GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 27, 2022

Sheila Leadbetter
Barrett Regency, Inc.
1318 Maple
Rochester, MI 48307

RE: License #: AS630377781
Investigation #: 2022A0991007
Barrett Regency Inc

Dear Ms. Leadbetter:

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 (248) 975-5053.

Sincerely,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630377781
Investigation #:	2022A0991007
Complaint Receipt Date:	11/17/2021
Investigation Initiation Date:	11/18/2021
Report Due Date:	01/16/2022
Licensee Name:	Barrett Regency, Inc.
Licensee Address:	5101 N. Rochester Rochester, MI 48306
Licensee Telephone #:	(248) 494-6719
Licensee Designee:	Sheila Leadbetter
Name of Facility:	Barrett Regency Inc
Facility Address:	5101 N. Rochester Rochester, MI 48306
Facility Telephone #:	(248) 494-6719
Original Issuance Date:	05/10/2016
License Status:	REGULAR
Effective Date:	06/07/2021
Expiration Date:	06/06/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive proper care at Barrett Regency. She lost an extreme amount of weight and did not have proper hygiene. Resident A was not showered during the eight months that she resided at the facility. Resident A was only taken out of bed for visits and meals, then staff put her back to bed. Resident A was never alert and seemed overmedicated.	No
Resident A was moved from a private to a semi-private room. The cost of care rate was not decreased as promised by the facility.	No
At the time of admission, Resident A had a new mattress delivered. When the medical equipment company came to pick up the mattress to bring to the new facility, it was dirty and covered in food crumbs, debris, and powder. It was not the same mattress that Resident A had when she moved into the facility.	No
Additional Findings	Yes

III. METHODOLOGY

11/17/2021	Special Investigation Intake 2022A0991007
11/18/2021	Special Investigation Initiated – Telephone Call to complainant
11/18/2021	APS Referral Adult Protective Services (APS) referral denied for investigation
11/18/2021	Contact - Document sent Email to complainant requesting any additional information or supporting documentation regarding allegations
11/30/2021	Contact - Telephone call made Left message for licensee designee
12/15/2021	Contact - Telephone call made Left message for Resident A's relative
12/28/2021	Inspection Completed On-site

	Unannounced onsite inspection- interviewed staff, licensee designee, and residents
12/28/2021	Contact - Telephone call received From licensee designee, Sheila Leadbetter
01/05/2022	Contact - Document Sent Follow up email to licensee designee re: requested documents
01/11/2022	Contact - Document Received Received assessment plan, resident care agreement, medication records, medical documents, funds forms
01/12/2022	Contact - Telephone call made Interviewed staff, Taryn Prather
01/12/2022	Contact - Telephone call made Interviewed staff, Tywanna Peoples
01/12/2022	Contact - Telephone call received From licensee designee
01/12/2022	Contact - Telephone call received From Tom Leadbetter
01/12/2022	Contact - Telephone call made Left message for Dr. Stamantin
01/12/2022	Contact - Telephone call made To Relative 1
01/13/2022	Contact - Telephone call received From Dr. Stamantin
01/14/2022	Contact - Telephone call made To home health care agency
01/18/2022	Exit Conference Via telephone with licensee designee, Sheila Leadbetter

ALLEGATION:

Resident A did not receive proper care at Barrett Regency. She lost an extreme amount of weight and did not have proper hygiene. Resident A was not showered during the eight months that she resided at the facility. Resident A was only taken out of bed for visits and meals, then staff put her back to bed. Resident A was never alert and seemed overmedicated.

INVESTIGATION:

