



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 30, 2022

Puja Borso
Creekside Place, INC.
2995 Weidemann Dr
Clarkston, MI 48348

RE: License #: AS630397523
Investigation #: 2022A0991026
Creekside Place

Dear Ms. Borso:

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,

A handwritten signature in black ink that reads "Kristen Donnay". The signature is written in a cursive style with a large, looped 'y' at the end.

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., 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 #:	AS630397523
Investigation #:	2022A0991026
Complaint Receipt Date:	05/16/2022
Investigation Initiation Date:	05/18/2022
Report Due Date:	07/15/2022
Licensee Name:	Creekside Place, INC.
Licensee Address:	7251 N. Briarcliff Knoll West Bloomfield, MI 48322
Licensee Telephone #:	(248) 346-4515
Licensee Designee:	Puja Borso
Name of Facility:	Creekside Place
Facility Address:	7251 N. Briarcliff Knoll West Bloomfield, MI 48322
Facility Telephone #:	(877) 327-5484
Original Issuance Date:	08/20/2019
License Status:	REGULAR
Effective Date:	08/20/2020
Expiration Date:	08/19/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There is no transportation available at the home.	No
The residents' guardians break confidentiality by looking at other residents' information. There are cameras in the bedrooms.	No
Residents are left in soiled briefs that are not changed for extended periods of time.	No
The medication cabinets are never locked. The residents and their guardians get what they want out of the medication cabinet. Some medications are being given without prescriptions.	Yes
The home manager, Puja Borso, does not run any of the required emergency drills in the home.	No
The cleaning supplies are not labeled or locked away with a key.	Yes
Food is not being prepared or stored properly. Some of the food is labeled and some of the food is labeled with incorrect dates.	No
The garage is a fire hazard, and there is a generator in the garage. The garage door cannot be used and does not go up and down, so the side door is the only way to get out. The exits inside the home are blocked except the front door and patio door. The resident's room is cluttered and is a fire hazard.	No
Staff use an electric heater in the bathroom while residents are in the shower.	No
Additional Findings	Yes

III. METHODOLOGY

05/16/2022	Special Investigation Intake 2022A0991026
05/17/2022	APS Referral Received from Adult Protective Services (APS) - denied for investigation.
05/18/2022	Special Investigation Initiated - On Site

	Unannounced onsite inspection
06/08/2022	Contact - Document Received Additional allegations received from APS- assigned to John Cavanaugh
06/08/2022	Contact - Telephone call made To APS worker, John Cavanaugh
06/23/2022	Contact - Telephone call made To licensee designee, Puja Borso
06/23/2022	Contact - Document Sent Request for documents sent to licensee designee
06/28/2022	Contact - Telephone call made Left message for licensee designee
06/28/2022	Contact - Document Sent Email to/from APS worker, John Cavanaugh- APS not substantiating allegations
06/28/2022	Contact - Telephone call received From licensee designee
06/29/2022	Contact - Document Received Assessment plans and resident care agreements
06/30/2022	Contact - Document Received Fire drill logs
06/30/2022	Exit Conference Via telephone with licensee designee, Puja Borso

ALLEGATION:

There is no transportation available at the home.

INVESTIGATION:

On 05/16/22, I received a complaint from Adult Protective Services (APS) regarding Creekside Place. The complaint listed multiple allegations including that the facility was using a space heater, was not providing transportation, had fire hazards in the garage, was not properly storing cleaning supplies, food, or medications, and was violating the privacy of the residents. APS denied the complaint for investigation. I received an

additional complaint from APS on 06/03/22, which was assigned to APS worker, John Cavanaugh, for investigation. This complaint included additional allegations that the facility was leaving the residents in soiled briefs and was not conducting fire drills as required. I initiated my investigation on 05/18/22 by conducting an unannounced onsite inspection.

On 05/18/22, I interviewed direct care worker, Carolyn Brown. Ms. Brown stated that she has worked in the home since 08/14/2021. There are currently three residents living at Creekside Place. Two of the residents were home at the time of the onsite inspection. I observed Resident C resting in her bed. Resident C was asleep and was unable to be interviewed for this investigation. I observed Resident D resting in a recliner chair in her bedroom. Resident D was asleep and was unable to be interviewed for this investigation.

