GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 30, 2023

Carol Del Raso
Grandhaven Living Center LLC
Suite 200
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL330378741
Investigation #: 2023A1029048
Grandhaven Living Center 3 (Harbor)

Dear Ms. Del Raso:

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330378741
Investigation #:	2023A1029048
Complaint Receipt Date:	07/03/2023
Investigation Initiation Date:	07/03/2023
Report Due Date:	09/01/2023
Licensee Name:	Grandhaven Living Center LLC
Licensee Address:	3196 Kraft Avenue SE, Suite 200 Grand Rapids, MI 49512
Licensee Telephone #:	(517) 420-3898
Administrator:	Carol Del Raso
Licensee Designee:	Carol Del Raso
Name of Facility:	Grandhaven Living Center 3 (Harbor)
Facility Address:	3145 West Mt. Hope, Lansing, MI 48911
Facility Telephone #:	(517) 485-5966
Original Issuance Date:	08/07/2017
License Status:	REGULAR
Effective Date:	02/07/2022
Expiration Date:	02/06/2024
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is regularly required to wait or one hour without receiving personal care assistance.	No
Resident A was not administered her medications as prescribed for two days because they were not ordered from the pharmacy.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/03/2023	Special Investigation Intake 2023A1029048
07/03/2023	Special Investigation Initiated – Telephone to Arianna Shaw
07/05/2023	Inspection Completed On-site Contact - Face to Face with Marie Jonzun, Resident A, Resident B, Paulina Gruesbeck, and Licensee designee Carol Del Raso
07/05/2023	Contact - Document Received - Email from Carol Del Raso
08/18/2023	Contact - Telephone call made to Relative A1, Ms. Gruesbeck, Ms. Kuzmanov, Celeste Weakly, Nicole Holland, Shannon Page - left messages.
08/21/2023	Contact - Telephone call received from Relative A1
08/23/2023	Contact - Telephone call made to Celeste Weakly, Relative A1
08/23/2023	Exit Conference with licensee designee Carol Del Raso, Left message and sent email.

ALLEGATION:

Resident A is regularly required to wait or one hour without receiving personal care assistance.

INVESTIGATION:

On July 3, 2023, a complaint was received via a denied Adult Protective Services (APS) complaint with concerns Resident A had to wait an hour before direct care staff members assisted her in using the bathroom.

On July 3, 2023, I contacted former direct care staff member Arianna Shaw. Ms. Shaw stated Resident A went without personal care often because direct care staff members would refuse to go into her room. Ms. Shaw stated a lot of times direct care staff members would refuse to go into the room because they did not like her personally. Ms. Shaw stated the other direct care staff members called people from other buildings to take her to the bathroom because they did not want to provide care to her. Ms. Shaw stated most of the time when she would come in, she would find her soaked in urine and feces. Ms. Shaw stated Resident A did wear a brief at all times due to incontinence but she also was also able to use the restroom with toileting assistance.

On July 5, 2023, I completed an unannounced on-site investigation at Grandhaven Living Center 3. I interviewed Resident A who informed me she had to wait sometimes for 45 minutes-1 hour before someone would assist her with using the restroom or needing assistance. Resident A stated in the past she had a yeast infection and she is concerned that it could be a result of having to wait for assistance. During my interview with Resident A, direct care staff member Paulina Gruesbeck came into administer her medications and I observed Resident A to have a pendant she uses to call for assistance. Resident A stated when she uses her call pendant there have been times no one has come to assist her but this has not occurred since May 2023. Resident A stated this has been better recently because there were more staff members hired. Resident A stated she has issues with urinary or bowel incontinence which makes her uncomfortable because she has had to wait for assistance.

During the on-site investigation, I reviewed Resident A's resident record. According to Resident A's *Assessment Plan for AFC Residents*, she requires assisted with transferring, toileting, bathing, grooming, personal hygiene, walking, stair climbing, and dressing.

