GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 21, 2022

Lynne Fossitt
P O Box 146
496 S Harrison
Houghton Lake, MI 48629

RE: License #: AL720007408
Investigation #: 2022A0360024
Mapleview AFC Home

Dear Mrs. Fossitt:

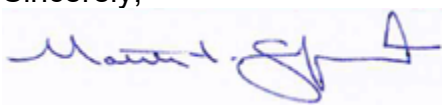
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (989) 732-8062.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL720007408
Investigation #:	2022A0360024
Complaint Receipt Date:	04/22/2022
Investigation Initiation Date:	04/25/2022
Report Due Date:	06/21/2022
Licensee Name:	Lynne Fossitt
Licensee Address:	P O Box 146 496 S Harrison Houghton Lake, MI 48629
Licensee Telephone #:	(989) 387-2568
Administrator:	Lynne Fossitt
Licensee Designee:	N/A
Name of Facility:	Mapleview AFC Home
Facility Address:	500 S Harrison Houghton Lake, MI 48629
Facility Telephone #:	(989) 387-2568
Original Issuance Date:	12/01/1983
License Status:	REGULAR
Effective Date:	12/15/2021
Expiration Date:	12/14/2023
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
A resident is taking Resident A's food.	No
Resident B was pushed by Resident C, the next day she was seen with her arm in a sling.	No
Resident A is supposed to get two pain pills per day and only receives one.	Yes
Resident A has bed bug bites.	No
Additional Findings	No

III. METHODOLOGY

04/22/2022	Special Investigation Intake 2022A0360024
04/25/2022	Special Investigation Initiated - On Site
04/25/2022	Inspection Completed On-site licensee Lynne Fossitt, DCS Jeremy Heisler, Resident A
05/13/2022	Inspection Completed On-site licensee Lynne Fossitt, Resident C
06/17/2022	Contact - Telephone call made Jessica Thieren Hospice of Michigan
06/17/2022	APS Referral
06/21/2022	Exit Conference With licensee Lynne Fossitt

ALLEGATION: A resident is taking Resident A's food.

INVESTIGATION: On 4/22/2022 I was assigned a complaint from the LARA online complaint system.

On 4/25/2022 I conducted an unannounced onsite inspection at the facility. The licensee Lynne Fossitt stated she was not aware of any resident taking any other resident's food. She stated if anyone tried to take Resident A's food, he would not tolerate it and let her know.

While at the facility on 4/25/2022 I interviewed direct care staff Jeremy Heisler. Mr. Heisler stated he has never witnessed or heard of any resident stealing food from other residents. He stated Resident A has never told him that anyone has taken any of his food and stated that Resident A would not put up with anyone stealing from

him. I then interviewed Resident A. Resident A stated no one is taking any food or drinks from him.

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:	The complaint alleged that another resident was taking Resident A's food. The licensee stated she has not heard or witnessed any resident taking Resident A's food. Direct care staff Jeremy Heisler stated he was not aware of any food being taken from Resident A and that Resident A would not tolerate anything being taken from him. Resident A denied that anyone is taking any food from him. There is no evidence that Resident A has not been treated with dignity and respect and that his personal needs, including protection and safety have not been attended to at all times.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident B was pushed by Resident C, the next day she was seen with her arm in a sling.

INVESTIGATION: On 4/25/2022 I conducted an unannounced onsite inspection at the facility. The licensee Lynne Fossitt stated Resident B and Resident C got into a verbal argument in the kitchen on 4/17/2022. Ms. Fossitt stated on 4/18/2022 Resident B was complaining of arm pain, and she was taken to the walk-in clinic and her arm was placed in a brace. She stated Resident B has been referred to an orthopedic doctor and has an appointment tomorrow. Ms. Fossitt stated Resident C was not at the facility as he goes to a day program until 4:30 p.m.

While at the facility on 4/25/2022 I interviewed direct care staff Jeremy Heisler. Mr. Heisler stated he was in the kitchen on 4/17/2022 when Resident B and Resident C were "bickering" with each other. He stated when he turned around Resident B had fallen on the floor. He stated she did not appear hurt and was not sure how she had fallen. I then interviewed Resident B. Resident B stated she got into a verbal argument with Resident C but denied that he pushed her or touched her in any way.

She stated she thinks she hurt her arm on the morning of 4/18/2022. She stated Resident C had come into her room to wake her up and when she got out of bed she fell and hit her arm. She denied that Resident C pushed her or hurt her arm.

On 5/13/2022 I conducted another onsite inspection. The licensee Lynne Fossitt stated during Resident B's follow up appointment there was a small fracture to her arm, and they placed it in a cast. I then interviewed Resident C. Resident C denied pushing Resident B and denied hurting her arm.

