GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 5, 2023

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

RE: License #: AL390007090
Investigation #: 2023A0581021
Park Place Living Centre #B

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.

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

I. IDENTIFYING INFORMATION

License #:	AL390007090
Investigation #:	2023A0581021
Complaint Receipt Date:	02/09/2023
Investigation Initiation Date:	02/13/2023
Report Due Date:	04/10/2023
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 #B
Facility Address:	4218 S Westnedge Kalamazoo, MI 49008
Facility Telephone #:	(269) 388-7303
Original Issuance Date:	01/01/1989
License Status:	REGULAR
Effective Date:	04/20/2021
Expiration Date:	04/19/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility does not have incontinence briefs for residents.	No
Residents are not receiving their medications.	Yes
The facility is not clean.	No
Additional findings.	Yes

III. METHODOLOGY

02/09/2023	Special Investigation Intake 2023A0581021
02/13/2023	Special Investigation Initiated - Telephone Interview with direct care staff.
02/28/2023	Inspection Completed On-site Interviewed staff, observed residents, and reviewed documentation.
02/28/2023	Contact - Document Received Email from Ms. Cummings
03/01/2023	Contact - Face to Face Interviewed staff, Administrator, and conducted a follow up onsite inspection.
03/01/2023	Contact - Document Received Email from Ms. Cummings.
03/03/2023	Contact - Document Sent Email to HomeTown Pharmacy
03/03/2023	Contact - Telephone call made Interview with Nancy Bradley, PACE
03/07/2023	Contact - Document Received Email from HomeTown Pharmacy
03/24/2023	Contact - Document Received Email from Ms. Cummings
04/06/2023	Exit conference with licensee designee, Connie Clauson.

ALLEGATION:

The facility does not have incontinence briefs for residents.

INVESTIGATION:

On 02/09/2023, I received this complaint through the Bureau of Community Health Systems (BHCS) online complaint system. The complaint alleged the facility does not have incontinence briefs and wipes available to residents. The complaint alleged direct care staff must go to other buildings to obtain these supplies.

On 02/13/2023, I interviewed direct care staff members Grace Kincaid, Alicia Wilson, and Chaleigh Lewis, via telephone. All three direct care staff members 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 resident family members were responsible to provide incontinence briefs; however, they indicated family members do not always provide these items. The three direct care staff indicated when this occurs, direct care staff members take another resident's incontinence briefs to ensure a residents' personal care needs are still being addressed appropriately rather than residents going without brief changes. None of the direct care staff members interviewed indicated residents were going without incontinence briefs when they needed the item. The direct care staff interviewed indicated if the facility was short on incontinence briefs, Administrator Janet White was contacted and obtained additional briefs for residents.

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 the PACE residents primarily have incontinence briefs while the other residents run low or out of these items. Ms. Nakken and Ms. Trevino also indicated they have taken incontinence briefs from residents who had them to accommodate the residents who were out of these items.

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

During my inspection, I went through each resident's bedroom and observed residents to have incontinence briefs available in their bedrooms. None of the residents had any notable odors indicating they were need of toileting or needed his or her incontinence briefs changed.

On 03/01/2023, I conducted an announced follow up investigation. I interviewed Administrator Ms. White who stated direct care staff have access to extra incontinence briefs contrary to the allegations. 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, the incontinence briefs and wipes were to be used for all residents if a resident runs out of them or if a resident family member(s) does not provide them.

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. Additionally, none of the RCAs indicated the facility was required to provide incontinence briefs.

I reviewed all resident care plans and their respective assessment plans; however, none of the assessment or care plans indicated the licensee was required to provide incontinence briefs.

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 staff. Additionally, Ms. White showed me extra incontinence briefs being kept in the facility's storage room.

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 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 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**

ALLEGATION:

Residents are not receiving their medications.

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.

Both Ms. Kincaid and Ms. Wilson stated staff do not pick up resident medication from the pharmacy as the pharmacy delivers all medications. Neither direct care staff members indicated any significant or notable concerns regarding medications in the facility.

Additionally, Ms. Cummings 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. Ms. Trevino was unable to recall the specific resident about whom she contacted the pharmacy. 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 inspection 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 such as "not in cart" indicated the medication was not administered:

- Acetaminophen 500 mg caplet, to be administered by giving 2 tablets by mouth every 8 hours. This medication was not administered to Resident A on 02/23.

