GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 4, 2023

Connie Clauson
Pleasant Homes I L.L.C.
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL390007089
Investigation #: 2023A0581020
Park Place Living Centre #A

Dear Mrs. Clauson:

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.

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. 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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390007089
Investigation #:	2023A0581020
Complaint Receipt Date:	02/08/2023
Investigation Initiation Date:	02/08/2023
Report Due Date:	04/09/2023
Licensee Name:	Pleasant Homes I L.L.C.
Licensee Address:	Suite 203 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Janet White
Licensee Designee:	Connie Clauson
Name of Facility:	Park Place Living Centre #A
Facility Address:	4214 S Westnedge Kalamazoo, MI 49008
Facility Telephone #:	(269) 388-7303
Original Issuance Date:	01/01/1989
License Status:	REGULAR
Effective Date:	07/19/2021
Expiration Date:	07/18/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED

	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had her arms pulled by a staff, which left a bruise.	Yes
The licensee is not providing residents with incontinence briefs and wipes.	No
Residents are going without their medication.	Yes
Residents are not receiving showers.	No
The facility is not clean.	Yes
Additional findings.	Yes

III. METHODOLOGY

02/08/2023	Special Investigation Intake 2023A0581020
02/08/2023	APS Referral- APS denied investigating the allegations; therefore, no referral necessary.
02/08/2023	Contact - Document Sent- Email to Administrator, Janet White, requesting documentation related to staff.
02/08/2023	Special Investigation Initiated – Telephone call made- Interview with direct care staff, Alica Wilson.
02/08/2023	Contact - Telephone call made- Interview with direct care staff, Grace Kincaid.
02/08/2023	Contact - Telephone call made- Interview with. Ariana Sharkey
02/08/2023	Contact - Document Received- Email from Ms. White.
02/08/2023	Contact - Document Sent- Requested police report from Dept. of Public Safety.
02/08/2023	Referral - Law Enforcement- Referral not necessary, due to LE already investigating.
02/09/2023	Contact - Document Received- Received additional allegations.
03/03/2023	APS Referral- Made APS referral concerning resident's not having medications in facility and facility conditions.
03/03/2023	Contact - Document Sent- Email sent to HomeTown Pharmacy

03/07/2023	Contact - Document Received- Email from HomeTown Pharmacy
03/08/2023	Contact – Document Received - Email from Ms. White.
03/24/2023	Contact – Document Received - Email from Ms. Cummings.
03/30/2023	Contact – Document Received - Email from HomeTown Pharmacy
03/30/2023	Contact – Telephone call made- Interview with HomeTown Pharmacy Long Term Service Coordinator.
04/06/2023	Exit conference with the licensee designee, Connie Clauson.

ALLEGATION:

Resident A had her arms pulled by a staff, which left a bruise.

INVESTIGATION:

On 02/08/2023, I received this complaint through the Bureau of Community Health Systems (BCHS') online complaint system. The complaint alleged on 01/30/2023, Resident A, who has a diagnosis of dementia and was residing in the licensee's "specialized care building", had her arms pulled by direct care staff, Ariana Sharkey, which left a bruise and a fingerprint mark on Resident A's arms. The complaint alleged Ms. Sharkey was attempting to move Resident A so she could clean around her. The complaint alleged Ms. Sharkey admitted to pulling Resident A and injuring her. The complaint also alleged Ms. Sharkey was terminated from employment because of the incident.

On 02/08/2023, I interviewed direct care staff, Alicia Wilson. Ms. Wilson stated on 01/30/2023, the evening of the incident between Resident A and Ms. Sharkey, she had been working in the licensee's neighboring licensed AFC facility. She stated sometime between 5:30 pm and 6:30 pm, direct care staff member Grace Kincaid came over to the facility and reported Ms. Sharkey grabbed Resident A's arm leaving a handprint. Ms. Wilson stated when she went over to the facility to assess the situation, she observed a handprint on Resident A's arm. She stated when she questioned Ms. Sharkey about it, Ms. Sharkey was "stammering and making excuses." Ms. Wilson stated Ms. Sharkey reported to her Resident A had been yelling at and attempting to hit her; however, Ms. Wilson stated Resident A does not have a history of being violent. Ms. Wilson stated that based on Resident A's injuries, she sent Ms. Sharkey home.

On 02/08/2023, I interviewed direct care staff, Grace Kincaid, via telephone. Ms. Kincaid's statement to me was consistent with Ms. Wilson's statement to me. She stated she had been working directly along with Ms. Sharkey the evening of the incident, which occurred after dinner on 01/30/2023. She stated Ms. Sharkey went over to Resident A, who was sitting, and tried taking a Styrofoam cup out of her hands. Ms. Kincaid stated Resident A said, "that's mine, don't take it." Ms. Kincaid stated when Resident A stood up, both she and Ms. Sharkey were holding onto the cup. She stated the cup ripped and Ms. Sharkey threw it at Resident A but did not hit her with it.

Ms. Kincaid stated she tried de-escalating the situation by removing Resident A from the situation. She stated she took Resident A into the living room where she sat her down. She stated she then had to assist another resident and left Resident A in the living room. She stated when she came back to the living room, she observed Resident A standing up and walking around seemingly distressed. She stated Resident A was making comments to the other residents like "someone took my stuff; someone took my cup from me." Ms. Kincaid stated she had to help another resident get from the dining room to his room and while she was in that resident's room, she heard Resident A "screaming." She stated at first it was a shriek and she thought she heard Resident A say "ouch", but Ms. Kincaid stated it sounded like Resident A was scared. Ms. Kincaid stated she went into the facility's dining room and kitchen area and saw Resident A standing in a corner with Ms. Sharkey across the table from her near the facility's garbage can. She stated Resident A was holding her left arm and saying, "she hurt me, she hurt the shit out of me." Ms. Kincaid stated she heard Ms. Sharkey say, "I'm just trying to get everyone out of the kitchen, I just want her out of the kitchen."

