GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 25, 2022

Rekha Panati
Alaya Care L.L.C.
7330 Tottenham
Shelby Twp, MI 48317

RE: License #: AS500393894
Investigation #: 2022A0990015
Alaya Care

Dear Ms. Panati:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500393894
Investigation #:	2022A0990015
Complaint Receipt Date:	01/21/2022
Investigation Initiation Date:	01/21/2022
Report Due Date:	03/22/2022
Licensee Name:	Alaya Care L.L.C.
Licensee Address:	46175 Sterritt St Utica, MI 48317
Licensee Telephone #:	(586) 453-5653
Administrator:	Rekha Panati
Licensee Designee:	Rekha Panati
Name of Facility:	Alaya Care
Facility Address:	46175 Sterritt St Utica, MI 48317
Facility Telephone #:	(586) 453-5653
Original Issuance Date:	10/19/2018
License Status:	REGULAR
Effective Date:	04/18/2021
Expiration Date:	04/17/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility is short staffed.	No
Resident A is left in his soiled diapers and clothing overnight.	No
Direct care staff Carol Latham called Resident A trifling.	Yes
Resident A is not given bed baths.	No
If Resident A's relatives bring food into the home for him, such as ham or turkey, the meat comes up missing.	No
Resident A's diapers are being given to other consumers at the home.	No
On Christmas 2021, Resident A asked direct care staff Trina Harrold for a second plate of dinner. Ms. Harrold brought Resident A more turkey and macaroni and cheese. Resident A did not eat all the food which upset Ms. Harrold. Ms. Harrold yelled at and cursed at Resident A and told him that she does not like people who do not eat her cooking or that waste food.	No
Direct care staff Trina Harrold then hit Resident A, with an open hand, on the side of his stomach and his leg for not eating his food. Resident A did not have any marks or injuries from the incident.	No
Resident A has been left in his room with the door shut at times.	Yes
There was someone at the facility last Wednesday that tested positive for Covid-19. Rekha Panati said that she is not having anyone tested because no one will come to the facility to test for Covid-19 and if Resident A ' needs to be tested, he must go to the hospital.	Yes
Resident A is not given his medications properly. Resident A is given random doses of medication that vary from day to day.	No
Resident A is also being given medications that he is no longer prescribed.	No

III. METHODOLOGY

01/21/2022	Special Investigation Intake 2022A0990015
01/21/2022	APS Referral Adult Protective Services (APS) complaint initiated at intake.
01/21/2022	Special Investigation Initiated - On Site I conducted an onsite investigation. I interviewed Rekha Panati licensee designee (LD) and direct care staff Trina Harrold. I briefly spoke to Resident A. I observed two residents that were not able to be interviewed.
02/04/2022	Contact - Telephone call made I called Resident A. I left a detailed voice message.
02/04/2022	Contact - Telephone call made I called Relative A. Relative A said that she was on a personal call and would call back. I received voice message from Relative A after business hours.
02/14/2022	Contact - Telephone call made I left a detailed voice mail message for Relative A.
02/14/2022	Contact - Telephone call made I left a detailed message with Resident A.
02/14/2022	Contact - Telephone call made I conducted a phone interview with Lisa Franzoni, APS investigator.
02/14/2022	Contact - Telephone call received I conducted a phone interview with Resident A.
03/08/2022	Contact - Telephone call made Telephone call to direct care staff Carol Latham. Ms. Latham said that she could not do phone interview at this time.
03/08/2022	Contact - Document Received I reviewed Resident A's documents related to the investigation.
03/08/2022	Contact - Document Sent I emailed Ms. Franzoni and requested the APS investigation. Ms. Franzoni sent the APS report on 03/09/2022.

03/22/2022	Exit conference I conducted an exit conference with Ms. Panati.

ALLEGATION:

The facility is short staffed.

INVESTIGATION:

On 01/21/2022, I received the complaint via email. In addition to the above allegation, it was reported that the licensee designee Rekha Panati does not plan to hire additional staff.

On 01/21/2022, I conducted an onsite investigation. I interviewed Rekha Panati licensee designee and direct care staff Trina Harrold. I briefly spoke to Resident A through his bedroom window due to him being quarantined for exposure to COVID-19. I observed two residents that were not able to be interviewed. The two residents were not interviewed due to their limited cognitive issues per Ms. Panati.

