GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 21, 2023

Donna Cassaday
695 S M18
Gladwin, MI 48624

RE: License #: AF260002091
Investigation #: 2023A1033027
Cassaday's AFC

Dear Ms. Cassaday:

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 (517) 284-9730.

Sincerely,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF260002091
Investigation #:	2023A1033027
Complaint Receipt Date:	02/07/2023
Investigation Initiation Date:	02/08/2023
Report Due Date:	04/08/2023
Licensee Name:	Donna Cassaday
Licensee Address:	695 S M18 Gladwin, MI 48624
Licensee Telephone #:	(989) 426-2788
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Cassaday's AFC
Facility Address:	695 S M18 Gladwin, MI 48624
Facility Telephone #:	(989) 426-2788
Original Issuance Date:	12/01/1984
License Status:	REGULAR
Effective Date:	08/01/2021
Expiration Date:	07/31/2023
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Licensee Donna Cassaday did not provide a 30-day discharge notice to Resident A and her family. She arranged to have Resident A dropped off at Citizen 1's home instead of following proper discharge protocol.	Yes
Proper medical treatment was not sought for Resident A while she was cared for by Licensee Donna Cassaday.	No
Licensee Donna Cassaday, used Zoloft medication as a chemical restraint for Resident A.	No
Licensee Donna Cassaday, was administering Zoloft to Resident A against request of family that Resident A not receive this medication.	No
Additional Findings	Yes

III. METHODOLOGY

02/07/2023	Special Investigation Intake 2023A1033027
02/08/2023	Contact - Telephone call made- Attempt to interview Complainant, voicemail message left.
02/08/2023	Special Investigation Initiated – Telephone call made- Interview with Complainant via telephone.
02/08/2023	Contact - Telephone call made- Interview with Citizen 1 via telephone.
02/13/2023	Inspection Completed On-site- Interview with Licensee, Donna Cassaday & Nurse Practitioner with Careline Physician Services, Renee Doherty. Review of Resident A's resident record completed.
02/13/2023	Inspection Completed-BCAL Sub. Compliance
02/13/2023	Exit Conference completed with Licensee, Donna Cassaday, during on-site investigation.
02/15/2023	Contact – Telephone call made- Follow-up interview with NP, Renee Doherty, with Careline Physician Services.

ALLEGATION:

Licensee Donna Cassaday did not provide a 30-day discharge notice to Resident A and her family. She arranged to have Resident A dropped off at Citizen 1's home instead of following proper discharge protocol.

INVESTIGATION:

On 2/7/23 I received an online complaint regarding Cassaday's AFC (the facility). The complaint alleged that licensee Donna Cassaday had discharged Resident A without providing she or her family with a proper 30-day discharge notice from the facility. On 2/8/23 I interviewed Complainant via telephone. Complainant reported Citizen 1 had additional information regarding this allegation.

On 2/8/23 I interviewed Citizen 1 who reported she is a relative of Resident A. She reported Resident A had been admitted to the facility on 10/3/22. Citizen 1 reported she received a text message from Ms. Cassaday on 1/21/23 which reported Ms. Cassaday did not feel she could continue to provide the level of care Resident A was requiring, and she may need to increase her rent based on increase in level of care. Citizen 1 reported she then received a text from Ms. Cassaday on 2/2/23 which stated that tomorrow, 2/3/23, Resident A's time would be ended at the facility. Citizen 1 further reported that on 2/4/23 Resident A was brought to Citizen 1's home and dropped off with all her belongings. Citizen 1 reported she did not receive a written 30-day discharge notice and had very little notice prior to Ms. Cassaday arranging for Resident A to be transported from the facility to Citizen 1's home.

