STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

February 1, 2023

Joseph Bates
CHS Group LLC
115 East Front
Monroe, MI  48161

RE: License #: AS580403346
Investigation #: 2023A0116017
Vineyard Home

Dear Mr. Bates:

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.

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.

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 (313) 456-0380.

Sincerely,

Pandrea Robinson

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AS580403346 |
| | |
| **Investigation #:** | 2023A0116017 |
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| **Complaint Receipt Date:** | 01/09/2023 |
| | |
| **Investigation Initiation Date:** | 01/10/2023 |
| | |
| **Report Due Date:** | 03/10/2023 |
| | |
| **Licensee Name:** | CHS Group LLC |
| | |
| **Licensee Address:** | 115 East Front<br>Monroe, MI 48161 |
| | |
| **Licensee Telephone #:** | (734) 240-0185 |
| | |
| **Administrator:** | Jill Jackson |
| | |
| **Licensee Designee:** | Joseph Bates |
| | |
| **Name of Facility:** | Vineyard Home |
| | |
| **Facility Address:** | 15127 S Dixie<br>Monroe, MI 48161 |
| | |
| **Facility Telephone #:** | (734) 636-9140 |
| | |
| **Original Issuance Date:** | 09/07/2022 |
| | |
| **License Status:** | TEMPORARY |
| | |
| **Effective Date:** | 09/07/2022 |
| | |
| **Expiration Date:** | 03/06/2023 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff are not trained. | No |
| Staff are sleeping on shift. | Yes |
| Staff is not assisting Resident A with his personal care and hygiene. | No |
| Resident A's medication is not given as prescribed, and staff have administered it outside of the allotted time frames. | Yes |
| There are times when there is no food in the home. | No |
| The home is not following Resident A's special diet. | No |
| There is no soap in the bathroom. | No |
| The overall upkeep and cleanliness of the home is not good. | Yes |
| Additional Findings | Yes |

**All allegations reported were not investigated as they were not rule related, were address in SIR #20230116012 or happened prior to licensure. **

## III. METHODOLOGY

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|---|---|
| 01/09/2023 | Special Investigation Intake<br>2023A0116017 |
| 01/09/2023 | Referral - Recipient Rights |
| 01/09/2023 | APS Referral<br>Made. |
| 01/10/2023 | Special Investigation Initiated - On Site<br>Interviewed Shilo Woods, Program Coordinator, Laura Reinhardt, Chief Operating Officer (COO), Residents B-E, reviewed Resident A's medication administration records (MARs), and his Individual Plan of Service (IPOS). I requested that Ms. Woods email me Resident's B-F December' 22 and January '23 MARs and other required documents that she was unable to locate during the onsite. |
| 01/11/2023 | Contact - Telephone call made |

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| | Interviewed Nicole Scharf, case manager, at Monroe Community Mental Health Authority (MCMHA). |
| 01/11/2023 | Contact - Telephone call received<br>Spoke with Alicia Riggs, contract manager, at MCMHA. |
| 01/12/2023 | Contact - Document Received<br>Received requested documents from Ms. Wood. |
| 01/17/2023 | Contact - Telephone call made<br>Interviewed staff, Darrel Mitchell. |
| 01/17/2023 | Contact - Telephone call made<br>Interviewed staff, Rochelle Wiblern |
| 01/23/2023 | Contact - Document Received<br>Email received from licensee designee, Joseph Bates, regarding the status of the license. |
| 01/25/2023 | Contact - Telephone call made<br>Interviewed assigned Adult Protective Services (APS) investigator, Tywonia Millender. |
| 01/25/2023 | Contact - Telephone call made<br>Interviewed Guardian (A). |
| 01/25/2023 | Inspection Completed-BCAL Sub. Non-Compliance |
| | Exit Conference<br>With licensee designee, Joseph Bates. |

**ALLEGATION:**

**Staff are not trained.**

**INVESTIGATION:**

On 01/10/23, I conducted an unscheduled onsite and interviewed program coordinator, Shilo Wood and COO, Laura Reinhardt. Ms. Wood and Ms. Reinhardt both reported that all staff are trained or in the process of being trained. They reported that the staff who are not fully trained are shadowing trained staff while working towards completion of training. They both reported being aware that untrained staff are unable to provide direct care or administer medications until they are trained and competent in all areas. Ms. Wood reported that along with the training provided by Monroe Community Mental Health Authority (MCMHA), the home also uses toolbox for all other required trainings. Ms. Wood reported that the staff training was not at the home at the time and reported that she would email it to me.

