GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 4, 2022

Corey Husted
Brightside Living LLC
PO Box 220
Douglas, MI 49406

RE: License #: AS410403030
Investigation #: 2022A0583042
Brightside Living - Cedar Springs

Dear Mr. Husted:

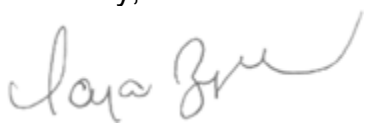
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (616) 356-0183.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410403030
Investigation #:	2022A0583042
Complaint Receipt Date:	09/08/2022
Investigation Initiation Date:	09/08/2022
Report Due Date:	10/08/2022
Licensee Name:	Brightside Living LLC
Licensee Address:	690 Dunegrass Circle Dr Saugatuck, MI 49453
Licensee Telephone #:	(614) 329-8428
Administrator:	Corey Husted
Licensee Designee:	Corey Husted
Name of Facility:	Brightside Living - Cedar Springs
Facility Address:	1880 18 Mile Rd NE Cedar Springs, MI 49319
Facility Telephone #:	(614) 329-8428
Original Issuance Date:	04/21/2020
License Status:	REGULAR
Effective Date:	10/21/2020
Expiration Date:	10/20/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Staff Derrick Brown leaves Resident A in soiled briefs.	No
Facility staff did not properly maintain Resident A's colostomy bag.	Yes
Resident C's medications were not administered from the pharmacy labeled container.	Yes
Staff Denise Collins incorrectly administered Resident C's medications.	No
Resident B did not eat for a weekend.	No
Additional Findings	Yes

III. METHODOLOGY

09/08/2022	Special Investigation Intake 2022A0583042
09/08/2022	APS Referral
09/08/2022	Special Investigation Initiated - Letter Ed Wilson, Recipient Rights
09/12/2022	Inspection Completed On-site
09/13/2022	Contact - Telephone call made Former staff Nikki Pennington
09/13/2022	Contact - Telephone call made Staff Brandi Ryan
09/15/2022	Contact - Telephone call made Staff Denise Collins
09/15/2022	Contact - Telephone call made Licensee Designee Corey Husted
09/19/2022	Contact - Document Received Licensee Designee Corey Husted
09/20/2022	Contact - Document Received Licensee Designee Corey Husted
09/21/2022	Contact - Telephone call made Staff Derrick Brown

09/29/2022	Contact - Telephone call made Friend 1
10/03/2022	Contact - Telephone call made Friend 1
10/04/2022	Exit Conference Licensee Designee Corey Husted

ALLEGATION: Staff Derrick Brown leaves Resident A in soiled briefs.

INVESTIGATION: On 09/08/2022 complaint allegations were received from Centralized Intake and screened out for adult protective services investigation. The complaint allegations stated staff "Derrick" has been "double briefing" Resident A rather than changing his soiled adult brief into a clean adult brief.

On 09/09/2022 I emailed complaint allegations to Ed Wilson of Network 180 Recipient Rights and it was confirmed that a recipient rights complaint would be opened.

On 09/12/2022 I completed an unannounced onsite investigation at the facility and privately interviewed staff Belle Allen, Resident A, Resident C, and Resident E. I attempted to interview Resident D however Resident D refused and stated she preferred to sleep rather than participate in an interview.

Staff Belle Allen stated Resident A requires the utilization of a colostomy bag and adult briefs due to incontinence. Ms. Allen stated staff are required to check and change Resident A's adult brief every "two to three hours" including during third shift. Ms. Allen stated she has no knowledge of staff Derrick Brown failing to check and check Resident A's soiled adult briefs.

While at the facility on 09/12/2022 I observed that Resident A appeared clean and free of foul odors. Resident A could not articulate how often staff check and change his adult briefs. Resident A stated he did not know if staff have "double briefed" him.

Resident C stated he has no knowledge of staff Derrick Brown failing to check and change Resident A on a regular basis during third shift Resident A third shift. Resident C stated he has observed staff check and change Resident A often during the day.

Resident D stated he had no knowledge of staff Derrick Brown failing to check and change Resident A on a regular basis during third shift. Resident D stated staff change Resident A's adult brief "one time" during day shifts and Resident A "smells" and is "wet a lot".