On 11/17/21, I received a complaint alleging that Resident A did not receive proper care while living at Barrett Regency from September 2020-April 2021. I made a referral to Adult Protective Services (APS) on 11/18/21, but it was denied for investigation. I initiated my investigation on 11/18/21 by contacting the complainant. The complainant indicated that Resident A moved into the facility on 09/10/2020. At first, they were very happy with the care that Resident A was receiving at Barrett Regency. The owner of the facility is a nurse, who made Resident A's family members feel very comfortable. They received videos from the facility of Resident A up and walking around. After a few months, things began to change. Staff stopped answering the phone when family members called. The owner of the facility, Sheila Leadbetter, was inconsistent with enforcing COVID protocols. Ms. Leadbetter would pick and choose who could visit. Some relatives were allowed to visit, while others were not allowed to visit. The complainant indicated that Resident A appeared very lethargic during visits. Her hair was never brushed. The family paid more for nutrition and personal care services, but Resident A was not showered for the eight months that she resided at the facility. Staff would give her a bed bath or use powder. Resident A was never actually taken into the shower. The complainant indicated that Ms. Leadbetter told one of Resident A's relatives that Resident A had not been showered in eight months. The complainant also stated that Resident A lost 40 pounds while residing at Barrett Regency. The facility has a visiting physician, but the complainant was not sure if Resident A saw him. Resident A developed drop foot while at the facility. Staff at the facility only got the residents out of bed to feed them and then put them back in bed. After the "honeymoon phase" the family stopped receiving pictures of Resident A getting up and walking. Resident A's family moved her out of the facility in April 2021. The complainant indicated that they would send any additional medical documentation or correspondence that they had to support the allegations; however, I did not receive any additional documentation.

On 12/28/21, I conducted an unannounced onsite inspection at Barrett Regency. I interviewed direct care worker, Deajeonna West. Ms. West indicated that she began working in the home in March 2021. She only worked in the home for one month while Resident A was living there. Ms. West stated that Resident A was bathed daily. She received a complete bed bath. Staff used two basins of water, one with soapy water and one with clean water. They washed her from head to toe and shampooed her hair. She stated that she did not have any concerns about Resident A's hygiene or the cleanliness of any of the residents in the home. Ms. West stated that Resident A stayed in bed a lot of the time. She was weak in the legs and had difficulty walking. Resident A

would sometimes sit in the living room area. Ms. West stated that the residents in the home are typically up and out of bed. They sit in the living room or dining room area. Nobody stays in their room for an extended period of time. Ms. West stated that Resident A was a consistent weight during the time that she worked in the home. She did not notice any weight loss. She did not have any concerns about Resident A being overmedicated. She stated that Resident A was in pain sometimes because of her legs. She only received medications as prescribed. Ms. West stated that she did not have any concerns about the care that Resident A was receiving in the home. She stated that staff did their very best with Resident A. Ms. West did not have any concerns about any staff in the home or the care that any of the other residents in the home were receiving.

On 12/28/21, I interviewed the owner/licensee designee, Sheila Leadbetter. Ms. Leadbetter indicated that she felt Resident A's family made a complaint to retaliate against her. She stated that Resident A's son moved Resident A from the home in April 2021 without giving a 30-day notice. The family refused to pay the last month's rent per the discharge policy, so she filed suit against them to obtain the funds. Ms. Leadbetter indicated that Resident A moved into the home during the COVID pandemic in September 2020. Prior to moving to Barrett Regency, Resident A had a stroke. She had right-sided hemiparesis and was weak on her right side. She moved from another facility, where she was not walking at all. Ms. Leadbetter indicated that during Resident A's time at Barrett Regency, Resident A received physical therapy services and staff were able to get Resident A up and walking. She showed me videos of Resident A walking with staff assistance, as well as pictures of Resident A sitting outside. Ms. Leadbetter indicated that Resident A made progress and was able to walk with the assistance of two people. Staff would pivot transfer Resident A to a chair, and they would try to walk with her every day. Resident A was not confined to her bed. She did not develop drop foot while residing at Barrett Regency. Ms. Leadbetter indicated that when Resident A moved into Barrett Regency, she had to be transported by ambulance and was immobile; however, when she moved out of Barrett Regency in April 2021, she was wheeled to her son's car in a wheelchair and stood with assistance.

Ms. Leadbetter stated that she never told Resident A's family that Resident A was not showered for the eight months she was living in the home. Ms. Leadbetter indicated that all of the residents receive a full bed bath every day and they are showered at least twice a week. She stated that Resident A was showered at least two times a week. Two staff would assist Resident A into the shower, and they used a shower chair, as Resident A could not stand. Ms. Leadbetter indicated that she personally showered Resident A with the assistance of her husband, Tom Leadbetter, who is trained as a staff, or another staff person. They do not maintain a shower log at the facility, as it is not a licensing requirement.