Ms. Panati said that when Resident A was admitted to the home in December 2021 and there were only two residents in the home, and he made number three. Ms. Panati said that she has one staff per shift. Ms. Panati said that she currently has four residents and one staff per shift including herself who is working in the home daily. Ms. Panati said that currently one resident is hospitalized therefore, there are three residents in the home. Ms. Panati described that Resident A is very demanding. Ms. Panati said that Resident A expects the staff to cater to him for his every need although he is independent of his activities of daily living. Ms. Panati said that Resident A calls the landline from his bedroom throughout the day making requests and at times is very impatient.

Ms. Harrold is direct care staff and was present. Ms. Harrold denied that they are short staffed.

I observed Resident A through his bedroom window from outside of the home. I introduced myself and received his phone number to conduct a phone interview due to the frigid temperatures outside.

On 02/14/2022, I conducted a phone interview with Resident A. Resident A said that he is no longer living in the home. Resident A said that there were five residents in the home including himself. Resident A said that the night staff person Carol Latham seemed to attend to the other residents more than him. Resident A said that there was a resident that yelled for help throughout the night. Resident A said that the resident that yelled was a male resident that had Alzheimer's and was in hospice care. Resident A said that it seemed as if that during the night shift Ms. Latham did not attend to him as

much because she was helping the other residents more and in his opinion that there was not enough staff.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	There are currently three residents in the home and one hospitalized. Ms. Panati has one staff per shift including herself which is, two staff during the day shift. Direct care staff Ms. Harrold denied that they are short staffed. Resident A expressed concerns that the staff did not attend to him as fast as he desired. Based on the investigation there is insufficient evidence to support that there is inadequate staffing. Resident A was very high demand for his needs and is no longer residing at the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATIONS:

- **Resident A is left in his soiled diapers and clothing overnight.**
- **Direct care staff Carol Latham called Resident A trifling.**
- **Resident A is not given bed baths.**
- **If Resident A's relatives bring food into the home for him, such as ham or turkey, the meat comes up missing.**
- **Resident A's diapers are being given to other consumers at the home.**

INVESTIGATION:

On 01/21/2022, I received the complaint via email. In addition to the above allegations, it was reported that Rekha Panati, the licensee designee says that direct care staff Trina Harrold and Carol Latham speak the way they do to Resident A is because they are African American and that is how they speak which is, loudly and that they yell at people. It was also reported that Resident A is not bathed because the staff members do not have time, and his relatives must assist with bathing him. Resident A is not dirty, and he does not have an odor. It was reported that one-time, Resident A soiled his clothing and when he told Carol Latham she screamed at Resident A and told him that

he should have tried to walk to the commode and that he should not have on adult diapers. When Resident A asked Ms. Latham to change him, she told him she did not want to talk to him and left the room. In addition, one of the staff members dropped Resident A' sandwich on the floor and gave it to him anyway with dirt on it.
On 01/21/2022, I conducted an onsite investigation. I interviewed Rekha Panati licensee designee and direct care staff Trina Harrold. Ms. Panati denied that Resident A is left in soiled diapers and clothing overnight. Ms. Panati said that Resident A has a urinal and can use the urinal independently. Ms. Panati said that Resident A is "independent" and can walk or wheel himself to the bathroom, but he would rather not. Ms. Panati said that he does has accidents, and the staff assists with cleaning him. Ms. Panati said that Resident A is demanding, and one-time direct care staff Carol Latham was feeding other residents and Resident A wanted to be changed when he could have used his urinal.

Ms. Panati denied telling anyone that her staff yells at residents because they are African American. Ms. Panati said that she believes that both speak stern at times but believes this is how they communicate. Ms. Panati said that she has an Indian accent and she had explained to someone that sometimes language and cultural ways of communicating can come across differently. Ms. Panati said that she has not observed her staff yell at residents.

Ms. Panati said that Resident A is given a bed bath every morning since he has been quarantined. Ms. Panati said that before he was quarantined, he was given a shower daily. Ms. Panati said that if Resident A has an accident his bed pad is checked and changed each morning.

