GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 29, 2022

Leah Allen
August Haus Assisted Living, LLC
1201 Village Parkway
Gaylord, MI 49735

RE: License #: AL690392652
Investigation #: 2022A0009037
August Haus Assisted Living, LLC

Dear Ms. Allen:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (231) 356-0100.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
701 S. Elmwood, Suite 11
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL690392652
Investigation #:	2022A0009037
Complaint Receipt Date:	08/03/2022
Investigation Initiation Date:	08/04/2022
Report Due Date:	09/02/2022
Licensee Name:	AUGUST HAUS ASSISTED LIVING LLC
Licensee Address:	1201 Village Parkway Gaylord, MI 49735
Licensee Telephone #:	(989) 732-6374
Administrator:	Leah Allen
Licensee Designee:	Leah Allen
Name of Facility:	August Haus Assisted Living, LLC
Facility Address:	1201 Village Parkway Gaylord, MI 49735
Facility Telephone #:	(989) 448-7094
Original Issuance Date:	10/23/2018
License Status:	REGULAR
Effective Date:	04/23/2021
Expiration Date:	04/22/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Untrained staff are caring for residents.	Yes
The facility has not been adequately staffed.	Yes
Residents are not cared for properly. The call alert system has been turned off at times when staff do not want to reply to resident calls.	Yes
Narcotic medication is missing from the facility and possibly used by staff.	Yes
Additional Finding	Yes

III. METHODOLOGY

08/03/2022	Special Investigation Intake 2022A0009037
08/04/2022	APS Referral
08/04/2022	Special Investigation Initiated – Telephone call made to adult protective services worker Ms. Penny Kelly
08/08/2022	Inspection Completed On-site Interviews with licensee designee/administrator Ms. Leah Allen, administrator Mr. Kory Feetham, home manager Ms. Sherie Roop, and medication supervisor Ms. Cayla Duncan
08/15/2022	Contact - Telephone call received from Mr. Gavin Babieracki, Otsego County Emergency Medical Services deputy chief
08/15/2022	Contact - Document Received from Mr. Gavin Babieracki, Otsego County Emergency Medical Services deputy chief
08/15/2022	Contact - Telephone call made to licensee designee/administrator Ms. Leah Allen
08/18/2022	Contact – Telephone call made to Resident D's Family Member
08/22/2022	Contact – Telephone call made to Mr. Gavin Babieracki, Otsego County Emergency Medical Services deputy chief
08/23/2022	Inspection Completed – Onsite Interviews with administrator Mr. Kory Feetham, home manager Ms. Sherie Roop and direct care worker Ms. Dani-Lin Marcinkowski

08/24/2022	Contact - Telephone call made to Ms. Tracy Secord
08/24/2022	Contact – Telephone call made to home manager Ms. Sherie Roop
08/24/2022	Contact – Telephone call made to licensee designee Ms. Leah Allen
08/24/2022	Contact - Telephone call made to former direct care worker Ms. Tiffani Sanchez, former direct care worker Ms. Samantha Johnson and Mr. Daniel Hodges
08/24/2022	Contact - Telephone call made to former direct care worker Ms. Candace Agattas
08/25/2022	Contact - Telephone call made to licensee designee/administrator Ms. Leah Allen
08/25/2022	Exit conference with licensee designee/administrator Ms. Leah Allen
08/25/2022	Contact – Document (emails with attachments) received from home manager Ms. Sherie Roop

ALLEGATION: Untrained staff are caring for residents.

INVESTIGATION: I spoke with adult protective services (APS) worker Ms. Penny Kelly by phone on August 4, 2022. She said that she did have a recent investigation with a resident at the August Haus facility but that she did not substantiate it. This matter was also investigated by the Adult Foster Care (AFC) Licensing unit (SI# 2022A0360033).

I made an unannounced site inspection at the August Haus Assisted Living facility on August 8, 2022. I spoke with administrator Ms. Leah Allen, administrator Mr. Kory Feetham and home manager Ms. Sherie Roop. Mr. Feetham was only present for the initial discussion, saying that he had to leave. I asked Ms. Allen and Ms. Roop about the report that direct care staff are put to work directly with residents without being properly trained. They reported that training is typically done within 30 to 90 days of someone being hired. During that time the new staff person completes a “training checklist” and also shadows a fully-trained direct care worker. The new employee is then shadowed themselves by fully-trained staff before being allowed to care for residents alone.

