GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 21, 2022

Paula Barnes
Central State Community Services, Inc.
Suite 201
2603 W Wackerly Rd
Midland, MI 48640

RE: License #: AS630405663
Investigation #: 2023A0611005
Seymour Home

Dear Ms. Barnes:

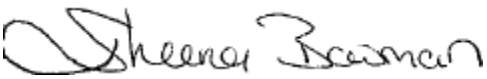
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

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

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630405663
Investigation #:	2023A0611005
Complaint Receipt Date:	11/29/2022
Investigation Initiation Date:	12/01/2022
Report Due Date:	01/28/2023
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 - 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Dezhanae Bennett
Licensee Designee:	Paula Barnes
Name of Facility:	Seymour Home
Facility Address:	241 Cheltenham Oxford, MI 48371
Facility Telephone #:	(248) 572-6040
Original Issuance Date:	03/04/2021
License **Status:**	REGULAR
Effective Date:	09/04/2021
Expiration Date:	09/03/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident T who is wheelchair bound, alleges that due to a prior complaint she made about the home, staff are mad and have taken her phone, restricted her visitation rights, and used her food stamp card without her permission.	No
Additional Findings	Yes

III. METHODOLOGY

11/29/2022	Special Investigation Intake 2023A0611005
11/30/2022	APS Referral According to the intake email, Adult Protective Services (APS) referral was denied.
12/01/2022	Special Investigation Initiated – Telephone I made a telephone call to the reporting source and discussed the allegations with the assistance of a deaf interpreter.
12/06/2022	Inspection Completed On-site I made an unannounced onsite. I interviewed Resident T and staff member Jessica Robinson. I received copies of Resident T's individualized plan of service (IPOS), and her MAR for the month of December 2022.
12/08/2022	Contact - Telephone call made I made a telephone call to the home manager, Isaiah Thomas. The allegations were discussed.
12/09/2022	Contact - Document Received I received a copy of Resident T's funds part II forms.
12/09/2022	Contact - Document Received I received a copy of Resident T's resident care agreement, visitor log, MAR for the month of November, and store receipts from October and November.
12/15/2022	Contact - Document Received I received a copy of Resident T's IPOS dated 05/01/22.

12/16/2022	Contact - Telephone call made I left a voice message for Resident T's guardian, Jim Starks requesting a call back.
12/16/2022	Contact - Telephone call made I made a telephone call to staff member, Tiffany Jones. The allegations were discussed.
12/16/2022	Contact - Telephone call received I received a return phone call from the Assistant Executive Director at MOGI, Teresa Moore. The allegations were discussed.
12/16/2022	Contact - Telephone call made I made a telephone call to the Program Coordinator, De'Zhanae Bennett. Resident T's MAR was discussed. Ms. Bennett also provided additional store receipts.
12/16/2022	Contact - Telephone call made I contacted Resident T's case manager Elizabeth Cossaboom. The allegations were discussed.
12/16/2022	Exit Conference I attempted to complete an exit conference with the licensee designee, Paula Barnes however; there was no answer. A voice message was left. Therefore, an exit conference was completed via email.

ALLEGATION:

Resident T who is wheelchair bound, alleges that due to a prior complaint she made about the home, staff are now retaliating against her. Staff are mad and have taken her phone, restricted her visitation rights, and used her food stamp card without her permission.

INVESTIGATION:

On 11/30/22, I received an intake referral from Adult Protective Services who denied their referral regarding the AFC group home door handle being difficult for Resident T to reach, staff taking Resident T's phone away, and threatening to not allow her to have visitors. It should be noted that a previous special investigation (SIR #2021A0993022) was completed on 06/24/21 regarding Resident T not being fed, sitting in a soiled brief, and staff throwing away her medications. The allegations regarding Resident T not being fed and sitting in a soiled brief was unsubstantiated. However, the allegations pertaining to Resident T not being administered her medications was substantiated.

On 12/01/22, I contacted the reporting source. Regarding the allegations, the reporting source was made aware of the allegations from Resident T's best friend who does not live at the AFC group home. Resident T's best friend is deaf. The reporting source stated staff member, Isaiah Thomas has Resident T's ID and food stamp card.