Ms. Panati said that Resident A eats two sandwiches daily and he specifically asks his family to bring him ham and turkey lunch meat. Ms. Panati said that Resident A has "particular tastes," and he does not eat bread with his meat. Ms. Panati denied that the other residents eat his lunch meat. Ms. Panati denied that staff fed Resident A meat from the floor. Ms. Panati said that Resident A has severe anxiety and calls the landline from his bedroom/cell phone several times a day making requests. I observed Resident A's ham and turkey lunch meat which was in deli wrap refrigerated. Ms. Panati displayed the turkey lunch meat that the home has for the other residents.

Ms. Panati denied that Resident A's diapers are used for the other residents. Ms. Panati said that Resident A is over 250 pounds and wears extra-large diapers. Ms. Panati said that the other residents that require diapers wear smaller sizes and could not fit Resident A's diapers. I observed diapers in two resident bedrooms sizes medium and small.

Ms. Harrold denied that Resident A is left in soiled diapers and clothing overnight. Ms. Harrold says that she changes Resident A per his request because he can toilet himself. Ms. Harrold said that he also has a bedside commode that he can use. Ms. Harrold said that Resident A does not wear pajamas to bed and only wears a t-shirt therefore, he is never soiled in the mornings. Ms. Harrold said that she works shifts

alone or with Ms. Panati. Ms. Harrold said that prior to Resident A being quarantined, he cleaned and showered himself daily with assistance. Ms. Harrold said that she would assist Resident A with applying ointment to his genital area and buttocks to prevent rashes. Ms. Harrold said that Resident A is given his meds by 8AM is up and cleaned. Ms. Harrold said that since he is quarantined, they have been instructed to give him bed baths to avoid using the shower that is shared with the other residents.

Ms. Harrold said that she does not work on shift with Ms. Latham, therefore, is not able to attest to the allegations regarding her calling Resident A trifling.

Ms. Harrold said that Resident A family brings him ham and turkey lunch meat weekly. Ms. Harrold said that Resident A requests 2-3 pieces of ham or turkey per day. Ms. Harrold said that Resident A is the only resident that makes this request. Ms. Harrold said that there is a set menu and Resident A does not like what is on the menu, and he is prepared a separate meal daily. Ms. Harrold said that if she cooks chicken, he will request fish. Ms. Harrold said that he requests different side items as well. Ms. Harrold denied that she served him meat that dropped on the floor. Ms. Harrold said that she would throw it in the trash if it did. I observed the menu, and it was adequate.

On 02/14/2022, I conducted a phone interview with Lisa Franzoni, Adult Protective Services (APS) investigator. Ms. Franzoni said that her investigation is completed and believes that Resident A is no longer living at the home. Ms. Franzoni said that Resident A seemed high demanding which did not work for the staff at that home.

On 02/14/2022, I conducted a phone interview with Resident A. Resident A said that there were times he was left in a wet diaper overnight while direct care staff Carol Latham worked the night shift. Resident A said that he recalls that this occurred one time with Ms. Latham. Resident A said one night he asked Ms. Latham to apply an ointment to his bottom area which is, to prevent chafing and she refused to do it. Resident A said that during the night shift Ms. Latham would attend to him last because he felt that she thought he could do everything for himself. Resident A expressed that he could do most things but at times due to his severe arthritis and pain he has difficulty moving around and cleaning himself.

Resident A said that Ms. Latham called him “trifling” one time but does not recall the specific date and there were no other witnesses. Resident A said that during the night shift, he asked her to assist him with using the bathroom and she refused. Resident A said that he used the urinal several times and it was full therefore, he needed assistance getting out of bed to use the bathroom. Resident A said that because Ms. Latham refused to assist him, so he dumped his urine in his bedroom trash can so that he could use the urinal. Resident A said that when Ms. Latham came to his bedroom, he told her what he did, and she called him trifling. Resident A said that Ms. Latham hardly attended to him and at night he was in more pain and had mobility issues.

Resident A said that when he was admitted to the home December 2021 the staff was good about assisting him with his hygiene. Resident A said that as time went on the

help decreased. Resident A said that he is given bed baths because they had him quarantined to his bedroom. Resident A said that direct care staff Trina Harrold would assist him more that Carol Latham with cleaning and applying ointment to his buttocks. Resident A could not recall if they refused to bathe him, but he expressed that the assistance changed as more residents arrived. Resident A said that before quarantine he would use the showers more.