Ms. Kincaid stated nothing else was said by anyone except when she was taking Resident A back to her room she stated, "ouch, she hurt me, ow, my arm hurts." Ms. Kincaid stated when she observed Resident A's arm, she saw a bruise had formed as she could see a thumb and fingerprints on Resident A's arm. She stated it also looked like Ms. Sharkey's fingernails had gone into her arm as there were two little marks. She stated after she got Resident A to her bedroom, she went to a neighboring facility to talk to Ms. Wilson and another staff about the incident.

On 02/08/2023, I interviewed direct care staff, Ariana Sharkey, via telephone. Ms. Sharkey's statement to me was consistent with Ms. Kincaid's statement to me regarding the timeframe of the incident. Ms. Sharkey stated while she was attempting to clear the facility's dining room tables after dinner, Resident A was attempting to take a bowl back to her room. Ms. Sharkey stated Resident A was trying to hit her while she attempted take the bowl from her. She stated Resident A "got real upset and hit me", which she stated was once in the face and once in the chest. Ms. Sharkey stated she grabbed Resident A's arm in the "wrong way" and tried taking her to her room, but Resident A backed up into a corner of the dining room.

She stated Resident A did not say anything as she was backing away from her. Ms. Sharkey stated Ms. Kincaid was not in the dining room with her at that time as she was assisting another resident. Ms. Sharkey denied she and Resident A ever were holding onto a bowl or a cup at the same. She denied throwing a cup at Resident A, as well. Ms. Sharkey stated she told Resident A to go to her room because Resident A was hitting her and she "didn't want to be around that behavior." Ms. Sharkey stated she did not observe any bruises on Resident A, but the other staff told her there were. She stated, "I could have left her alone, but I didn't want her stealing any of the bowls."

Ms. Sharkey stated she started working at the facility on 12/06/2022 through 01/30/2023. She stated she worked approximately 16-18 hours per week. She stated all the residents have diagnoses of Dementia or Alzheimer's. She stated she "wasn't trained properly" to work in the facility because she did not know what to do if a resident started experiencing behaviors.

On 02/08/2023, the facility's Administrator, Janet White, emailed pictures of Resident A's arm taken on or around 01/30/2023. Upon review of the pictures, I was unable to determine if it was actually Resident A in the picture because it was just a picture of an arm. I did observe in one picture an approximate one inch by two-inch light purple bruise on an upper arm. The second picture showed an upper arm with quarter sized light purple bruise with two marks in the top center. Approximately one inch above the quarter sized bruise was a quarter inch scrape.

Ms. White also provided me with the facility's current staff schedule to confirm Ms. Sharkey was no longer working at the facility.

On 02/09/2023, I conducted an unannounced onsite inspection at the facility. I interviewed direct care staff, Bambi Keckler, Moriah Nakken, and Lakeisha Brimite. Ms. Brimite was unable to provide any information due to it being her first day of work. Ms. Nakken stated she had completed training and orientation and was still shadowing. Ms. Keckler stated she came back to work at facility in July 2023. I attempted to interview Resident A; however, she didn't recall a staff by the name of Ariana Sharkey or any incidences involving her. Resident A stated she felt safe in the facility. I interviewed Resident B who also could not recall a staff by the name of Ariana Sharkey or any incidences concerning her and Resident A. She stated she also felt safe in the facility.

I interviewed the facility's Administrator, Janet White. Ms. White stated Ms. Sharkey was hired on 12/05/2022 and started working directly with residents on 12/12/2022. Upon review of Ariana Sharkey's file, there was no verification of training pertaining to residents with Alzheimer's or Dementia; despite the facility being licensed for this population. The only training Ms. Sharkey had in her staff file was relating to medication training and resident care. Ms. White stated the facility's Resident Care Manager (RCM) would provide training to all direct care staff upon hire; however,

she stated the RCM's, "got behind" and Ms. Sharkey did not receive the additional training. Ms. White acknowledged Ms. Sharkey had not received appropriate training prior to working in the facility.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Direct care staff, Ariana Sharkey, admitted she grabbed Resident A's arm on 01/30/2023 when Resident A tried taking dining bowls back to her room. By forcibly grabbing Resident A's arms, Ms. Sharkey left bruises and marks on Resident A's arms. Subsequently, Ms. Sharkey used physical force on a resident, other than physical restraint, which is not allowed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15204	**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: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**

ANALYSIS:	Based on my review of direct care staff member Ariana Sharkey's, employee file, there was no documentation or confirmation she had completed all required training prior to performing direct care staff duties on 12/12/2023. The facility's Administrator, Janet White, acknowledged training had not been completed due to Resident Care Managers, who provide the training, "got behind." Additionally, despite the facility being licensed to provide care to residents with Alzheimer's there was no verification Ms. Sharkey had received any type of specific training relating to working with residents with Alzheimer's or a related diagnosis.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The licensee is not providing residents with incontinence briefs and wipes.

INVESTIGATION:

On 02/09/2023, I received an additional complaint alleging the facility is not stocked with incontinence briefs or wipes. The complaint alleged direct care staff cut up towels "to wash resident's behinds" because they do not have enough wipes.

Direct care staff members Grace Kincaid, Alicia Wilson, and Chaleigh Lewis all indicated if a resident was not a participant of a program like Senior Care Partners' Program of All-Inclusive Care for the Elderly (PACE), then a resident's family members were supposed to provide incontinence briefs; however, they indicated family members do not always provide them. The three direct care staff members indicated when this occurs, direct care staff may take another resident's incontinence briefs to ensure residents' personal care is still being addressed appropriately rather than residents going without them. None of the staff indicated residents were going without incontinence briefs when they needed to have them. The direct care staff indicated if the facility was short on incontinence briefs, Administrator Janet White is contacted and she obtains additional briefs for residents.

Ms. Kincaid denied cutting up towels to make washcloths but indicated she had heard of direct care staff doing it. Ms. Wilson also stated towels had been cut up to make extra wash cloths when wash clothes were low.