On 01/12/23, I received an email from Ms. Wood that contained verification of training for the 10 employees currently working at the home. I confirmed that each of the staff members had completed all of the required training.

| **APPLICABLE RULE** | |
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| **R 400.14204** | **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:**<br>**(a) Reporting requirements.**<br>**(b) First aid.**<br>**(c) Cardiopulmonary resuscitation.**<br>**(d) Personal care, supervision, and protection.**<br>**(e) Resident rights.**<br>**(f) Safety and fire prevention.**<br>**(g) Prevention and containment of communicable diseases.** |
| **ANALYSIS:** | Based on the findings of the investigation, which included interviews of Ms. Wood, Ms. Reinhardt and review of training records, I am unable to corroborate the allegation.<br><br>Ms. Wood and Ms. Reinhardt both reported that all staff are trained in all the required areas and reported the staff who are not yet fully trained, shadow trained staff until completion of their training.<br><br>I also received and reviewed verification of training of all 10 of the staff employed in the home. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Staff are sleeping on shift.**

**INVESTIGATION:**

On 01/10/23, I conducted an unscheduled onsite inspection and interviewed Ms. Wood, Ms. Reinhardt, and Residents B-F. Ms. Wood and Ms. Reinhardt both reported that last month (December ’22) they were informed that staff Darrel Mitchell was sleeping during his midnight shift (12:00 a.m.-8:00 a.m.). Ms. Wood reported that she spoke with Mr. Mitchell about the matter, and he admitted that he had fallen asleep a few times on different days during his midnight shift. Ms. Wood reported that Mr. Mitchell was written up, suspended for three days without pay and moved to afternoon shift (4:00 p.m.-12:00 a.m.). Ms. Wood and Ms. Reinhardt reported being unaware of any new instances of Mr. Mitchell sleeping on shift.

I interviewed Residents B-E and they all reported that staff, Darrel Mitchell, sleeps on shift all the time. They reported that he slept every night while he worked the midnight shift and reported that he still sleeps now on his afternoon shift. Residents B-D reported that staff, Rochelle Wiblern works the midnight shift and reported that she sleeps during her shift and if they need something she will not get up.

I attempted to interview Resident F; however, he would not answer any questions.

On 01/17/23, I interviewed staff, Darrel Mitchell, and he admitted that a few times while working the midnight shift, he fell asleep. Mr. Mitchell reported that he was written up, suspended without pay for three days and moved to the afternoon shift. Mr. Mitchell reported that since being on the afternoon shift, he has not fallen asleep. I reminded Mr. Mitchell of his responsibilities as a direct care staff and the requirement to provide supervision, protection and personal care to the residents at all times. Mr. Mitchell reported an understanding.

On 01/17/23, I interviewed staff, Rochelle Wiblern and she denied that she sleeps on shift. Ms. Wiblern reported that she couldn’t sleep if she wanted to because Residents B and C are awake most of the night and she is up doing puzzles and chatting with them. Ms. Wiblern reported that Resident B normally doesn’t fall asleep until around 6:30 a.m. and reported she gets off at 8:00 a.m. I cautioned Ms. Wiblern against sleeping during her shift and reminded her of staff responsibilities as it relates to the supervision, protection, and personal care of the residents.

On 01/25/23, I interviewed APS investigator, Tywonia Millender and she reported that she is in the process of completing her investigation and at this time she does not have sufficient evidence to substantiate neglect.

| **APPLICABLE RULE** | |
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| **R 400.14206** | **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** |

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| | **specified in the resident's resident care agreement and assessment plan.** |
| **ANALYSIS:** | Based on the findings of the investigation, which included interviews of Ms. Wood, Ms. Reinhardt, Residents B-E, Mr. Mitchell and Ms. Wiblern, I am able to corroborate the allegations.<br><br>Ms. Wood and Ms. Reinhardt confirmed that Mr. Mitchell was caught sleeping on different occasions during his midnight shift. They reported he was written up, suspended without pay, and moved to the afternoon shift.<br><br>Residents B-E all reported that Mr. Mitchell and Ms. Wiblern sleep during their respective shifts. They reported that Mr. Mitchell continues to sleep, even after being moved to afternoon shift.<br><br>Mr. Mitchell admitted to sleeping on occasion while working the midnight shift. He denies sleeping since being moved to afternoon shift.<br><br>Ms. Wiblern denied that she has ever fallen asleep during any of her shifts and reported that she is up talking and doing puzzles with Residents B and C.<br><br>This violation is established as the licensee designee, did not have sufficient staff on duty at all times for the supervision, person care and protection of residents. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Staff is not assisting Resident A with his personal care and hygiene.**

**INVESTIGATION:**

On 01/10/23, I conducted an unscheduled onsite inspection and interviewed Ms. Wood, Ms. Reinhardt and Residents B-D. Resident A was not interviewed as his Guardian had picked him up and according to Ms. Wood, it is unlikely that he will be returning to the home.