Resident A said that a relative brought him ham and bologna to the home. Resident A said that he does not recall anyone taking his personal ham and bologna.

Resident A said that he observed direct care staff Trina Harrold come into his bedroom and asked to borrow a diaper because another resident had run out.

On 03/08/2022, I reviewed Resident A's documents related to the investigation. I observed that APS substantiated the investigation for emotional abuse for intimidation through yelling and threats. According to the APS report, it is believed that Resident A was yelled at and felt threatened and moved out of the facility on 01/31/2022 because he did not feel that the staff cared for him properly and uncomfortable with the staff. Ms. Franzoni interviewed Carol Latham who denied yelling at Resident A. The APS report documented that Ms. Latham denied yelling at Resident A but stated that he could walk and should be walking to the commode as often as he could. Ms. Penati informed the APS investigator that Carol Latham and Trina Harrold are stern.

I reviewed Resident A's *Assessment Plan* and it documented that he is able to provide self-care with some staff assistance. The *Assessment Plan* documented that Resident A is mobile and uses a wheelchair and a walker. I observed that Resident A's *Health Care Appraisal* documented has impaired mobility and diagnosis is urine retention, hypertension, GERD, Anxiety and Anemia.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.

ANALYSIS:	Based on the interviews conducted, Resident A receives ham and turkey sandwiches per his preference. There is no evidence to support that his personal food is given away or he is made to eat food that drops on the floor. There is insufficient information to support that Resident A's diapers are being used by other residents. Resident A wears an extra-large. The other residents in the home wear size small or medium. On 01/21/2022, I observed in other resident's bedrooms that they had diapers in their closets.
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 interviews conducted, Resident A is independent and can do most hygiene activities with some assistance. Resident A is given bed baths because he was quarantined due to exposure to COVID-19. Ms. Panati and Ms. Harrold explained that Resident A requires some assistance with applying ointment to his bottom area. Resident A has a urinal and bedside commode, and he is mobile. Although, Resident A expressed that during the night shift he does not feel that he is attended to as much as he would like by direct care staff Carol Latham. Due to his quarantine, the level of his movement decreased however, he can toilet and clean himself. Resident A's *Assessment Plan* documented that he could provide self-care activities with assistance.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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 interviews conducted, Resident A said that direct care staff Carol Latham called him trifling one time during the night shift because he dumped urine from his full urinal in the trash can in his bedroom. Ms. Latham no longer works for the home and did not participate in an interview with licensing. According to the APS investigation, the APS investigator substantiated their investigation for emotional abuse for intimidation through yelling and threats. The APS investigator was able to conduct an interview with Carol Latham. Although, Ms. Latham denied doing this, there was evidence to support that this allegation was true. The APS report documented that Ms. Latham denied yelling at Resident A but stated that he could walk and should be walking to the commode as often as he could.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #2019A0990023, dated 08/19/2019, CAP dated 08/26/2019**

ALLEGATIONS:

- **On Christmas 2021, Resident A asked direct care staff Trina Harrold for a second plate of dinner. Ms. Harrold brought Resident A more turkey and macaroni and cheese. Resident A did not eat all the food which upset Ms. Harrold. Ms. Harrold yelled at and cursed at Resident A and told him that she does not like people who do not eat her cooking or that waste food.**
- **Direct care staff Trina Harrold hit Resident A, with an open hand, on the side of his stomach and his leg for not eating his food. Resident A did not have any marks or injuries from the incident.**

INVESTIGATION:

On 01/21/2022, I conducted an onsite investigation. I interviewed Rekha Panati licensee designee and direct care staff Trina Harrold. Ms. Panati said that they encourage the residents to eat their meals. Ms. Panati said that she was informed by the family that Resident A lost a significant amount of weight at his prior placement. Ms. Panati said that she was not present on Christmas Day for dinner but was informed by Ms. Harrold that Resident A refused to eat what was on the menu. Ms. Panati said that Ms. Harrold prepared a traditional Christmas dinner and Resident A wanted an alternative meal. Ms. Panati said that Resident A does not like what is on the menu most days and his family brings him meals per his request.