I interviewed Grandhaven Living Centers Executive Director, Marie Jonzun. Ms. Jonzun denied Resident A or any other resident has been required to wait for one hour to receive assistance. Ms. Jonzun stated the call light system is tracked by response times because the direct care staff members need to "clear the call" on their iPhone in order for the light to turn off. Ms. Jonzun stated she forwarded these concerns to their Regional Operations Manager Carol Del Raso who scheduled a care conference with Relative A1 is being held to address her showering and toileting needs which Resident A feels are not being addressed. Ms. Jonzun stated this is the third assisted living Resident A has resided in and she wants to make sure they can meet her needs. Ms. Jonzun stated Relative A1 stated Resident A had to wait more than 20 minutes but when she reviewed the call light log she noticed that Resident A would push the button and then pull the cord again so it was hard to have an accurate record. Ms. Jonzun stated there is no documentation regarding which resident received toileting assistance and when but she did provide documentation showing when the call lights were answered. I reviewed the call light times and there were times of 36 minutes, 32 minutes, 50 minutes, most of the times were between 1 and 20 minutes when she would receive assistance. Ms. Jonzun stated she believes this system is inaccurate at

times since there are issues with the staff not hitting complete when they finish the call and therefore the time is longer.

On July 5, 2023, I interviewed Resident B who stated she has a hard time receiving assistance from the direct care staff members because she will use her call button for 1.5 hours and no one assists her. Resident B did not recall when this occurred that she had to wait for assistance or how frequently this occurs but stated she is unsure why they do not have more direct care staff members available to assist her.

On July 5, 2023, I interviewed direct care staff member Paulina Gruesbeck who stated there are currently fifteen residents at Grandhaven Living Center 3 (Harbor) and there are always at least two direct care staff members working. Ms. Gruesbeck stated the residents do not have to wait an hour to receive assistance and she does not recall a time when Resident A waited that long.

On July 5, 2023, I interviewed licensee designee Ms. Carol Del Raso. Ms. Del Raso stated all direct care staff members have an iPhone and when a resident uses their call pendant they have to accept it on their phones, then they provide care, then clear the light. Ms. Del Raso stated if any of the direct care staff members forget to clear it on their phones it will look like the resident waited longer than they did hence making the report unreliable. Ms. Del Raso stated none of the resident families have mentioned their family member had to wait too long for assistance.

On August 18, 2023, I interviewed direct care staff member Nicole Holland. Ms. Holland stated she does not know of a time that someone has waited for one hour to receive assistance for toileting. The longest she has observed Resident A wait for assisted would be 15-20 minutes because they were waiting for the other direct care staff members to assist with a two person assist. Ms. Holland stated the only time Resident A has had issues with incontinence is when she had stomach issues due to foods that did not agree with her. Ms. Holland stated they push a pendant light and it alerts them on the phone and they go in the room to reset the light. Ms. Holland stated they will not clear it on their phone until they walk out of their resident bedroom. Ms. Holland stated if they do not reset it on their phone they will continue to receive an alert.

On August 23, 2023, I interviewed Relative A1. Relative A1 stated the wait times have improved but there was an incident she had to wait this past weekend once for an hour and the other time she waited for 28 minutes. Relative A1 stated Resident A called 911 the weekend of August 19, 2023 because she could not get anyone to come to the bathroom. When the paramedics arrived, they stated the call was received that a resident was on the floor and could not get assistance but Resident A denied she stated that. Resident A told Relative A1 she called them because she needed to use the bathroom and no one would come assist her. Relative A1 stated she feels Resident A would not lie about what occurred but somehow this was misconstrued on the phone. Relative A1 stated she has been told by the direct care staff members that the pendant was cleared from the time before and other times where they will forget. Resident A1 stated she or Resident A would ask the direct care staff members if they remembered to

clear the pendant when they leave her room and they said, “I forgot!” Relative A1 stated this week there is another care conference with the facility which she is going to address these concerns again. Relative A1 stated there was another care conference in July 2023 where she also tried to address these concerns regarding the medications not being there, gait belt usage, and her needing to wait for assistance. Relative A1 stated they will come in to clear the pendant, ask her what she needs done, not complete the task, and tell Resident A they will be right back. Relative A1 stated she will then need to wait another 25 minutes at times when they come back to the room. Relative A1 has been told 8-10 minutes should be the average amount of time they should be waiting for assistance. Relative A1 stated there have been several times where Resident A has had issues with incontinence because of having to wait too long and them not taking her to the bathroom. Relative A1 stated she does not understand this because it would take a lot longer to change her clothes and assist her than taking her to the bathroom. Relative A1 stated this has occurred at least once per week. Relative A1 stated Resident A does experience incontinence so sometimes she knows she needs assistance with toileting and sometimes this will come on quickly without warning.

