her to have a bowel movement in the incontinence briefs, but they were used as a precautionary method in case Resident A was unable to make it to the bathroom.

On 5/11/2021, I contacted Karen Phillips, Resident A's nurse regarding the reported allegations. She confirmed Resident A had severe pressure wounds on her foot and that she trained the staff to properly care for the wounds with the dressing. Ms. Phillips explained that PT was very concerned about the condition of Resident A's ankle and didn't want her to be transferred to prevent the possibility of applying pressure to her foot. Ms. Phillips said Resident A was bedridden as it pertains to daily movement to prevent further injury. Ms. Phillips explained that Relative A was hopeful that Resident A would walk, but it's unrealistic. Ms. Phillips denied having any knowledge of Resident A being encouraged to have a bowel movement in incontinence briefs but said Resident A shouldn't apply any pressure on her left foot at all.

On 6/23/202, I contacted Davida Schlager-Kass, Resident A's physical therapist regarding the allegations. Ms. Kass explained that she was not Resident A's initial assigned PT, she said she was filling-in for someone. Ms. Kass denied having knowledge of Resident A being "bedridden" but possibly wheelchair bound. Ms. Kass said she's uncertain how Resident A's foot got in that condition, but any weight applied to her left foot could cause severe injury. She said the staff could transfer her but would have to avoid applying pressure to her foot at all costs, she said her ankle was severely inverted. Ms. Kass said the safest way to transfer her would've been to use a Hoyer Lift or a sit-to-stand device, which is not commonly used in home settings. Ms. Kass said the staff took excellent care of Resident A and rotated her often. She said they wanted to transfer her to-and-from her recliner regularly but were possibly scared to take the risk of further injuring her. She said she does not believe the staff were neglectful at all but more so cautious. Ms. Kass denied having any knowledge of Resident A being encouraged to have a bowel movement in her incontinence briefs. Ms. Kass said she visited with Resident A a couple times at the home and every time she appeared to be comfortable, well-kept, clean, and well-groomed. She said the staff was very attentive and took good care of her. Ms. Kass said she never observed Resident A disheveled or unkept. She said she doesn't think the staff were neglectful.

On 6/23/2021, I conducted an exit conference with Ms. Rice and addressed the allegation. I explained there is sufficient evidence that Resident A was not provided with personal care as specified on her assessment plan and/or health care appraisal, which indicates she is a two-person assist. As it pertains to personal care, direct care staff is responsible for assisting Resident A with toileting as outlined in her assessment plan, opposed to encouraging her to have a bowel movement in her incontinence briefs. I further explained that I was unable to ascertain documentation to confirm Resident A was bedridden and although she was unable to apply pressure on her left foot, staff should have transferred her to a wheelchair and assisted her with toileting. I informed her that if Resident A's health declined to the point that she and/or her staff could no longer care for her, that Resident A should have been discharged. I further explained that based on the violation cited, a corrective action plan is required, in which Ms. Rice agreed. Ms. Rice asked about

the special investigation being published in which I explained; Ms. Rice denied having any questions.

| APPLICABLE RULE | |
|---|---|
| **R 400.14303** | **Resident care; licensee responsibilities.** |
| | **(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.** |
| **ANALYSIS:** | During this investigation, I interviewed Lisa Rice, licensee designee, Jammie McFalls, home manager; Tammy Sinelli, direct care staff; Karen Phillips, Resident A's nurse; Davida Schlager-Kass, Resident A's physical therapist; and the Complainant regarding the allegations. Resident A has bouts of confusion and was not interviewed regarding the allegations.<br><br>I was unable to ascertain documentation to confirm Resident A was bedridden but based on Resident A's assessment plan direct care staff is responsible for assisting Resident A with toileting, which they failed to do.<br><br>Based on the investigative findings, there is sufficient evidence to support the allegations, therefore, the allegation is substantiated. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

- **Resident A is not receiving medication as prescribed. Resident A moved to another facility and the Tylenol PRN is missing. Direct care staff stated it was never refilled after Resident A returned to the home from the rehabilitation facility.**
- **Complainant is concerned Resident A is receiving CBD gummies/lollipops to treat anxiety without a doctor's prescription.**

**INVESTIGATION:**

On 4/16/2021, I contacted Lisa Rice, licensee designee, and interviewed her regarding the allegations, in which she denied. Ms. Rice said staff would ever overdose, underdose, or miss administered medication. Ms. Rice further explained that she receives her medications from Innovative Pharmaceuticals Solutions Group and during the time Resident A was in the rehabilitation facility, her medications

were delivered and placed in a drawer. Ms. Rice said once it was brought to her attention, the medications were returned to the pharmacy. Ms. Rice denied cannabidiol (CBD) was given to Resident A, she said only prescribed medication is administered to the residents. Ms. Rice agreed to provide me with a copy of Resident A's medication administration records (MARS).