Ms. Wood and Ms. Reinhardt both reported that Resident A is independent with showering and grooming. They reported that Resident A’s IPOS states that staff are to encourage him to shower daily and to assist him with washing his back and prompt him to clean all of his body parts. Ms. Wood reported that staff is doing this. She reported that most times Resident A refuses to shower daily and when staff request and prompt him to do so, he has a behavior. Ms. Wood reported that when Resident A is having a good day he will shower, and staff assist him as outlined in his IPOS if he allows them to.

I interviewed Residents B-E and they reported that they shower at least three times per week and do not require assistance from the staff. Resident C reported that if he wants help, he asks the staff, and they will assist. Residents B-D reported that the staff also assists Resident A when he showers but reported most times, he will not allow them in the bathroom to help. Resident C added that Resident A refuses to shower most days.

I reviewed Resident A’s current IPOS effective 12/01/22, and confirmed that the staff are to encourage Resident A to shower daily, assist him with washing his back, prompt him to clean all body parts, and educate him on how to soap his washcloth to wash his body and hair

On 01/17/23, I interviewed Mr. Mitchell and he reported that he will and has assisted Resident A and the residents with showering when needed. Mr. Mitchell reported that the residents are capable of showering independently, however, at times will ask for help with washing their backs. Mr. Mitchell reported that Resident A requires more prompting and staff know to help him wash his hair and his back. Mr. Mitchell reported the problem is most times Resident A refuses to shower most days and if staff continue to encourage or prompt him to do so, he will have a behavior.

On 01/17/23, I interviewed Ms. Wiblern and she reported that she does not assist with showers because the residents have normally showered before she reports to work at midnight.

On 01/25/23, I interviewed Guardian (A) and she reported that Resident A has shared with her that sometimes the staff will not help him in the shower. Guardian

(A) reported her overall disappointment and concern with the staff at the home and reported Resident A will not be returning to the home as long at the current corporation is running it. Guardian (A) reported that Resident A has been at her home since 01/07/23 and she has been meeting with MCMHA to determine the next placement for Resident A.

On 01/25/23, I interviewed APS investigator, Tywonia Millender and she reported there was no evidence for her to substantiate that the staff at the home were not assisting Resident A or the other residents in the home with their personal hygiene.

| **APPLICABLE RULE** | |
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| **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.** |

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| **ANALYSIS:** | Based on the findings of the investigation, which included interviews of Mr. Wood, Ms. Reinhardt, Residents B-E, Mr. Mitchell, and Ms. Millender I am unable to corroborate the allegations.<br><br>Ms. Wood and Ms. Reinhardt both reported that staff assist Resident A with the showering based on what is outlined in his IPOS. They reported that most times Resident A refuses to shower at all. They reported when he agrees to shower, staff assist.<br><br>Residents B-E all reported that they shower multiple times per week and do not require staff assistance. They reported if they want help and ask staff, they will assist. Resident C reported that staff assist Resident A, however, reported that most times he refuses to shower at all.<br><br>Mr. Mitchell also reported that staff are aware of the requirement to encourage and assist Resident A with showering. Mr. Mitchell reported most days Resident A refuses to shower.<br><br>This violation is not established, as there is insufficient evidence to substantiate that the staff is not providing supervision, protection and personal care as defined in the act and specified in Resident A's written assessment plan/IPOS. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Resident A's medication is not given as prescribed, and staff have administered it outside of the allotted time frames.**