On August 23, 2023, I interviewed direct care staff member whose role is a “care coordinator” Celeste Weakly. Ms. Weakly stated the direct care staff members try to provide help within 8-10 minutes but sometimes that is not easy to do because they have more residents than just Resident A. Ms. Weakly stated Resident A will complain the whole time someone is assisting her that she is not receiving care as she needs. Ms. Weakly stated she has not had accidents on herself because of not receiving care. Ms. Weakly stated she will tell them she urinated on herself she is actually dry and she will say that she thought she did. Ms. Weakly stated she has not had any yeast infections because of not being cared for timely. Ms. Weakly stated she did have a kidney infection in the past and they had her on a medication because she was urinating more often. Ms. Weakly stated she has worked with the direct care staff members to let them know how to triage the call pendant lights. Ms. Weakly stated some of the direct care staff members will have a habit for not clearing the call lights because she will see something going off for an hour and the direct care staff member will say they have already been in there and they forgot to clear it. Ms. Weakly stated the majority of the direct care staff members time is spent on personal care for Resident A and if Resident A does not receive care as she wants “she will call the police or the State if she does not get her way.” Ms. Weakly stated she has asked Resident A why she does not have a “one on one assigned to her” because she will tell them she deserves more care than other residents.

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:	Resident A has been provided supervision, protection, and personal care according to her *Assessment Plan for AFC Residents*. Grandhaven Living Center 3 (Harbor). Ms. Jonzun, Ms. Weakly, and Ms. Del Raso all indicated the call light system times are not accurate because of direct care staff members not "clearing the pendant light." Resident A stated she has not had to wait for more than one hour for assistance in the last three months since there were more direct care staff members hired. Ms. Weakly stated there are times when Resident A questions the direct care staff members about the care she provides and feels they should respond quicker, however, there is no indication Resident A has been harmed as a result of waiting for assistance.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was not administered her medications as prescribed for two days because they were not ordered from the pharmacy.

INVESTIGATION:

On July 3, 2023, a complaint was received via a denied Adult Protective Services (APS) complaint with concerns Resident A did not receive her blood thinner and hypertension medication for two days because it was not ordered timely.

On July 3, 2023, I interviewed former direct care staff member Arianna Shaw. Ms. Shaw stated there were several instances when residents did not have their proper medications for the direct care staff members to administer them. Ms. Shaw stated she spoke to Ms. Torok who informed her everyone who is trained as a medication technician has the ability to order medications and if it is ordered and the pharmacy does not deliver on time, then it's documented in the Quick MAR. Ms. Shaw stated there were several times Resident A was not administered her medications, especially her PRN's and eye drops.

On July 5, 2023, I completed an unannounced on-site investigation at Grandhaven Living Center 3. I interviewed Resident A who informed me she only received her medication because Relative A1 filled the prescription at Walgreens with a few tablets to hold her over until her medications arrived. Resident A stated she did not receive her Eliquis which is a blood thinner for three days because it was not available at the facility. Resident A also did not receive her Synthroid, Omeprazole, and Metroprol. Resident A stated she was on the fourth day of not receiving her medication and then received the medications on July 5 but was out of them since June 30, 2023. Resident A stated Relative A1 spoke to wellness director, Buffy Torok about the incident and then shortly after Resident A found out Ms. Torok is no longer employed at Grandhaven Living

Center 3 (Harbor). Resident A stated she had a headache from missing her medications. Resident A stated her PRN medications are always available so she was able to get something for her headache.

I interviewed Grandhaven Living Centers Executive Director, Marie Jonzun. Ms. Jonzun stated the facility is using an electronic medication administration record (eMAR) and direct care staff members known as “care coordinators and the wellness directors” are responsible for ordering medication. Ms. Jonzun stated direct care staff member whose role was the Harbor Wellness Director, Ms. Torok resigned on July 3, 2023 so there have been some medication errors since that time. Ms. Jonzun stated she is aware Resident A went without her medications because Ms. Torok emailed her and let her know she was not able to secure her medications before leaving. Ms. Jonzun stated she forwarded these concerns to their Regional Operations Manager Carol Del Raso who scheduled a care conference with Relative A1 and the CorsoCare Pharmacy to address their concerns. Ms. Jonzun did not have information how or when Resident A’s medications would arrive at the facility.