I asked each of them about the complaint that a newly-hired staff person recently cared for residents without being trained prior to the care. Ms. Allen admitted, “Yes,

that probably did happen." She stated the facility has been "very short-staffed" recently and a person that was not properly trained may have been asked to do direct care without all the training they needed. Ms. Roop also admitted that it might have happened. Ms. Roop said that it was "very chaotic" when she took over as home manager eight days ago. Ms. Roop said that hiring new staff and getting them properly trained is their number one priority at this time. She went on to say that in the eight days she has been home manager, she has hired seven new staff. We talked about the necessity of training new staff in a much shorter time-period than 30 to 90 days. Ms. Allen and Ms. Roop agreed that they thought they could have someone properly trained more quickly.

Ms. Allen provided me with a "New Hire Checklist" that included all necessary training objectives. I noted that Transfer techniques including Standing pivot, Assist with ambulation, Lifting, Wheelchair/Walker knowledge and Gait Belt Application and use were included on the checklist.

Ms. Allen and Ms. Roop also reported that a direct care worker had walked off the job during her shift on August 5, 2022. This left only one direct care worker with 17 residents. Ms. Tracy Secord, who lives locally, was called in to help care for the residents. Ms. Secord works for the same company that owns August Haus but as an apartment manager for some of their other properties. Ms. Allen and Ms. Roop admitted that Ms. Secord is not trained as a direct care worker.

I received a call from Mr. Gavin Babieracki on August 15, 2022. Mr. Babieracki is the deputy chief for the Otsego County Emergency Medical Services (EMS) unit. He said that he was concerned because they had been called to the August Haus facility the day before to transfer/lift Resident A and Resident B. The staff there told them that they had not been trained on how to lift a resident which is why they had called 911. One person said that she was not staff at all and was just there to help. She also denied being trained on how to lift or transfer a resident. Mr. Babieracki also sent me a copy of the Michigan EMS Patient Care Report dated August 14, 2022, regarding the incident. It was reported that the staff who met them at the door told them that they are "understaffed and need help getting patients out of their beds". The other person who was present told them that she "is not staff, she is an owner of the facility and is not qualified or trained on how to use a lift even if they had one".

I spoke with licensee designee Ms. Leah Allen by phone on August 15, 2022. I asked her what had happened the day before. Ms. Allen said that she was out sick the day before and so owner Ms. Secord came in to help. Direct care worker Ms. Dani-Lin Marcinkowski had just worked 24 hours straight because both third-shift staff had not shown up for work. None of their current workers could come in due to having worked so much already. Their nurse, Ms. Heather Reno, came in to cover part of the shift. Ms. Reno is trained as a direct care worker. Owners, Chad and Trisha Deshano also came in to help out. Ms. Allen acknowledged that Mr. and Mrs. Deshano have not been trained in the areas required by licensing for direct care

workers. She stated that because they are not trained to lift or transfer a resident, they called 911 to get assistance from EMS.

I spoke with Mr. Gavin Babieracki, Otsego County EMS deputy chief by phone on August 22, 2022. He said that he was concerned because EMS had been called to August Haus 15 times since he last spoke with me.

I made an unannounced site inspection at August Haus on August 23, 2022. I asked home manager Ms. Sherie Roop about the report that EMS had been called to the facility 15 times since I had been there. She admitted that some of the calls had been because their staff have not been properly trained to assist with “transfer techniques” and needed the assistance of EMS staff to make those transfers. She and administrator Mr. Kory Feetham stated that they had hired new staff and were trying to get them properly trained as quickly as possible.

On August 23, 2022, I spoke with direct care worker Ms. Dani-Lin Marcinkowski. I asked her about EMS being called to the facility. She said that a resident fell out of bed and that the staff who were working could not pick her up by themselves. Ms. Marcinkowski went on to say that some of the staff working second shift were not fully-trained. She said that she lives nearby and that the staff were calling her at home and asking her questions about how to do their jobs. They were asking her how to check blood sugar, give insulin and help with passing medication. Ms. Marcinkowski said that she came in when she wasn’t working to help them administer medication. She said that she, herself, was not fully trained for several months after being hired so felt that it was a “usual thing” there.