On 09/13/2022 I interviewed former staff Nicole Pennington via telephone. Ms. Pennington stated staff Derrick Brown works third shift alone at the facility. Ms. Pennington stated Resident A requires the assistance of adult briefs due to incontinence and staff are required to check and change him every two to three hours on all shifts. Ms. Pennington stated staff Brandi Ryan reported that staff Derrick Brown is “double briefing” Resident A third shift rather than changing Resident A’s adult brief. Ms. Pennington stated Ms. Ryan reported having a conversation with Mr. Brown in which Mr. Brown admitted to “double briefing” Resident A during his third shift.

On 09/13/2022 I interviewed staff Brandi Ryan via telephone. Ms. Ryan stated staff Derrick Brown “openly admitted” several times to “double briefing” Resident A while working independently third shift so that he didn’t have to change his soiled briefs. Ms. Ryan stated approximately two weeks ago she worked first shift at the facility and observed Resident A “double briefed” and observed the brief was soiled with urine. Ms. Ryan stated Mr. Brown had worked the preceding third shift independently thus Mr. Brown was the only staff to have “double briefed” Resident A.

On 09/15/2022 I interviewed Staff Denise Collins via telephone. Ms. Collins stated she has not observed Resident A “double briefed” or wearing soiled briefs and has no knowledge of staff Derrick Brown doing so.

On 09/15/2022 I interviewed Licensee Designee Corey Husted via telephone. Mr. Husted stated he heard secondhand information from various staff members that staff Derrick Brown had been “double briefing” Resident A because Resident A’s adult briefs were wet with urine while Mr. Brown worked alone third shift. Mr. Husted stated he recently held a staff meeting and informed all staff members that “double briefing” residents is not appropriate resident care. Mr. Husted stated during the staff meeting staff Derrick Brown neither confirmed nor denied “double briefing” Resident A.

On 09/20/2022 I received an email from Licensee Designee Corey Husted. I reviewed that the email contained Resident A’s Assessment Plan for AFC Residents which is signed by Resident A’s legal guardian on 09/16/2022 and signed by the administrator on 09/12/2022. The Assessment Plan indicates Resident A requires staff assistance with toileting and utilizes an ostomy bag. Resident A’s Assessment plan states Resident A requires staff assistance with changing and emptying his ostomy bag.

On 09/21/2022 I interviewed staff Derrick Brown via telephone. Mr. Brown stated he works independently third shift at the facility. Mr. Brown stated he has never “double briefed” Resident A. Mr. Brown stated he awakens Resident A “every three hours” and places Resident A on the toilet for urination.

On 10/04/2022 completed an Exit Conference with Licensee Designee Corey Husted via telephone. Mr. Husted stated he agreed with the findings.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Staff Belle Allen and Staff Denise Collins each reported they have never observed Resident A wearing two briefs and have never observed Resident A in urine soaked briefs. Staff Derrick stated he has never "double briefed" Resident A rather than change his soiled adult briefs. Mr. Brown stated he awakens Resident A "every three hours" and places Resident A on the toilet for urination. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility staff did not properly maintain Resident A's colostomy bag.

INVESTIGATION: On 09/08/2022 complaint allegations were received from Centralized Intake and screened out for adult protective services investigation. The complaint allegations stated that Resident A utilizes a colostomy bag and last week facility staff utilized "binder clips" to close Resident A's colostomy bag because the proper "clips" were missing.

On 09/12/2022 I completed an unannounced onsite investigation at the facility and privately interviewed staff Belle Allen, Resident A, Resident C, and Resident E. I attempted to interview Resident D however Resident D refused and stated she preferred to sleep rather than participate in an interview.

Staff Belle Allen stated Resident A utilizes a colostomy bag and adult briefs due to incontinence. Ms. Allen stated Resident A's colostomy bag requires clips for secure closure. Ms. Allen stated she has never observed or heard of Resident A's colostomy bag being closed utilizing "binder clips" by facility staff.

I attempted to interview Resident A however due to his significant memory deficit he was unable to identify if he had ever run out of colostomy clips and could not remember if his colostomy bag was ever sealed with binder clips.

Resident C and Resident D both stated Resident A utilizes a colostomy bag however both residents stated they have no knowledge of Resident A running out of colostomy bag clips and no knowledge of staff utilizing binder clips for closure.

While onsite I observed a small bag that Ms. Allen identified as Resident A's colostomy bag clips for Resident A's colostomy bag. The small bag was opaque therefore I could not visually observe the contents of the bag.

On 09/13/2022 I interviewed former staff Nicole Pennington via telephone. Ms. Pennington stated on 09/01/2022 she received a telephone call from staff Brandi Ryan and Ms. Ryan reported she was working at the facility but could not locate Resident A's colostomy bag clips. Ms. Pennington stated she did not know where the clips were and why the facility ran out Resident A's clips. Ms. Pennington stated she advised Ms. Ryan to seal Resident A's colostomy bag with "binder clips".

