GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 4, 2022

Catherine Reese
New Friends Dementia Community, LLC
3700 W Michigan Ave
Kalamazoo, MI 49006

RE: License #: AL390299687
Investigation #: 2022A0578023
Vibrant Life Senior Living Kalamazoo 3

Dear Ms. Reese:

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 (517) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390299687
Investigation #:	2022A0578023
Complaint Receipt Date:	03/15/2022
Investigation Initiation Date:	03/16/2022
Report Due Date:	05/14/2022
Licensee Name:	New Friends Dementia Community, LLC
Licensee Address:	3700 W Michigan Ave Kalamazoo, MI 49006
Licensee Telephone #:	(734) 819-7790
Administrator:	Catherine Reese
Licensee Designee:	Catherine Reese
Name of Facility:	Vibrant Life Senior Living Kalamazoo 3
Facility Address:	3708 W. Michigan Ave. Kalamazoo, MI 49006
Facility Telephone #:	(269) 372-6100
Original Issuance Date:	04/23/2012
License Status:	REGULAR
Effective Date:	04/20/2021
Expiration Date:	04/19/2023
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents go long periods of time without receiving their medications.	Yes
Resident L was physically abused by staff which may have contributed to Resident L's death.	No
Residents are not being fed.	No
The facility is dirty and has bed bugs and roaches.	No
Additional Findings	Yes

III. METHODOLOGY

03/15/2022	Special Investigation Intake. 2022A0578023
03/15/2022	APS Referral.
03/16/2022	Special Investigation Initiated - On Site. -Interview with administrator Laurel space and staff member Destiny Lewis.
03/16/2022	Contact-Document Reviewed. -Medication Administration Records for January 2022, February 2022 and March 2022 for Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, Resident H, Resident I, Resident J and Resident K. As such, medications for Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, Resident H, Resident I, Resident J and Resident K.
03/16/2022	Contact-Document Reviewed. -*Accident/Incident Report* for Resident L, dated 11/26/2021.
04/20/2020	Exit Conference. -With licensee designee Catherine Reese.
04/20/2022	Contact-Telephone. -With Ms. Amber Sherman, administrative assistant, Office of the Medical Examiner.
04/25/2022	Contact-Telephone. -Medication Review, with Dr. Burke-Pappas, HomeTown Pharmacy.

04/29/2022	Contact-Document Reviewed. -*Certificate of Death* for Resident L.
04/29/2022	Contact-Telephone. -Interview with staff member Suzanne Boyer.
04/29/2022	Contact-Telephone. -Interview with administrator Laurel Space.

ALLEGATION:

Residents go long periods of time without receiving their medications.

INVESTIGATION:

On 03/15/2022, I received this complaint through the BCHS on-line complaint system. Complainant alleged that residents go for long periods of time without their medications. No additional information was provided.

On 03/16/2022, I completed an unannounced investigation on-site and interviewed administrator Laurel Space regarding the allegations. Ms. Space acknowledged that some residents had missed medications and acknowledged having “troubles” in the past with medications. Ms. Space explained direct care staff hired through an agency are no longer allowed to pass medications and explained that some staff had been terminated due to poor performance with medication administration. Ms. Space reported that a new medication coordinator has been appointed and this direct care staff member completes a review of medications on a routine basis when medication errors occur and when medications need to be ordered. Ms. Space acknowledged that despite these actions, medication errors still occurred. Ms. Space clarified the previous staff member that served as a medication coordinator was recently fired, and suspected these complaints were related. I requested copies of the medication administration records for all residents of this facility. Ms. Space clarified that “NOC” recorded on the medication administration records indicated the identified medication was not located on the medication cart by the direct care staff member administering the medication at the time. Ms. Space clarified that some medications that have been marked as “NOC” have been located after the fact by the medication coordinator, indicating the direct care staff member administrating the medication simply could not find the medication at the time of administration. Ms. Space explained that a mobile and secure medication cart was used to store medications.