**INVESTIGATION:**

On 01/10/23, I conducted an unscheduled onsite inspection and interviewed Ms. Wood, Residents B-E and reviewed Resident A's December '22 and January '23 MARs. Ms. Wood admitted that there have been some issues with Resident A's medications and staff not always administering the medication as prescribed. Ms. Wood reported that on the evening/night of 12/31/22, Resident A called 911 for a wellness check and stated that he was not being properly medicated. Ms. Wood reported that she was contacted and went to the home a few hours later (could not remember the time) to review Resident A's medication and MARs and determined that Mr. Mitchell, failed to administer Resident A's 300mg tablet of Seroquel, 100mg tablet of Trazodone, and 10mg capsule of Melatonin. Ms. Wood reported that she administered the medications at that time. I observed that the three 3:00 a.m. doses of medications were supposed to be administered at 9:00 p.m. I asked Ms. Wood did she contact Resident A's doctor, the pharmacist or another medical professional before modifying how the medication is to be given. Ms. Wood reported that she called Resident A's doctor and the pharmacist; however, reported, "They were taking too long to call back, so I just gave him the medications." Ms. Wood added that the next dose of Trazadone was not due until 12:00 noon the following day and believed there would not be any issues or any ill effects by her administering the medication when she did. Ms. Wood added that the Melatonin and Seroquel were not required to be given until the following day at 9:00 p.m.

I asked Ms. Wood to allow me to review Resident A's medication however, I was unable to do so as Guardian (A) had taken all of Resident A's medication on 01/07/23 when she picked him up. Ms. Wood reported her belief that Resident A, for the most part was getting all of his medications as prescribed. Ms. Wood further reported that Resident A often refuses medications, sometimes will refuse to take them until he takes a picture of them to send to his Guardian (A) and reported it has been challenging. Ms. Wood reported that since the medication error by Mr. Mitchell, he is no longer administering medication and will have to complete medication training again through MCMHA. Ms. Wood added that Mr. Mitchell will also be shadowed by another staff for six medication passes before he can pass medication again independently.

I interviewed Residents B-D and they reported that they receive their medications daily and to their knowledge, they get all medications as prescribed.

On 01/11/23, I interviewed Resident A's case manager, Nicole Scharf, and she reported that she has had ongoing concerns about the home and their inability to properly administer and track Resident A's medication. Ms. Scharf reported staff are not passing all of the prescribed medication and reported they are giving it outside of the time frames. Ms. Scharf reported the doctors allow staff to administer medication one hour before or one hour after the prescribed times. She reported that the staff at the home has been giving the medications outside of this timeframe, in addition to not giving Resident A all of his prescribed medications. Ms. Scharf reported that Resident A is unstable and has been exhibiting behaviors, but she determined that it is because the staff are not giving him his medications as prescribed. Ms. Scharf reported she has been to the home often, some weeks multiple times, trying to help the staff get things better organized, to no avail. Ms. Scharf reported that the staff appear to be overwhelmed and are not doing what is required of them. Ms. Scharf reported that she will be moving Resident A and F as she is the case manager for both of them. She further reported that MCMHA administration and the licensee designee, Joseph Bates, and COO, Laura Reinhardt of CHS Group (licensee) are about to convene and discuss their concerns and plans moving forward. Ms. Scharf reported that at this point she does not even know how to help the staff at the home.

I expressed to Ms. Scharf my concerns regarding my observations the previous day while onsite and informed her of the possible outcomes of the investigation. Ms. Scharf reported that she or someone from MCMHA would be in contact with me regarding the decisions that are made in the meeting regarding the future of their relationship with CHS Group.

On 01/11/23, I received a call from Alicia Riggs, contract manager at MCMHA. Ms. Riggs informed me that due to the ongoing concerns regarding staff, medication errors, and other concerns they have decided to terminate their contract with the home. Ms. Riggs reported that the lease agreement in place is between MCMHA and the landlord. Therefore, Mr. Bates will be requesting voluntary closure of the license, they will be moving some of the residents to other settings and will have another corporation apply for licensure. Ms. Riggs reported that this decision is ultimately in the best interest of the residents.

On 01/17/23, I interviewed Mr. Mitchell and he reported that he does not recall a time where he failed to administer Resident A all of his prescribed medications. Mr. Mitchell reported that he gives the medications that are in the house in each resident’s medication basket. Mr. Mitchell confirmed that he does have to complete medication training again but could not give a reason as to why he would need to be re-trained. Mr. Mitchell added that Resident A keeps the house in chaos and reported since he has been out of the home things have run so much smoother.

On 01/23/23, I received an email from Mr. Bates stating that the home will be requesting voluntary closure of the license and reported being blindsided by MCMHA. Mr. Bates desired to continue providing services to the residents in the home, however, has decided to honor the request of MCMHA who will be terminating their contract with the home.