On 09/13/2022 I interviewed staff Brandi Ryan via telephone. Ms. Ryan stated that on 09/01/2022 she checked Resident A's colostomy bag at approximately 08:30 PM and observed that the colostomy bag was unsealed and without a clip. Ms. Ryan stated she searched the facility and could not locate Resident A's colostomy clips and therefore utilized "binder clips" to seal Resident A's bag. Ms. Ryan stated she observed Resident A had more colostomy bag clips the next shift Ms. Ryan worked and he currently has colostomy clips.

On 09/15/2022 I interviewed Staff Denise Collins via telephone. Ms. Collins stated she has always observed Resident A to have an adequate supply of colostomy clips. Ms. Collins stated she has never observed Resident A's colostomy bag unsealed.

On 09/15/2022 I interviewed Licensee Designee Corey Husted via telephone. Mr. Husted confirmed Resident A requires the utilization of a colostomy bag with clip closure. Mr. Husted stated on 09/01/2022 he received a telephone call from staff Brandi Ryan who reported Resident A's colostomy was unsealed and no clips could be located at the facility. Mr. Husted stated Ms. Ryan subsequently utilized binder clips to secure Resident A's colostomy bag. Mr. Husted stated he purchased a new box of colostomy clips from Amazon on 09/01/2022 which were shipped to the facility the following day on 09/02/2022. Mr. Husted stated Resident A currently has colostomy bag clips. Mr. Husted stated he does not know where Resident A's colostomy bag clips disappeared to on 09/01/2022.

On 10/04/2022 I completed an Exit Conference with Licensee Designee Corey Husted via telephone. Mr. Husted stated he agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Staff Brandi Ryan stated that on 09/01/2022 she checked Resident A's colostomy bag at approximately 08:30 PM and observed that the colostomy bag was unsealed and without a clip. Ms. Ryan stated she utilized "binder clips" to seal Resident A's bag. Licensee Designee Corey Husted confirmed Resident A requires the utilization of a colostomy bag with clip closure. Mr. Husted stated on 09/01/2022 he received a telephone call from staff Brandi Ryan who reported Resident A's colostomy was unsealed and no clips could be located at the facility. Mr. Husted stated Ms. Ryan subsequently utilized binder clips to secure Resident A's colostomy bag. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident C's medications were not administered from the pharmacy labeled container.

INVESTIGATION: On 09/08/2022 complaint allegations were received from Centralized Intake and screened out for adult protective services investigation. The complaint allegations stated that facility staff removed Resident C's medications from the original pharmacy container and preset the medications into a seven day medication organizer.

On 09/12/2022 I completed an unannounced onsite investigation at the facility and privately interviewed staff Belle Allen, Resident A, Resident C, and Resident E. I attempted to interview Resident D however Resident D refused and stated she preferred to sleep rather than participate in an interview.

Staff Belle Allen stated she had no knowledge of Resident C's medications being preset into a seven day medication organizer.

Resident A started he had no knowledge of Resident C's medications being preset into a seven day medication organizer.

Resident C stated he is administered his medications as prescribed. Resident C stated he had no knowledge of his medications being preset into a seven day medication organizer.

Resident D started he had no knowledge of Resident C's medications being preset into a seven day medication organizer.

While onsite I observed Resident C's medications were stored in the original pharmacy containers.

On 09/13/2022 I interviewed former staff Nicole Pennington via telephone. Ms. Pennington stated Resident C receives his medications from the Veterans Administration and the medications are sent to the facility in "pill bottles". Ms. Pennington stated each week staff Denise Collins removes Resident C's medications from the pharmacy provided containers and places them into a weekly store bought pill container that is divided by day and AM/PM.

On 09/13/2022 I interviewed staff Brandi Ryan via telephone. Ms. Ryan stated Resident C's medications are sent to the facility in pill bottles. Ms. Ryan stated each week staff Denise Collins removes Resident C's medications from the pharmacy provided containers and places them into a weekly store bought pill container that is divided by day and AM/PM.

On 09/15/2022 I interviewed staff Denise Collins via telephone. Ms. Collins confirmed that at the beginning of each week she removed Resident C's medications from the pharmacy provided containers and placed them into a weekly store bought pill container that is divided by day and AM/PM. Ms. Collins stated that she never administered Resident C's morning medications in the evening and never administered Resident C's evening medications in the morning.