Ms. Leadbetter indicated that Resident A did not lose weight while she was at the facility. She stated that Resident A ate a lot of food. Ms. Leadbetter stated that Resident A saw Dr. Stamantin while she was living at the facility. Dr. Stamantin is a visiting physician, who typically comes to the home every other Wednesday. Dr. Stamantin prescribed Resident A's medications. Resident A received her medications as prescribed. Ms. Leadbetter stated that Resident A was never overmedicated

During the unannounced onsite inspection, I observed the residents sitting in the living room area of the home watching television. They all appeared to be clean and had good hygiene. The residents were alert and did not appear to be overmedicated. I interviewed Resident B and Resident C. They both indicated that they are bathed every morning. Resident B did not have any concerns about the staff and stated that they are nice. Resident B typically hangs out in the living room area. Staff always give him his medications. Resident C stated that she usually watches television, and that staff are nice.

I reviewed a copy of Resident A's weight record. It notes that she weighed 206 pounds at the time of admission on 09/10/2020. The most significant weight loss recorded was from 02/01/21-03/01/21, when Resident A lost 4.5 pounds, going from 200 pounds to 195.5 pounds. Resident A's weight as of 04/01/21 was recorded as 197 pounds.

I reviewed copies of Resident A's medication administration records. There was no indication that Resident A was receiving more medication than what was prescribed.

I reviewed a copy of an email exchange between the licensee designee, Sheila Leadbetter, and Resident A's relative (Relative 1) from March and April 2021. The emails were in reference to a proposed increase in the rate for Resident A's cost of care payment. Relative 1 responded, "I'm a little surprised that there is an increase since (Resident A) is doing much better now than when she came to Barrett. I believe she had more care at the beginning than now." She also states, "I know you have mentioned that (Resident A) hasn't had a shower since she's been there and I understand, as long as she is clean and happy. I have done her nails and cut her hair and that's ok with me." The email from Relative 1 concludes by asking Ms. Leadbetter to reconsider increasing the cost of care rate and states, "I know she is very happy there and is getting the best care."

On 01/12/22, I interviewed Relative 1 via telephone. Relative 1 stated that during the time Resident A was living at Barrett Regency, another family member was diagnosed with glioblastoma cancer, so the family had a lot going on. She felt that the owners took advantage of the family, and they had some concerns regarding Resident A's care. Relative 1 indicated that it probably would not have gone any further, except that the owner, Sheila Leadbetter, was trying to get money from them by stating that they did not give a 30-day notice for Resident A's discharge. Ms. Leadbetter filed a lawsuit against them for nonpayment. Relative 1 indicated that Resident A was getting bed baths while she was living in the home, but she was not showered at all the entire time she lived

there. Relative 1 observed Resident A's skin to be very dry and scaly, which she attributed to staff only using powder to clean her. A staff person told Relative 1 that they could not get Resident A into the shower. Relative 1 stated that the family never saw Resident A's bedroom, the bathroom, or the rest of the home. They were not let past the kitchen and had to conduct visits outdoors due to COVID protocols. The facility was not consistent with enforcing COVID protocols. They would let some relatives visit, while requiring other family members to show negative COVID test results prior to visiting. Relative 1 indicated that Resident A lost 30-40 pounds while she was at the facility. Relative 1 stated that Resident A "was like a zombie" and always appeared "out of it" during visits. Resident A looked terrible during visits and there were times when she was wearing another resident's clothes. Relative 1 indicated that they tried to work with the facility and be nice. The family offered to help and would trim Resident A's nails and hair during their outdoor visits. They even referred another individual to the facility, which Relative 1 stated was "a big mistake". Relative 1 indicated that Resident A's care went downhill over time as she was living at the facility. Relative 1 indicated that they would provide my contact information to another family member who could provide additional information and documentation to support the allegations, but I did not receive any additional information.