While at the facility, I requested to compare medications present in the medication cart to the medication identified on the medication administration records for each resident. With the assistance of Ms. Space, I determined Resident C had Fish Oil 2400MG present in the medication cart while the medication administration records

identified that Resident C was prescribed Fish Oil 1000MG. Resident C was observed having Vitamin D3 125MCG present in the medication cart while the medication administration records identified that Resident C was prescribed Vitamin D3 25MCG. The Vitamin D3 125MCG and the Fish Oil 2400MG did not have a pharmacy label or any other identifying resident or physician information beyond the medication cart drawer number written on the medication package.

Resident G was observed having Refresh Tears .5% present in the medication cart while the medication administration records identified that Resident G was prescribed Genteal Tears .1%-.3%.

When addressing these medications of wrong dosage, Ms. Space clarified that relatives purchased these medications and delivered them to the facility.

On 03/16/2022, I reviewed the Medication Administration Record for Resident A. The Medication Administration Record for Resident A documented that on 01/23/2022, 01/24/2022, 01/25/2022, 01/26/2022 and 01/2/2022, Resident A did not receive his Acetaminophen 325MG TID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident A documented that on 01/18/2022, 01/19/2022, 01/20/2022, 01/21/2022, 01/23/2022, 01/24/2022, 01/25/2022 and 01/26/2022, Resident A did not receive his Amlodipine Besylate 5MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident A documented that on 01/26/2022, 01/28/2022, 01/29/2022, 01/30/2022, 01/31/2022, 02/01/2022, 02/02/2022, 02/03/2022, 02/04/2022, 02/05/2022, 02/06/2022, 02/07/2022, and 02/08/2022, Resident A did not receive his Aripiprazole 5MG BID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident A documented that on 01/09/2022, Resident A did not receive his Divalproex 125MG BID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident A documented that on 01/18/2022, 01/19/2022, 01/20/2022, 01/21/2022, 01/22/2022, 01/23/2022, 01/25/2022, 01/26/2022, 02/18/2022, 02/21/2022, 03/02/2022, 03/03/2022 and 03/05/2022, Resident A did not receive his Famotidine 20MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident A documented that on 01/29/2022, 01/31/2022, 02/01/2022, 02/02/2022, 02/03/2022, 02/04/2022, 02/05/2022, and 02/06/2022, Resident A did not receive his Lorazepam .5MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident A documented that on 01/16/2022, 01/19/2022, 01/29/2022, 01/23/2022 01/24/2022, 01/25/2022, 03/10/2022 and 03/11/2022, Resident A did not receive his Trazadone 100MG as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident A documented that on 01/17/2022, 01/18/2022, 01/19/2022, 01/20/2022 01/21/2022, 01/23/2022, 01/25/2022, 01/26/2022, 03/10/2022 and 03/11/2022, Resident A did not receive his Trazadone 50MG BID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident A documented that on 01/26/2022, 01/28/2022, 01/29/2022, 01/30/2022 and 01/31/2022, Resident A did not receive his Aripiprazole 5MG BID as this medication was charted as “medication not on cart.”

On 03/16/2022, I reviewed the Medication Administration Record for Resident B. The Medication Administration Record for Resident B documented that on 01/19/2022, 01/21/2022, 01/22/2022, 01/23/2022, and 01/25/2022, Resident B did not receive her Acetaminophen 500MG TID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident B documented that on 02/16/2022, 02/23/2022, 03/04/2022 and 03/07/2022, Resident B did not receive her Potassium 20MEQ QD as this medication was charted as “medication not on cart.”

On 03/16/2022, I reviewed the Medication Administration Record for Resident C. The Medication Administration Record for Resident C documented that on 02/16/2022, Resident C did not receive her Atorvastatin 10MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident C documented that on 02/16/2022, 02/18/2022, 03/10/2022, 03/11/2022, 03/12/2022 and 03/16/2022, Resident C did not receive her Sinemet 25/250 QID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident C documented that on 02/16/2022, 02/17/2022, 02/20/2022 and 02/24/2022, Resident C did not receive her Nuplazid 34MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident C documented that on 02/18/2022, Resident C did not receive her Pramipexole 1MG TID as this medication was charted as “medication not on cart.”