According to documentation on Resident C's generated February eMAR, Resident C was prescribed the following medication, but eMAR notations of "no boost will call pharmacy", "out", or "on order" indicated the medication was not administered:

- Boost, to be administered by giving 1 Boost daily at breakfast. This supplement was not administered to Resident C on 02/02, 02/16, 02/17, 02/25, and 02/26.

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

- Omeprazole 40 mg capsule, to be administered by giving 1 capsule by mouth once daily. This medication was not administered to Resident D on 02/02, 02/03, 02/04, 02/05, 02/07, 02/08, 02/10, 02/11, 02/12, 02/16, 02/17, 02/19, and 02/20.

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

- Boost nutritional supplement 240 ml, to be administered by giving 240 ml by mouth twice a day every day. This medication was not administered to Resident E at 7 pm on 02/02, 10 am on 02/10, 10 am on 02/20, 7 pm on 02/20, 10 am on 02/25, 10 am on 02/26, 7 pm on 02/26 and 10 am on 02/28.

According to documentation on Resident F's generated February eMAR, Resident F was prescribed the following medication, but eMAR notations of "out", "on order", "awaiting pharmacy", "there is no Boost in this med cart or the fridge, will call hometown", "awaiting pharmacy", and "I will check the kitchen" indicated the medication was not administered:

- Boost, to be administered by giving 1 can of Boost three times daily. This supplement was not administered to Resident F at 5 pm on 02/01, 8 am on 02/02, 12 pm on 02/02, 5 pm on 02/10, 5 pm on 02/13, 8 am on 02/16, 12 pm on 02/16, 8 am on 02/17, 12 pm on 02/17, 5 pm on 02/20, 5 pm on 02/21, 8 am on 02/25, 12 pm on 02/25, 5 pm on 02/25, 8 am on 02/26, 12 pm on 02/26, 5 pm on 02/27, 8 am on 02/28 and 12 pm on 02/28.

- Prozac 20 mg, to be administered by giving 1 capsule orally once a day. This medication was not administered to Resident F on 02/01 and 02/02.

According to documentation on Resident G's generated February eMAR, Resident G was prescribed the following medication, but the eMAR indicated it was not passed; however, there was no reasons identified in the notation section:

- Levothyroxine 75 mcg tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident G on 02/04.

According to documentation on Resident H's generated February eMAR, Resident H was prescribed the following medication, but eMAR notations such as "out", "on order", "waiting", and "not in chart[*sic*" indicated the medication was not administered:

- Acetaminophen 500 mg caplet, to be administered by giving 2 tablets by mouth three times daily. This medication was not administered to Resident H at 8 am on 02/23.

- Aspirin 81 mg chew tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident H on 02/14, 02/15, 02/19, 02/20, 02/22, 02/23, 02/24, 02/25, 02/26, 02/27, and 02/28.

- Boost chocolate, to be administered by giving 1 shake 3 times daily. This supplement was not administered to Resident H at 5 pm on 02/01, 8 pm on 02/01, 8 am on 02/02, 8 am on 02/10, 5 pm on 02/13, 8 am on 02/17, 5 pm on 02/24, 8 am on 02/25, 8 am on 02/26, 5 pm on 02/26, 5 pm on 02/27, and 8 pm on 02/27.

- Quetiapine fumarate tablet/Seroquel, to be administered by giving 1 tablet by mouth twice daily. This medication was not administered to Resident H at 8 am on 02/14 and 8 am on 02/15.

According to documentation on Resident I's generated February eMAR, Resident I was prescribed the following medication, but eMAR notations such as "out", "on order", "waiting", "not in chart[*sic*" and "not in med cart will call pharmacy" indicated the medications were not administered:

- Amiodarone hcl 100 mg tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident I on 02/01, 02/02, 02/03, 02/04, 02/05, 02/06, 02/07, 02/08, 02/10, 02/11, 02/12, 02/13, 02/14, 02/15, 02/16, 02/17, 02/18, 02/19, 02/20, 02/21, 02/22, 02/24, 02/25, 02/26, 02/27, and 02/28.