On 2/13/23 I completed an on-site investigation at the facility. I interviewed licensee Donna Cassaday who reported she had cared for Resident A but had recently discharged her from the facility. Ms. Cassaday reported Citizen 1 had signed a discharge policy, upon Resident A's admission to the facility, which noted that any resident who becomes incontinent of bowel will need to be discharged from the home due to level of care needs. Ms. Cassaday reported she had verbally and through text reported to Citizen 1 that Resident A was experiencing incontinence of bowel and was using blankets, sheets, washcloths, and towels to clean the feces and was hiding the items around the facility. Ms. Cassaday reported Resident A had been experiencing incontinence of bowel since admission to the facility and they had been working with a physician group, Careline Physician Services, in efforts to address this issue. Ms. Cassaday reported she had given Citizen 1 a verbal discharge notice on an unidentified date in January 2023. She reported she did not provide a written notice to Citizen 1 or Resident A. Ms. Cassaday further reported it was only about two weeks between the verbal discharge notice and when Ms. Cassaday arranged for responsible person, Randy Cassaday, to transport Resident A to Citizen 1's home on 2/3/23. Ms. Cassaday reported Citizen 1 had agreed to the discharge notice and reported she was planning to care for Resident A at her home.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians instructions; health care appraisal.**
	(12) A licensee shall provide a resident with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency.
ANALYSIS:	Based upon interviews with Citizen 1 and Ms. Cassaday, the licensee did not provide a written 30-day discharge notice for Resident A or Citizen 1 prior to arranging for Resident A to be transported from the facility to Citizen 1's home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Proper medical treatment was not sought for Resident A while she was cared for by licensee Donna Cassaday.

INVESTIGATION:

On 2/7/23 I received an online complaint alleging licensee Donna Cassaday did not seek appropriate medical attention for Resident A while she was residing at the facility. On 2/8/23 I interviewed Citizen 1, via telephone. Citizen 1 reported that on the date of 2/3/23, when Ms. Cassaday arranged for Resident A to be dropped off at her home, Resident A was in a very weakened state and exhibiting multiple physical symptoms of diarrhea and confusion. Citizen 1 reported she took Resident A to the local emergency department, where she was diagnosed with a urinary tract infection, on 2/5/23.

On 2/13/23, I completed an on-site investigation at the facility. I interviewed licensee Donna Cassaday. Ms. Cassaday reported Resident A had been experiencing issues with on and off loose stools since she was admitted to the facility in October 2022. Ms. Cassaday reported she had been working closely with the Careline Physician Services, Nurse Practitioner, Renee Doherty, for Resident A's medical needs. Ms. Cassaday reported Resident A did not appear ill or in need of medical attention on the date of discharge from the facility. She reported Resident A was experiencing diarrhea but also noted that this had been happening since she was admitted.

On 2/13/23, during the on-site investigation, I interviewed Careline Physician Services, Nurse Practitioner, Renee Doherty. Ms. Doherty was making a routine visit

to the facility and reported she had been the care provider for Resident A, while she was admitted to the facility. Ms. Doherty reported she had lengthy conversation with Citizen 1, regarding Resident A's diarrhea and behaviors. Ms. Doherty reported she did not have her documentation at this time and would need to read these notes for clarification purposes.

On 2/15/23 I conducted a follow-up interview with Ms. Doherty, via telephone. Ms. Doherty reported she had frequent conversations with Citizen 1 regarding Resident A's continued issues with diarrhea. She reported she had made a referral for a gastroenterologist to evaluate Resident A and had referred Resident A to Dr. Todd Holtz, gastroenterologist in Midland, MI. Ms. Doherty reported Citizen 1 was planning to schedule the appointment with this provider, and she is uncertain that the appointment had been scheduled to this date. Ms. Doherty reported she had a physical contact with Resident A on 2/2/23 and noted no concerns about her physical health, beyond the continued diarrhea. She reported that on 2/2/23 Resident A was up, walking and talking, and appeared to be in good spirits.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians instructions; health care appraisal.**
	(7) A licensee shall contact a resident's physician for instructions as to the care of the resident under the following conditions: **(b) If the resident requires the care of a physician while living in the home.**
ANALYSIS:	Based upon interviews with Citizen 1, Ms. Cassaday, and Ms. Doherty it can be determined licensee Cassady did seek medical attention for Resident A and had an active visiting physicians service coming to the facility for regular care and evaluations. Ms. Doherty reported she conducted an on-site physical assessment of Resident A on 2/2/23, the day before she was discharged to Citizen 1's home and reported no obvious concerns about her health status. Ms. Doherty had made a referral for follow-up with a gastroenterologist to address the ongoing diarrhea Resident A was experiencing. It cannot be determined that the urinary tract infection, diagnosed on 2/5/23, was an obvious concern on the date 2/3/23, provided the given statements.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Licensee Donna Cassaday used Zoloft medication as a chemical restraint for Resident A.**