On 09/15/2022 I interviewed Licensee Designee Corey Husted via telephone. Mr. Husted stated that he aware that each week former staff Nikki Pennington removed Resident C's medications from the pharmacy provided containers and placed them into a weekly store bought pill container that is divided by day and AM/PM.

On 10/04/2022 I completed an Exit Conference with Licensee Designee Corey Husted via telephone. Mr. Husted stated he agreed with the findings and would submit an acceptable Corrective Action Plan.

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:	Former staff Nicole Pennington stated each week staff Denise Collins removes Resident C's medications from the pharmacy provided containers and places them into a weekly store bought pill container that is divided by day and AM/PM. Staff Brandi Ryan stated each week staff Denise Collins removes Resident C's medications from the pharmacy provided containers and places them into a weekly store bought pill container that is divided by day and AM/PM. Staff Denise Collins confirmed that at the beginning of each week she removed Resident C's medications from the pharmacy provided containers and placed them into a weekly store bought pill container that is divided by day and AM/PM. Licensee Designee Corey Husted stated that he aware that each week former staff Nikki Pennington removed Resident C's medications from the pharmacy provided containers and placed them into a weekly store bought pill container that is divided by day and AM/PM. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff Denise Collins incorrectly administered Resident C's medications.

INVESTIGATION: On 09/08/2022 complaint allegations were received from Centralized Intake and screened out for adult protective services investigation. The complaint allegations stated that one time staff "Denise" administered a resident's night time medication in the morning.

On 09/12/2022 I completed an unannounced onsite investigation at the facility and privately interviewed staff Belle Allen, Resident A, Resident C, and Resident E. I attempted to interview Resident D however Resident D refused and stated she preferred to sleep rather than participate in an interview.

Staff Brandi Allen stated she had no knowledge of staff members administering any residents' morning medications incorrectly or at the wrong time.

Resident A, Resident C, and Resident E each reported that they have no knowledge of their medications being administered at the wrong time.

While onsite I observed Resident A, Resident C, Resident D, and Resident E's Medication Administration Records. I did not observe that any residents' medications were administered at the wrong time.

On 09/13/2022 I interviewed former staff Nicole Pennington via telephone. Ms. Pennington stated Resident C receives his medications from the Veterans Administration and the medications are sent to the facility in pill bottles. Ms. Pennington stated, "multiple times" Ms. Collins "mixed up" Resident C's AM and PM medications in the pill box and administered Resident C's "AM medications in the PM" and "PM medications in the AM".

On 09/13/2022 I interviewed staff Brandi Ryan via telephone. Ms. Ryan stated Resident C's medications are sent to the facility in pill bottles. Ms. Ryan stated that on multiple occasions Ms. Collins accidentally placed Resident C's "AM medications in the PM portion" and "PM medications in the AM portion" of the pill box. Ms. Ryan stated Ms. Collins subsequently administered Resident C his AM medications in the PM and his PM medications in the AM on more than one occasion.
On 09/15/2022 I interviewed Staff Denise Collins via telephone. Ms. Collins confirmed that at the beginning of each week she removed Resident C's medications from the pharmacy provided containers and placed them into a weekly store bought pill container that is divided by day and AM/PM. Ms. Collins stated that she never administered Resident C's morning medications in the evening or Resident C's evening medications in the morning.

On 09/15/2022 I interviewed Licensee Corey Husted via telephone. Mr. Husted stated that he was never aware of staff Denise Collins administering Resident C's morning and evening medications at incorrect times.

On 10/04/2022 I completed an Exit Conference with Licensee Designee Corey Husted via telephone. Mr. Husted stated he agreed with the findings.

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:	Resident A, Resident C and Resident E each reported that they have no knowledge of their medications being administered at the wrong time. While onsite I observed Resident A, Resident C, Resident D, and Resident E's Medication Administration Records. I did not observe that any residents' medications were administered at the wrong time. Staff Denise Collins stated that she never administered Resident C's morning medications in the evening or Resident C's evening medications in the morning. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident B did not eat for a weekend.

INVESTIGATION: On 09/08/2022 complaint allegations were received from Centralized intake and screened out for adult protective services investigation. The complaint alleged that two weeks ago staff Denise let Resident B go all weekend without eating.

On 09/12/2022 I completed an unannounced onsite investigation at the facility and privately interviewed staff Belle Allen, Resident A, Resident C, and Resident E. I attempted to interview Resident D however Resident D refused and stated she preferred to sleep rather than participate in an interview.