- Aspirin ec 81 mg tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident I on 02/01, 02/02, 02/03, 02/04, 02/06, 02/07, 02/08, 02/09, 02/10, 02/11, 02/12, 02/13, 02/14, 02/15, 02/16, 02/17, 02/18, 02/19, 02/20, 02/21, 02/22, 02/24, 02/25, 02/26, 02/27, and 02/28.

- Combivent 20-100 mcg inhaler, to be administered by inhaling 1 puff three times daily. This medication was not administered to Resident I at 8 am on 02/01, 8 pm on 02/01, 8 am on 02/02, 12 pm on 02/02, and 8 pm on 02/02.

- Levothyroxine 50 mcg tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident I on 02/21.

- Boost, to be administered by giving resident boost twice a day with breakfast and dinner. This supplement was not administered to Resident I at 8 am on 02/02, 8 am on 02/10, 8 am on 02/16, 8 am on 02/17, 8 am on 02/19, 8 am on 02/25, 8 am on 02/26, and 8 am on 02/28.

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

- Mirtazapine 15 mg tablet, to be administered by giving 1 tablet by mouth at bedtime. This medication was not administered to Resident J on 02/22.

According to documentation on Resident K's generated February eMAR, Resident K was prescribed the following medication, but eMAR notations such as "out" indicated the medications were not administered:

- Folic Acid 1 mg tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident K on 02/05, 02/06, 02/07, 02/08, 02/10, 02/11, 02/12, 02/13, 02/14, 02/15, 02/16, 02/17, 02/19, 02/20, 02/21, 02/22, 02/24, 02/25, 02/26, 02/27, and 02/28.

- Trazadone 50 mg, to be administered by giving ½ tablet by mouth at bedtime. This medication was not administered to Resident K on 02/21.

- Vitamin B-12 1,000 mcg tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident K on 02/05, 02/06, 02/07, 02/08, 02/10, 02/11, 02/12, 02/13, 02/14, 02/15, 02/16, 02/17, 02/18, 02/19, 02/20, 02/21, 02/22, 02/24, 02/25, 02/27, and 02/28.

- Aspirin ec 81 mg tablet, to be administered by giving 1 tablet by mouth once daily. This medication was not administered to Resident K on 02/05, 02/06, 02/07, 02/08, 02/10, 02/11, 02/12, 02/13, 02/15, 02/16, 02/17, 02/18, 02/19, 02/20, 02/21, 02/22, 02/24, 02/25, 02/26, 02/27, and 02/28.

- Donepezil hcl 10 mg tablet, to be administered by giving 1 tablet by mouth once daily at bedtime. This medication was not administered to Resident K on 02/20, 02/22, 02/25, 02/26, and 02/27.

According to documentation on Resident L's generated February eMAR, Resident L was prescribed the following medication, but eMAR notations such as "out", "on order", "awting[*sic*] pharmacy", and "not on med cart will call pharmacy" indicated the medications were not administered:

- Vitamin D2 50,000 softgel, to be administered by giving 1 capsule by mouth once every 14 days. This medication was not administered to Resident L on 02/28.

- Sertraline hcl 100 mg tablet, to be administered by giving 1 tablet by mouth every evening with dinner. This medication was not administered to Resident L on 02/28.

- Ensure Liq Vanilla, to be administered by drinking 1 bottle twice daily. This supplement was not administered to Resident L at 8 am on 02/25, 8 am on 02/26, and 8 am on 02/28.

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

- Tylenol 500 mg, to be administered by giving 2 tablets by mouth 3 times daily for pain. This medication was not administered to Resident M at 8 am on 02/24 and 12 pm on 02/24.

According to documentation on Resident N's generated February eMAR, Resident N was prescribed the following medication, but eMAR notations such as "on order", "there was no patch", and "out" indicated the medications were not administered:

- Boost, to be administered by giving 2 boost per day. This supplement was not administered to Resident N at 8 am on 02/02, 12 pm on 02/02, 8 am on 02/10, 12 pm on 02/10, 8 am on 02/16, 12 pm on 02/16, 8 am on 02/17 and 12 pm on 02/17.