On 02/28/2023, I conducted an unannounced investigation at the facility. I interviewed the facility's Business Office Manager, Tasha Cummings, who indicated she has worked in the capacity of a direct care staff. Ms. Cummings stated the

licensee provides PACE residents with their incontinence briefs because it's in the licensee's contract with PACE. She stated otherwise, resident family members are responsible to provide these items. I interviewed direct care staff members Moriah Nakken and Giselle Trevino. Ms. Nakken and Ms. Trevino stated residents who receive PACE services primarily have incontinence briefs while the other residents run low or out of them. They also indicated they take incontinence briefs from residents who have these items in order to accommodate the residents who were out of them.

The facility's maintenance director, Todd Richardson, stated the facility's overflow of incontinence briefs are kept in a neighboring licensed AFC facility, which direct care staff can access.

During my investigation, I went into each resident bedroom, but only observed Resident G, K, I and J with incontinence briefs available in their bedrooms. I did not interview the residents due to their cognitive deficits; however, none of the residents had any notable odors indicating they were need of toileting or needed his or her incontinence brief changed.

During my investigation, there were only two washcloths in the facility for 14 residents. I checked all the restrooms and the laundry room. These washcloths appeared to have been cut from towels due to the frayed edges.

On 03/01/2023, I conducted an announced follow up investigation. Ms. White stated direct care staff have access to extra incontinence briefs. She stated the licensee does not provide incontinence briefs and wipes to residents, except residents involved with PACE, which is per the PACE contracts. She stated if the licensee provides incontinence briefs, then the licensee can charge the resident or resident's family additional costs for the supplies, per the licensee's "General Fee Policy". Ms. White stated she orders incontinence briefs through Medline, which are primarily for PACE residents; however, they can be used for all residents if a resident runs out of them or resident family members do not provide the products.

I reviewed each resident's *Resident Care Agreement* (RCA) and the licensee's corresponding "General Fee Policy" (GFP) for each resident. Upon review of each of these documents, residents and/or their designated representatives signed the GFP's indicating "additional costs for personal care products (e.g., incontinence supplies, dietary supplements, glucose testing, bathroom supplies, etc.) provided by the Facility and used by the Resident will be added to the monthly statement of charges." Ms. White indicated; however, that she has not been charging residents the additional costs for incontinence briefs.

I reviewed all resident care plans and their respective assessment plans, which indicated Residents C, D, E, G, I, J, K, L, and M are all incontinent and require the use of incontinence briefs; however, none of the assessment or care plans indicated the licensee was required to provide incontinence briefs or wipes. Only Resident L's

assessment plan indicated the facility was to provide incontinence briefs; however, Resident L is also involved with PACE.

During the inspection, Ms. White took me to the neighboring licensed AFC facility confirming there were multiple boxes of various sized incontinence briefs available to direct care staff to utilize for prescribed residents. Additionally, Ms. White showed me extra incontinence briefs being kept in the facility's storage room.

I conducted an additional walk through of the facility and again only observed two washcloths available for all the residents. Direct care staff, Bambi Keckler, stated the washcloths "go fast." Ms. Keckler stated if staff feel the facility is low on towels, washcloths, or anything else then they should make a request to Ms. White who will obtain whatever is needed. When I brought the lack of washcloths to Ms. White's attention, she obtained additional ones over from the facility's storage site to provide an adequate supply.

On 03/03/2023, I interviewed Nancy Bradley with PACE, who manages the contracts between PACE and the licensee. Ms. Bradley confirmed that based on the contract with the licensee, the licensee purchases incontinence briefs for PACE residents. She stated PACE pays a flat fee to the licensee, which also includes fees for incontinence briefs. Ms. Bradley stated it is the licensee's responsibility to purchase these incontinence briefs. She stated the licensee is not required to send PACE any documentation over to confirm incontinence briefs were purchased or to send them a bill. Ms. Bradley forwarded me the contract between PACE and the licensee, which indicated the licensee is a provider of health care services and per the agreement, the licensee agreed to provide health care services to PACE participants. The contract defined "health care services" as hospital services, professional services, social services and/or other services and items provided by the licensee.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based on my investigation, which included a review of the resident's *Resident Care Agreements* and the licensee's General Fee Policy, resident assessment and care plans, interviews with the Administrator, Janet White, and multiple direct care staff, as well as my observations of the licensee's storage of incontinence briefs, there is no evidence the licensee is required to provide incontinence briefs to the residents not receiving PACE services and is failing to do so. Per the licensee's General Fee Agreement, residents or their family members are required to provide residents with their personal care products like incontinence supplies unless the resident is involved with PACE, whereas the licensee is required to provide these items per their contract with PACE. During my inspection, I observed incontinence briefs and wipes at the facility and in storage, which were accessible to direct care staff.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15411	**Linens.**
	(3) A licensee shall provide bath towels and washcloths. Towels and washcloths shall be changed and laundered not less than twice weekly or more often if soiled.
ANALYSIS:	When I conducted my onsite inspections at the facility on 02/28/2023 and 03/01/2023, there were only two washcloths for 14 residents available in the facility. The Administrator, Janet White, did obtain more washcloths from an overflow and storage site at a neighboring facility and brought them over.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are going without their medication.

INVESTIGATION:

The complaint alleged residents are not getting their medications because the medications are not getting picked up from the pharmacy when they are ready. The

complaint alleged residents have gone six months without some of their medications.

During my interview with Ms. Kincaid and Ms. Wilson on 02/08/2023, they both stated direct care staff members do not pick up resident medication form the pharmacy as the pharmacy delivers all medications. Though Ms. Wilson did not indicate any major medication issues with the pharmacy, Ms. Kincaid stated some of the residents went without their medications.

Ms. Cummings also stated on 02/28/2023 she was not aware of any medication issues or concerns within the facility.