Ms. Harrold denied yelling and cursing at Resident A due to him refusing to eat Christmas dinner. Ms. Harold said that on Christmas Day she made turkey, stuffing and macaroni and cheese all homemade. Ms. Harrold said that she does not recall Resident A not eating but him requesting a different meal after he had eaten. Ms. Harrold said that she had a conversation with him about the alternative meal that he expected her to prepare after eating his dinner in which, she said he was being demanding. Ms. Harrold denied that she would ever force him or any resident to eat food that they do not like. Ms. Panati denied hitting Resident A. Ms. Harrold said that she would never hit a resident for any reason and appeared very upset about the allegation.

On 02/14/2022, I conducted a phone interview with Lisa Franzoni, APS investigator. Ms. Franzoni said that Ms. Harrold denied the incident on Christmas day. Resident A denied any physical abuse but said that staff yelled at him often.

On 02/14/2022, I conducted a phone interview with Resident A. Resident A said that he recalls the incident that occurred on Christmas dinner. Resident A said that he ate very little of the food and Ms. Harrold made a comment that she did not like that he wasted the food. Resident A denied that Ms. Harrold yelled or hit him because of this incident.

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: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Direct care staff Trina Harrold denied that she yelled and hit Resident A due to him not eating Christmas dinner. Ms. Harrold said that Resident A asks for alternate meals but had eaten a generous portion of the dinner but requested that she prepare something different. Resident A denied that Ms. Harrold yelled and hit him for not eating Christmas dinner. Resident A said that she made a comment that she did not like that he wasted food.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Resident A has been left in his room with the door shut at times.**
- **There was someone at the facility last Wednesday that tested positive for COVID-19. Rekha Panati said that she is not having anyone tested because no one will come to the facility to test for COVID-19 and if Resident A needs to be tested, he must go to the hospital.**

INVESTIGATION:

On 01/21/2022, I conducted an onsite investigation. I interviewed Rekha Panati licensee designee and direct care staff Trina Harrold. Ms. Panati said that a relative of Resident A called the home on 01/14/2022 informing them that they were positive for COVID-19. Ms. Panati said that the relative insisted that Resident A be tested. Ms. Panati said that she did inform the family of Resident A that they would need to take him to be tested. Ms. Panati said that she was going to take Resident A to be tested on the Monday after the relative called but it was Dr. Martin Luther King Jr. Holiday. Ms. Panati said that the relative wore a mask when they visited the home. Ms. Panati said that she was informed that if the resident had more than 15 minutes of close contact with a person positive diagnosed with COVID-19 that the resident had to quarantine. Ms. Panati said that Resident A is quarantined to his bedroom to prevent the spread. Ms. Panati said that Resident A does not have symptoms and is fully vaccinated. Ms. Panati said that when she contacted clinics that test, they were told that if Resident A did not have symptoms that he did not need to be tested. Ms. Panati said she recently ordered COVID-19 tests for the home which have not arrived.

Ms. Harrold said that no residents have symptoms of COVID-19 virus. Ms. Harrold said that she was informed that Resident A's relative was positive for COVID-19 and as a result she was informed that Resident A had to quarantine.

On 02/14/2022, I conducted a phone interview with Resident A. Resident A said that he always isolated himself to his bedroom prior to being quarantined. Resident A said that Ms. Panati always closed his bedroom door and told him that she did not want the other visitors looking in the other residents' bedrooms. Resident A said that he was quarantined because one of his relatives was positive for COVID-19 however, he is fully vaccinated and had no symptoms of the COVID-19. Resident A was tested and does not recall the date that he was negative for COVID-19.

On 03/08/2022, I reviewed Resident A's documents related to the investigation. I reviewed the Michigan Department of Health and Human Services (MDHHS) direction regarding COVID-19 rule *QSO-20-38-NH* indicates that a fully vaccinated resident in an adult foster care facility does not need to quarantine unless they develop symptoms and the facility must conduct a COVID-19 diagnostic test (with consent from the resident or designated representative).