On 4/21/2021, I received Resident A's medication administration records (MARs) from March 2021 through April 2021. I reviewed the MARs to determine Resident A's medication regimen and if she received medications as prescribed. CBD was not listed on Resident A's MARs

On 5/04/2021, I interviewed Tammy Sinelli, direct care staff, regarding the allegations, in which Ms. Sinelli denied. She said apparently Relative A overheard her talking on a personal call to her daughter regarding CBD. Ms. Sinelli denied ever suggesting Resident A be given and/or prescribed CBD.

On 5/04/2021, I contacted Jammie McFalls, home manager, and interviewed her regarding the allegations. Ms. McFalls said the previous home manager didn't suspend Resident A's medication while she was in the rehabilitation facility, so the pharmacy continued to deliver her medications. She said once Relative A brought it to her attention, she gathered the medications that were sitting in a drawer and returned them back to the pharmacy. Ms. McFalls said apparently Relative A was being billed for medications that Resident A wasn't receiving. She said once the medications were returned, Relative A received a refund for the medications. As far as the missing Tylenol PRN, Ms. McFalls explained that Resident A returned from rehabilitation with her remaining Tylenol, once it was out that was it.

On 6/23/2021, I contacted Ashley Labrake, Innovative Pharmaceutical Solutions Group and interviewed her regarding the medication being returned, in which she confirmed. She said it is the pharmacy's protocol that once the medications are delivered, they cannot be returned. However, in this instance it appears as though Resident A was not in the home at the time the medications were delivered, and the medications were not used. She said the medications were returned and destroyed and Relative A's account was credited in 4/2021.

On 6/23/2021, I conducted an exit conference with Ms. Rice and individually addressed the allegations. I explained that upon completion of the investigation, I was unable to determine Resident A was not given her medication as prescribed by a licensed physician or given CBD. Due to insufficient evidence the allegation is unsubstantiated. Ms. Rice denied having any questions.

| **APPLICABLE RULE** | |
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| **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:** | During this investigation, I interviewed Lisa Rice, licensee designee, Jammie McFalls, home manager; Ashley Labrake, and Innovative Pharmaceutical Solutions Group regarding the allegations.<br><br>I reviewed the MARs to determine Resident A's medication regimen and if she received medications as prescribed by a licensed physician. Based on the MARs there was one discrepancy observed. As it pertains to CBD, CBD is not listed on Resident A's MARs and I am unable to determine, it was given to Resident A.<br><br>Based on the investigative findings, there is insufficient evidence that Resident A was not given her medication as prescribed by a licensed physician. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:** I reviewed Resident A's MARs, which was not initialed on 3/31/2021, ACETAMINOPHEN TAB 325MG was not initialed for the 4:00 p.m. dosage.

On 6/23/2021, I conducted an exit conference with Ms. Rice and made her aware of the investigative findings. Ms. Rice agreed to look into this matter to determine why the medication was not initialed.

On 6/29/2021, I received a daily log from Ms. Rice which outlined daily activities, notes and updates for each resident at the home but there was no explanation as to why Resident A's Mars was not initialed on 3/31/2021, ACETAMINOPHEN TAB 325MG for the 4:00 p.m. dosage.

| APPLICABLE RULE | |
|---|---|
| **R 400.14312** | **Resident medications** |
| | **(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:**<br>**(b) Complete an individual medication log that contains all of the following information:**<br>**(i) The medication.**<br>**(ii) The dosage.**<br>**(iii) Label instructions for use.**<br>**(iv) Time to be administered.**<br>**(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**<br>**(vi) A resident's refusal to accept prescribed medication or procedures.** |
| **ANALYSIS:** | Based on the findings, there is sufficient evidence that the person who administered the medication on 3/31/2021, failed to initial Resident A's ACETAMINOPHEN TAB 325MG 4:00 p.m. dosage at the time the medication is given**.** |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

7/2/2021

_____

Denasha Walker Date
Licensing Consultant

Approved By:

7/6/2021

_____

Ardra Hunter Date
Area Manager