Staff Belle Allen stated she has worked with the Brightside Living LLC for three years but at the current facility for approximately two weeks. She stated Resident B left the facility just before she started working at the facility and she had no knowledge of Resident B not eating for a weekend.

Resident A stated he is provided an adequate volume of food. Resident A stated he could not remember a time in which Resident B wasn't offered three meals daily.

Resident C stated he is provided with an adequate quantity of food. Resident C stated Resident B resided at the facility for approximately two weeks prior to discharging to the hospital due to being "ill". Resident C stated the weekend preceding Resident B's hospitalization staff Denise Collins offered Resident B "plenty of food" however Resident B chose to only eat items such as pudding, crackers, and other items.

Resident D stated he is provided an adequate amount of food. Resident D stated Resident B resided at the facility "only a couple weeks" and the weekend preceding his discharge to the hospital staff Denise Collins provided Resident B with regular meals however Resident B declined due being "sick" as evidenced by nausea and diarrhea. Resident D stated Ms. Collins provided Resident B with other food options which were easily digestible such as crackers which Resident B consumed.

While onsite I observed the facility's menu which was clearly posted and contained adequate nutrition. I observed a plentiful quantity of food in the kitchen cabinets and refrigerator.

On 09/13/2022 I interviewed former staff Nicole Pennington via telephone. Ms. Pennington stated she heard from staff Denise Collins that Resident B had been ill as evidenced by nausea and diarrhea the weekend preceding his hospitalization. Ms. Pennington stated she was informed that staff Denise Collins worked at the facility independently first shift the weekend preceding Resident B's hospitalization and Resident B had not "eaten anything" that weekend. Ms. Pennington stated Resident B has not returned to the facility.

On 09/15/2022 I interviewed staff Denise Collins via telephone. Ms. Collins stated she worked first shift at the facility the weekend Resident B was "sick". Ms. Collins stated Resident B displayed nausea and diarrhea throughout the weekend which necessitated Resident B to be sent to the hospital for further treatment the following Monday. Ms. Collins stated Resident B was not returned to the facility since he was hospitalized. Ms. Collins stated the weekend she worked at the facility she offered Resident B three meals daily however Resident B refused. Ms. Collins stated during the weekend Resident B did consume food items such as "milk, pop, pudding, applesauce, and crackers". Ms. Collins stated Resident B's "girlfriend", Friend 1, visited the facility during the weekend and also provided Resident B with food.

On 09/15/2022 I interviewed Licensee Corey Husted via telephone. Mr. Husted stated that he was unaware of Resident B's diet the weekend preceding his 08/22/2022 hospitalization.

On 09/21/2022 I interviewed staff Derrick Brown via telephone. Mr. Brown stated he worked one evening third shift at the facility during the weekend Resident B was "sick". Mr. Brown stated Resident B was sleeping during Mr. Brown's shift and Mr. Brown had no direct knowledge regarding Resident B's diet.

On 09/29/2022 I telephoned Friend 1 who did not answer the telephone call. I left a voicemail message and requested a return telephone call back. I left Friend 1 a text message requesting a telephone call back.

On 10/03/2022 I interviewed Friend 1 via telephone. Friend 1 stated Resident B resided at the facility briefly before leaving the facility for a hospital admission on 08/22/2022 due to flu like symptoms caused by Diverticulitis. Friend 1 stated she visited Resident B at the facility the weekend preceding Resident B's hospitalization and Resident B refused to eat because he was ill and unhappy to be residing at the facility. Friend 1 stated facility staff did offer Resident B food items that were easily digestible but Resident B refused while Friend 1 was at the facility. Friend 1 stated Resident B was ultimately hospitalized on 08/22/2022 for seven to ten days and then transferred to a new facility where he died on 09/11/2022 due to lung cancer complications.

On 10/04/2022 I completed an Exit Conference with Licensee Designee Corey Husted via telephone. Mr. Husted stated he agreed with the findings.