On 01/25/23, I interviewed Guardian (A) and she reported that the number of medication errors that have happened in this home is unacceptable and has resulted in Resident A having an increase in behaviors. Guardian (A) reported that medication errors have been an ongoing issue even prior to the home being licensed. Guardian (A) reported on 12/23/22, she picked Resident A up for a few days for the holiday and upon receiving his medication noticed that his 5 mg Asenapine tablets were not opened and had not been administered for several days.

Guardian (A) further reported that on the late evening hours of 12/31/22 Resident A called the police after he noticed that he had not been given three of his medications. Guardian (A) reported the officers confirmed that Resident A was not given all of his medications. Guardian (A) reported that Ms. Wood came in the facility at 3:00 a.m. after Mr. Mitchell reported he couldn’t find the medication. Guardian (A) reported she is aware of the time because Resident A called and informed her. Guardian (A) reported that Ms. Wood knows better and reported she overmedicated Resident A by giving him the Trazadone at 3:00 a.m. knowing that the next dose was at 12:00 noon. Guardian (A) reported that she has had Resident A in her care since 01/07/23 and has no plans to return him as long as this corporation is running the home.

| APPLICABLE RULE | |
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| **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.** |

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| **ANALYSIS:** | Based on the findings of the investigation, which included interviews of Ms. Wood, Ms. Scharf, Ms. Riggs, and Guardian (A), I am able to corroborate the allegations.<br><br>Ms. Wood admitted that on 12/31/22, staff, Mr. Mitchell failed to administer Resident A's p.m. dose 300mg tablet of Seroquel, 100mg tablet of Trazodone, and 10mg capsule of Melatonin.<br><br>Ms. Scharf reported that there have been ongoing issues with medication errors in the home, which has precipitated an increase in behaviors in Resident A. Ms. Scharf reported that she has exhausted all of her resources in helping the staff at the home. Ms. Scharf reported that the needs of the residents are not being met in the home and she will be moving Resident A and F into a new placement.<br><br>Ms. Riggs echoed Ms. Scharf's concerns regarding ongoing medication errors, staffing concerns and other areas of contract non-compliance. Ms. Riggs reported that MCMHA will be terminating the contract with the home and will have a new apply for licensure at the home.<br><br>Guardian (A) reported ongoing concerns in the home regarding medication errors even before the home was licensed. Guardian (A) reported that there have been several instances where Resident A was not given all of his medications, and or times when he was overmedicated.<br><br>This violation is established as Resident A's prescription medication was not given as prescribed. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **APPLICABLE RULE** | |
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| **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:**<br>**(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.** |

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| **ANALYSIS:** | Based on the findings of the investigation, which included interviews of Ms. Wood, Ms. Scharf and Guardian (A), I am able to corroborate the allegation.<br><br>Ms. Wood admitted that on 12/31/22, Mr. Mitchell failed to administer three of Resident A's medication. Ms. Wood further reported that sometime that night she came to the home and administered the medications to Resident A. Ms. Wood reported that she called Resident A's doctor and the pharmacist but stated, "They were taking too long to call back, so I just gave him the medications."<br><br>Ms. Scharf reported that she is aware of the issues surrounding medication administration and confirmed that staff were administering medications well outside of the allotted 1 hour before or 1 hour after time frame.<br><br>Guardian (A) reported her ongoing concerns regarding the improper administration of medication in the home. Guardian (A) reported her frustration at Ms. Wood for administering Resident A's medication six hours after he was supposed to take it but most importantly failing to contact a medical professional for instructions when the medication error occurred.<br><br>This violation is established as Ms. Wood failed to contact and speak with a medical professional when a medication error occurred and made the decision to administer the medication without knowing the possible implications of doing so. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**There are times when there is no food in the home.**

**INVESTIGATION:**

On 01/10/23, I conducted an unscheduled onsite inspection and interviewed Ms. Wood and Residents B-E. Ms. Wood reported that there is always plenty of food in the home and reported that the residents eat three meals per day and have access to snacks.  Ms. Wood reported Guardian (A) will have Shipt shop and deliver food to the home, if Resident A calls and request things that he wants that may not be in the home. Ms. Wood reported that Guardian (A) will often send enough for all of the residents. Ms. Wood reported that this is not required of Guardian (A), but reported she does it at the request of Resident A.

I interviewed Residents B-E and they all reported that there is always food in the home and that they eat three meals a day and can have snacks whenever they want them. Resident B reported that the staff are good cooks and reported that they can have seconds if they are still hungry and want more to eat.