Ms. Brown stated that the home does not provide transportation to any of the residents. Resident P attends Kathleen’s Adult Day Care. Transportation to and from the program is arranged with the day care provider. Ms. Brown stated that the residents’ physicians visit them at the home. If care is needed by a physician who does not complete home visits, the residents’ family members arrange transportation via a medical transportation company.

On 06/28/22, I interviewed the licensee designee, Puja Borso, via telephone. Ms. Borso stated that staff do not provide transportation to the residents. The home utilizes an outside transportation company if residents need to be transported. Ms. Borso stated that this is specified in the resident care agreements.

I reviewed a copy of the resident care agreements for Resident C, Resident D, and Resident P. The resident care agreements for Resident C and Resident P note that the basic fee does not include transportation service. Resident D’s resident care agreement indicates that the basic fee includes transportation to four medical appointments per year.

APPLICABLE RULE	
R 400.14303	Resident care; licensee responsibilities.
	(3) A licensee shall assure the availability of transportation services as provided for in the resident care agreement.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that there is no transportation available at the home. Staff do not transport the residents; however, transportation can be arranged through an outside transportation company to take residents to medical appointments and day programs. The resident care agreements for Resident C and Resident P note that the basic fee does not include transportation service. Resident D’s resident care

	agreement indicates that the basic fee includes transportation to four medical appointments per year.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The residents' guardians break confidentiality by looking at other residents' information. There are cameras in the bedrooms.

INVESTIGATION:

On 05/18/22, I interviewed direct care worker, Carolyn Brown. Ms. Brown stated that the residents regularly have family visits. Family members do not have access to any resident records or medications. Ms. Brown has never witnessed any family member go into any resident files.

Ms. Brown stated that Resident C and Resident D have baby monitors in their bedrooms. These monitors do not record. Ms. Brown stated you can see the video and hear sound. There are cameras in the main living space at the home and outside near the garage where staff park their cars. Ms. Brown did not know if the assessment plans state that cameras and/or baby monitors are used in the home.

On 06/23/22, I interviewed the licensee designee, Puja Borso. Ms. Borso stated that there are cameras in the home. There are two cameras in the common area and two cameras outside the home. She stated that when the residents move in, they are given a form to sign which states that they are aware there are cameras in the home. She stated that they also have signs posted indicating that cameras are used in the common areas. Ms. Borso stated that there are baby monitors in the bedrooms, which are used by staff to monitor the residents. They do not record video or sound. Ms. Borso stated that the use of baby monitors is not specified in the assessment plans. I provided technical assistance to Ms. Borso and she stated that she would add the use of baby monitors to the resident's assessment plans.

I reviewed copies of the assessment plans for Resident C, Resident D, and Resident P. The assessment plans did not mention video monitoring or recording devices in the home. However, there is an attachment to the assessment plans that is signed by each resident or their designated representative stating that they have been notified of video monitoring in the common areas of the home.

APPLICABLE RULE	
R 400.14304	Resident rights; licensee responsibilities.
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated

	<p>representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:</p> <p>(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.</p> <p>(q) The right to confidentiality of records as stated in section 12(3) of the act.</p>
ANALYSIS:	<p>Based on the information gathered through my investigation, there is insufficient information to conclude that the right to privacy and confidentiality are not being safeguarded. Staff reported that the guardian's do not have access to other resident's case files. There are baby monitors in the bedrooms that do not record sound or video. At the time of admission, the residents and their designated representatives are provided with documentation that they sign stating that cameras are used in the home.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Residents are left in soiled briefs that are not changed for extended periods of time.

INVESTIGATION:

On 05/18/22, I interviewed direct care worker, Carolyn Brown. Ms. Brown stated that the residents are changed regularly and are well cared for in the home. During the onsite inspection, I observed Resident C and Resident D, who were both resting and could not be interviewed. They appeared to be well-groomed and had good hygiene. I did not observe any odors in any of the residents' bedrooms.

On 06/23/22, I interviewed the licensee designee, Puja Borso, via telephone. Ms. Borso stated that she did not have any concerns about any of the residents being left in soiled briefs. The residents are checked and changed at least every two hours or more often if necessary. Resident D tells staff when she needs to use the toilet. She wears a brief for emergencies only. Resident C has difficulty bearing weight and cannot use the toilet or a commode. Staff put her in bed to check and change her briefs. She is checked at least every two hours. The night staff always check the residents before they leave their shift at 7:00am. Resident P can use the toilet, but he sometimes chooses not to use the toilet and will go to the bathroom in his brief instead. Staff always change him if his clothing or bedding is soiled. None of the residents have wounds or sores from not being changed promptly.