- **Licensee Donna Cassaday was administering Zoloft to Resident A against request of family that Resident A not receive this medication.**

INVESTIGATION:

On 2/7/23 I received an online complaint alleging that licensee Donna Cassaday was administering Zoloft medication as a means of a chemical restraint for Resident A. On 2/8/23 I interviewed Citizen 1 regarding this allegation. Citizen 1 reported Resident A had resided at the facility from 10/3/22 through 2/3/23. She reported she had advised Ms. Cassaday that Resident A was allergic to Zoloft and could not be prescribed this medication. She reported that when Resident A was discharged from the facility on 2/3/23, she was provided a piece of paper with Resident A's current medications written on the paper and one of the medications was Zoloft. She reported she asked Ms. Cassaday about the medication being on the list and Ms. Cassaday reported she forgot to take that medication off the list as Resident A no longer takes this medication. Citizen 1 reported she had a conversation with Careline Physician Services, Nurse Practitioner, Renee Doherty, on 11/16/22, regarding starting Resident A on Zoloft and Citizen 1 reported that at this time she had forbid Ms. Doherty from ordering this medication for Resident A. Citizen 1 reported she was uncertain of the date on which the Zoloft was ordered and started but Ms. Cassaday, admitted, through text messages, that she did administer the Zoloft at some point in time while Resident A was at the facility. Citizen 1 had no further information to report about the use of the Zoloft. She reported she feels the Zoloft medication was the reason why Resident A was experiencing diarrhea.

On 2/13/23 I completed an on-site investigation at the facility. I interviewed Ms. Cassaday regarding the allegations. Ms. Cassaday reported Citizen 1 had not reported any medication allergies to her at the time of admission. She reported Citizen 1 had noted non-specific medication sensitivities but not allergies. Ms. Cassaday reported Citizen 1 completed the *Assessment Plan for AFC Residents* form, at her own choosing/request, and allergies to Zoloft were not listed on this document. Ms. Cassaday reported Zoloft was ordered by Ms. Doherty on 11/17/23 and Ms. Cassaday did administer 2 doses before stopping the medication due to Resident A exhibiting increased confusion. Ms. Cassaday reported she had contacted Ms. Doherty and explained the side effects being observed with Resident A and it was agreed the medication should be stopped. Ms. Cassaday reported one bottle of the Zoloft was ordered, and it contained 30 pills. Ms. Cassaday reported that she still had the remaining pills in the bottle as she had not discarded the medication yet.

On 2/13/23, during on-site investigation, I interviewed Ms. Doherty. Ms. Doherty reported that she had started Resident A on the Zoloft after she had a telephone conversation with Citizen 1, who agreed to the addition of the medication. Ms. Doherty reported that Citizen 1 then made a telephone call to Ms. Cassaday and requested the medication be stopped, at which time it was discontinued. Ms. Doherty could not provide specific dates for these events at this time. Ms. Doherty reported that Citizen 1 did not make a telephone contact with Ms. Doherty regarding her request to discontinue the Zoloft medication.

On 2/15/23, I conducted a follow-up interview with Ms. Doherty, via telephone. Ms. Doherty reported that she had not observed an allergy to Zoloft written in any of Resident A's paperwork. Ms. Doherty reported that when there is an allergy, that the provider has not observed, the pharmacy will alert the provider to the allergy. Ms. Doherty reported she received no report from the pharmacy regarding a Zoloft allergy for Resident A. Ms. Doherty reported that the Zoloft medication was stopped after two days, two administered doses, and there was not a refill of this medication ordered for Resident A.

On 2/13/23, during on-site investigation, I reviewed the remaining bottle of Zoloft medication prescribed to Resident A. The prescription was ordered for 30 tablets. I counted the tablets left in the bottle. There were 28 tablets remaining in this bottle.