On 01/12/22, I interviewed direct care worker, Taryn Prather. Ms. Prather indicated that she has worked at Barrett Regency since they opened. Ms. Prather stated that Resident A received a full bed bath daily. She was showered two or three times a week when two staff were on shift. Staff always used lotion and Resident A's skin was in good condition. Ms. Prather indicated that Resident A was heavier, so one staff person could not shower her alone. Sheila and Tom Leadbetter would typically assist with showering Resident A. Ms. Prather stated that staff always got Resident A up and out of bed. Resident A would walk with staff assistance, but prior to moving out of the home Resident A started to refuse to walk. Ms. Prather stated that Resident A would come to the dining room for meals and would sit in the living room. She did not have any concerns about Resident A being overmedicated. Staff only gave Resident A medications as prescribed by the doctor. She stated that Resident A never seemed "doped up". Ms. Prather did not have any concerns about the care Resident A was receiving in the home. She stated that Resident A was happy most of the time and staff took really good care of her. She did not have any concerns about the care that any of the residents were receiving in the home.

On 01/12/22, I interviewed direct care worker, Tywanna Peoples. Ms. Peoples indicated that she has worked in the home since September 2021. She was not working in the home when Resident A lived there. Ms. Peoples stated that she did not have any concerns about the care of the residents in the home. She stated that none of the residents appear to be overmedicated and they only give medications as prescribed. The residents are bathed and showered regularly. She did not have any concerns about their hygiene.

On 01/12/22, I interviewed Tom Leadbetter via telephone. Mr. Leadbetter indicated that he provided assistance with showering Resident A at least two or three times a week. They would transfer Resident A into her wheelchair, take her into the bathroom, and then transfer her to the shower chair. Mr. Leadbetter stated that Resident A was a larger individual. One staff person could assist Resident A with a pivot transfer into her wheelchair, but she required two staff to assist with getting her over the threshold into the shower. Resident A required maximum assistance to walk, but staff would assist her with walking regularly.

On 01/13/22, I interviewed the visiting physician, Dr. Stamantin, via telephone. Dr. Stamantin indicated that he has worked with the facility for five or six years. He stated that he typically visits every other week, but at a minimum once a month depending on the needs of the residents in the home. Dr. Stamantin indicated that Resident A was obese. He stated that weight loss would have been beneficial for Resident A, but he did not recall Resident A losing a significant amount of weight while in the home. Dr. Stamantin reviewed his notes and indicated that Resident A weighed approximately 200 pounds while she was living at Barrett Regency. Dr. Stamantin stated that there was no indication that staff were overmedicating Resident A. Resident A had dementia and often became agitated and violent, especially in the evenings. He stated that he prescribed medications to assist with these symptoms. There was no indication that staff were not giving Resident A her medications as prescribed. Dr. Stamantin stated that Resident A had drop foot prior to moving to Barrett Regency. He stated that drop foot is usually the result of having a small stroke. Dr. Stamantin indicated that Resident A did not present with poor hygiene or a bad odor when he saw her. He felt that staff were addressing her needs appropriately. Dr. Stamantin stated that he did not have any concerns about the care that the residents were receiving at Barrett Regency.

APPLICABLE RULE	
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.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that Resident A's personal needs were not met in the home. Resident A's weight records did not show that she lost any significant weight while she was residing in the facility. The visiting physician indicated that Resident A did not appear to be overmedicated and he did not have any concerns about the care she was receiving in the home. Staff denied overmedicating Resident A and indicated that staff assisted Resident A with walking in the home. Resident A moved out of the home in April 2021, so I was

	unable to assess her condition. The family members did not provide any additional documentation to support the allegations.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that Resident A was not bathed regularly. Staff who were interviewed indicated that Resident A received a bed bath daily and was showered at least twice a week. Resident A moved out of the home in April 2021, so I could not observe her in the home or assess her hygiene. During an unannounced onsite inspection, I observed that the other residents in the home appeared to have good hygiene and were clean.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A was moved from a private to a semi-private room. The cost of care rate was not decreased as promised by the facility.

INVESTIGATION:

On 11/18/21, I interviewed the complainant via telephone. The complainant indicated that Resident A had a private room when she moved into the facility. The owner contacted the family and asked to move Resident A to a semi-private room due to a male resident moving into the facility. There was supposed to be a reduction in the monthly rate for Resident A's cost of care due to this change; however, the reduction never happened. The complainant stated that they signed a contract for what the rates were initially, but they did not sign anything indicating that the rate had been reduced.