I spoke with Ms. Tracy Secord by phone on August 24, 2022. She is the “owner” who was identified as helping at the facility when they were short-staffed. Ms. Secord did not identify herself as an owner, instead saying that she manages some other properties for the company in Gaylord, Michigan. I asked how much she helped out at August Haus. She said that there were “many, many” days that she worked at August Haus during a five-week period when “they needed help”. Ms. Secord said that she helped in the kitchen, cleaned and helped with residents. She denied that she administered medication. She said that she did serve lunch and dinner to the residents and “chit-chatted” with them. Ms. Secord said that she did provide some personal care to the residents but only the ones who can move on their own. She denied that she had any formal training as a direct care worker. She did say that she has experience with the elderly population but was only there to help out. Ms. Secord stated that two residents did need to be lifted with a Hoyer lift but she is not qualified to use one. There was no one there who could use the Hoyer lift. Ms. Secord said that she called EMS to assist with lifting the two residents because they could not do that. She said that no one in administration was answering their phones and she could not get any other staff to come in. I asked her who she had tried to contact in administration. Ms. Secord replied that she had tried to contact Ms. Allen and Ms. Roop who were unavailable.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: (a) Reporting requirements. (b) First aid. (c) Cardiopulmonary resuscitation. (d) Personal care, supervision, and protection. (e) Resident rights. (f) Safety and fire prevention. (g) Prevention and containment of communicable diseases.
ANALYSIS:	It was confirmed through this investigation that direct care staff or others caring for residents were not competent in all the required, above-mentioned areas. The licensee designee acknowledged that the individuals who provided personal care and supervision of the residents have not been trained in the required areas. Licensee designee Ms. Leah Allen and home manager Ms. Sherie Roop admitted that untrained staff have probably worked in the facility due to a severe staffing shortage over the last several weeks. EMS was called to the facility due to staff or other volunteers on-hand who did not know how to lift or transfer residents. A current direct care worker stated that she has received calls from direct care workers at the facility who were not fully trained. These workers reportedly needed instruction over the phone on how to check blood sugar, give insulin and assistance with administering medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility has not been adequately staffed.

INVESTIGATION: I asked the administrators and home manager about the allegation that the facility has not been adequately staffed. They reported that there are typically two or three direct care staff on duty at all times. Mr. Feetham stated that they are in the process of implementing a specific scheduling tool that will aid in determining how many staff should be on-site at any given time. Ms. Roop did

acknowledge that when a staff person walked off the job on August 5, 2022 at 5:40 p.m., there was only one direct care staff left to care for 17 residents. Ms. Roop stated that she was not there at the time. They were able to call Ms. Secord who works as an apartment manager for the same company to come in to help. Ms. Roop and Ms. Allen admitted that the owner is not trained to be a direct care worker. A second, trained direct care worker did come into the facility to work at 9:00 p.m.

Mr. Feetham, Ms. Allen and Ms. Roop stated that they plan to staff two or three direct care workers during the day shifts and at least two direct care workers during the night shift. They reported that they are working diligently to try to hire new staff and ensure that they have adequate staffing for each shift going forward.

On August 15, 2022, Ms. Allen told me that three owners had helped with resident care the day before. They have not been trained as direct care workers.

I spoke with assistant chief Gavin Babieracki, Otsego County EMS deputy chief by phone on August 22, 2022. He said that he was concerned because EMS had been called to August Haus 15 times since he last spoke with me.

I made another unannounced site visit at August Haus on August 23, 2022. Administrator Mr. Kory Feetham and home manager Ms. Sherie Roop were both present during the time of my visit. Mr. Feetham stated that he had received permission to raise starting pay for new hires, increase pay for existing staff and give hiring incentives. Mr. Feetham stated that they were using his new scheduling computer program. He and Ms. Roop reported that they had hired eight or nine new staff in the last two weeks. The new staff are being trained quickly and thoroughly so that they can care for residents. They will always have at least two direct care staff working during each shift, and more if needed. They have all the shifts covered through Saturday of that week and are working on next week's schedule. Former Resident A required the most support from staff but she is gone now. They currently have 17 residents at this time. Mr. Feetham also wanted me to know that they have a nurse on staff now who is working there three days a week. She is trained as a direct care worker and is currently working on making sure the medication counts are accurate.

