GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 2, 2022

Moonyeen Lincoln & Cyndie Lake
19138 144th Ave.
Fruitport, MI 49415

RE: License #: AF700380762
Investigation #: 2023A0350005
Rocking Horse Ranch

Dear Ms. Lincoln and Mrs. Lake:

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) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF700380762
Investigation #:	2023A0350005
Complaint Receipt Date:	10/31/2022
Investigation Initiation Date:	10/31/2022
Report Due Date:	11/30/2022
Licensee Name:	Moonyeen Lincoln & Cyndie Lake
Licensee Address:	19138 144th Ave. Fruitport, MI 49415
Licensee Telephone #:	(616) 846-6593
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Rocking Horse Ranch
Facility Address:	19138 144th Avenue Fruitport, MI 49415
Facility Telephone #:	(616) 846-6593
Original Issuance Date:	01/22/2016
License Status:	REGULAR
Effective Date:	07/21/2022
Expiration Date:	07/20/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
Staff made Resident B sit and took away some of her personal belongings (DVD's) as punishment for screaming. Resident B does not have a Behavior Plan stating these forms of discipline can be used.	Yes
Staff have been giving Resident A his Diazepam orally, but it is prescribed to be given rectally.	Yes
Staff member Kerri Bauer recently signed that she was the one who gave Resident A a dose of his Diazepam, when it was actually Moonyeen Lincoln, Licensee, who gave it to him.	Yes

III. METHODOLOGY

10/28/2022	APS referral made
10/31/2022	Special Investigation Intake 2023A0350005
10/31/2022	Special Investigation Initiated - On Site I made an onsite inspection and spoke with Cyndie Lake, Home Manager, and Moonyeen Lincoln, Licensee Designee, and Jessica Sobers, RN from HealthWest
11/01/2022	Contact - Telephone call made I spoke with Kerri Bauer, DCW
11/02/2022	Exit conference – Held with Cyndie Lake, Co-Licensee

ALLEGATION: Staff made Resident B sit and took away some of her personal belongings (DVDs) as punishment for screaming. Resident B does not have a Behavior Plan stating these forms of discipline can be used.

INVESTIGATION: On 10/31/2022, I made an onsite inspection, and spoke with Moonyeen Lincoln, Licensee. I asked her if she had recently required Resident B sit down as punishment for her yelling, and also if she had taken away Resident B's DVDs as a disciplinary measure for Resident B. Ms. Lincoln acknowledged that she did do these things. When I asked if these forms of discipline were written in Resident B's Community Mental Health (CMH) Treatment or Behavior Plans, Ms. Lincoln ackowledged that they were not, and added that Resident B did not have a

Behavior Plan. Mrs. Lake, who was present during part of this interview, said that she had requested that Resident B's Case Manager write a Behavior Plan and add these forms of discipline, but was told that because Resident B does not have acting out behaviors often enough, it was not necessary to draw up a Behavior Plan. However, Mrs. Lake said she was going to continue to pursue having this done. Ms. Lincoln informed me that before she had Resident B sit in a "timeout" or took away her DVDs, she first asked Resident B to go to her room to calm down. Resident B did go to her room but continued screaming and tore up one of her books. Ms. Lincoln told me that she asked Resident B to take a walk with her, which she did, but afterward she continued having a "screaming fit". Mr. Lincoln reported that she now knows she cannot use any methods of discipline with a resident who acts out unless such measures are written in their Treatment of Behavior Plans from CMH.

On 11/02/2022, I called and held an exit conference with Cyndie Lake, Co-Licensee. I informed Mrs. Lake that I was citing a violation of this rule. Mrs. Lake thanked me and had no further comment.

APPLICABLE RULE	
R 400.1413	**Resident behavior management; time-out restrictions; time-out reporting.**
	Resident behavior management; time-out restrictions; time-out reporting. **(1) A licensee shall not use time-out unless authorized, in writing, in the resident's written assessment plan, by the resident's designated representative and responsible agency.** **(2) A licensee shall not use time-out until he or she has successfully completed time-out training as required by the responsible agency.** **(3) A licensee shall maintain a written record of each occurrence of time-out. The record shall include all of the following information:** **(a) The nature of the time-out.** **(b) The reason for time-out.** **(c) The types of less restrictive alternatives which were tried.** **(d) The name of the person authorizing the use of time-out.** **(e) The times and dates time-out was used.** **(4) A licensee shall make available reports of all uses of time-out when requested by the resident's designated representative, responsible agency, or the department.**

ANALYSIS:	Moonyeen Lincoln, Licensee, acknowledged that she made Resident B sit and took away her DVDs as punishment because Resident B had been yelling and screaming. Resident B is a recipient of Community Mental Health services; however, a Behavior Plan has not been written and there is no documentation approving time-outs or the taking away of personal items as forms of discipline regarding Resident B. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff have been giving Resident A his Diazepam orally, but it is prescribed to be given rectally.