On 12/06/22, I made an unannounced onsite. I interviewed Resident T and staff member Jessica Robinson. I received copies of Resident T's individualized plan of service (IPOS), and her MAR for the month of December 2022. I observed three residents in the living area who appeared to be low functioning and non-verbal.

On 12/06/22, I interviewed Resident T. Prior to my interview, Resident T's brief was changed by Ms. Robinson. Resident T is deaf, and wheelchair bound. I interviewed Resident T by talking to her through her voice command on her iPad and she responded via text. Regarding the allegations, Resident T stated she was tired of staff member Isaiah Thomas as he is mean to her and does not listen to her. Resident T stated that Mr. Thomas used her food stamp card twice on November 23, 2022 without her permission. I observed Resident T's food stamp transaction history on her iPad. A food stamp purchase was made on 11/23/22 at Wal-Mart for $93.92 and at Kroger on 11/23/22 for $7.95. Resident T stated her food stamp card is only for her and no one else in the AFC group home. Resident T stated staff do change her briefs everyday however; sometimes she has to wait three or four hours before staff will change her briefs. Staff member, Tiffany Jones is the only staff that takes three to four hours to change Resident T's brief. Resident T stated only female staff members change her briefs.

Resident T stated Mr. Thomas is mean to her as he will push her in her wheelchair when she doesn't want him too and he will bring her into her bedroom. Resident T stated Mr. Thomas will sit in her bedroom and watch her because he thinks she is going to kill herself however; she told him she is not going to kill herself. Mr. Thomas will also take Resident T's iPad away which is also her cell phone. Resident T stated she has no idea why Mr. Thomas takes away her iPad. Resident T stated Mr. Thomas has told her she cannot have any visitors. Mr. Thomas does not listen to Resident T's case manager or guardian.

Resident T stated she does have trouble reaching the outside door handle because it is too far away. Resident T stated staff members do help her with opening the door. Resident T denied any issues with leaving in and out of the group home in her wheelchair. Resident T denied any other problems with any other staff members.

On 12/06/22, I observed the front and back door of the AFC group home. The backdoor has an appropriate wheelchair ramp to allow accessibility in and out of the home. The front door leads to street level and does not require any modifications to allow staff and/or residents to enter the home. Pictures of both doors were taken.

On 12/06/22, I interviewed staff member Jessica Robinson. Ms. Robinson has worked at the AFC group home for two weeks. Ms. Robinson stated Resident T prefers for staff to change her briefs twice a day and when she has a bowel movement. Although, staff prefer to change Resident T's briefs more often, Resident T likes her brief change when she wakes up in the morning and before she goes to bed. Ms. Robinson stated the reason why Resident T only wants her brief changed twice a day because she does not like being transferred back and forth from her wheelchair to her bed for changing. Ms. Robinson stated she is not aware of any staff members who refuse to change Resident T's briefs or allow Resident T to sit in a soiled brief for three or four hours before changing her. Ms. Robinson confirmed that only female staff members change Resident T's briefs.

Ms. Robinson stated as far as she knows, Resident T has visitors every other week. Resident T has never been denied visitors at the AFC group home nor has a staff member taken away her visitation rights. Ms. Robinson denied ever witnessing Mr. Thomas being mean to Resident T or prevent her from having visitors. Mr. Thomas has Resident T's food stamp card as he is responsible for taking her grocery shopping. Resident T's guardian prefers Mr. Thomas to manage Resident T's food stamp card however; Resident T can log into her account and see her balance. Resident T's food stamp card is only for Resident T. Ms. Robinson stated Resident T never leaves the AFC group home by herself.

On 12/06/22, I received a copy of Resident T's IPOS dated 07/07/22. The IPOS does not indicate any instructions regarding Resident T's food stamp card or changing briefs. The IPOS also indicates that Resident T would like to visit her friends at least once a month. Resident T is responsible for providing the home manager with enough notice to schedule staffing to provide transportation and remain with Resident T during the outing.