I interviewed direct care staff member Paulina Gruesbeck who also was able to show me the medication cart and the eMAR in order to verify which medications were missing for Resident A. Ms. Gruesbeck stated she did not work the days Resident A did not receive her medication and she did not know why the medication was not ordered timely. Ms. Gruesbeck stated typically the direct care staff member whose assigned as the ”med tech” on that day is the one who places the order for the medication. Ms. Gruesbeck was able to show me the process of ordering a refill for a resident’s medication which was a simple process and a note was sent straight to CorsoCare.

According to the July 2023 eMAR and reviewing the medication cart with Ms. Gruesbeck, the following medications were not administered as prescribed for Resident A. All medications which were not administered had a note in the eMAR indicating “Awaiting arrival from the pharmacy” or “medication never arrived.”

Medication:	Dates medication was not administered:	Present at time of on-site inspection:
*Acetamin tab 650 mg	July 1-5	Yes
*Amlodipine tab 10 mg	July 2 and 3	Yes, 2 tablets- filled by Relative A1 at Walgreens
*Atorvastatin tab 10 mg	July 1-4	No
*BioFreeze Gel 4%	AM on July 2, 3, and 1:00 p.m. dose on July 3	No
Digestive chew advantage	July 2 and 3	Yes
*Eliquis tab 2.5 mg	July 2-4 (AM and PM dose)	Yes, filled by Relative A1 at Walgreens July 4
*Escitalopram 5 mg	July 3	Yes

*Fluticasone spray 50 mcg	July 2 PM, July 3 PM, July 4 and 5- AM dose	Yes
Lactase Tab 3000 Un.	July 3	Yes
Levothyroxine tab 75 mcg	July 2-5	No
Lidocaine Patch	July 3	Yes
Lisinopril	July 2 and 3	Yes, 3 left filled by Relative A1 at Walgreens July 4
Lotemax .5%	July 1-5	No
*Metoprol tab 50 mg	July 2-4 AM	Yes, 6 left filled by Relative A1 at Walgreens July 4
Myrbetriq tab 25 mg	July 3 and 4	Yes
Nyamyc POW	July 3-5	Yes
*Nystatin	July 3-5	Yes, found in Resident A's room.
*Omeprazole 20 mg	July 1-5	No
*Refresh Liquigel 1% gel	July 1-5	No
*Rivastigmine DIS	July 1 and 3	Yes
*Soothe XP Drops	July 1-5	No
Vitamin D Cap 5000	July 1-5	Yes
*Peg 3350 scoop powder / PRN	Was not needed during this time.	No
*Reguloid Cap .52 GM \ PRN	Was not needed during this time.	No
*Sore throat Lozenge PRN	Was not needed during this time.	Yes
Trazodone Tab 50mg PRN	July 1 and 2	Yes

During the on-site investigation, I reviewed Resident A's resident record. I was able to review a current order for medication as of March 2, 2023 which stated:

> *"unless otherwise designated by the prescriber the pharmacy may refill a medication order as needed for twelve months. The dispensed quantity shall be for 30 day supply unless otherwise designated by the prescriber."*

The medication order included different medications than the medications listed on the eMAR which indicated there is a more updated order which I did not find in the resident record, however the medications with an (*) were all included on the March 2, 2023 order.

There was also an order from McLaren Health Care Emily Korneffel PA on November 10, 2022 with instructions to discontinue Escitalopram 5mg daily and continue Escitalopram 10mg daily. According to Resident A's eMAR, Resident A was still receiving 5mg daily which was prescribed on October 11, 2022.

On July 5, 2023, I interviewed Resident B who stated she has had problem with her medications not being at the facility. Resident B did not recall which medication but stated it was a muscle relaxer and it took over twenty days for CorsoCare to deliver this. Resident B stated all the medications used to be delivered on time but since they changed to CorsoCare they are sent on a FedEx truck and it takes too long. Resident B stated if she does not receive her medication, she is a lot of pain.