INVESTIGATION: On 10/31/2022, I made an onsite inspection, and spoke with Cyndie Lake, Home Manager. I informed Mrs. Lake that it was alleged that staff members have been giving Resident A his Diazepam orally, but it is prescribed to be given rectally. Mrs. Lake confirmed this, and said that they used to give it to him rectally, but because, “he does not have a lot of rectal tone,” he does not retain this medication (it oozes back out), they give it to him orally. Mrs. Lake told me that a doctor or Nurse Practitioner from Visiting Physicians told her they could give it to him orally if they do so in very small amounts being put between his gum and cheek. Mrs. Lake believed the doctor or nurse wrote this out for her, and that she would check to see if she could find that documentation.

During my onsite inspection on 10/31/2022, Mrs. Lake, two staff members, and two nurses from HeatlhWest were in the middle of a medication review regarding Resident A. Jessica Sobers, Registered Nurse, was going over the correct procedure of administering Resident A’s Diazepam, emphasizing that it is only to be administered rectally because this form of Diazepam is a gel and giving giving it orally could cause him to asperate. Mrs. Lake stated that they have been giving Resident A this form of Diazepam orally for about 2 ½ years, and reiterated that a doctor or nurse from Visiting Physicians informed her that it could be given to him orally if done so in small amounts applied between his gum and cheek. Ms. Sobers stressed that this form of Diazepam should only be given rectally; however, she stated that this medication also comes as a nasal spray. Mrs. Lake said that she would like to try the nasal spray Diazepam with Resident A.

On 11/02/2022, I called and held an exit conference with Cyndie Lake, Co-Licensee. I informed Mrs. Lake that I was citing a violation of this rule. Mrs. Lake informed me that she has since spoken with someone at the Visiting Physicians Association (VPA) and requested a prescription for a nasal spray of Diazepam for Resident A. Mrs. Lake also said that she remembered that the nurse from VPA who used to visit a few years ago was the one who said the gel version of Diazepam, the version they

have been using for the past few years, could be giving orally, and she asked the VPA if they would check their records to see if that nurse ever wrote an order for the gel version to be given orally. Mrs. Lake said she was told her request would have to go through their legal department, so she decided not pursue this any further.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(2) Medication shall be given pursuant to label instructions.
ANALYSIS:	Staff have been giving Resident A his Diazepam orally for over two years, but it was prescribed to be given rectally. There was no doctor or nurse's order approving the giving of this medication orally. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Recently, staff member Kerri Bauer, signed that she was the one who gave Resident A a dose of his Diazepam, when it was actually Moonyeen Lincoln, Licensee, who gave it to him.

INVESTIGATION: On 10/31/2022, I made an onsite inspection, and spoke with Cyndie Lake, Home Manager. I informed Mrs. Lake that it was alleged that Moonyeen Lincoln, Licensee Designee, recently gave Resident A a dose of Diazepam, which is given if Resident A has a seizure lasting more than five minutes, but she failed to initial the Medication Administration Record (MARs), and that Kerri Bauer, Direct Care Worker (DCW) initialed the MARs instead. Mrs. Lake stated that Ms. Lincoln and Ms. Baurer confirmed this, and that she advised Ms. Lincoln not to administer medications anymore and told Ms. Bauer she is not sign the MARs for someone else; she is only to sign it when she passes the medication(s) herself.

On 10/31/2022, I spoke with Moonyeen Lincoln and she acknowledged that the last time she gave Resident A his Diazepam, it was in the middle of the night when he was having a seizure, and she forgot to initial the MARs.

On 11/01/2022, I called and spoke with Ms. Bauer. I asked her if she had signed the MARs for a dosage of Diazepam that Ms. Lincoln gave to him recently, and she said she did. Ms. Bauer stated that this was the only time she signed the MARs when someone else gave a resident his or her medication, and that she has since been informed not to do that, and she said she would not do this again.

On 11/02/2022, I called and held an exit conference with Cyndie Lake, Co-Licensee. I informed Mrs. Lake that I was citing a violation of this rule. Mrs. Lake thanked me and had no further comment.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: **Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.**
ANALYSIS:	Recently, Moonyeen Lincoln, Licensee, gave Resident A a dose of Diazepam and failed to initial the Medication Administration Record. Instead, staff member Kerri Bauer initialed the log as if she had administered the medication. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

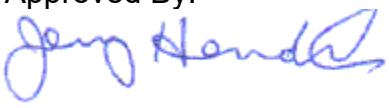
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

November 2, 2022

Ian Tschirhart — Date
Licensing Consultant

Approved By:



November 2, 2022

Jerry Hendrick — Date
Area Manager