Ms. Trevino stated she's contacted the facility's primary pharmacy, Hometown pharmacy, on or around 02/27/23 regarding a resident's melatonin not being in stock at the facility. She stated the pharmacy indicated to her it was the first time the facility's staff had called them about the concern. Ms. Trevino stated she communicated the concern about medications not being refilled to the facility's Administrator, Ms. White. Ms. Trevino also stated HomeTown Pharmacy does not bring resident medication when the reorder buttons have been pressed on the electronic Medication Administration Record (eMAR) through the Extended Care Professional (ECP) online system.

During my 03/01/2023 investigation at the facility, I reviewed each resident's February 2023 eMAR to determine if medications were administered, as required. According to documentation on Resident A's generated February eMAR, Resident A was prescribed the following medication, but the eMAR notation of "on order" indicated the medication was not administered:

- Vitamin B-6, 100 mg tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident A on 02/04.

- Vitamin D3 2,000IU softgel, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident A on 02/22, 02/23, 02/24, 02/26, 02/27, and 02/28.

- Ferrous Sulfate, 325 mg tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident A on 02/15 and 02/23.

- Thiamine (B1), 100 mg tablet, to be administered by giving 1 tablet by mouth every evening. This medication was not administered to Resident A on 02/14, 02/15, 02/16, 02/17, 02/18, 02/19, 02/20, 02/21, 02/22, 02/24, 02/26, 02/27, and 02/28.

According to documentation on Resident C's generated February eMAR, Resident C was prescribed the following medication, but the eMAR notations of "on order", "not

in cart", "out", and "medication ordered" indicated the medication was not administered:

- Melatonin, 5 mg tablet, to be administered by giving one tablet by mouth at bedtime. This medication was not administered to Resident C on 02/06, 02/10, 02/20, 02/25, and 02/26.

According to documentation on Resident D's generated February eMAR, Resident D was prescribed the following medication, but the eMAR notations of "on order", "out", and "waiting on deliver" indicated the medication was not administered:

- Ensure, to be administered by giving one supplement drink 3 times daily. This medication was not administered to Resident D at 8 am on 02/01, 12 pm on 02/01, 8 am on 02/02, 12 pm on 02/02, 8 am on 02/14, 12 pm on 02/14, 5 pm on 02/15

According to documentation on Resident E's generated February eMAR, Resident E was prescribed the following medication, but the eMAR notations of "out" and "no boost" indicated the medication was not administered:

- Boost, to be administered by administering one boost every evening. This dietary supplement was not administered to Resident F on 02/14, 02/15, and 02/27.

According to documentation on Resident F's generated February eMAR, Resident F was prescribed the following medication, but the eMAR notations of "medication re-ordered" and "out" indicated the medication was not administered:

- Divalproex 500 mg tablets, to be administered by taking 2 tablets by mouth at bedtime. This medication was not administered to Resident E on 02/27.

According to documentation on Resident G's generated February eMAR, Resident G was prescribed the following medication, but the eMAR notations of "on order" and "out" indicated the medication was not administered to the resident:

- Aspirin 81 mg chewable tablet, to be administered by giving one tablet by mouth once daily. This medication was not administered to Resident G on 02/26, 02/27, and 02/28.

- Atorvastatin 40 mg tablet, to be administered by giving 1 tablet by mouth every evening. This medication was not administered to Resident G on 02/20 and 02/27.

- Cefidinir 300 mg capsule, to be administered by giving 1 capsule by mouth twice daily x 7 days. This medication was not administered to Resident G at 8 pm on 02/25 or 8 pm on 02/27.

According to documentation on Resident H's generated February eMAR, Resident H was prescribed the following medication, but the eMAR notations of "on order", "out of medication" and "out" indicated the medication was not administered to the resident:

- Atorvastatin 40 mg tablet, to be administered by giving one tablet by mouth at bedtime. This medication was not administered to Resident H on 02/27.

- Vitamin D2 50,000iu softgel, to be administered by taking 1 capsule by mouth once a week. This medication was not administered to Resident H on 02/02, 02/09, or 02/16.

- Amphetamine salts 10 mg tablet, to be administered by taking 1 tablet by mouth once daily. This medication was not administered to Resident H on 02/04, 02/07, 02/08, 02/09, 02/10, 02/11, 02/12, 02/14, 02/15, and 02/17.

According to documentation on Resident J's generated February eMAR, Resident J was prescribed the following medication, but eMAR notations of "medication ordered", "on order", and "out" indicated the medication was not administered to the resident:

- Questran 4 grams, to be administered by giving 4 grams daily, mixed with water. This medication was not administered to Resident J on 02/14, 02/18, 02/21 and 02/27.

- Ketoconazole 2% cream, to be administered topically to the feet, face, and neck twice daily and both breasts. This medication was not administered to Resident J at 8 am on 02/14, 8 am on 02/15, 8 am on 02/18, 8 am on 02/20, 8 pm on 02/20, 8 am on 02/21 and 8 am on 02/22.

- Buspirone HCL 10 mg tablet, to be administered by taking 1 tablet by mouth three times daily. This medication was not administered to Resident J at 2 pm on 02/21.

- Escitalopram 50 mcg tablet, to be administered by taking 1 tablet by mouth once daily. This medication was not administered to Resident J on 02/24.

- Hydroxyzine HCL 25 mg tablet, to be administered by taking 1 tablet by mouth once daily. This medication was not administered to Resident J on 02/27.

According to documentation on Resident K's generated February eMAR, Resident K was prescribed the following medication, but the eMAR notations of "on order", "out", "medication on order", "can't find", "out", "don't have one", "do not have one", and "waiting on delivery" indicated the medication was not administered to the resident:

- Pantoprazole Sod Dr 40 mg tab, to be administered by giving 1 tablet by mouth twice daily. This medication was not administered to Resident K at 7:30 am on 02/01, 7:30 am on 02/02, 4:30 pm on 02/02, 7:30 am on 02/03, 7:30 am on 02/04, 4:30 pm on 02/04, 7:30 am on 02/05, 4:30 pm on 02/05, 7:30 am on 02/06, 4:30 pm on 02/06, 7:30 am on 02/07, 4:30 pm on 02/07, 7:30 am on 02/08, 4:30 pm on 02/08 and 4:30 pm on 02/09.