On July 5, 2023, I interviewed licensee designee Carol Del Raso. Ms. Del Raso stated when the monthly cycle of medications arrived Resident A's medications were not there. Ms. Del Raso stated Relative A1 reached out to Walgreens and was able to get her medications temporarily refilled. Ms. Del Raso stated she has a "cycle refill report" which was sent to Ms. Torok but she did not have access to this report since Ms. Torok was no longer employed at Grandhaven Living Centers 3 (Harbor). After the on-site inspection, I received email from Carol Del Raso who stated she did reach out to Resident A's primary provider and pharmacy for updates. Ms. Del Raso advised per Corso pharmacy, a new prescription with 3 refills was received for the following medications only: Amlodipine, Eliquis, Metoprolol, Omeprazole, and Trazadone which were being processed today (7/5/2023) and will be sent. All other prescriptions have not been renewed. Ms. Del Raso stated she also advised a direct care staff member to resend the request to the primary care provider and left a message with them herself. Ms. Del Raso stated she was advised by Jamie, last name unknown, at the pharmacy that multiple requests had been sent to PCP and either not replied to or most recently replied to with, "pt not recognized."

On August 18, 2023, I interviewed direct care staff member Nicole Holland. Ms. Holland stated she knew there was a period of time in the beginning of July 2023 where Resident A needed a new prescription so medications were not administered. Ms. Holland stated the medications were filled from CorsoCare and the new refill was requested from direct care staff members when they are low. Ms. Holland stated some of the medications are "cycle filled" each month and would automatically come to the facility. Ms. Holland stated Resident A would need a new prescription in order to receive these medications which she did not have. Ms. Holland stated there have been some concerns with getting medications on time since they switched from a different pharmacy in the last couple years.

On August 23, 2023, I interviewed Relative A1 who confirmed Resident A missed her medications in the beginning of July 2023 and this has occurred before because it normally happens around the holidays. Relative A1 stated CorsoCare is in Eastpointe so an employee drives medication refills to the facility as needed but not on weekends or holidays. Relative A1 stated she noticed Resident A was missing Metoprol and Eliquis and she knew she could not be without these medications for three or four days.

Relative A1 stated she attempted to contact facility administration regarding the concern by emailing the facility and they did not respond. Relative A1 stated she contacted Dr. Grace Escamilla who was able to have an emergency prescription sent to Walgreens for 3-5 days until the other medications arrived. Relative A1 stated she was told by the direct care staff members the system would "flag" the medications two weeks ahead of time to let them know they needed a new medication. Relative A1 stated to her knowledge all the medications from July 2023 had an active order however she spoke with two different pharmacists at CorsoCare and she received conflicting information about whether or not there was an active order. Relative A1 stated the concerns started when they changed to CorsoCare due to this company not delivering on the weekends. Relative A1 stated Resident A was having headaches because she was not receiving her medications.

On August 23, 2023, I interviewed direct care staff member whose role is a "care coordinator" Celeste Weakly. Ms. Weakly stated it has been difficult to get in touch with Resident A's primary physician Dr. Escamilla for a new prescription. Ms. Weakly stated to her knowledge the medications Resident A did not receive did not have an updated prescription. Ms. Weakley stated direct care staff member can reorder medication and if they noticed the medication still not being filled, the MAR should give a message to see the reason it was not filled. Ms. Weakly stated she remembers making calls to the physician's office in the beginning of July 2023 and she also informed Relative A1 about the medications. Ms. Weakly stated Resident A also missed receiving a Rivastigmine patch on an unknown date due to the medication being unavailable. Ms. Weakly stated she informs direct care staff members to reorder medication refills when there are five days left of a medication but sometimes insurance will not allow medications to be filled this early. Ms. Weakly stated she would have them do it that early because it takes almost a week to receive the new medication. Ms. Weakly stated they have to reorder the medications that are not on "cycle fill" which a lot of them are and there is nothing which tells them when a prescription does not have any refills remaining until it cannot be filled.

Special Investigation Reports #2023A0577008 dated December 1, 2022 and SIR # 2022A0577061 dated September 20, 2022 cited Rule 400.14312 (2). A CAP was completed for both investigations. The violation cited for SIR# 2022A0577061 was due because a resident developed pressure sores on her heels and buttocks area due to direct care staff members not following the physicians order. A Corrective Action Plan was signed on December 8, 2022 indicating the following corrections would be made:

> *"One on one education with all direct care staff member following instructions and recommendations of the physician or health care professional. Direct training competency checkoffs regarding repositioning techniques to alleviate pressure. Monitoring electronic medical records daily for 45 days to ensure staff are documenting and following instructions. Licensee designee will intermittently monitor physician or other health care professional, including any resident with*

health care needs that can be provided in the home for three months to continued compliance."