On 03/16/2022, I reviewed the Medication Administration Record for Resident D. The Medication Administration Record for Resident D documented that on 01/01/2022, 01/02/2022, 02/06/2022, 02/08/2022, 02/15/2022, 02/21/2022,

02/22/2022, and 02/23/2022, Resident D did not receive her Memantine 10MG BID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident D documented that on 01/13/2022, 01/14/2022, 01/15/2022, 01/16/2022, and 01/02/2022, Resident D did not receive her Methimazole 5MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident D documented that on 01/11/2022, 01/21/2022, 01/25/2022, 01/26/2022, 01/27/2022, 01/28/2022, 01/29/2022, 01/31/2022, 02/01/2022, 02/02/2022, 02/03/2022, 02/05/2022, 02/06/2022, 02/07/2022, 02/08/2022, 02/09/2022, 02/10/2022 and 03/08/2022, Resident D did not receive her Mirtazapine 7.5MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident D documented that on 02/11/2022, 02/12/2022, 02/13/2022, 02/14/2022, and 02/15/2022, Resident D did not receive her Digoxin .125MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident D documented that on 02/11/2022, 02/13/2022, 02/14/2022, and 02/15/2022, Resident D did not receive her Sertraline HCL 50MG QD as this medication was charted as “medication not on cart.”

On 03/16/2022, I reviewed the Medication Administration Record for Resident E. The Medication Administration Record for Resident E documented that on 01/13/2022, 01/14/2022, 01/15/2022, and 01/16/2022, Resident E did not receive her Trazadone 50MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident E documented that on 01/23/2022, 01/24/2022, 01/25/2022, 01/26/2022, and 01/29/222, Resident E did not receive her Valproic Acid 250MG TID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident E documented that on 02/21/2022, Resident E did not receive her Atorvastatin 20MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident E documented that on 02/21/2022, Resident E did not receive her Melatonin 3MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident E documented that on 02/08/2022, Resident E did not receive her Quetiapine 50MG TID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident E documented that on 02/13/2022, 02/14/2022, 02/15/2022, 02/16/2022, 02/17/2022, 02/18/2022, 02/19/2022, and 02/24/2022, Resident E did not receive her Raloxifene 60MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident E documented that on 02/11/2022, 02/12/2022 and 02/13/2022, Resident E did not receive her Tramadol HCL 50MG BID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident E documented that on 02/17/2022, 02/18/2022, 02/19/2022, and 02/20/2022, Resident E did not receive her Vitamin D3 25MCG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident E documented that on 02/12/2022, 02/13/2022, 02/14/2022. 02/15/2022, 02/16/2022, 02/17/2022, 02/18/2022, 02/19/2022, 02/21/2022, 02/22/2022, 02/24/2022, 02/26/2022, 02/27/2022, 02/28/2022, 03/01/2022, 03/02/2022, 03/04/2022, 03/06/2022, 03/07/2022, 03/09/2022, 03/10/2022, 03/11/2022, 03/12/2022, 03/13/2022, 03/14/2022 and 03/15/2022, Resident E did not receive her Mirtazapine 15MG QD as this medication was charted as “medication not on cart.”

On 03/16/2022, I reviewed the Medication Administration Record for Resident F. The Medication Administration Record for Resident F documented that on 01/13/2022, 01/17/2022, 02/18/2022, 02/19/2022, 02/20/2022, 02/21/2022, 02/22/2024, 02/23/2022, 02/24/2022, 03/01/2022, 03/04/2022, 03/05/2022, 03/06/2022, 03/07/2022, 03/08/2022, and 03/09/2022, Resident F did not receive her Levothyroxine 100MCG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident F documented that on 01/06/2022, 01/07/2022, 01/08/2022, 01/09/2022, 01/10/2022, and 01/11/2022, Resident F did not receive her Memantine 10MG BID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident F documented that on 01/15/2022 and 03/03/2022, Resident F did not receive her Senna Plus BID as this medication was charted as “medication not on cart.”