On 12/08/22, I made a telephone call to the home manager, Isaiah Thomas. Mr. Thomas has been the home manager since October 2022. Mr. Thomas stated the other residents in the AFC group home are non-verbal. Regarding the allegations, Mr. Thomas is responsible for managing Resident T's food stamps. Resident T is given 10% of her food stamps each month and the rest contributes to the food in the AFC group home. Mr. Thomas takes Resident T grocery shopping once a month and she gets what she wants. Resident T also receives checks for $20-$60 and the staff takes her to cash the checks and buy what she wants. Mr. Thomas stated these instructions were given by Resident T's guardian. Mr. Thomas stated these instructions are in place to prevent Resident T from selling her food stamps. Mr. Thomas stated the previous home manager use to give Resident T her food stamp card and let her do whatever she wanted to do. Mr. Thomas stated that he explained to Resident T that she is allotted 10% of her food stamps each month and she was fine with that. Mr. Thomas stated Resident T food stamp card is locked up in the AFC group home and he is the only one who has access to it. Resident T's ID is kept in her medical book. Resident T has access to her ID and takes it with her when she goes to the store or the bank.

Mr. Thomas denied ever taking Resident T's iPad away from her. Mr. Thomas stated no one takes or touches Resident T's iPad as that is how she communicates. Mr. Thomas denied ever threatening to prevent Resident T from having visitors. Resident T had a visitor two or three weeks ago. Resident T has visitors on a regular basis. Mr. Thomas stated Resident T has never had an issue with reaching the door handle. Resident T's wheelchair extends up and leans back. Resident T pushes the door open with her feet and she can reach items out of the kitchen pantry. Mr. Thomas stated everything in the home is accessible to Resident T. Resident T prefers to be independent and do things on her own.

Mr. Thomas stated Resident T's briefs are changed every two hours or when she ask to be changed. Mr. Thomas stated at times Resident T will refuse to have her brief changed. Mr. Thomas stated he started having the staff document in the health care chronological (HCC) when Resident T refuses to have her brief changed. Mr. Thomas stated the staff do not keep a record for every time they change Resident T's brief. Mr. Thomas denied staff member, Tiffany Jones ever leaving Resident T in a soiled brief for three or four hours.

Mr. Thomas stated when he became the home manager, he was informed that Resident T has a history of lying on staff and making up false allegations on every home manger. Mr. Thomas denied pushing Resident T around in her wheelchair. Resident T's wheelchair is automatic. Mr. Thomas denied ever bringing Resident T in her bedroom to watch her because he thought she was going to harm herself. Mr. Thomas stated at times he has talked to Resident T in her bedroom per her request because she was feeling down because her relatives didn't come to visit her. Resident T has a history of suicidal thoughts and attempts which has resulted in being admitted into the hospital.

On 12/09/22, I received a copy of Resident T's Funds Part II forms regarding her room and board and personal expenses for the entire year of 2022. The Funds Part II forms were completed and documented accurately.

On 12/09/22, I received a copy of Resident T's resident care agreement, visitor log, and store receipts from October and November. Resident T's resident care agreement is signed by Resident T on 01/21/22 and by her guardian, Jim Starks on 02/2/22. The licensee designee, Paula Barnes did not sign the resident care agreement. On the second page of the resident care agreement, it is written under additional services "individual will receive 10% of any food stamps funds for personal spending if applicable".

According to the visitor log, Resident T received a visitor on 11/19/22 and on 11/29/22. According to the store receipts, $173.05 was spent at Meijer's on 10/18/22 for Resident T and $49.25 was spent at Kroger on 11/23/22 for Resident T.

On 12/15/22, I received a copy of Resident T's IPOS dated 05/01/22. This IPOS is similar to the IPOS dated 07/07/22 as I did not observe any instructions pertaining to Resident T's food stamp card or changing her briefs.