I observed the food supply and confirmed that there was an adequate food supply. The refrigerator and freezer were stocked with meat, frozen vegetables, and breakfast food, there was also fresh fruit available. I also observed a freezer located in the garage that was also stocked with food.

On 01/17/23, I interviewed Mr. Mitchell, and he reported that there is always food in the home and reported that the residents eat very good. Mr. Mitchell reported that the residents eat three meals per day and have access to snacks in between meals and after if they want one.

On 01/25/23, I interviewed APS investigator, Tywonia Millender and she reported that when she conducted her visit to the home, the food supply was more than adequate and reported she would not be substantiating neglect allegations.

On 01/25/23, I interviewed Guardian (A) and she reported that on or about 12/31/22, Resident A contacted her and reported that there wasn't any food in the home. Guardian (A) reported that she did a Shipt order and had meat and vegetable trays, bottled water and a few other items delivered to the home. Guardian (A) reported she did not actually see or confirm that there was no food in the home but sent food just in case.

| **APPLICABLE RULE** | |
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| **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.** |

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| **ANALYSIS:** | Based on the findings of the investigation, which included interviews of Ms. Wood, Residents B-E, Mr. Mitchell, Ms. Millender, and consultant observation, I am unable to corroborate the allegations.<br><br>Ms. Wood reported that there is always food in the home and reported that the residents eat three meals per day and have access to snacks.<br><br>Residents B-E all reported that they eat three meals per day, and have access to snacks. Resident B added that they also can have seconds if they desire.<br><br>Mr. Mitchell reported that the residents eat good and reported that there is always food in the home.<br><br>Ms. Millender reported during her visit to the home that the food supply was more than adequate.<br><br>I observed the food supply to be adequate.<br><br>This violation is not established as the residents are being provided three meals daily as required. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**The home is not following Resident A's special diet.**

**INVESTIGATION:**

On 01/10/23, I conducted an unscheduled onsite and interviewed Ms. Wood. Ms. Wood reported that Resident A is not on a special diet and denied that the home was ever provided any documentation from any of Resident A's doctors stating that.

I reviewed Resident A's IPOS effective 12/01/22. The IPOS did not document any special diet or requirements for staff to adhere to regarding Resident A's food consumption or limitations. The IPOS only requested that staff encourage Resident A to drink only one 20oz bottle of diet pop per day and explore other non-sugar drinks that Resident A may like. I also reviewed Resident A's records and did not observe any orders from any of his doctors regarding a special diet.

On 01/25/23, I interviewed Guardian (A) and she reported that Resident A was prescribed a special diet some time ago and reported that it should be in his IPOS. I informed Guardian (A) that it is not documented in his IPOS and that I didn't observe an order from Resident A's doctor when I reviewed his records. Guardian (A) reported that she would forward a copy of the order and special diet if she could locate it.

| **APPLICABLE RULE** | |
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| **R 400.14313** | **Resident nutrition.** |
| | **(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.** |

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| **ANALYSIS:** | Based on the findings of the investigation, which included interviews of Ms. Wood, Guardian (A) and review of Resident A's records, I am unable to corroborate the allegation.<br><br>Ms. Wood reported that since Resident A's placement in the home they have never been informed or provided with a special diet prescribed by any of Resident A's doctors and reported that it is also not documented in his IPOS.<br><br>I reviewed Resident A's IPOS and other records and did not see any mention of a special diet or an order from any of Resident A's doctors prescribing a special diet.<br><br>Guardian (A) reported that Resident A is prescribed a special diet, however, to date was unable to provide a copy of the special diet or the order from the prescribing doctor.<br><br>This violation is not established as there is insufficient evidence to substantiate that Resident A is prescribed a special diet by a doctor that the home is failing to provide. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**There is no soap in the bathroom.**

**INVESTIGATION:**

On 01/10/23, I conducted an unscheduled onsite and interviewed Ms. Wood. Ms. Wood reported that the home always has soap. She reported if there are times that there isn't any in the bathroom, it is usually because a resident has used the remaining soap, has thrown the container away and not informed staff that they need a new bottle. Ms. Wood reported that they keep a supply of hand soap locked up with the caustics, laundry detergents, and cleaning supplies. Ms. Wood reported that staff replenish the soap in the bathroom as needed.

I observed both bathrooms to have hand soap during my onsite.