On 06/28/22, I received an email from the assigned APS worker, John Cavanaugh. Mr. Cavanaugh stated that he was not substantiating the allegations of neglect. He stated that he conducted two unannounced visits at the home and did not have any concerns about the care of the residents.

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 staff are not attending to the personal needs of the residents at all times. Staff stated that the residents are changed regularly, and they did not have any concerns about residents being left in soiled briefs. During my onsite inspection, the residents appeared to be well cared for and had good hygiene.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The medication cabinets are never locked. The residents and their guardians get what they want out of the medication cabinet. Some medications are being given without prescriptions

INVESTIGATION:

On 05/18/22, I interviewed direct care worker, Carolyn Brown. Ms. Brown stated that she has been employed with the company since 08/14/2021. Ms. Brown reported that the medications are stored in a filing cabinet that is inside of a closet. The filing cabinet is kept locked. Ms. Brown stated medications are passed at 8:00am and 8:00pm. At the time of the onsite inspection at 10:30am, I noted that the medication cabinet was not locked. Ms. Brown stated that she did not lock it after passing morning medications. Ms. Brown stated that Resident C and Resident D were the only residents in the home at the time of the onsite inspection. Neither resident would have an interest in or the ability to independently access the medication cabinet. None of the residents or their family members ever access the medication cabinet. Ms. Brown stated that all of the medications that are administered are prescribed. When medications are administered, staff document it on the medication administration record (MAR).

During the onsite inspection I reviewed the medications and medication logs for Resident C, Resident D, and Resident P. I noted that Resident P's May 2022 MAR

included Vitamin D 10mcg, take 2 tabs by mouth daily. This medication was not in Resident D's medication basket. Resident D was receiving Vitamin D3 25mcg instead. There were no discrepancies noted for the medications and prescriptions for Resident C or Resident D.

On 06/23/22, I interviewed the licensee designee, Puja Borso. Ms. Borso stated that the residents only receive medications as prescribed by their physicians. Ms. Borso stated that Resident D's daughter wanted her to take powdered supplements. They are over the counter and are not prescribed by a doctor. Ms. Borso followed up with Resident D's primary care physician to ensure that the supplements would not have any negative interactions with her prescribed medications. Ms. Borso provided documentation from Resident D's physician dated 04/20/21 indicating that she can take econugenics lime infusion pectasol-c and turkey tail super food powder extract. Ms. Borso stated that she goes to the home several times per week and the medication cabinet is always locked.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the medication cabinet was not locked during my unannounced onsite inspection on 05/18/22. Staff stated that they did not relock the cabinet after passing morning medications. Resident D was not receiving Vitamin D 10mcg as prescribed by the physician, as the medication she was receiving was Vitamin D3 25mcg.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

The home manager, Puja Borso, does not run any of the required emergency drills in the home.

INVESTIGATION:

On 05/18/22, I interviewed direct care worker, Carolyn Brown. Ms. Brown was aware of the evacuation plan and which exit doors could be used for egress in an emergency. She stated that she has not practiced any fire drills with the residents since she has worked in the home.

On 06/23/22, I interviewed the licensee designee, Puja Borso, via telephone. Ms. Borso stated that she conducts fire drills once a month. She stated that she activates the alarm on the smoke detector and then begins the procedure of assisting the residents. They go fully outside when practicing fire drills. Ms. Borso stated that she typically comes in to conduct the fire drills.

I reviewed copies of the fire drill logs for the first and second quarter of 2022. Fire drills were conducted during daytime, evening, and sleep hours for each quarter. The logs note that the residents were evacuated from the home and went to the end of the driveway. The drills took between two minutes and three minutes and twenty seconds.

APPLICABLE RULE	
R 400.14318	Emergency preparedness; evacuation plan; emergency transportation.
	(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.
ANALYSIS:	Based on the information gathered during my investigation, there is insufficient information to conclude that fire drills are not being conducted as required. I reviewed copies of the fire drill logs, which showed that evacuation procedures were practiced during daytime, evening, and sleeping hours each quarter.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The cleaning supplies are not labeled or locked away with a key.