I asked administrator Kory Feetham and home manager Sherie Roop about EMS being called to the facility 15 times. Ms. Roop stated that they have a resident who is calling 911 whenever her medication is even two minutes late. Their medication passer had been administering medication from the "front" of the hallway to the back. The resident is near the back and is calling 911 when her medication is late. Ms. Roop stated that she has tried to resolve the issue by having this resident receive her medication first and has also given the resident her personal phone number for her to call if she has any concerns.

I asked Ms. Roop for Resident A and Resident B's written assessments. Ms. Roop acknowledged that a written assessment has not been completed for Resident A

because she was an “emergency placement”. She was not aware of where Resident B’s written assessment was but said that she would get that to me.

On August 23, 2022, I spoke with direct care worker Ms. Dani-Lin Marcinkowski. She admitted that things had not been good at the facility in the last several weeks. I asked her how long things have not been good. Ms. Marcinkowski said since the last home manager left which was several weeks before. I asked her to tell me how things were not good. She said that they had been extremely short-staffed. Due to the lack of any kitchen staff, direct care workers have needed to prepare food for residents. She said that she worked a 24-hour shift starting on August 13, 2022. For part of that time, 7:00 a.m. to 7:00 p.m., she was alone with 18 residents. That is unusual for there to be only one direct care staff on during a day shift but there has also sometimes been only one direct care staff on duty during the night shift, 11:00 p.m. to 7:00 a.m. I asked her if all the residents are sleeping during that time. She said that some of them need to be checked on and assisted with using the bathroom during the night shift. One resident does stay up and sits at a dining room table drinking coffee and eating snacks.

I spoke with Tracy Secord by phone on August 24, 2022. She said that she had been asked to help at August Haus due to them being short-staffed. She said that she had gone in on several occasions when there was only one direct care staff on duty caring for all 17 or 18 residents. She not only helped out when she was there but also tried calling the administrators and tried to get other staff to come in to work. They could not always get in contact with the administrators who she identified as Ms. Allen and Ms. Roop.

I spoke with home manager Ms. Sherie Roop by phone on August 24, 2022. I requested copies of Resident A and Resident B’s resident care agreements. Ms. Roop said that there was no resident care agreement for Resident A because she was an “emergency placement” and was only there for a week. She said that she would get me Resident B’s written care agreement.

I spoke with former direct care worker Tiffani Sanchez by phone on August 24, 2022. She said that she was the worker who walked off the job on August 5, 2022. She said that she had been working with former direct care worker Candace Agattas and that Ms. Agattas “pissed her off”. She said that Ms. Agattas had made a comment about her Mexican heritage in which she took offense. Ms. Sanchez stated that if she would have stayed something might have happened between her and Ms. Agattas. Ms. Agattas was the only direct care worker left at the facility at that time.

I spoke with former direct care worker Candace Agattas by phone on August 24, 2022. I asked her about her time working at August Haus. Ms. Agattas stated that she had quit so they offered her a raise of $2.00 an hour to have her remain employed. She accepted their offer and they then fired her two days later. She said that she genuinely does not know why they fired her when she was working as hard as she possibly could to care for the residents there. She was often the only direct

care worker there and that at other times she had a trainee or two with her. On August 5, 2022, she was the only trained direct care worker on-site. She was passing medications, cooking dinner and caring for all the residents at the same time. There was a resident there who she was supposed to be check on every 30 minutes but she couldn't possibly do that even though she tried. They then got a new resident who needed a two-person lift assist. Ms. Agattas said that she called Ms. Roop and asked her how she was supposed to do a two-person assist by herself. Ms. Roop asked her if she could go home and get her husband who could help her. Ms. Agattas said she went to get her husband leaving Ms. Secord with the residents. Ms. Agattas said that there were probably three or four nights total that she worked by herself with 17 or 18 residents.

I spoke with licensee designee Ms. Leah Allen by phone on August 25, 2022. I told her of my request for Resident A and Resident B's written assessments and resident care agreements and that I also wanted copies of Resident C's written assessment and resident care agreement. She said that she did not believe these existed for Resident A and stated that Ms. Roop had been brand new to her position when Resident A was admitted to the facility.