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.
ANALYSIS:	There is sufficient evidence to support a rule violation regarding other health care needs of Resident A not being provided. According to Ms. Panati, a relative of Resident A called the home on 01/14/2022 informing them that they were positive for COVID-19. Ms. Panati said that the relative insisted that Resident A be tested. Ms. Panati did inform the family of Resident A that they would need to take him to be tested and she could not take him to be tested because of the holiday and he had no symptoms. Based on the MDHHS rule *QSO-20-38-NH* Ms. Panati was not to quarantine Resident A unless he was symptomatic because he is fully vaccinated. Ms. Panati did not provide a COVID-19 test as required per the MDHHS rules for adult foster care facilities.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Resident A is not given his medications properly. Resident A is given random doses of medication that vary from day to day.**
- **Resident A is also being given medications that he is no longer prescribed.**

INVESTIGATION:

On 01/21/2022, I conducted an onsite investigation. I interviewed Rekha Panati licensee designee and direct care staff Trina Harrold. Ms. Panati said that Resident A's medication were given as prescribed. Ms. Panati said that Resident A came from a facility called the Ambassador located in Detroit, MI. When Resident A was admitted to her home on December 15, 2021, his relative brought all his medications in a bag from the other facility. Ms. Panati said that the Resident A was seen by the visiting physician in her home name Dr. Aleksandra Tasevski from Michigan Primary Care on 01/12/2022. Ms. Panati said that medications that Resident A came with were in pill bottles but after

seeing the new doctor two medications were changed and they came from the pharmacy in a box. Ms. Panati said that Resident A thought that since the medications were prepared differently that they were incorrect. Ms. Panati said that she showed Resident A the scripts that were written on the box however, he insisted that they were different. Ms. Panati said that on 01/12/2022, Dr. Tasevski discontinued Resident A's Mirtazapine 15 mg and Sertraline 50mg. I observed Resident A's medication administration record (MAR) and the medications that began at admission were listed except for the two medications that were discontinued on 01/12/2022 (observed written note by doctor). The MAR and medications were initialed and labeled correctly.

Ms. Harrold said that she administers Resident A's medications as they are prescribed. Ms. Harrold said that Resident A occasionally asks for a pain medication which is, prescribed as a PRN (as needed) every six hours. Ms. Harrold said that at times Resident A asks for pain medications less than six hours from the dose already provided and gets agitated however, she would explain to him that he is not able to take the next dose until six hours have passed.

On 02/14/2022, I conducted a phone interview with Resident A. Resident A said that he was concerned about his medications because it took a while before the doctor reviewed his medications. Resident A said that the new medications looked different and came in a box. Resident was aware that the pharmacy sends his medications as prescribed by licensed medical professional. Resident A questioned the medications because of how the new ones appeared. Resident A said that he was aware that two medications were discontinued, and he had no issue with that.

On 03/22/2022, an exit conference was conducted with Ms. Panati. Ms. Panati explained that Resident A's doctor and physical therapist stressed encouraging him to move and do more self-care activities independently. Ms. Panati said that Resident A was very demanding and thought that the staff were his private caregivers and he did not respect that the staff had to attend to other residents as well. After the onsite visit, Ms. Panati had Resident A tested for COVID-19 and he was negative. I explained the MDHHS rule that due to Resident A being fully vaccinated, not symptomatic, he did not need to quarantine, and she was required to test him with permission from the resident and/or his designated representative. Resident A was quarantined for seven days until he was tested. I informed Ms. Panati that a corrective action plan would be required.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 01/21/2022, I observed Resident A's MAR and medications for Resident A were administered properly. According to Ms. Panati, Resident A was concerned about how the new medications were prepared by the pharmacy. Ms. Panati said

	that the medications Resident arrived at the home with at his admission on 12/15/2021, were packaged differently than the ones that the new pharmacy provided on 01/12/2022. There is no information to support that Resident A medications were not given, taken pursuant to label instructions.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	According to and I observed a note written by Resident A's doctor on 01/12/2022, the medications Mirtazapine 15 mg and Sertraline 50mg were discontinued by Dr. Tasevski. There is no information to support that medications not prescribed were given to Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

L. Reed

03/24/2022

LaShonda Reed — Date
Licensing Consultant

Approved By:

Denise Y. Nunn

03/25/2022

Denise Y. Nunn — Date
Area Manager