- Acetaminophen er 650 mg tablet, to be administered by giving 2 tablets by mouth every 8 hours. This medication was not administered to Resident N at 12 am on 02/01.

According to documentation on Resident O's generated February eMAR, Resident O was prescribed the following medication, but eMAR notations such as "out" and "can't find them" indicated the medication was not administered:

- Refresh Optive Advanced Drops, to be administered by instilling 1 drop in both eyes four times daily. This medication was not administered to Resident O at 5 pm on 02/06, 8 pm on 02/16, 5 pm on 02/18, 5 pm on 02/19, and 5 pm on 02/26.

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

- Hydroxyzine 10 mg tablet with the instruction to give 1 tablet by mouth once daily at bedtime as needed for agitation.

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

- Lorazepam 2 mg / ml oral concentrate with the instruction to give 0.25 ml by mouth twice daily as needed for anxiety / agitation.

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

- Aspirin 81 mg chew tablet with the instruction to give 1 tablet by mouth once daily.

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

- Aspirin 81 mg chew tablet with the instruction to give 1 tablet by mouth once daily.

- Amiodarone Hcl 100 mg tablet with the instruction of take 1 tablet by mouth once daily.

- Combivent 20-100 Mcg Inhaler with the instruction of inhale 1 puff three times daily.

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

- Aspirin ec 81 mg tablet with the instruction of take 1 tablet by mouth once daily.

- Donepezil hcl 10 mg tablet with the instruction of take 1 tablet by mouth once daily at bedtime.

- Folic acid 1 mg tablet with the instruction of take 1 tablet by mouth once daily.

- Trazadone 50 mg with the instruction of take ½ tablet by mouth at bedtime.

- Acetaminophen 325 mg tablet with the instruction of take 2 tablets by mouth every 6 hours as needed **max 3,000 mg /day**

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

- Sertraline hcl 100 mg tablet with the instruction of take 1 tablet by mouth every evening with dinner.

Direct care staff member 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, direct care staff 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 direct care staff should always contact the pharmacy via telephone.

During the inspection, 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 stated she would inform all staff about the second step in ordering medication, so medications are not only in the que, but are 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. 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 does not prompt staff to refill medications therefore, direct care 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 their 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 timely and therefore, had not been delivered by the pharmacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is not clean.

INVESTIGATION:

The complaint alleged the facility is never cleaned; however, no additional information was provided.

During my inspection, I walked through every resident bedroom and observed the resident's common areas. Based on my observations, the facility appeared clean, comfortable, and orderly. There were also no notable smells indicating areas needed to be cleaned.

Direct care staff members Moriah Nakken and Giselle Trevino did not indicate any issues with the facility not being cleaned appropriately. They stated a housekeeper comes into at least once a week to clean the resident bedrooms and clean the common areas, but they indicated it was also the responsibility of direct care staff member to clean during the interim. They both stated direct care staff members were expected to clean up any messes that were observed.

During the inspection, I reviewed the job description for "Resident Care Specialist", which is the name given by the licensee to direct care staff. According to this job

description, staff are to “perform general housekeeping/laundry tasks and related duties.”

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based on my observations of the facility, all resident spaces were comfortable, clean and orderly appearance, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

During my inspection on 03/01/2023, I discovered there were multiple medications in the medication 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 J’s active medication list and were not listed on the eMAR as a current medication:

- Ibuprofen 600 mg tablet, to be given 1 tablet by mouth three times daily as needed (pain).

- Allergy relief tab 10 mg, to be given 1 tablet by mouth once daily as needed for allergy symptoms.

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

- Eloquis 5 mg, to be given 1 tablet by mouth twice daily.
    - Review of ECP indicated medication was discontinued 02/26/2023.

- Aspirin 81 mg tablet chew, to be given 1 tablet by mouth once daily.

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

- Ondansetron 4mg, to be given 1 tablet by mouth every eight hours as needed (nausea).

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.**

ANALYSIS:	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 04/06/2026, I conducted the exit conference with the Licensee Designee, Connie Clauson, via telephone. I informed Ms. Clauson of my findings. She indicated she would review the report with the facility's Administrator and would reach out if she had questions.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

Cathy Cushman 04/03/2023

Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm 04/05/2023

Dawn N. Timm Date
Area Manager