- Lidocaine 5% Ointment, to be administered topically to affected areas 2 times daily. This medication was not administered to Resident K on 02/14,

- Spiriva Respimat 2.5 mcg spray, to be administered by inhaling 2 puffs once daily. This medication was not administered to Resident K on 02/03, 02/15, 02/16, and 02/17.

- Isosorbide Mn 60 mg Sa Tab (Imdur 60 mg tablet Sa), to be administered by giving 1 tablet by mouth every morning. This medication was not administered to Resident K on 02/05.

- Atorvastatin 10 mg tablet, to be administered by giving 1 tablet by mouth every morning. This medication was not administered to Resident K on 02/05, 02/20, and 02/27.

- Metroprolol Succ ER 25 mg tab, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident K on 02/01, 02/02, 02/03, 02/04, 02/05, 02/06, 02/07, and 02/08.

- Olanzapine 15 mg tablet, to be administered by giving 1 tablet by mouth once daily x 30 days. This medication was not administered to Resident K on 02/28.

- Duloxetine 60 mg capsule, to be administered by giving 1 capsule by mouth once daily with 30 mg capsule. This medication was not administered to Resident K on 02/04, 02/05, 02/15, 02/16, 02/18, 02/20, 02/21, and 02/22.

- Boost / Ensure supplemental drink, to be administered by giving resident one Boost / Ensure supplemental drink once daily. This supplemental drink was not administered to Resident K on 02/01, 02/02, 02/14, 02/18, 02/24 and 02/27.

- High potency probiotic 11.5 B, to be administered by giving 1 capsule by mouth once daily. This medication was not administered to Resident K on 02/04, 02/05, 02/16, 02/18, 02/19, 02/20, and 02/21.

- Magnesium Oxide 400 mg tablet, to be administered by giving 1 tablet by mouth twice daily. This medication was not administered to Resident K at 8

am on 02/03, 8 am on 02/04, 4 pm on 02/04, 8 am on 02/05, 4 pm on 02/05, 8 am on 02/14, and 4 pm on 02/20.

According to documentation on Resident L's generated February eMAR, Resident L was prescribed the following medication, but the eMAR notation of "on order" indicated the medication was not administered to the resident:

- Ketoconazole 2% shampoo, to be administered by applying to flaky skin around head/face with each shower, allow to soak for 5 minutes before rinsing. This medication was not administered or applied to Resident L on 02/05.

- Dialyvite Supreme D tablet, to be administered by giving 1 tablet by mouth once daily, take whole with applesauce. This medication was not administered to Resident L on 02/19 and 02/20.

According to documentation on Resident M's generated February eMAR, Resident M was prescribed the following medication, but the eMAR notation of "on order" indicated the medication was not administered to the resident:

- Aspirin EC 81 MC tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident M on 02/01, 02/02, 02/03, 02/04, 02/05, 02/06, 02/07, 02/08, 02/09, 02/10, 02/11, 02/14, 02/15, 02/16, 02/17, 02/18, 02/19, 02/20, 02/21, 02/22, 02/24 02/26, 02/26, 02/27, and 02/28.

- Melatonin 5 mg tablet, to be administered by giving 1 tablet by mouth at bedtime. This medication was not administered to Resident M on 02/20.

According to documentation on Resident N's generated February eMAR, Resident N was prescribed the following medication, but the eMAR notations of "on order", "not in cart", "medication ordered", "out of med", "out of medication", "out", and "out need asap" indicated the medication was not administered to the resident:

- Vitamin D2 50,000 IU softgel, to be administered by giving 1 tablet by mouth once weekly. This medication was not administered to Resident N 02/05, 02/12, 02/19, and 02/26.

- Humalog Kwikpen Insulin 100-unit vial, to be administered by injecting insulin sub-q sliding scale according to blood sugar results. 150-200 = 2 units 201-250 = 4 units 251-300 = 6 units 301-350 = 8 units 351-400 = 10 units 401-450 = 12 units 451 or above 14 units. This medication was not administered to Resident N on 02/20, 02/21, and 02/25, despite his blood sugar testing at 219, 225, 236*, respectively.

* It should be noted that per the eMAR, Resident N's blood sugar tested 236 at 7:16 pm, but tested 194 when it was retested at 8:28 pm. Despite the difference in blood sugar readings, the eMAR notation still indicated the Humalog was "out".

- Multivitamin tablet, to be administered by giving 1 tablet by mouth every day. This medication was not administered to Resident N on 02/01, 02/02, 02/03, 02/04, 02/05, 02/06, 02/07, 02/08, 02/09, 02/10, 02/11, 02/14, 02/15, and 02/16.

- Carbamazepine 200 mg tablet, to be administered by giving 2 tablets (400 mg) by mouth at bedtime. This medication was not administered to Resident N on 02/08.

- Vitamin B-12 1,000 mcg sa tab, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident N on 02/01, 02/02, 02/03, 02/04, 02/07, 02/08, 02/09, 02/10, 02/11, 02/12, 02/13, 02/14, 02/15, and 02/16.

- Calcium 600 mg-vit D3 10mcg tb, to be administered by giving one tablet by mouth twice daily. This medication was not administered to Resident N at 8 am on 02/01, 8 pm on 02/01, 8 am on 02/02, 8 pm on 02/02, 8 am on 02/03, 8 am on 02/04, 8 pm on 02/04, 8 am on 02/05, 8 am on 02/05, 8 am on 02/06, 8 am on 02/07, 8 am on 02/08, 8 pm on 02/08, 8 am on 02/09, 8 am on 02/10, 8 pm on 02/10, 8 am on 02/11, 8 am on 02/12, 8 am on 02/14, 8 am on 02/15, 8 pm on 02/15, and 8 am on 02/16.

- Alendronate 70 mg tablet, to be administered by giving 1 tablet by mouth once weekly. This medication was not administered 02/03.

- Simvastatin 40 mg tablet, to be administered by giving one tablet by mouth at bedtime. This medication was not administered on 02/05 and 02/06.