On 12/16/22, I made a telephone call to staff member, Tiffany Jones. Ms. Jones has worked at the AFC group home since February 2022. Regarding the allegations, Ms. Jones stated she works closely with Resident T as well as the other three female residents in the AFC group home. Ms. Jones changes Resident T's briefs every two hours and/or when Resident T ask for her brief to be changed. Ms. Jones stated she also changes the other two female residents briefs every two hours. Ms. Jones denied Resident T ever sitting in a soiled brief for three or four hours; with the exception of when she wakes up in the morning and at that time her brief is changed. Resident T has complained to Ms. Jones about staff member Brittany Grass leaving her in a soiled brief about two months ago and; Ms. Grass was written up for it. Ms. Jones stated when Resident T gets upset, she will make up false allegations against staff. Ms. Jones stated when she first started working at the AFC group home, Resident T told her case manager that she left her sitting on the toilet for hours. Ms. Jones stated that was clearly a lie because Resident T does not use the toilet.

Ms. Jones stated the home manager, Isaiah Thomas is responsible for Resident T's food stamp card. According to Resident T's resident care agreement, Resident T is allotted 10% of her food stamp card and the rest contributes to the food in the AFC group home. Ms. Jones stated Resident T is still allowed to get what she wants when the staff buy food for the home. Ms. Jones denied observing any staff member taking Resident T's iPad away from her.

On 12/16/22, I received a return phone call from the Assistant Executive Director at MOGI, Teresa Moore. Regarding the allegations, Mrs. Moore stated Resident T's guardian, Jim Starks would have never agreed for Resident T to only receive 10% of her food stamps and for the remaining balance to go to the other residents in the AFC group home. I informed Mrs. Moore that it is written on Resident T's resident care agreement that she will receive 10% of any food stamps for personal spending if applicable. I further explained that the resident care agreement is signed by Resident T and her guardian Jim Starks. Mrs. Moore stated it is possible that a staff member from the AFC group home wrote that statement after Mr. Starks signed it. Mrs. Moore stated she will locate a copy of the resident care agreement to verify if the statement about the food stamps is written on their copy.

Mrs. Moore stated it is the responsibility of the home manger to safeguard Resident T's food stamp card. Mrs. Moore stated Resident T's ID should be in her personal book in the AFC group home. Mrs. Moore stated although Resident T is high functioning it is not in her best interest to have her ID in her possession because she has a history of giving out her address on her computer. Mrs. Moore stated there has been ongoing complaints regarding Resident T's briefs not being changed. Resident T has a history of lying however; Mrs. Moore stated there is a possibility of some truth to the allegations about Resident T sitting in soiled briefs. The AFC group home issued a 30-day discharge notice on 11/21/22 and Resident T's move out date was 12/14/22 however; a placement has not been located for her. Mrs. Moore could not provide anymore details pertaining

to Resident T's iPad, visitors, or medications as she does not work directly with Resident T however; Mr. Starks can answer those questions.

On 12/16/22, I received a return phone call from Resident T's guardian Jim Starks. Regarding the allegations, Mr. Starks stated he does not have an electronic copy of the resident care agreement for Resident T, and he would have to see if he has a copy in his office. However, Mr. Starks stated he would not normally agree to Resident T only receiving 10% of her food stamps as her food stamps are for her. Mr. Starks stated Resident T has damaged a lot of property at the AFC group home as recent as a couple weeks ago when she knocked over a water cooler. Mr. Starks stated he will not say whether or not if someone has a history of lying but he will say that Resident T has her own opinion. Resident T has told Mr. Starks that she has sat in a soiled brief for three hours and when he contacted the staff, they said that wasn't true. Mr. Starks stated he feels good about the current staff members in the AFC group home. The home manager, Isaiah Thomas appears to be attentive, organized and he knows sign language. Mr. Starks stated Mr. Thomas is doing the best he can with Resident T as she is combative and can be difficult to handle.

Mr. Starks stated Resident T is currently at St. Joseph hospital regarding stomach pains. Resident T contacted Mr. Starks around 1:00am complaining about not having an interpreter in the hospital. Mr. Starks stated Resident T has been admitted into St. Joseph hospital about every two weeks for the past two to three months. Mr. Starks stated he is not aware of Resident T having any bed sores or skin tears on her buttock. Therefore, if Resident T was sitting in soiled briefs for long periods of time there would be some skin tears and; due to all of her frequent hospital visits the hospital staff would have reported any concerns pertaining to bed sores or skin tears. Mr. Starks stated it is possible that it may take staff about 30 minutes to change Resident T's brief as they are caring for other residents however; he does not believe that Resident T has sat in a soiled brief for three hours.