INVESTIGATION:

On 05/18/22, I interviewed direct care worker, Carolyn Brown. Ms. Brown stated that all cleaning supplies are kept locked under the kitchen sink and in the garage. During the onsite inspection, I observed that the cabinet under the kitchen sink was not locked. Ms. Brown stated that the cabinet was not locked at the time of the inspection, because she was actively cleaning when I arrived at the home. During the unannounced onsite

inspection on 05/18/22, I also observed a bottle of toilet bowl cleaner in Resident C's bathroom.

APPLICABLE RULE	
R 400.14401	Environmental health.
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	During my unannounced onsite inspection on 05/18/22, the cabinet under the kitchen sink where cleaning supplies were being stored was not locked. I observed a bottle of toilet bowl cleaner in Resident C's bathroom.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Food is not being prepared or stored properly. Some of the food is labeled and some of the food is labeled with incorrect dates.

INVESTIGATION:

On 05/18/22, I interviewed direct care worker, Carolyn Brown. Ms. Brown stated that she regularly prepares meals for the residents. Ms. Brown follows the menu that is posted in the kitchen. If she makes a substitution, it is documented in the staff log. Ms. Brown stated that the meals are healthy and regularly include fruits and vegetables. Staff do not add salt to the food, as they use Mrs. Dash seasoning. Occasionally, family members of the residents will bring prepared meals into the home that are shared amongst all the residents. Ms. Brown stated that the grocery shopping is completed by her coworker, Lakarra Bell. Ms. Brown never observed expired or spoiled food in the home. Ms. Brown explained that when food is purchased staff date the item using the date it is brought into the house. Before cooking a meal, Ms. Brown double checks the expiration dates to ensure that food is not expired before using it.

During the onsite inspection, I observed an adequate supply of food in the pantry, cupboards, refrigerator, and freezer. The canned goods were dated. The menus reflected a balanced, healthy diet.

APPLICABLE RULE	
R 400.14402	Food service.
	(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for

	human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that the food in the home is not being stored or prepared properly. The cans in the home were dated and staff indicate that they check the expiration dates before serving food. There was an adequate supply of food in the home at the time of the onsite inspection. The menus reflected a balanced and healthy diet.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **The garage is a fire hazard, and there is a generator in the garage. The garage door cannot be used and does not go up and down, so the side door is the only way to get out.**
- **The exits inside the home are blocked except the front door and patio door.**
- **The resident's room is cluttered and is a fire hazard.**

INVESTIGATION:

On 05/18/22, I interviewed direct care worker, Carolyn Brown. Ms. Brown stated that while she is on shift, she keeps the home clean and orderly. Ms. Brown stated that to her knowledge, the home has never used a generator. The home has only lost power one time while she was working. Ms. Brown stated the lights blinked then immediately came back on. During the onsite inspection on 05/18/22, I observed a generator being stored in the garage. It was not in use at the time of my visit.

Ms. Brown stated that the residents typically exit the home using the front door, which has a ramp. The residents can also use the sliding glass door that opens onto the patio. Ms. Brown stated the back door in the kitchen opens into the garage. This door is primarily used by staff to take out the garbage. There is a service door in the garage that would allow staff or residents to exit the garage. Both the back door and service door are equipped with a ramp. Ms. Brown stated that the garage door opens and closes manually. Some staff utilize the garage door to enter the home. Resident C's bedroom also has a sliding glass door that opens onto the patio in the backyard; however, this door is rarely utilized by Resident C. Ms. Brown stated that she has never seen any of the doors in the home blocked or obstructed.

During the unannounced onsite inspection on 05/18/22, I observed three means of egress in the home including the front door, patio door, and back door off the kitchen. All the doors had a ramp, were well-maintained, and provided free and unobstructed egress. The back door in the kitchen was marked with an exit sign, equipped with a ramp, and opened into the garage. Once in the garage you could exit using the garage

door and/or the service door. The service door was marked with an exit sign, equipped with a ramp, maintained, and unobstructed. I observed the garage door to open and close manually without issue.

During the onsite inspection, I observed that the home was clean and well-maintained. I did not observe any of the bedrooms to be cluttered or hazardous. The garage was being used for storage; however, a clear path to the egress door was maintained.

On 06/23/22, I interviewed the licensee designee, Puja Borso. Ms. Borso stated that the home is always clean and well-maintained. She stated that they are “neat freaks.” She stated that the garage is used for storage, and she sometimes uses the garage to store personal items that she is trying to sell, as it is a more central location. Ms. Borso stated that there was a generator being stored in the garage, but she has removed it. The generator was never used in the garage.