On August 25, 2022, I received copies of Resident B and Resident C's Assessment Plan for AFC Residents (BCAL-3265) and AFC – Resident Care Agreement (BCAL-3266). In Resident B's written assessment it indicated that Resident B required a "Wheelchair and Hoyer lift". Resident C's written assessment indicated that Resident C is unable to wheel himself in his wheelchair, that he needs assistance with toileting, transferring in and out of the shower, help with washing and that staff will assist Resident C in his wheelchair. Each resident care agreement indicated that the facility agreed to follow the resident's written assessment and provide personal care, supervision and protection.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	It was confirmed through this investigation that on several occasions, the ratio of direct care staff to residents was 1 to 17 or 1 to 18 during waking hours. This occurred on August 5, 2022, when a direct care worker left during her shift and also several other times by report of staff, former staff and a volunteer.

CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15206	**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 was sometimes only one fully-trained direct care staff was working and was expected to provide personal care, supervision and protection to 17 or 18 residents. Other times, there were non-fully-trained staff or volunteers who were not able to help with transfers and lifting of residents. EMS services were called 16 times to the facility during a two-week period to assist staff or residents there. It was confirmed through this investigation that the facility did not have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of the residents and to provide the services specified in their resident care agreement and assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are not cared for properly. The call alert system has been turned off at times when staff do not want to reply to resident calls.

INVESTIGATION: On August 8, 2022, I asked Ms. Allen and Ms. Roop about the report that the residents' call alert system was being disabled or ignored. They said that they heard that one staff, Candace Agattas, got tired of the call alerts going off repeatedly and so she unplugged it on at least two occasions. Direct care worker Dani-Lin Marcinkowski has direct knowledge of this happening. They understood that this is a serious threat to resident protection and that if they have this system in place, the calls need to be attended to.
I spoke with Resident D's Family Member by phone on August 18, 2022. She said that her family member stayed at August Haus starting on August 5, 2022. They were assured by staff there that her family member would be checked on every 30 minutes and that she had a call alert button she could use any time she needed assistance. Resident D's Family Member said that she observed the call alert system being ignored by staff there. In fact, it kept sounding for so long that a cook finally came out of the kitchen and casually turned it off. The next morning, Resident

D was still in bed at 10:45 a.m. and she told them that no one had been in to help her get out of bed or use the bathroom. She and her other family members did not believe that Resident D had been checked on every 30 minutes as agreed and were so concerned, they took her out that day. Resident D's Family Member said that it was her impression that the facility was short-staffed. She said that she could not understand why they would agree to take her family member in the first place if they could not properly care for her.

On August 23, 2022, I asked direct care worker Dani-Lin Marcinkowski about the report that the residents' call alert system was being turned off by staff. She said that she knew that former direct care worker Candace Agattas had turned off the call system on at least two occasions because a resident had told her that happened.

On August 24, 2022, I spoke to former direct care worker Tiffani Sanchez. I asked her if she knew about the resident call alert system being disabled. Ms. Sanchez said that she had observed former direct care worker Ms. Agattas unplug the system for 30 minutes. Former direct care worker Samantha Johnson was also on the call and stated that she observed Ms. Agattas unplug the call alert system for an hour. Ms. Agattas had done it right in front of her because she was tired of hearing the alerts going off constantly.

On August 24, 2022, I spoke with former direct care worker Candace Agattas. I asked her about the residents' call alert system being disabled. She said that there were times when Resident C knocked into the call alert system with his wheelchair which would unplug it. Upon further questioning, Ms. Agattas did admit that she had also unplugged it herself when she was working alone. She said that the alerts were sounding but there was nothing she could do when she was caring for someone anyway. She said that as soon as she was done with that particular resident, she would plug it back in. Ms. Agattas said that she would also always check on each resident after she had unplugged the system.

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:	Resident D's Family Member reported that Resident D was not attended to every 30 minutes as had been agreed to and that she found her family member still in bed at 10:45 a.m. She did not believe that her family member had been properly cared for during the almost 24-hour period that she had been at the facility.

	It was confirmed through this investigation that the residents' personal needs, including protection and safety, were not attended to at all times. A call alert system is in place at the facility in order for residents to alert staff when they have personal needs. There is an expectation that this alert will be responded to in a reasonable time-frame. The call alert system was disabled several times by staff who were reportedly overwhelmed with care responsibilities.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Narcotic medication is missing from the facility and possibly used by staff.