Mr. Starks stated Resident T has never told him that staff have taken her iPad away. Mr. Starks stated three weeks ago, Resident T attempted to cut herself with the window blinds and she was throwing her iPad and; it's possible that staff may have removed her iPad due to the circumstances. However, other than that incident staff do not take Resident T's iPad away because that's how she communicates.

Mr. Starks stated staff do not restrict Resident T's visits however; the staff are responsible to know who, where, and when someone is coming to visit Resident T. Resident T thinks she runs the AFC group home as she wants people to visit her whenever she wants them too. The staff also take Resident T to Flint, MI to visit her friends. Mr. Starks stated both the AFC group home and Resident T have submitted 30-day discharge notices. Currently, an appropriate placement has not been identified for Resident T.

On 12/16/22, I made a telephone call to the Program Coordinator, De'Zhanae Bennett. Ms. Bennett stated that the home manager is responsible for sending the resident care

agreements to the residents guardian for signatures. Ms. Bennett stated the previous home manager (Dionne Thompson) would have been the person to send Resident T's resident care agreement to her guardian at the beginning of this year. Ms. Bennett stated Ms. Thompson was terminated this summer for falsifying a staff schedule after a case manager arrived to the AFC group home and no staff members were present in the home with the residents. Ms. Thompson was responsible for being in the home during that time however; she tampered with the staff schedule to make it look like a different staff member was supposed to be present in the home however; the staff member that Ms. Thompson placed on the schedule was a former employee. Ms. Bennett stated she does not think it is possible for a staff member to write additional information regarding food stamps on a resident care agreement after the guardian has signed it. Ms. Bennett stated it has always been the group home's policy for residents to only receive 10% of their food stamps.

Ms. Bennett provided copies of two additional store receipts dated for 11/23/22. One receipt was for $7.95 at Kroger which coincides with the transaction history I observed on Resident T's iPad. The second receipt was from Walmart for $93.92; which was paid with an EBT card. This transaction also coincides with Resident T's transaction history. The Walmart receipt also indicates that a credit card was used in the amount of $52.85. Ms. Bennett confirmed that a company credit card was used for the remaining amount of $52.85.

On 12/16/22, I contacted Resident T's case manager Elizabeth Cossaboom. Regarding the allegations, Ms. Cossaboom stated she does not know what the instructions are regarding Resident T's food stamp card. Ms. Cossaboom stated she has no concerns regarding Resident T sitting in soiled briefs. Ms. Cossaboom stated there has been no concerns about Resident T having any bed sores or rashes. Staff always change Resident T when she needs to be changed. There are times when Resident T has refused to have her brief changed in the morning as she does not want to be waken up due to staying up late the night before talking to her friends. Resident T has never told Ms. Cossaboom that staff have restricted her visits. Ms. Cossaboom stated Resident T has tons of friends who visit her at the AFC group home. Resident T has never told Ms. Cossaboom that staff have taken her iPad. Ms. Cossaboom has regular contact with Resident T and whenever she needed to contact Resident T she has had her iPad.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on the information above, there is not sufficient information to confirm the allegations pertaining to the home manager, Isaiah Thomas using Resident T's food stamp card without Resident T's permission. On 12/06/22, I observed Resident T's food stamp transaction history on her iPad. A food stamp purchase was made on 11/23/22 at Wal-Mart for $93.92 and at Kroger on 11/23/22 for $7.95. Resident T stated her food stamp card is only for her and no one else in the AFC group home. On 12/16/22, I received copies of two additional store receipts dated for 11/23/22. One receipt was for $7.95 at Kroger which coincides with the transaction history I observed on Resident T's iPad. The second receipt was from Walmart for $93.92; which was paid with an EBT card. This transaction also coincides with Resident T's transaction history. The Walmart receipt also indicates that a credit card was used in the amount of $52.85. On 12/09/22, I received a copy of Resident T's resident care agreement that was signed by Resident T and her guardian, Jim Starks. The resident care agreement indicated that Resident T would receive 10% of food stamp funds for personal spending. Mr. Thomas stated that the remaining monthly balance of Resident T's food stamps contributes to the food in the AFC group home. Mr. Starks stated he would not normally agree to Resident T only receiving 10% of her food stamps as her food stamps are for her. However, Mr. Starks was unable to locate an electronic copy of Resident T's resident care agreement to confirm whether or not if he consented.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.