APPLICABLE RULE	
R 400.14403	Maintenance of premises.
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that the home is not maintained to provide for the health and safety of the residents. The home was clean and orderly during the onsite inspection. The garage was being utilized for storage, but a clear path to the egress door was maintained.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14507	Means of egress generally.
	(2) A means of egress shall be arranged and maintained to provide free and unobstructed egress from all parts of a small group home.
ANALYSIS:	During the onsite inspection, I observed that the home had three means of egress that were maintained to provide free and unobstructed egress from the home. There were no hazards or clutter blocking the exits.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff use an electric heater in the bathroom while residents are in the shower.

INVESTIGATION:

On 05/18/22, I interviewed direct care worker, Carolyn Brown. Ms. Brown stated that she never observed any staff bring a space heater into the bathroom while showering any of the residents. Ms. Brown stated she never used a space heater in the bathroom while showering any of the residents. Ms. Brown has never seen a space heater at the home. Resident C is showered by her hospice provider. Ms. Brown never observed anyone from hospice using a space heater in the bathroom with Resident C.

During the unannounced onsite inspection, I did not observe a space heater in the bathroom or any other area of the home.

On 06/23/22, I interviewed the licensee designee, Puja Borso, via telephone. Ms. Borso stated that they do not have any space heaters in the home. Staff do not use a space heater in the bathroom while giving showers.

APPLICABLE RULE	
R 400.14510	Heating equipment generally.
	(5) Portable heating units shall not be permitted.
ANALYSIS:	Based on the information gathered during my investigation, there is insufficient information to conclude that a portable heating unit is being used in the home. Staff denied using a portable space heater while showering the residents. I did not observe any space heaters in the home during my unannounced onsite inspection.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the investigation, I reviewed copies of the assessment plans for Resident C, Resident D, and Resident P. Resident C's assessment plan was dated 06/26/20. Resident D's assessment plan was dated 10/27/20. Resident P's assessment plan was dated 08/23/20. None of the assessment plans specified the use of baby monitors or

cameras in the home. The licensee designee, Puja Borso, stated that she had not updated the assessment plans annually, as there were no changes. I provided technical assistance to Ms. Borso and informed her that the assessment plans must be updated and signed annually even if there are no changes. Ms. Borso stated that she would update the plans and would add information about the use of video monitoring in the home.

APPLICABLE RULE	
R 400.14301	Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician’s instructions; health care appraisal.
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the written assessment plans for Resident C, Resident D, and Resident P were not updated annually and did not reflect the use of video monitoring in the home. The licensee designee did not update the residents’ assessment plans in 2021, as she stated that there were no changes.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

During the investigation, I reviewed copies of the resident care agreements for Resident C, Resident D, and Resident P. Resident C’s resident care agreement was dated 06/16/20. Resident D’s resident care agreement was dated 10/22/20. Resident P’s resident care agreement was dated 06/16/20. The licensee designee, Puja Borso, stated that she did not update the resident care agreements annually, as there were no changes. I provided technical assistance to Ms. Borso and informed her that the resident care agreement must be reviewed and updated annually even if there are no changes.

APPLICABLE RULE	
R 400.14301	Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the resident care agreements for Resident C, Resident D, and Resident P were not updated annually. The licensee designee did not update the forms annually, as she stated there were no changes.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

During the onsite inspection on 05/18/22, I reviewed the medications and medication logs for Resident C, Resident D, and Resident P. Resident C had several expired medications that were still being stored in her medication basket, including:

- Senna S Tab 8.6-50mg- expiration dates: 9/10/20, 12/18/20, 01/20/21, 04/26/21, and 04/16/21
- Risperidone 1mg tab- discard after 03/28/22
- Prochlorperazine 10mg tab- expiration dates: 07/30/20, 12/27/20, 04/26/21, and 04/26/21

On 06/30/22, I conducted an exit conference with the licensee designee, Puja Borso, via telephone. Ms. Borso stated that she disposed of the expired medications. She stated that she would submit a corrective action plan to address the violations identified during the investigation.

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:	During the onsite inspection, I observed that Resident C had several medications in her medication basket that were expired and had not been properly disposed of by the licensee.
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.




06/30/2022

Kristen Donnay
Licensing Consultant

Date

Approved By:



06/30/2022

Denise Y. Nunn
Area Manager

Date