On 03/16/2022, I reviewed the Medication Administration Record for Resident G. The Medication Administration Record for Resident G documented that on 01/01/2022, 01/02/2022, 02/04/2022, 02/05/2022, 02/06/2022, 02/07/2022,

02/08/2024, 02/10/2022, 02/11/2022, 02/12/2022, 02/13/2022, 02/14/2022, and 02/27/2022, Resident G did not receive her Citalopram 20MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident G documented that on 01/18/2022, 01/19/2022, 01/20/2022, 02/20/2022, 02/21/2022, 02/22/2022, 02/23/2022, and 02/24/2022, Resident G did not receive her Memantine 10MG BID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident G documented that on 01/28/2022, 01/29/2022, 02/02/2022, and 02/03/2022, Resident G did not receive her Metoprolol 25MG BID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident G documented that on 01/28/2022, 01/30/2022, 02/01/2022, 02/03/2022, 02/05/2022, 02/07/2022, and 02/14/2022, Resident G did not receive her Omeprazole 20MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident G documented that on 01/22/2022, 01/25/2022, 01/26/2022, and 02/27/2022, Resident G did not receive her Vitamin C 500MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident G documented that on 01/05/2022, 01/14/2022, 01/15/2022, 01/16/2022, 01/17/2022, 02/13/2022, 02/14/2022, 02/22/2022, 02/23/2022, and 02/24/2022, Resident G did not receive her Buspirone 10MG TID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident G documented that on 01/13/2022, 01/14/2022, 01/15/2022, 01/16/2022, 02/18/2022, 02/19/2022, 02/20/2022, 02/21/2022, 02/21/2022, 02/22/2022, 02/23/2022, 02/24/2022, 02/25/2022, 02/26/2022, 02/27/2022, 03/01/2022, 03/02/2022, and 03/03/2022, Resident G did not receive her Divalproex 125MG BID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident G documented that on 01/05/2022, 01/06/2022, 01/07/2022, and 01/08/2022, Resident G did not receive her Fenofibrate 145MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident G documented that on 01/20/2022 and 03/01/2022, Resident G did not receive her Galantamine 4MG BID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident G documented that on 02/03/2022 and 02/22/2022, Resident G did not receive her Glucosamine Complex TID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident G documented that on 02/07/2022, Resident G did not receive her High Potency Multivitamin TAB QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident G documented that on 02/02/2022, 02/03/2022, 02/04/2022, 02/05/2022, 02/06/2022, 02/07/2022, and 02/08/2022, Resident G did not receive her Vitamin B Capsule QD as this medication was charted as “medication not on cart.”

On 03/16/2022, I reviewed the Medication Administration Record for Resident H. The Medication Administration Record for Resident H documented that on 01/26/2022, 01/27/2022, 01/28/2022, and 03/03/2022, Resident H did not receive her Aspirin 81MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident H documented that on 01/28/2022 and 01/29/2022, Resident H did not receive her Donepezil 10MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident H documented that on 01/16/2022 and 01/17/2022, Resident H did not receive her Potassium 10MEQ QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident H documented that on 01/28/2022, Resident H did not receive her Guaifenesin 600MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident H documented that on 02/15/2022 and 02/16/2022, Resident H did not receive her Clopidogrel 75MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident H documented that on 02/05/2022 and 03/03/2022, Resident H did not receive her Metoprolol 25MG BID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident H documented that on 02/07/2022, 02/08/2022, 02/16/2022, and 03/03/2022, Resident H did not receive her Tamsulosin .4MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident H documented that on 01/28/2022, Resident H did not receive her Atorvastatin 20MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident H documented that on 03/03/2022, Resident H did not receive her Torsemide 10MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident H documented that on 03/01/2022, Resident H did not receive her Eucerin Creme BID as this medication was charted as “medication not on cart.”