On 2/13/23, during on-site investigation, I reviewed Resident A's *Health Care Appraisal* form, dated 9/7/22. Under section *9. Allergies*, it reads, "Augmentin, Procaine, Crestor, Succinylcholine, Tetracaine, Chloroprocaine." Zoloft, or any other version of Zoloft, were not listed as an allergy on this form. I also reviewed the *Assessment Plan for AFC Residents* form during this investigation. There were no notations of medication allergies listed on this form. This form was dated and signed by Ms. Cassaday and Citizen 1 on 10/3/22. I requested to review the Medication Administration Record (MAR) for Resident A, during this investigation. Ms. Cassaday reported she has not been documenting on resident MARs in recent months and could not supply a copy of Resident A's MAR for the months of October 2022 through February 2023.

APPLICABLE RULE	
R 400.1415	**Resident behavior management; chemical restraint restriction; chemical restraint report.**
	(1) The use of a chemical restraint shall only be prescribed and authorized by a licensed physician.

ANALYSIS:	Based upon interviews with Citizen 1, Ms. Cassaday, and Ms. Doherty, as well as review of Resident A's *Health Care Appraisal* & *Assessment Plan for AFC Residents* forms, there is not sufficient evidence to indicate that Ms. Cassaday was using the Zoloft medication as a chemical restraint for Resident A. Citizen 1 had little information regarding the usage of the medication and Ms. Cassaday and Ms. Doherty both agreed that the medication was prescribed and administered for two days before the medication was discontinued.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(1) Prescription medication, including tranquilizers, sedatives, dietary supplements, or individual special medical procedures, shall be given or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy container which shall be labeled for the specific resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being (33.1101 et. seq. of the Michigan Compiled Laws.
ANALYSIS:	Based upon interviews with Citizen 1, Ms. Cassaday, and Ms. Doherty, as well as review of Resident A's *Health Care Appraisal* and *Assessment Plan for AFC Residents* forms, there was no supporting documentation to be found that clarified Resident A had an allergy to Zoloft medication, or that the medication allergy was verbally reported to Ms. Cassaday or Ms. Doherty. Ms. Cassaday reported Citizen 1 completed the *Assessment Plan for AFC Residents* form and signed this document. There was not an allergy to Zoloft listed on this document. Ms. Doherty provided a medical prescription for the Zoloft medication and reports ordering this medication to be discontinued after two doses were given, based upon Resident A's reaction to the medication.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During on-site investigation on 2/13/23 I requested to view the MARs for Resident A. Ms. Cassaday reported the MARs were missing for Resident A. I requested to view the MARs for all the current residents at the facility. Ms. Cassaday reported she has not been recording medications administered to any of the current residents at the facility.

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: **(a) 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:	Based upon interview with Ms. Cassaday, she has not been maintaining a record of prescription medications administered to any of the current residents at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During on-site investigation, on 2/13/23 I spoke with Ms. Cassaday about the Zoloft medication that had been ordered for Resident A. Ms. Cassaday acknowledged the medication had been ordered 11/17/22 and was discontinued two days later. Ms. Cassaday reported she still had the bottle of Zoloft that had been prescribed to Resident A despite this medication being discontinued in November 2022.

During the on-site investigation on 2/13/23, I interviewed Ms. Doherty. Ms. Doherty reported the Zoloft medication had been ordered for Resident A in November 2022 and administered for just two days prior to being discontinued, at Citizen 1's request. Ms. Doherty reported a conversation was had with Ms. Cassaday about discontinuing this medication for Resident A's use.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(7) Prescription medication which is no longer required by a resident shall be destroyed after consultation with a physician or a pharmacist.
ANALYSIS:	Based upon an interview with Ms. Cassaday, as well as observing the bottle of Zoloft, prescribed to Resident A, during the on-site investigation, Ms. Cassaday did not destroy the Zoloft medication after the conversation with Ms. Doherty regarding discontinuing the medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

03/20/2023

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Jana Lipps Date
Licensing Consultant

Approved By:

03/21/2023

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Dawn N. Timm Date
Area Manager