I interviewed Residents B-E and they all reported that there is always soap in the bathroom for them to wash their hands. Residents B and C reported if they run out of soap, they inform the staff and they will get a new bottle from the closet.

| APPLICABLE RULE | |
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| **R 400.14401** | **Environmental health.** |
| | **(8) Hand-washing facilities that are provided in both the kitchen and bathroom areas shall include hot and cold water, soap, and individual towels, preferably paper towels.** |
| **ANALYSIS:** | Based on the findings of the investigation, which included interviews of Ms. Wood, Residents B-E and consultant observation, I am unable to corroborate the allegations.<br><br>Ms. Wood and Residents B-E all reported that there is always soap in the home and available for use by the residents.<br><br>I also observed soap in both bathrooms during my unscheduled onsite.<br><br>This violation is not established as soap is being provided in bathroom areas as required by these rules. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**The overall upkeep and cleanliness of the home is not good.**

**INVESTIGATION:**

On 01/10/23, I conducted an unscheduled onsite and interviewed Ms. Wood. Ms. Wood reported that the staff struggle with getting the residents to keep their rooms clean. I informed Ms. Woods that if the residents are able and it is documented in their IPOSs, but if they aren't willing to help then the responsibility ultimately falls on staff. I informed Ms. Wood that the staff have the responsibility to maintain the home to ensure the overall safety and well-being of the residents. Ms. Wood understood and agreed.

I observed the resident's bedrooms to be unkept, clothes, shoes, papers, cigarette filler and food containers strewn about. The beds were not made, sheets and blankets were on the floor, stuffed animals, books, and small crates filled with miscellaneous items were on the floor and could potentially pose a trip hazard. I also observed the carpeting in the back room that leads to the garage to be dirty and in need of cleaning. The resident bathroom also permeated of urine and needs cleaning.

On 01/25/23, I interviewed APS investigator, Tywonia Millender and she reported that during her visit to the home the resident's bedrooms were in disarray and needed some attention. Ms. Millender reported that she was under the impression that if the residents are higher functioning, it was their responsibility to clean their rooms. I explained to Ms. Millender that as it relates to the licensing rules, the staff is ultimately responsible for the overall upkeep of the home to ensure the safety and well-being of the residents.

On 01/25/23, I interviewed Guardian (A) and she reported that the home is always dirty and unkept. Guardian (A) reported that although the residents should assist if they can, the deep and thorough cleaning is the responsibility of the staff. Guardian (A) reported that the upkeep of the home has been an ongoing issue.

| **APPLICABLE RULE** | |
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| **R 400.14403** | **Maintenance of premises.** |
| | **(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.** |

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| **ANALYSIS:** | Based on the findings of the investigation, which included interviews of Ms. Wood, Guardian (A), Ms. Millender and consultant observation, I am able to corroborate the allegation.<br><br>Ms. Wood reported the staff struggle with getting the residents to clean their bedrooms. I informed Ms. Wood that ultimately the responsibility of the upkeep of the home falls on the staff.<br><br>Ms. Millender confirmed that the resident's bedrooms were in disarray during her visit.<br><br>Guardian (A) reported that the upkeep and cleanliness of the home has been an ongoing issue.<br><br>I observed areas of the home to be upkept and in need of cleaning. The resident's bedrooms were dirty, items strewn about and miscellaneous items all over the floors. The carpeting in the rear area of the home was dirty and in need of cleaning. The resident's bathroom also permeated of urine.<br><br>This violation is established as the home is not arranged and maintained to provide adequately for the health, safety and well-being of the residents. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 01/10/23, I conducted an unscheduled onsite inspection and reviewed Resident A's records. I was unable to locate a current health care appraisal in his file.

I interviewed Ms. Wood and she reported that she was not sure where the health care appraisal was but would attempt to locate it and forward it to me.

On 01/12/23, Ms. Wood emailed me some of the requested documents, however, they did not include a copy of Resident A's health care appraisal. To date, I have still not received it.

On 01/25/23, I interviewed Guardian (A) and she reported she normally keeps copies of all of Resident A's paperwork and accompanies him on medical appointments. Guardian (A) reported that the home likely cannot find the copy, because they did not ensure an appointment was scheduled for Resident A to have his physical.

| APPLICABLE RULE | |
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| **R 400.14301** | **Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.** |
| | **(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.** |
| **ANALYSIS:** | This violation is established, because the home was unable to provide a current written health care appraisal for Resident A. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

On 01/10/23, I conducted an unscheduled onsite inspection and requested to review Resident A's MARs. While reviewing the MAR's I observed that during the month of December of '22, the initials of the person that administered the medication was missing.