ANALYSIS:	On 12/09/22, I received a copy of Resident T's resident care agreement and observed that the resident care agreement was not signed by the licensee designee, Paula Barnes.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(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.**
ANALYSIS:	Based on the information above, there is not sufficient information to confirm the allegations pertaining to the door handle of the home being difficult for Resident T to reach in her wheelchair. I observed the front and back door of the AFC group home. The backdoor has an appropriate wheelchair ramp to allow accessibility in and out of the home. The front door leads to street level and does not require any modifications to allow staff and/or residents to enter the home. Resident T stated staff members do help her with opening the door. Resident T denied any issues with leaving in and out of the group home in her wheelchair.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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

	(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.
ANALYSIS:	Based on my findings and information gathered, there is no information to support any staff members restricting or denying Resident T telephone access. Resident T communicates on her iPad. Resident T's case manager, Elizabeth Cossaboom stated whenever she needs to contact Resident T, she is able to do so on her iPad. Mr. Starks stated Resident T has never told him that staff have taken her iPad away. Mr. Thomas and Ms. Jones denied any staff member taking Resident T's iPad away from her.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(k) The right to have contact with relatives and friends and receive visitors in the home at a reasonable time. Exceptions shall be covered in the resident's assessment plan. Special consideration shall be given to visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.**
ANALYSIS:	Based on my findings and information gathered, there is no sufficient evidence to support Resident T being denied her visitation rights. According to the visitor log, Resident T received a visitor on 11/19/22 and on 11/29/22. Resident T's guardian and case manager confirmed that Resident T receives regular visits as well as outings with friends.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL ALLEGATIONS:

INVESTIGATION:

On 12/06/22, I interviewed Resident T. Resident T stated there are times she is not administered her morning or evening medications as the medications are missing. Resident T stated the last time she was not given her medications was in November 2022.

On 12/06/22, I requested a copy of Resident T's MAR for the month of November 2022. Ms. Robinson provided a copy of Resident T's December 2022 MAR however; November was listed on the MAR but only the first four days of the MAR was initialed. Ms. Robinson explained that someone must have written the wrong month on the MAR. Ms. Robinson was unable to locate the MAR for the month of November. I observed Resident T's medications. The medications in the bubble packets for 12/4/22 and 12/5/22 were all still in the bubble packets. Resident T was not administered any of her medications on 12/05/22 or her evening medications on 12/4/22. Ms. Robinson explained that Resident T had surgery on 12/05/22 and it was instructed for her not to receive her medications during the evening of 12/04/22 or on 12/05/22. However, there were no initials or explanation documented on the MAR as to why Resident T did not receive her medications on 12/04/22 or 12/05/22. According to the MAR, there were no staff initials for Resident T's morning medications for today's date (12/6/22). I also observed on the December MAR that the following medications did not include the time the medication was prescribed to be given:

- Ventolin HFA
- Sertraline
- Simvastatin

I received a copy of Resident T's IPOS on 12/06/22. According to Resident T's IPOS dated 07/07/22, Resident T has a history of ordering medications online and attempting to overdose on the medications.

On 12/08/22, Mr. Thomas stated Resident T is always administered her medications. Mr. Thomas stated he inadvertently marked the month of November on the December MAR for Resident T. Mr. Thomas stated Resident T had surgery on 12/5/22 which is why she was not administered any medications.

On 12/09/22, I received a copy of Resident T's MAR for the month of November. According to Resident T's MAR for the month of November, there were missing staff initials for the following medications:

- Advair 8:00pm dose on 11/02/22
- Metformin 8:00pm dose on 11/08/22
- Ativan 8:00pm dose on 11/01/22

Resident T is prescribed Vitamin D2 one cap every week however; according to the MAR she was administered this medication on 11/01/22, 11/02/22, 11/03/22 and 11/15/22. Resident T was administered the following PRN's in November:

- Hydrocodone 325mg
- Meloxican 75mg

There were no comments documented on the MAR indicating why Resident T was administered a PRN.