APPLICABLE RULE	
R 400.14313	**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:	Resident C stated the weekend preceding Resident B's hospitalization staff Denise Collins offered Resident B "plenty of food" however Resident B chose to only eat items such as pudding, crackers, and other items. Staff Denise Collins via telephone. Ms. Collins stated she worked at the facility first shift the weekend Resident B was "sick". Ms. Collins stated Resident B displayed nausea and diarrhea throughout the weekend, Ms. Collins stated the weekend she worked at the facility she offered Resident B three meals daily however Resident B refused. Ms. Collins stated

	during the weekend Resident B did consume food items such as “milk, pop, pudding, applesauce, and crackers”. Resident D stated the weekend preceding Resident B’s discharge to the hospital staff Denise Collins provided Resident B with regular meals however Resident B declined due being “sick” as evidenced by nausea and diarrhea. Resident D stated Ms. Collins provided Resident B with other food options which were easily digestible such as crackers which Resident B consumed. Friend 1 stated she visited Resident B at the facility the weekend preceding Resident B’s hospitalization and Resident B refused to eat. Friend 1 stated facility staff did offer Resident B food items that were easily digestible but Resident B refused while Friend 1 was at the facility. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: An Assessment Plan was not completed by facility staff for Resident B.

INVESTIGATION: On 09/22/2022 I received and reviewed an email from Licensee Designee Corey Husted. The email stated that an Assessment Plan had not been completed for Resident B. Mr. Husted stated that Resident B “came in with very limited function and left before we could get anything signed or filled out”.

On 10/04/2022 I completed an Exit Conference with Licensee Designee Corey Husted via telephone. Mr. Husted stated he agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions:

	(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home. **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.** **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	Licensee Designee Corey Husted acknowledged that an Assessment Plan was not completed for Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Resident B was hospitalized and an Incident Report was never completed.

INVESTIGATION: On 09/15/2022 I interviewed Licensee Corey Husted via telephone. Mr. Husted confirmed that Resident B was hospitalized on 08/22/2022 after exhibiting a lack of appetite, diarrhea, and general malaise. Mr. Husted stated he was unsure if an incident report has been completed.

On 09/19/2022 I completed a LARA file review and was unable to locate an incident report regarding Resident B's 08/22/2022 hospitalization.

On 09/30/2022 I received a text message from Licensee Designee Corey Husted. The text message stated Resident B was hospitalized on 08/22/2022 and did not return to the facility. Mr. Husted stated an Incident Report was not completed regarding Resident B's 08/22/2022 hospitalization and Mr. Husted does not know which hospital Resident B was hospitalized at.

On 10/04/2022 I completed an Exit Conference with Licensee Designee Corey Husted via telephone. Mr. Husted stated he agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:

	(b) Any accident or illness that requires hospitalization.
ANALYSIS:	Licensee Designee Corey Husted acknowledged that Resident B was hospitalized on 08/22/2022 and an Incident Report was not completed regarding the hospitalization. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Staff Denise Collins administered Resident D's medications on 09/11/2022 but failed to initial Resident D's Medication Administration Record.

INVESTIGATION: While onsite on 09/12/2022 I observed B, Resident C, Resident D, and Resident E's Medication Administration Records. Resident D's Medication Administration Record indicated that on 09/11/2022 Resident D did not receive her prescribed "AM" medications which included Benztropine Tab .5 mg, Escitalopram Tab 20 mg, Levothyroxin Tab 100 mg, Omeprazole Cap 20 mg, Restasis .05 Emul, Tamsulosin Cap .4 mg, Vitamin C 500 mg, Zafirluskast Tab 20 mg. I observed that on 09/11/2022 Resident B, Resident C, and Resident E's Medication Administration Records indicated that they had received their "AM" medications as prescribed with no evidence of medication error by staff Denise Collins.
On 09/15/2022 I interviewed staff Denise Collins via telephone. Ms. Collins stated she administered Resident D's 09/11/2022 "AM" medications as prescribed however forgot to initial Resident D's Medication Administration Record as doing so.

On 10/04/2022 I completed an Exit Conference with Licensee Designee Corey Husted via telephone. Mr. Husted stated he agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14312	**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: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.**

	(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Resident D's Medication Administration Record indicated that on 09/11/2022 Resident D did not receive her prescribed "AM" medications which included Benztropine Tab .5 mg, Escitalopram Tab 20 mg, Levothyroxin Tab 100 mg, Omeprazole Cap 20 mg, Restasis .05 Emul, Tamsulosin Cap .4 mg, Vitamin C 500 mg, Zafirluskast Tab 20 mg. I observed that on 09/11/2022 Resident B, Resident C, and Resident E's Medication Administration Records indicated that they had received their "AM" medications as prescribed with no evidence of medication error by staff Denise Collins. Staff Denise Collins stated she administered Resident D's 09/11/2022 "AM" medications as prescribed however forgot to initial Resident D's Medication Administration Record as doing so. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

10/04/2022

Toya Zylstra Date
Licensing Consultant

Approved By:

10/04/2022

Jerry Hendrick
Area Manager

Date