On 12/28/21, I interviewed the licensee designee, Sheila Leadbetter. Ms. Leadbetter indicated that when Resident A moved into the home, they did not have a private room available, they only had a semi-private room. The semi-private room was not occupied, and Resident A resided in the semi-private room by herself the entire time she lived in the home. Resident A required full care and there was never a reduction in her cost of care payment. Prior to Resident A moving out, they were looking at increasing the cost of care due to Resident A's needs.

On 01/12/22, I interviewed Relative 1. Relative 1 stated that the owner, Sheila Leadbetter, asked if they could move Resident A to a semi-private room because they had a male resident moving into the facility. Relative 1 agreed to this move, but they never received a reduction in the amount of Resident A's cost of care. She stated that Ms. Leadbetter was trying to raise the rate, because she was stating that Resident A required more care. Relative 1 indicated that they did not sign a new care agreement. She did not observe Resident A's bedroom, as they were not allowed into the home due to COVID restrictions.

I reviewed a copy of Resident A's resident care agreement dated 09/09/2020. It notes that Resident A will pay $6500 a month for the cost of care. It notes that the basic fee includes incontinent care, food, showers, and baths. The resident care agreement does not specify if Resident A was residing in a private or semi-private room. There were no updates to the resident care agreement reflecting any decrease or increase in the cost of care rate. I reviewed a copy of Resident A's Funds Part II form which shows she was paying $6500 a month for her cost of care each month.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(12) Charges against the resident's account shall not exceed the agreed price for the services rendered and goods furnished or made available by the home to the resident.
ANALYSIS:	Based on the information gathered during my investigation, there is insufficient information to conclude that Resident A was charged more than the agreed upon price for the services made available by the home. Resident A's resident care agreement did not specify if she was paying for a private or semi-private room. The resident care agreement was not updated to reflect any changes in the cost of care amount that was initially agreed upon at the time of Resident A's admission to the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

At the time of admission, Resident A had a new mattress delivered. When the medical equipment company came to pick up the mattress to bring to the new facility, it was dirty and covered in food crumbs, debris, and powder. It was not the same mattress that Resident A had when she moved into the facility.

INVESTIGATION:

On 11/18/21, I interviewed the complainant via telephone. The complainant stated that Resident A had a new mattress when she moved into the home. It was a special mattress to help with bed sores. When the medical equipment company went to pick up the mattress, they stated that it was not Resident A's mattress. The mattress was dirty and covered with powder.

On 12/28/21, I interviewed the licensee designee, Sheila Leadbetter. Ms. Leadbetter indicated that the medical supply company picked up the same mattress for Resident A that they had delivered when she moved into the facility. Ms. Leadbetter indicated that she had been in communication with Resident A's daughter about dropping off the mattress and arranging for it to be picked up when Resident A moved out. She stated that the mattress was in good shape. She was not aware of it being dirty or covered in powder. She stated that there was a mattress cover on the bed. Resident A's family members never contacted her to say that Resident A received the wrong mattress after she left the facility.

On 01/12/22, I interviewed Relative 1. Relative 1 stated that when Resident A moved out, she did not receive the same mattress that she had when she moved into the facility. She stated that they mattress Resident A received upon discharge was a flimsy air mattress. When the medical supply company went to pick up the mattress, it was covered in so much powder that they had to wipe it down.

APPLICABLE RULE	
R 400.14410	**Bedroom furnishings.**
	(5) A licensee shall provide a resident with a bed that is not less than 36 inches wide and not less than 72 inches long. The foundation shall be clean, in good condition, and provide adequate support. The mattress shall be clean, comfortable, in good condition, well protected, and not less than 5 inches thick or 4 inches thick if made of synthetic materials. The use of a water bed is not prohibited by this rule.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that Resident A's mattress was in poor condition and was not the mattress that

	she had when she moved into the facility. The licensee designee indicated that it was the same mattress she had when she moved in and the mattress was in good condition when she moved out. Resident A moved out of the facility in April 2021, so I was not able to observe her mattress.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection, I observed Resident B sitting in a chair in the living room area. He had a gait belt around his waist that went around the back of the chair. The gait belt was fastened behind the chair so that Resident B could not move from the chair. I observed Resident C sitting in a wheelchair in the living room with a gait belt around her waist and wheelchair. The gait belt was fastened in the back of the wheelchair, preventing her from moving out of the chair. I informed the licensee designee that a gait belt could not be used as a restraint to keep the residents in their chairs. Ms. Leadbetter indicated that the doctor had ordered that the device be used in this manner to prevent falls. I provided technical assistance to Ms. Leadbetter and her husband, Tom Leadbetter, regarding the licensing rules about restraint. Ms. Leadbetter indicated that she informed staff that they could not use the gait belt in this manner any longer and they stopped this practice immediately following my inspection.