Additionally, on 03/01/2023, I reviewed each resident's active medication list provided by Ms. Cummings and determined the following medications were not present or available in the facility's medication cart for Resident A:

- Acetaminophen 650 mg suppose, instruction of insert 1 suppository rectally every four hours as needed for pain/general discomfort

- Alprazolam .025 mg tablet, instruction of take 1 tablet twice a day as needed

- Pink Bismuth Liquid, instruction of take as directed per package directions for diarrhea after stools

- Acetaminophen 325 mg tablet, instruction of take 2 tablets by mouth every four hours as needed for pain/general discomfort

- Acetaminophen 500 mg caplet, instruction of take 2 tablets by mouth ever four hours as needed for pain/general discomfort

- Ibuprofen 200 mg tablet, instruction of take 1 tablet by mouth every four hours as needed for general discomfort

The following medications were not present or available in the facility's medication cart for Resident C:

- Melatonin 5 mg tablet, instruction of take 1 tablet by mouth at bedtime\

The following medications were not present or available in the facility's medication cart for Resident D:

- Ensure, instruction of take 1 supplement by mouth twice daily

The following medications were not present or available in the facility's medication cart for Resident E:

- Boost once a day, instruction of give one boost every evening

The following medications were not present or available in the facility's medication cart for Resident F:

- Melatonin 3 mg tabs, instruction of take 1 tablet by mouth at bedtime as needed for sleep

The following medications were not present or available in the facility's medication cart for Resident G:

- Melatonin 3 mg tablet, instruction of take 1 tablet by mouth at bedtime as needed for sleep

- Lorazepam .05 mg twice daily as needed, instruction of one tablet, twice daily, as needed for anxiety

- Lorazepam .05 mg tablet, instruction of take 1 tablet by mouth twice daily as needed for anxiety

The following medications were not present or available in the facility's medication cart for Resident H:

- Atorvastatin 40 mg tablet, instruction of take 1 tablet by mouth at bedtime

The following medications were not present or available in the facility's medication cart for Resident J:

- Diphenox-Atropine 2.5-.025 mg, instruction of take 1 tablet by mouth twice daily, as needed
- Hydroxyzine Hcl 25 mg tablet, instruction of take 1 tablet by mouth once daily
- Vitamin D2 50,000iu softgel, instruction of take 1 capsule by mouth ever two weeks
- Albuterol Hfa 90Mcg Inhaler, instruction of inhale 1 puff every 4 hours as needed for wheezing
- Nystop 100k U/gm Pwd 60mg, instruction of apply topically under breasts twice daily, as needed

The following medications were not present or available in the facility's medication cart for Resident K:

- Atorvastatin 10 mg tablet, instruction of take 1 tablet by mouth once daily
- Boost/Ensure supplemental drink, instruction of give resident one boost/ensure drink once daily

The following medications were not present or available in the facility's medication cart for Resident L:

- Boost Plus Chocolate, instruction of drink 1 bottle if less than 50% of meal is consumed
- Mircera 100 mcg/0.3 ml syringe, instruction of administer 1 ML IM as directed

The following medications were not present or available in the facility's medication cart for Resident M:

- Aspirin Ec81 mg tablet, instruction of take 1 tablet by mouth once daily
- Clonazepam 0.5 mg tablet, instruction of take 1 tablet by mouth twice daily

The following medications were not present or available in the facility's medication cart for Resident N:

- Vitamin D2 50,000iu Softgel, instruction of take 1 capsule by mouth once weekly

- Humalog Kwikpen Insulin 100 unit vital daily, instruction of inject insulin sub-q using sliding scale according to blood sugar results

- Alum/mag/simeth Suspension, instruction of take 15ml by mouth every two hours as needed for indigestion

- Chewable antacid 500 mg tab, instruction of chew 2 tablets by mouth ever two hours as needed for indigestion

- Glycolax Powder, instruction of dissolve 17gm in 4-8 oz of fluid and take by mouth once daily as needed for constipation

- Loperamide 2 mg tablet, instruction of take 2 tablets by mouth after first loose stool, then 1 tablet after each loose stool

- Milk of Magnesia Suspension, instruction of take 30 ml by mouth once daily as needed for constipation

- Dulcolax Supp 10mg, instruction of take 1 suppository rectally once daily as needed for constipation

- Lopermide Hcl Anti-diarrheal 2 mg PRN, instruction of give 1 capsule by mouth every 6 hours for 3 days as needed for loose stools

- Acetaminophen 325 mg tablet, instruction of take 2 tablets by mouth every 4 hours as needed for discomfort or fever greater than 100.4

- Acetaminophen 500 mg caplet, instruction of take 1 tablet by mouth every 4 hours as needed for pain, discomfort or fever greater than 100.4

- Ibuprofen 600 mg tablet, instruction of take 1 tablet by mouth every 6 hours as needed

I interviewed Resident N regarding his insulin medication not being administered. Resident N stated he hadn't received his insulin in the evening the last "2-3 days." He stated direct care staff told him the medication was "out." He acknowledged receiving his morning insulin, as prescribed.

Direct care staff, Chaleigh Lewis, stated direct care staff are supposed to reorder resident medications on the computer when a resident has at least a week's worth of medication left. Ms. Lewis stated once medications are refilled on the computer then staff should go into the refill que and send the medications to the pharmacy. She stated if there were any medication concerns or medication that needed to be refilled right away then direct care staff should always contact the pharmacy via telephone.

Direct care staff, Bambi Keckler, stated she knew how to refill medications on ECP; however, she was not able to determine who was responsible for sending the medications to the pharmacy. Ms. Keckler indicated the facility did not have an assigned Resident Care Manager (RCM). She indicated the RCM usually oversees resident's medications and was responsible for reviewing refills and contacting the pharmacy.

During the investigation, I informed Ms. White about the vast number of medication errors at the facility and provided her with my documentation indicating the medications not present in the medication carts. Ms. White contacted HomeTown Pharmacy and requested a refill of Resident N's Humalog insulin Kwikpen. The pharmacy reordered the medication while on the phone with Ms. White indicating there were no issues being able to reorder the medication.