INVESTIGATION: On August 8, 2022, I asked Ms. Allen and Ms. Roop about the report that narcotic medication has gone missing from the facility and that it was possibly used by staff. Ms. Roop stated that former direct care worker Tiffani Sanchez had texted her about former direct care worker Candace Agattas being in the parking lot "doing prescription medication". It was unclear from the text whether the "prescription medication" belonged to Ms. Agattas or was from the facility. They did not have any other further information about that reported incident. I asked whether the medication counts had been off recently. They reported that they had recently been "under by 2 or 3 pills" or "over by 2 or 3 pills". They do "narcotic counts" at shift change. Ms. Allen reported that they use the QuickMAR computer system to keep track of their medication passes. Ms. Allen said that there is a way to have the system print off exactly how much medication should be in the building at that time. I asked Ms. Allen if she would do that for the current narcotic medication that was on-hand. Ms. Allen then provided me with a QuickMAR Inventory Report for August Haus. She agreed that the medication on the inventory should align with the medication that was present in the facility.

Ms. Allen introduced me to their new medication supervisor Cayla Duncan. I asked if we could compare what I had for the QuickMar Inventory Report against what was present in the facility. We found that some narcotic medication was missing when we compared what was present to what should be there according to the Inventory Report. Resident B was missing a Lorazepam tablet and her Morphine solution. Resident E was missing 3 Hydrocodone tablets and a Lorazepam tablet. Resident F was missing 3 Oxycodone tablets and a Pregabalin tablet. Resident G was missing 17 Tramadol tablets. Resident H was missing an Alprazolam tablet and a Tramadol tablet. Other counts were over what should have been there. Resident E had 20 mg. of Haloperidol solution and 6 doses of Morphine solution more than what the Inventory Report showed she should have. Resident I had one extra tablet of Hydrocodone than what the Inventory Report showed and Resident J had 262 more tablets of Lorazepam than what the Inventory Report showed.

Ms. Duncan stated that she did not have an explanation for the medication counts being off by so much. She reiterated that she had not been the medication supervisor for long and was still getting a handle on things. She said that she did not know if the discrepancies reflected medication that was actually missing or some system error. Ms. Allen stated that the former home manager was using an administrative function in QuickMAR to try to match what was there with the QuickMAR count. She showed me a QuickMAR Med Disposition Log that showed that in July of 2022 the former home manager had used an "Inventory Adjustment" function to try to match what was on-hand with the QuickMAR inventory. She put in the comments "Fixing Medication Count". Ms. Allen said that she finally told the former home manager that she could not continue doing that. Ms. Allen stated that that was a possible explanation for the medication counts being so far off.

I received an email from licensee designee Leah Allen on August 15, 2022. She reported that they had located Resident B's Morphine solution. It had been in the medication room refrigerator.

On August 23, 2022, I spoke with administrator Kory Feetham and home manager Sherie Roop about the missing narcotic medication. Mr. Feetham stated that they brought in a nurse to help them put an appropriate system in place to track all medication. He also pointed out that the Morphine solution that was believed to be missing was found on the premises. I spoke with the nurse, Heather Reno, who stated that she was almost done taking a complete inventory of what medication was on-site. They were putting several safeguards in place to track the medication especially in terms of narcotics. There will be secondary checks regarding narcotics and a witness whenever staff administer or count narcotics. Ms. Reno went on to say that she found errors in "merging" new prescriptions with existing prescriptions. This was a possible explanation for the missing narcotics. She also reported that all staff were being trained and continue to be trained regarding proper medication administering and documentation.

On August 23, 2022, I asked direct care worker Dani-Lin Marcinkowski about resident medications. She said that the medication counts have been "off" for a long time. Ms. Marcinkowski said that a former direct care worker, Candace Agattas, was a medication passer and had access to resident medication. Ms. Marcinkowski however did not have any evidence that Ms. Agattas took medication. Ms. Marcinkowski also said that she thought that something was wrong with the computer system they use. They have tried to fix the system to make it match what medications are on-site but then the system shows the count to be off again the next day.