On 01/13/22, I interviewed Dr. Stamantin via telephone. Dr. Stamantin verified that he had instructed the facility to use a gait belt to restrain the residents in their chairs to make sure they do not fall. He stated that the residents have dementia and an impaired gait. He stated that it is better to confine them to a chair than to allow them to fall.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident B and Resident C were restrained with a gait belt during my onsite

	inspection on 12/28/21. I observed Resident B and Resident C secured to their chairs with gait belts tied around their waists and fastened behind the chairs, preventing them from getting out of the chairs.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the investigation, I reviewed copies of Resident A's medication administration records and noted the following:

Resident A's April 2021 medication log was not initialed for the entire month of April for the 8:00am dose of Vitamin B12 500MCG- take 1 tablet by mouth once daily at 8:00am. The licensee designee indicated that the medication might have been discontinued by Resident A's doctor. There was no indication on the medication log that the medication was discontinued. Ms. Leadbetter indicated that she typically writes any changes in prescriptions on the medication log. Ms. Leadbetter did not provide any additional documentation from the physician showing that the medication was discontinued.

Resident A's March 2021 medication log indicated that she was prescribed Morphine Sulfate ER 15MG - take 1 tablet by mouth once daily at 8:00am as needed. The medication log shows that the medication was being administered at 8:00pm. Ms. Leadbetter indicated that they were told to pass the medication in the evening by Resident A's physician. There was no indication on the medication log that this change was authorized by Resident A's doctor. Ms. Leadbetter did not provide any additional documentation showing that the physician changed the time for this medication to be administered.

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: (e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that there were no written instructions regarding changes that were made to the prescriptions for Resident A's Vitamin B12 or Morphine Sulfate ER.

CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

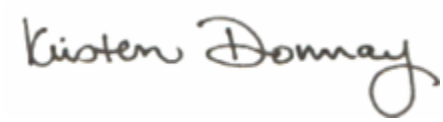
During the investigation, Ms. Leadbetter indicated that Resident A was seen by a physical therapist twice a week and was seen regularly by the visiting physician at the home, Dr. Stamantin. I requested documentation of these visits from Ms. Leadbetter. She indicated that she did not maintain a record of physician contacts, as she did not know this was required. She stated that the physical therapist has a folder where they document their visits and she writes the appointments on the calendar, but this is not maintained in the residents' files.

On 01/18/22, I conducted an exit conference with the licensee designee, Sheila Leadbetter, via telephone and reviewed my findings. Ms. Leadbetter indicated that she was not happy with the investigation and did not feel she should be cited. She felt the complaint was made in retaliation for filing a lawsuit against Resident A's family. Ms. Leadbetter stated that they have discontinued the use of gait belts to restrain the residents in their chairs, but the use of this device was ordered by the physician in order to prevent falls. I provided technical assistance to Ms. Leadbetter and informed her that restraints could not be utilized in an adult foster care facility. She stated that they are exploring other options to keep the residents safe. She stated that she confirmed with the doctor that Resident A's vitamin B was discontinued, and that the morphine was to be administered at 8:00pm. I provided technical assistance to Ms. Leadbetter and informed her that any changes to prescriptions need to be clearly documented on the medication log and in the resident's record. Ms. Leadbetter indicated that she did not know that physician contacts needed to be kept in the resident's record or she would have been doing this all along. She indicated that she would make the required changes and would submit a corrective action plan to address the violations.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: (d) Health care information, including all of the following: (iv) A record of physician contacts.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the resident files did not include documentation of physician contacts.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



01/18/2022

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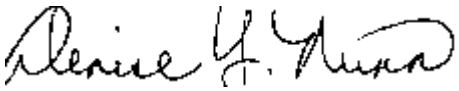
Kristen Donnay Date
Licensing Consultant

Approved By:



01/27/2022

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Denise Y. Nunn Date
Area Manager