Ms. White stated she would inform all direct care staff about the second step in ordering medication so medications are not simply in the que but are actually sent to the pharmacy.

On 03/03/2023, I sent an email to HomeTown Pharmacy requesting clarification on refills and reorders at the facility and documentation showing when refills were reordered in the last month and when medications were delivered.

On 03/07/2023, I interviewed HomeTown Pharmacy employee, Steve Woltanski, who stated he's worked with the licensee for at least 25 years. He stated the ECP online system is also where the licensee's facility staff documents on the resident's eMARs. He stated ECP has been implemented at the facility for approximately five years. He stated he was contacted last week by facility staff about medications not being requested. He stated that upon review of the ECP system, pharmacy staff discovered the medications were in ECP's "que" waiting to be sent to the pharmacy. He stated if a refill is requested in ECP by a staff pressing the refill button, the request is then sent to a que where the refill remains until a staff at the facility presses another button which then sends all the refill requests to the pharmacy.

Mr. Woltanski stated if a direct care staff requests a medication refill by 6 pm then a pharmacy staff will deliver it by that evening. He stated residents should not be waiting for several days for a medication to be delivered. He stated a fax is sent to the facility if a medication is unable to be refilled.

Mr. Woltanski stated a HomeTown Pharmacy trainer was going to the facility on or around 03/22/2023 to train direct care staff on pharmacy hours, cut off times for refilling medications, how to access pharmacy staff, and ordering and refill information. He stated HomeTown Pharmacy is available to conduct retraining for staff at any time and upon request.

On 03/10/2023, Mr. Woltanski, indicated in an email to me that HomeTown pharmacy's ECP trainer, Dan Mueller, investigated the licensee's ECP system and

found the licensee didn’t go longer than three days when submitting the que for refills to the pharmacy within the last two months. Mr. Woltanski stated it “it may be more a matter of refills weren't even asked for”.

On 03/30/2023, I interviewed Dan Mueller, Long Term Care (LTC) Service Coordinator for HomeTown Pharmacy. Mr. Mueller provided me with a copy of documentation from HomeTown Pharmacy showing when medication refills were sent to HomeTown Pharmacy for residents at the facility. He confirmed he provided a training on ECP for Resident Care Managers (approximately 8-12 individuals) at Park Place this past month. He stated these individuals were primarily responsible for passing medications and utilizing ECP for medications.

Mr. Mueller stated the licensee could appoint anyone to have the ability to "push" medications to the pharmacy after they have been refilled. He stated ECP doesn't prompt staff to refill medications therefore, staff will need to pay attention to how many medications are left in the resident's medication bottle or pack(et). Mr. Mueller stated he was unsure of the breakdown or specific issues the facility was experiencing with the ECP program since they do regularly receive refill requests from the licensee. He also confirmed medications could be requested, refilled and delivered the same day/evening if they were submitted prior to HomeTown Pharmacy’s cut off, which he indicated was sometime between 4 pm and 6 pm. He indicated if staff missed the deadline to submit medications, then the medication would be delivered the next day. He stated if a refill needed to be ordered by a resident's physician, then the notification would be faxed to the licensee. He stated residents requiring refills from their physician does occur and the pharmacy will attempt to contact the prescribing physician; however, not all the physicians work directly with the pharmacy and prefer to coordinate with the licensee.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation, which included a review of each resident’s February 2023 eMARs and their active medication lists and interviews with direct care staff and HomeTown Pharmacy personnel, residents were not receiving the medication as required. Resident eMARs indicated residents were not receiving their medication because the medications were not in the medication cart or had not been refilled and therefore, weren’t delivered by the pharmacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are not receiving showers.

INVESTIGATION:

The complaint alleged the residents do not shower and if they refuse, then direct care staff allow it.

Both Ms. Kincaid and Ms. Wilson indicated some residents refuse showers; however, they both indicated a resident going longer than a week without a shower was “rare.” They indicated if a resident refused to be bathed, then direct care staff still attempt to prompt the resident, find a different care staff to work with the resident, or provide a different method for bathing the resident (e.g., bed bath, wiping private areas).

Ms. Cummings’ statement to me was consistent with Ms. Kincaid’s and Ms. Wilson’s statement to me. She stated residents have identified shower days, which is twice a week.

Direct care staff members Ms. Nakken and Ms. Trevino did not indicate any issues with residents not showering or bathing at least weekly.

During my on-site investigations, I did not observe any residents that had unpleasant odors, or who appeared visually dirty indicating they had not been bathed. I also observed a posted shower day schedule for residents.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	There is no evidence indicating the licensee is not ensuring residents are bathed at least weekly, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is not clean.

INVESTIGATION:

The complaint provided no additional information other than what was provided in the allegations.

Direct care staff members Ms. Kincaid and Ms. Wilson both provided me with similar statements. They both stated the facility has a housekeeper that is supposed to keep clean the facility once to twice a week but it was direct care staff members' responsibility to keep the rooms clean the rest of the week and if a room is particularly dirty or something occurs to cause a room to become dirty, then direct care staff are expected to clean it. Ms. Kincaid stated some of the rooms appeared "cluttered", but they were vacuumed and mopped, when needed, but Ms. Wilson indicated the housekeeper "doesn't do anything" other than put toilet bowl cleaner in toilets and vacuum.

During my 02/28/2023 inspection I did not observe any major uncleanliness issues or concerns; however, I observed the toilet bowl within Resident A's bathroom to be dirty and unclean as it was visibly soiled with excrement.

Ms. Cummings stated a housekeeper comes into the facilities at least weekly to deep clean; however, direct care staff should be cleaning in the interim.

On 03/01/2023, I conducted a follow up announced onsite investigation and reinspected Resident A's toilet in her bathroom and determined there was no change in the visual appearance of it indicating the toilet had not been cleaned since my onsite inspection yesterday.