- On 12/10/22,12/18/22-12/20/22, 12/22/22,12/24/22-12/26/22 and 12/28/22-12/30/22 Resident A's a.m. doses of Androderm 4mg patches, Doxycycline Hyclate 100mg tablets, Famotidine 20 mg tablets, Finasteride 5mg tablet, Levothyroxine 88mcg tablet, Montelukast 10 mg tablet, Toviaz 4mg tablet, Asenapine 5mg tablet, Topiramate 200mg tablet and Hydroxyzine 50mg tablet were not initialed as applied or given.

- On 12/17/22-12/19/22, 12/22/22, and 12/24/22 Residents A's Clonidine HCL 0.2mg a.m. dose was not initialed as given.

- On 12/09/22, 12/13/22,12/17/22-12/19/22, 12/22/22, 12/25/22 Resident A's a.m. dose Desmopressin Acetate 0.2 mg was not initialed as given.

- On 12/03/22,12/09/22, 12/10/22, 12/18/22-12/20/22, 12/22/22, 12/24/22-12/26/22 and 12/28/22-12/30/22 Resident A's weekly a.m. dose of Ozempic 1mg dose was not initialed as given. This is a weekly medication, although staff initialed the MAR the remaining days of the month.

- On 12/10/22, 12/12/22, 12/13/22, 12/18/22-12/22/22, 12/24/22-12/26/22, 12/28/22-12/30/22 Resident A's a.m. dose of Metformin HCL 1000mg tablet was not initialed as given.

- On 12/01/22-12/03/22, 12/05/22-12/08/22, 12/10/22, 12/15/22-12/26/22, 12/28/22-12/31/22 noon dose of Trazodone 100mg tablet was not initialed as given.

- On 12/09/22-12/11/22, 12/16/22-12/26/22,12/28/22-12/30/22 a.m. dose of Calcium/D3600 tablet was not initialed as given.

- On 12/23/22, 12/17/22-12/19/22, 12/22/22,12/25/22, 12/27/22 Resident A's p.m. dose of Seroquel 300mg tablet was not initialed as given.

- On 12/13/22, 12/17/22-12/19/22, 12/22/22-12/23/22, 12/25/22 p.m. doses of Tresiba Flextouch 100 units, Lamotrigine 100mg tablet, Trazodone 100mg tablet, Melatonin 10mg capsule, Asenapine 5mg tablet were not initialed as given.

- On 12/01/22, 1213/22, 12/18/22-12/19/22, 12/22/22-12/25/22, 12/27/22 Resident A's p.m. dose of Metformin HCL 1000mg tablet was not initialed as given.

On 01/10/23, I interviewed Ms. Wood and she reported she has been reminding staff that they must initial the MARs at the time of administration, but reported staff are failing to do so. I explained to Ms. Wood my concern and that without staff initials I do not know if Resident A was actually administered these medications. Ms. Wood understood the concerns and reported she will continue stressing to the staff the rule requirements.

On 01/25/23, I interviewed Guardian (A) and she reported that the staff are not only failing to initial and properly track the medication, but reported that they are not administering the medication properly. Guardian (A) reported that this is another reason that Resident A will not be returning to this home.

| **APPLICABLE RULE** | |
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| **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:** |

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| | **(b) Complete an individual medication log that contains all of the following information:**<br>**(i) The medication.**<br>**(ii) The dosage.**<br>**(iii) Label instructions for use.**<br>**(iv) Time to be administered.**<br>**(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**<br>**(vi) A resident's refusal to accept prescribed medication or procedures.** |
| **ANALYSIS:** | This violation is established as the staff are failing to appropriately complete the MARs. The staff are not initialing the MARs at the time the medication is given |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

I recommend that the license be modified to provisional. The licensee designee, Mr. Bates, has informed me that he will be submitting a voluntary closure letter in lieu of a corrective action plan at the insistence of MCMHA. Mr. Bates reported that MCMHA has decided to terminate their contract with them and bring in a different licensee to apply for licensure of the home. Mr. Bates reported that they would not be operating the home during the provisional period as the license will be closed.

Pandrea Robinson 02/01/23

Pandrea Robinson Date
Licensing Consultant

Approved By:

A. Hunter 02/01/23

Ardra Hunter Date
Area Manager