On 03/16/2022, I reviewed the Medication Administration Record for Resident I. The Medication Administration Record for Resident I documented that on 01/01/2022, 01/02/2022, and 01/03/2022, Resident I did not receive her Aspirin 81MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident I documented that on 01/28/2022, 01/29/2022, 01/30/2022, 02/18/2022, and 02/19/2022, Resident I did not receive her Sertraline 50MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident I documented that on 01/12/2022, 01/14/2022, 01/18/2022, 01/19/2022, and 01/28/2022, Resident I did not receive her Quetiapine Fumarate 25MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident I documented that on 02/10/2022, 02/11/2022, 02/12/2022, 02/13/2022, 02/14/2022, 02/16/2022, and 02/19/2022, Resident I did not receive her Amlodipine Besylate10MG QD as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident I documented that on 02/04/2022, 02/05/2022, 02/06/2022, 02/07/2022, 02/08/2022, and 02/18/2022, Resident I did not receive her Clonazepam 0.5MG TID as this medication was charted as “medication not on cart.”

On 03/16/2022, I reviewed the Medication Administration Record for Resident J. The Medication Administration Record for Resident J documented that on 03/01/2022, 03/02/2022, 03/03/2022, 03/07/2022, and 03/10/2022, Resident J did not receive her Isosorbide Mononit 30MG QD as this medication was charted as “medication not on cart.”

On 03/16/2022, I reviewed the Medication Administration Record for Resident K. The Medication Administration Record for Resident K documented that on 01/03/2022, 01/10/2022, 01/11/2022, 01/12/2022, 01/13/2022, 01/14/2022, 01/15/2022, 01/17/2022, 01/29/2022, 02/01/2022, 02/02/2022, 02/03/2022, 02/04/2022, 02/06/2022, Resident K did not receive his Naproxen Sodium 220MG BID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident K documented that on 01/09/2022, 01/10/2022, 01/11/2022, 01/12/2022, 01/13/2022, 01/14/2022, 01/15/2022, 01/17/2022, 01/19/2022, 01/20/2022, 01/21/2022, 01/23/2022, 01/24/2022, 01/25/2022, 01/26/2022, Resident K did not receive his SM Cough BID as this medication was charted as “medication not on cart.”

The Medication Administration Record for Resident K documented that on 03/11/2022, 03/12/2022, 03/13/2022, 03/14/2022, 03/15/2022, 03/16/2022, Resident K did not receive his Lorazepam .5MG QD as this medication was charted as “medication not on cart.”

APPLICABLE RULE	
R 400.15312	**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 S333.1101 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 an unannounced investigation on-site, I inspected resident medications available on-site and determined direct care staff at this facility had been administrating Fish Oil 2400MG and Vitamin D3 125MCG to Resident C while Resident C was prescribed Fish Oil 1000MG and Vitamin D3 25MCG. I determined staff at this facility had been administrating Refresh Tears .5% to Resident G while Resident G was prescribed Genteal Tears .1%-.3%. The Fish Oil 2400MG and Vitamin D3 125MCG was not kept in a pharmacy-supplied container and was not labeled for each specific resident in accordance with the requirements. I determined multiple missed medications as indicated by the staff use of the “medications not on cart” code for Residents A- Resident K. As such, medications for Residents A- Resident K were not given, taken, or applied as prescribed by a licensed physician or kept in an original pharmacy-supplied container labeled for the specific resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident L was physically abused by staff which may have contributed to Resident L's death.

INVESTIGATION:

On 03/15/2022, Complainant alleged that Resident L's head was put inside a trashcan with a plastic bag by staff member Destiny Lewis. Complainant reported that Resident L passed away a couple hours after this incident occurred. Complainant believes that Resident L died as a result of Ms. Lewis' actions.

On 03/16/2022, I interviewed administrator Laurel Space regarding the allegations. Ms. Space denied being aware of any staff member assaulting Resident L and contributing to Resident L's death. Ms. Space clarified that Resident L was on Hospice while at this facility and had passed away as expected. Ms. Space reported that residents in this facility are mostly non-verbal and unable to be interviewed.