The violation cited SIR #2023A0577008 was because a resident did not receive her Rivastigmine Disc for six days even though there were refills available. A Corrective Action Plan was signed on January 27, 2023 indicating the following corrections would be made:

"Operations Specialist B. Huizen initiated monthly initiated monthly refill repots from pharmacy which are emailed to Wellness director, Wellness Care Coordinators were educated on the process for medication refills and reorder needs, daily medication exception reports ran from Quick MAR, and weekly medication cart audits."

A State of Correction was received stating, *"All wellness staff were educated as outlined in the CAP. Supplementary education tools were provided to all educated staff."*

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A was not administered several of her medications as prescribed during the week of July 1, 2023 because the medications were not refilled and therefore not available at the facility. As a result, Relative A1 had to refill the medication at Walgreens 3-5 days as an emergency because the direct care staff members did not have the medication available for Resident A. There was also a note from McLaren Health Care Emily Korneffel PA on November 10, 2022 with instructions to discontinue Escitalopram 5 mg. daily and continue Escitalopram 10 mg daily. According to Resident A's eMAR, Resident A was still receiving 5 mg daily which was initially prescribed on October 11, 2022. Based on interviews from Ms. Del Raso, Ms. Weakly, Resident A, and Relative A1, there have been previous instances where medications were not administered as prescribed and this appears to be an ongoing issue.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SIR# 2023A0577008 DATED DECEMBER 1, 2022. CAP COMPLETED AND SIR # 2022A0577061 DATED SEPTEMBER 20, 2022. CAP COMPLETED.]**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on July 5, 2023, while reviewing medications with Ms. Gruesbeck, she informed me there were medications (Biofreeze Gel 4%, Nyamyc, Nystatin, and A&D Ointment) which were not in the medication cart because they were likely kept in Resident A's bedroom.

After the review of the medication report, Ms. Gruesbeck and I went Resident A's bedroom and bathroom where I found Nystatin Powder which she is prescribed twice per day in an unlocked container on a bathroom shelf. I reviewed the Medication Administration Records (MARs) for Resident A and she was prescribed the Nystatin Powder.

Resident A did not have a physician's order allowing Resident A to administer her own medication without direct care staff supervision. I reviewed Resident A's resident record which included the Resident Medication Policy #8 which stated:

"All prescribed medications, any over the counter medications, dietary supplements, or treatments shall be given to the staff on duty for properly storage as directed by licensing rules and regulation. Medications shall be secured in an approved locked storage container."

On August 23, 2023, I interviewed Relative A1. Relative A1 stated Resident A no longer requires BioFreeze gel so that no longer is in Resident A's bedroom however the Nystatin powder has always been kept in Resident A's bedroom. Relative A1 stated at one point, the previous director came in and took everything out of the rooms because there was a state inspection coming up, but outside of that incident, she has always found it in her bathroom.

On August 23, 2023, I interviewed direct care staff member whose role is a "care coordinator" Celeste Weakly. Ms. Weakly stated there are no tablet medications kept in the resident bedroom, however, Resident A does keep a cream and her Nystatin powder in her room. Ms. Weakly stated the Nystatin powder, A&D barrier cream, and Voltaren (pain and joint reliever) is kept in the bathroom because Resident A wants to see how much cream she has left. Ms. Weakly stated Resident A does not have a physician order to put it on herself or to keep it in her room.

Special Investigation Report #2023A1033024 cited Rule 400.14312 (1) on March 14, 2023, after a medication was found in Resident A's bedroom. This current investigation also included the same medications which were found in Resident A's bedroom four months later. The licensee designee submitted an acceptable corrective action plan.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based upon interview with Gruesbeck and Relative A1 as well as observations made during the on-site investigation it can be determined that Resident A was found to her prescribed medications, Nystatin, in her resident bedroom in unlocked containers.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SIR#2023A1033024 DATED MARCH 14, 2023. CAP COMPLETED.]**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning _____08/24/2023_____

Jennifer Browning
Licensing Consultant
Date

Approved By:

Dawn Timm 08/30/2023

_____

Dawn N. Timm
Area Manager
Date