On 12/16/22, Ms. Jones stated Resident T receives her medications every day at 10:00am, 4:00pm, and 8:00pm. Ms. Jones stated at times Resident T is denied a PRN because she doesn't need it. Resident T has called the hospital in the past and complained about stomach pain in order to get admitted and receive pain medications. Resident T has a history of suicide ideations. Ms. Jones stated two weeks ago, Resident T tried to slit her wrist. The police were called as well as Resident T's case manager. The staff were advised by Resident T's case manager to clean out Resident T's bedroom of any potential items she can harm herself with.

On 12/16/22, Mr. Starks stated Resident T informed him the other day that she did not get her morning medications. Mr. Starks spoke with Mr. Thomas, and he stated that Resident T did get her medications. Resident T has a history of hoarding her medications when she is suicidal.

On 12/16/22, I made a telephone call to Ms. Bennett. I asked Ms. Bennett if a written order was received from a doctor instructing staff not to administer Resident T's medications on the evening of 12/04/22 and on 12/5/22 due to having surgery on 12/05/22. Ms. Bennett stated staff received a verbal order from a prep nurse at St. Joseph hospital. Ms. Bennett confirmed that a written order is not in the AFC group home regarding this matter. Mr. Bennett stated Resident T returned to the AFC group home after her surgery during the evening time on 12/6/22; which is why she did not receive her medications on 12/6/22. Ms. Bennett confirmed that staff are not documenting comments when PRN's are being administered.

On 12/16/22, I completed an exit conference with the licensee designee, Paula Barnes via email as she was not available over the phone. Ms. Barnes was informed that some of the allegations will be substantiated, and a corrective action plan will be required.

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:** **(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.**
ANALYSIS:	Resident T was not administered any of her medications on 12/05/22 or her evening medications on 12/4/22. Ms. Robinson explained that Resident T had surgery on 12/05/22 and was instructed not to receive her medications during the evening of 12/04/22 or on 12/05/22. However, there were no initials or explanation documented on the MAR as to why Resident T did not receive her medications on 12/04/22 or 12/05/22. According to the MAR, there were no staff initials for Resident T's morning medications on 12/6/22. According to Resident T's MAR for the month of November, there were missing staff initials for the following medications: • Advair 8:00pm dose on 11/02/22 • Metformin 8:00pm dose on 11/08/22 • Ativan 8:00pm dose on 11/01/22 On the December MAR the following medications did not include the time the medication was prescribed to be given: • Ventolin HFA • Sertraline • Simvastatin
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**

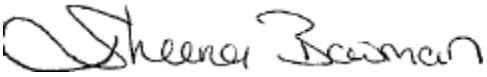
ANALYSIS:	Resident T was administered Hydrocodone 325mg and Meloxican 75mg, two PRNs in November. There were no comments documented on the MAR indicating why Resident T was administered a PRN. Ms. Bennett confirmed that staff are not documenting comments when PRN's are being administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	Staff did not administer Resident T's evening medication on 12/04/22 or at all on 12/05/22 as she had surgery on 12/5/22. Ms. Bennett stated staff received a verbal order from a prep nurse at St. Joseph hospital to not administer Resident T's medications on the abovementioned dates. However, Ms. Bennett confirmed that staff never received a written order from a doctor to not administer Resident T's medications on 12/04/22 or 12/05/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident T is prescribed Vitamin D2 once a week. However, according to the MAR she was administered this medication on 11/01/22, 11/02/22, 11/03/22 and 11/15/22. Therefore, staff are not administering this medication pursuant to the label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

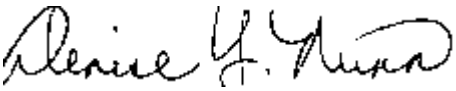
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



12/19/22

Sheena Bowman — Date
Licensing Consultant

Approved By:



12/21/2022

_____

Denise Y. Nunn — Date
Area Manager