While at the facility, I interviewed staff member Destiny Lewis regarding the allegations. Ms. Lewis reported working at this facility for over a year. Ms. Lewis acknowledged working with Resident L for approximately eight months, and clarified that Resident L was briefly hospitalized before returning to the facility for about a month before passing away. Ms. Lewis denied having ever physically assaulting or being physically aggressive with Resident L. Ms. Lewis denied ever putting Resident L's head in a plastic bag in a garbage can prior to Resident L passing away. Ms. Lewis became visibly emotional during the interview and clarified that working at this facility, she has been physically assaulted by residents and has never retaliated in any way. Ms. Lewis reported that she would have no reason to physically assault Resident L as he was compliant with all services. When asked why such a complaint might have been made, Ms. Lewis suspected the allegations were a result of the previous medication coordinator being fired or Ms. Lewis being promoted to the role of medication coordinator before other direct care staff members at this facility. Ms. Lewis denied observing any other direct care staff being physically aggressive with any other resident.

On 03/15/2022, I reviewed the *Accident/Incident Report* for Resident L, dated 11/26/2021 and completed by staff member Brianna White. The *Accident/Incident Report* for Resident L documented that when Ms. White went to check on Resident L at 3AM, Resident L was not breathing, and Ms. White was unable to obtain vitals. The *Accident / Incident Report* for Resident L documented that Ms. White called Hospice, family and management, and that Resident L was picked up by Langland Funeral Home at 5:53AM.

On 04/29/2022, I interviewed staff member Suzanne Boyer regarding the allegations. Ms. Boyer reported working at this facility for two years. Ms. Boyer reported that as a shift supervisor, she is frequently in this facility completing checks

with residents and staff. Ms. Boyer acknowledged being familiar with Resident L and denied observing anyone being physically aggressive with or assaulting Resident L. Ms. Boyer reported that if physical aggression with residents was something that she observed, or was reported to her by staff, she would follow the reporting requirements.

On 04/20/2022, I requested pathology reports for Resident L from the Office of the Medical Examiner. Ms. Amber Sherman, administrative assistant, reported that Resident L's death was not referred to the Office of the Medical Examiner.

On 04/29/2022, I reviewed the *Certificate of Death* for Resident L. The *Certificate of Death* for Resident L was dated 11/26/2021.The *Certificate of Death* for Resident L verified that Resident L's "manner of death" was "natural" and not referred to the Office of the Medical Examiner for autopsy or investigation. The *Certificate of Death* for Resident L identified that Resident L's death was due to "Senile Degeneration of the Brain"

APPLICABLE RULE	
R 400.15305	**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:	During an unannounced interview on-site, staff member Destiny Lewis denied ever putting Resident L's head in a garbage can with a plastic bag and denied ever being physically aggressive with Resident L. In an interview, staff member Suzanne Boyer denied observing or receiving a report of any staff member assaulting Resident L. I reviewed the *Certificate of Death* for Resident L, which identified Resident L's "manner of death" as "natural" and due to "Senile Degeneration of the Brain" with no referral to the Office of the Medical Examiner for autopsy or investigation. As such, there is no evidence that Resident L's safety and protection was not attended to at all times.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not being fed.

INVESTIGATION:

On 03/15/2022, Complainant alleged residents are not fed at this facility. No additional information was provided.

On 03/16/2022, I interviewed administrator Laurel Space regarding the allegations. Ms. Space reported the allegations were false and that clarified this facility provides three meals a day in addition to snacks and reported that fresh fruit is openly available in the facility. Ms. Space clarified that one resident prefers sandwiches as snacks and as a result, sandwiches are always available in the facility refrigerator and made available to all residents. Ms. Space denied that any resident had gone without being offered a meal or snack for any reason.

While at the facility, I reviewed menus for this facility and found them to be complete with three meals a day consisting of protein, vegetables, fruit, and snacks. I inspected the kitchen for this facility and observed meals being prepared by staff for residents. I examined two commercial refrigerators and a walk-in pantry and found an abundance of shelf stable, canned, and fresh and frozen foods.