I interviewed Ms. White regarding the cleanliness of the facility. She stated housekeeping goes in to all the buildings once a week to "deep clean" while direct care staff were expected to clean up in the interim or if there were areas that needed to be addressed. Ms. White stated Resident A "puts everything" in her toilet indicating this was why it looked the way it did. I informed Ms. White there had been no improvement of the toilet between my two onsite investigation dates.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.

ANALYSIS:	During my 02/28/2023 and 03/01/2023 inspections of the facility, its overall appearance was clean and orderly; however, during my 02/28/2023 inspection, I observed Resident A's toilet bowl to be visually dirty and stained with what appeared to be excrement. When I conducted a follow-up inspection on 03/01/2023, I observed no change in the visual appearance of the toilet indicating it was not cleaned after my first inspection.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

During my inspection on 03/01/2023, I discovered there were multiple medications in the cart that were not listed on resident eMARs or active medication lists. Upon review of the facility's medication cart, I discovered the following medications in the medication cart that were not indicated on Resident C's active medication list and were not listed on the eMAR as a current medication:

- Donepezil 10 mg, to be administered by giving 1 tablet by mouth at bedtime after 30 days five mg

- Prochlorperazine Maleate 10 mg, to be administered by giving one tablet by mouth every 6 hours as needed for nausea and vomiting

- Hyoscyamine .0125 mg, to be administered by giving one tablet under the tongue every 4 hours as needed for increased secretions

- Haloperidol Lac 2 mg, comfort pack from hospice

- Nitrofurantoin Mono 100 mg, to be given by giving 1 tablet twice daily for seven days.
    - Upon review of Resident C's eMAR this medication started 02/07/2023 and ended 02/09/2023, per the physician

The following medications were discovered in the medication cart, but were not indicated on Resident F's active medication list and were not listed on the eMAR as a current medication:

- Hyralazine 25 mg, to be administered by giving 1 tablet by mouth three times daily as needed.
    - Review of ECP indicated medication was discontinued 11/23/2022

The following medications were discovered in the medication cart, but were not indicated on Resident I's active medication list and were not listed on the eMAR as a current medication:

- Vitamin D3 25 mcg, to be administered by giving 2 tablets by mouth in the morning.
    - Review of ECP indicated the medication was discontinued on 01/25/2022

The following medications were discovered in the medication cart, but were not indicated on Resident J's active medication list and were not listed on the eMAR as a current medication:

- Levemir flextouch, to be administered by injecting 20 units sub-q in the morning and 5 units at bedtime.
    - Review of ECP indicated the medication was discontinued 02/24/2023

- Novolog flexpen syringe, to be administered by injecting 15 units sub-q three times daily as needed per sliding scale.
    - Review of ECP indicated the medication was discontinued on 02/17/2023

- Furosemide 20 mg, to be administered by giving 1 tablet by mouth one time a day for edema; decreased breath sounds in the bases

- Losartan Potassium 50 mg, to be administered by giving 1 tablet by mouth one time a day for HTN and DM2

The following medications were discovered in the medication cart, but were not indicated on Resident K's active medication list and were not listed on the eMAR as a current medication:

- Levothyroxine 50 mcg tablet, to be administered by giving 1 tablet by mouth once daily
    - Review of ECP indicated the medication was discontinued on 01/09/2023

- Nitrofurantoin mono capsule 100 mg, to be administered by giving 1 capsule by mouth twice daily x 7 days

- Over the counter allergy medication, iron supplements, and laxative

The following medications were discovered in the medication cart, but were not indicated on Resident L's active medication list and were not listed on the eMAR as a current medication:

- Glucose 4 mg tablet, to be administered by chewing 4 tablets now, and then repeat after 15 minutes if blood sugar is below 70

- Cimetidine 400 mg tablets, to be administered by giving 1 tablet by mouth twice daily, in the morning on non-dialysis days, and following
    - Review of ECP indicated the medication was discontinued on 01/09/2023

- Aripiprazole 5 mg, to be administered by giving 1 tablet by mouth at bedtime.
    - Review of ECP indicated the medication was discontinued on 01/06/2023

- Lorazepam 2 mg oral, to be administered three times daily as needed for anxiety
    - Review of ECP indicated the medication was discontinued on 01/31/2023

- Over the counter arthritis acetaminophen 650 mg
    - Review of ECP indicated the medication was discontinued on 03/26/2022

Ms. Keckler and Ms. Lewis were unable to indicate why discontinued medications were still in the facility's medication cart. They both indicated any discontinued medications should be removed from the facility's medication cart; however, they both indicated a discontinued order from a physician is needed prior to removing the medication from the cart.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	Based on my review of the facility's medication cart, direct care staff are not removing medications that are no longer required by residents. Subsequently, medications that are no longer required by residents are not being properly disposed of and are being kept in the facility's medication cart.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

As described above multiple direct care staff members use the adult incontinence briefs prescribed to specific residents when residents, who do not have a physician's

order and whose family members do not consistently supply incontinence briefs, run out. Based on my interviews with multiple direct care staff members, this is done regularly and consistently which may affect the supply for the resident to whom the incontinence briefs are prescribed and belong.

APPLICABLE RULE	
R 400.15304	**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 the following resident rights: **(j) The right of reasonable access to and use of his or her personal clothing and belongings.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
	Although it is with good intention direct care staff members are using adult incontinence briefs prescribed to a specific resident to meet the personal care needs of another resident, direct care staff members are misusing these residents' personal belongings which may affect the accessibility for the resident to whom the briefs are prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/06/2023, I conducted the exit conference with Licensee Designee, Connie Clauson, via telephone, and informed her of my findings and recommendation. Ms. Clauson indicated the medication errors were concerning. She stated she would review my report with the facility's Administrator and reach out if she had questions.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend the license be modified to a provisional license due to the significant quality of care violations.

04/03/2023

_____

Cathy Cushman Date
Licensing Consultant

Approved By:

04/05/2023

_____

Dawn N. Timm Date
Area Manager