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:	The complaint alleged that Resident B was pushed by Resident C and the next day she was seen with her arm in a sling. Licensee Lynne Fossitt stated Resident B and C were in a verbal argument but was not sure how Resident B hurt her arm. Direct care staff Jeremy Heisler stated he heard Resident B and C "bickering" in the kitchen and noticed Resident B fall on 4/17/2022 but she stated she was not hurt at that time. Resident B stated she hurt her arm getting out of bed on 4/18/2022 and stated that Resident C did not hurt her. Resident C denied hurting Resident B's arm. There is no evidence that Resident B was not treated with dignity and respect and that her personal needs, including protection and safety, was not attended to at all times.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A is supposed to get two pain pills per day and only receives one.

INVESTIGATION: On 4/25/2022 I conducted an unannounced onsite inspection at the facility. The licensee Lynne Fossitt stated they read Resident A's prescription for Norco wrong. She stated the prescription directions stated he is to take 1 tablet by mouth twice daily and he is also prescribed an additional Norco as a PRN to be administered every four hours as needed. Ms. Fossitt provided Resident A's prescription Norco which was prescribed as she stated. She stated when they were

administering his regular scheduled Norco they were only giving him one per day but often gave him 1-2 PRN Norco which is the same dosage tab of 5-325MG. Ms. Fossitt stated she clarified with Resident A's hospice nurse and he is supposed to receive at least two per day and can receive additional as needed as prescribed. Ms. Fossitt provided me with a copy of Resident A's medication administration record for April 2022. Resident A was only administered one dosage of Norco 5-325MG on 4/5/22, 4/7/22, 4/9/22, 4/11/22, 4/13/22 and 4/18/2022. He was not administered any Norco 5-325MG on 4/12/22 and 4/19/22. As of 4/20/22 it was documented that he was administered at least two Norco as prescribed.

While at the facility on 4/25/2022 I interviewed Resident A. Resident A stated he gets at least two pills per day and usually gets at least 1 PRN. He stated he did not remember not being administered any of his medications.

On 6/17/2022 I contacted Resident A's hospice nurse, Jessica Thieren. Ms. Thieren stated the facility was not administering Resident A's Norco as prescribed. She stated they were supposed to give him a minimum of twice per day and were only giving him one per day. She stated he is also prescribed a Norco PRN as needed which he received some of the time. She stated she has completed a medication count on all his narcotic medications and since April they have been administering the medication as prescribed.

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 {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	The complaint alleged Resident A is supposed to get two pain pills per day and only receives one. The licensee Lynne Fossitt stated Resident A is prescribed Norco 5-325MG to be administered twice per day and they misread the prescription and were only administering one per day. She stated he is also prescribed the same Norco 5-325MG as a PRN to be administered once every four hours as needed and received at least one PRN dose most days.

	Resident A's medication administration record for April 2022 documented that Resident A was only administered one dosage of Norco 5-325MG on 4/5/22, 4/7/22, 4/9/22, 4/11/22, 4/13/22 and 4/18/2022. He was not administered any Norco 5-325MG on 4/12/22 and 4/19/22. Resident A stated he gets at least two pills per day and usually gets at least 1 PRN. He stated he did not remember missing any of his medications. Resident A's hospice nurse, Jessica Thieren, stated the facility was supposed to be administering one Norco 5-325MG twice per day and were only administering the medication once per day. She stated since April they have been administering the medication as prescribed. There is a preponderance of evidence that Resident A was not administered his medication as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A has bed bug bites.

INVESTIGATION: On 4/25/2022 I conducted an unannounced onsite inspection at the facility. The licensee Lynne Fossitt stated they have a pest control program in place specifically for bed bugs. She stated Orkin comes to the facility every two weeks. She stated she has not seen any bed bugs lately. She stated Orkin treated the facility most recently on 4/7/22, 3/24/22, 3/10/22 and 2/24/22. Ms. Fossitt provided me with the invoices verifying Orkin treated the facility on these dates for bed bugs.

While at the facility on 4/25/2022 I interviewed Resident A. Resident A stated there is no bed bug problem and he does not have any bed bug bites. I then inspected Resident A's bedroom and found no evidence of bedbugs.

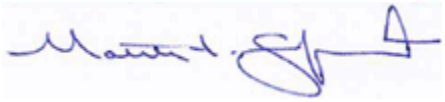
APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	The complaint alleged Resident A has bed bug bites.

	The licensee has a pest control program in place through Orkin and provided documentation. Resident A denied having bed bug bites and there was no evidence of bed bugs in his room. There is not a preponderance of evidence that the facility does not have a pest control program that continually protects the health of residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 06/21/2022 I conducted an exit conference with licensee Lynne Fossitt. Ms. Fossitt concurred with the findings of the investigation and stated she would submit a corrective action plan for approval.

IV. RECOMMENDATION

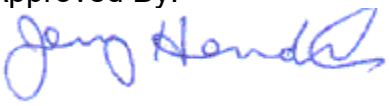
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



06/21/2022

Matthew Soderquist Date
Licensing Consultant

Approved By:



06/21/2022

Jerry Hendrick Date
Area Manager