On 04/29/2022, I interviewed staff member Suzanne Boyer regarding the allegations. Ms. Boyer denied that residents are ever not provided with a meal or snack for any reason. Ms. Boyer reported that residents are provided with three meals a day in addition to snacks. Ms. Boyer added that as a supervisor, she routinely observes and ensures that residents are being fed promptly at this facility.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	During an unannounced investigation on-site, I observed an abundance of shelf stable, canned, and fresh and frozen foods available at this facility. I observed meals being prepared for residents and reviewed a posted menu that consisted of protein, vegetables, fruit, and snacks. During interviews, administrator Laurel Space and staff member Suzanne Boyer denied the allegations and reported that residents have never not received a meal for any reason.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is dirty and has bed bugs and roaches.

INVESTIGATION:

On 03/15/2022, Complainant alleged the facility is dirty and has bed bugs and roaches. Complainant added that one resident bedroom had bedbugs and staff closed the door and sealed the room.

On 03/16/2022, I interviewed administrator Laurel Space regarding the allegations. Ms. Space denied the allegations of bed bugs and roaches and reported these allegations occurred at an adjacent facility. Ms. Space clarified that it was suspected that a resident was admitted at that facility with bed bugs which resulted in his bedroom being treated by Griffin Pest Control. Ms. Space acknowledged this required the resident's bedroom to be temporarily sealed but clarified this was done by Griffin Pest Control and not staff. The allegations of bed bugs and roaches were added to a co-occurring investigation at the adjacent facility being completed by AFC licensing consultant Cathy Cushman. Ms. Space clarified that Griffin Pest Control provided extermination services to this facility under contract. While at this facility, I inspected resident bedrooms and common areas of the facility. I found this facility neat and clean and observed staff engaged in cleaning the bathrooms.

On 04/29/2022, I interviewed staff member Suzanne Boyer regarding the allegations. Ms. Boyer denied the allegations and reported that as a supervisor, she routinely observes and ensures the facility is cleaned. Ms. Boyer clarified this facility had bed bugs in the past but clarified the bed bugs were treated by an exterminator and had no current concerns for bed bugs or roaches.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.

ANALYSIS:	During an unannounced investigation on-site, Ms. Laurel Space clarified that allegations of bed bugs and roaches occurred at an adjacent facility operated by the licensee and these allegations were added to a co-occurring investigation at that facility. In an interview, staff member Suzanne Boyer reported that as a supervisor, she routinely observes and ensures this facility is cleaned by staff. During the unannounced investigation on-site, I inspected the facility and found it to be neat and clean with staff engaged in cleaning.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

On 04/25/2022, I completed a medication consultation and review with Katia Burke-Pappas, PharmD, of Hometown Pharmacy. Dr. Burke-Pappas reported her agency receives multiple phone call from facilities regarding medications but could not recall any specific calls related to missed medications from this facility.

Dr. Burke-Pappas reported that Resident A's repeatedly missed Amlodipine Besylate 10MG could result in a heart attack, stroke, or organ failure.

Dr. Burke-Pappas reported that Resident G's repeatedly missed Buspirone 10MG could result in increased anxiety and behavioral stress. Dr. Burke-Pappas reported that Resident G's repeatedly missed Divalproex 125MG could result in seizures and behavioral stress.

Dr. Burke-Pappas reported that Resident I's repeatedly missed Clonazepam .5MG could result in symptoms of withdrawal. Dr. Burke-Pappas reported that Resident I's repeatedly missed Amlodipine Besylate 10MG could result in a heart attack, stroke, or organ failure.

On 04/25/2022, I interviewed administrator Laurel Space regarding documentation of contacting the appropriate health care professional regarding the medication errors noted in this report. Ms. Space reported it was the facility's procedure to notify the pharmacy or prescribing physician regarding medication errors, but she was unaware if this was done by the previous medication coordinator and no longer had access to the medication coordinator's emails. Ms. Space reported having no record of the pharmacy or the prescribing physician being contacted regarding medication errors, or record of the instructions from the pharmacy or prescribing physician related to the medication errors.

APPLICABLE RULE	
R 400.15312	**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: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	During an interview, administrator Laurel Space acknowledged having no record of the instructions provided by the pharmacy or the prescribing physician regarding medication errors that occurred in this facility despite the potential for serious medical consequences.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

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05/04/2022

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Eli DeLeon Date
Licensing Consultant

Approved By:

05/05/2022

_____

Dawn N. Timm Date
Area Manager