I spoke with former direct care worker Tiffani Sanchez and former direct care worker Samantha Johnson by phone on August 24, 2022. I told Ms. Sanchez that her name had come up as someone who knew about possible misuse of medication at August Haus. Ms. Johnson was also present during the call and wished to speak with me about her experience there. I asked Ms. Sanchez about the report that she might

know something about narcotic medication missing from the facility. Ms. Sanchez was a medication passer at August Haus and said that she had noticed that things were very unorganized and that it looked as if narcotic medication was regularly missing from the facility. A whole bottle of Morphine solution went missing from the facility and was mysteriously returned two days later when staff were confronted about it. Former direct care worker Ms. Johnson added at this point that home manager Sherie Roop had "group chatted" them around that time about missing narcotics. She had sent a picture of empty blister packs (of medication) saying "This is unacceptable. There are 14 pills missing from this blister pack. Can anyone explain this?" The resident's name or the type of medication are illegible in the photo. I asked about Ms. Sanchez texting home manager Ms. Roop about former direct care worker Ms. Agattas taking pills in the parking lot. At this point in the discussion, a third person spoke who identified himself as Mr. Daniel Hodges. He said that he is Ms. Sanchez's "husband". He said that the information had come from him since he had been in the parking lot of August Haus on August 5, 2022. He was waiting for Ms. Sanchez so they could "have a smoke together". Ms. Hodges said that he observed Ms. Agattas sitting in her car "eating" pills. He did not see what the pills looked like but said that he distinctly saw her taking the pills from a blister pack. He thought she took about 4 pills. Ms. Sanchez confirmed that after her husband had told her what he saw, she texted the home manager Sherie Roop about it.

On August 24, 2022, I asked former direct care worker Candace Agattas about resident medications. She said there had been "issues" with medication at August Haus. She said that narcotic medication kept coming up missing and no one knew why. She found an empty prescription bottle belonging to Cayla Duncan in the trash and reported it to administration. Ms. Agattas said that she just found it "suspicious" that Ms. Duncan would dispose of that at work. It was her understanding that Ms. Duncan was drug-tested at that time and was positive for what was prescribed to her. Ms. Agattas also said that she thought that narcotic medication was missing after Ms. Duncan had worked a shift. She did not have any specific information about this, just that she thought she was seeing a pattern. Ms. Agattas said that it got to the point where none of the workers wanted to pass medications there because they didn't want to be accused of stealing narcotic medication. I asked Ms. Agattas about the specific complaint of her possibly stealing narcotic medication and her being seen taking pills in the parking lot of the facility. Ms. Agattas said that she keeps her own medication, over-the-counter and prescribed, in her car. She has taken her own medication in the parking lot. I told her that it was reported that she was seen taking pills out of a blister pack which is how most resident medications are kept. Ms. Agattas explained her medical condition to me and said that one of the medications she is prescribed does come in a blister pack. Ms. Agattas denied that she would ever steal residents' medication.

I spoke with licensee designee Ms. Leah Allen. She confirmed that the resident medication was now all accounted for and that they had a system in place to track all medications including narcotic medication. I told her that I had spoken with some of

the former direct care workers the day before and some of what they had told me. I asked her about one of the former direct care workers having suspicions about the current medication supervisor, Cayla Duncan. Ms. Allen agreed that it was true that Ms. Agattas raised a concern after finding Ms. Duncan's empty prescription bottle in the garbage at the facility. They did drug test Ms. Duncan at that time and found that she did have the substance that she was prescribed in her system. There have been no other concerns raised about Ms. Duncan regarding any medication misuse.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	On August 8, 2022 the facility was missing several narcotic tablets and solution. They reported to have found the missing solution a week later. In some instances, their accounting showed that they had more narcotic medication than they should. Staff reported that narcotic medication was regularly coming up missing and made allegations against other staff in an effort to explain the missing narcotic medication. The lack of accounting of the narcotic medication created the opportunity for someone to use it other than the resident for whom the medication was prescribed. It was confirmed through this investigation that the licensee did not take reasonable precautions to ensure that prescription medication was not used by a person other than the resident for whom the medication was prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On August 23, 2022, home manager Ms. Sherie Roop acknowledged that a written resident care agreement was not completed for Resident A. She said that Resident A was an "emergency placement" and that she was not aware of all that needed to be done during an admission.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**

	(6) At the time of the resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party.
ANALYSIS:	It was found during the investigation that a written resident care agreement was not completed for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted exit conferences with licensee designee/administrator Ms. Leah Allen by phone on August 24, 2022 and August 25, 2022. I explained the findings of my investigation and gave her the opportunity to ask questions.

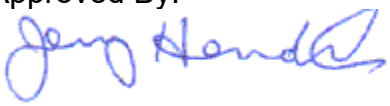
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend issuance of a six-month provisional license for quality of care violations.

08/29/2022

Adam Robarge — Date
Licensing Consultant

Approved By:



08/29/2022

Jerry Hendrick — Date
Area Manager