GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 10, 2023

Thomas Hart
Independent Living Solutions, LLC
2786 Cecelia St.
Saginaw, MI 48602

RE: License #: AS730296476
Investigation #: 2023A0576052
Cardinal Care AFC

Dear Thomas Hart:

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.
- Be signed and dated.

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) 643-7960.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730296476
Investigation #:	2023A0576052
Complaint Receipt Date:	06/15/2023
Investigation Initiation Date:	06/30/2023
Report Due Date:	08/14/2023
Licensee Name:	Independent Living Solutions, LLC
Licensee Address:	2786 Cecelia St., Saginaw, MI 48602
Licensee Telephone #:	(989) 752-6142
Administrator:	Thomas Hart
Licensee Designee:	Thomas Hart
Name of Facility:	Cardinal Care AFC
Facility Address:	2700 Cecelia St., Saginaw, MI 48602
Facility Telephone #:	(989) 401-2802
Original Issuance Date:	09/18/2008
License Status:	REGULAR
Effective Date:	03/18/2023
Expiration Date:	03/17/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, ALZHEIMERS AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On June 13, 2023, Case Manager went to see Resident A who reported they were not sleeping well. Case manager was alerted that Resident A had been out of medications since June 8, 2023.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/15/2023	Special Investigation Intake 2023A0576052
06/30/2023	Special Investigation Initiated - On Site Interviewed Staff Aniya West, and Resident A
08/10/2023	Contact - Telephone call made Interviewed Shawn Schultz, TTI Nurse
08/10/2023	APS Referral Referral made to APS
08/10/2023	Contact - Telephone call made Interviewed Staff, Michelle Hines
08/10/2023	Contact - Telephone call made Interviewed Home Manager, Jasmine Tillman
08/10/2023	Contact - Document Received Reviewed Resident A's Individual Plan of Service (IPOS)
08/10/2023	Exit Conference Exit Conference conducted with Licensee Designee, Thomas Hart

ALLEGATION:

On June 13, 2023, Case Manager went to see Resident A who reported they were not sleeping well. Case manager was alerted that Resident A had been out of medications since June 8, 2023.

INVESTIGATION:

On June 30, 2023, I completed an unannounced on-site inspection at Cardinal Care and interviewed Resident A. Resident A has lived at her home since 2018 and has no guardian. Resident A reported she is not certain of all the medications she is prescribed and does not know their names or doses. Staff administer Resident A her medications and she believes she gets all her medications she is supposed to. Resident A takes a medication to sleep however she does not know the name and she is not sure if she gets this medication as ordered.

On June 30, 2023, I reviewed Resident A's medications and medication administration sheets for June 2023. The medication sheets reveal Resident A did not receive Benztropine 0.5mg at 8am from June 12, 2023, through June 16, 2023; Resident A did not receive Trazadone 100mg at bedtime on June 9, 2023, and June 12, 2023, through June 15, 2023; Resident A did not receive Olanzapine 20mg on June 9, 2023, June 13, 2023, and June 14, 2023; Resident A did not receive Fluoxetine 40mg at 8am June 12, 2023, through June 16, 2023. I reviewed Resident A's AFC Assessment Plan, which indicated Resident A requires staff assistance with taking medication.

On August 10, 2023, I interviewed Training & Treatment Innovations (TTI) Nurse, Shawn Schultz who reported Resident A has been a patient at TTI since at least 2019. Resident A sees Physician Assistant (PA) Maggie Roth who prescribes Resident A her psychotropic medications (Benztropine, Olanzapine, Prozac, and Trazadone). Regarding the allegations, Nurse Schutz reported she was advised there was some issues with Resident A's medications in June 2023. The home did not call TTI to advise that Resident A was out of medications and needed refills, which resulted in Resident A being without several medications between June 9, 2023, through June 13, 2023. As a result, Resident A began to decompensate and had trouble sleeping for several days. Once TTI staff were made aware of Resident A needing medication, the PA called in one week of medications and Resident A was given an appointment for Monday, June 19, 2023, to get refills. Nurse Schultz advised that the home did not let anyone know Resident A was out of medications and needed refills and it is the home's responsibility to contact TTI to ensure there is no lapse in medications.

On August 10, 2023, I interviewed Staff, Michelle Hines who reported per Resident A's Individual Plan of Service (IPOS) staff are responsible for Resident A's medication and medication administration and Resident A is unable to perform this task.

On August 10, 2023, I interviewed Home Manager, Jasmine Tillman regarding the allegations. Manager Tillman reported there was a problem with getting Resident A's medications in June 2023, due to the previous medication coordinator resigning from the position. No one else at the home knew the process or who to call to get resident medications/refills in the home. As a result, there were a few days in June 2023 where Resident A did not get her medications. Manager Tillman reported Resident A relies on staff to ensure medication compliance and this is not a task Resident A could do for herself.

On August 10, 2023, I viewed Resident A's Individual Plan of Service (IPOS), which indicated Cardinal Care will distribute and administer medications to Resident A. Cardinal Care will provide Resident A transportation to all medical and mental health appointments and accompany Resident A to assist with listening to instructions.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	It was alleged that Resident A was out of medications for several days in June 2023. Upon conclusion of investigative interviews and a review of documentation, there is a preponderance of evidence to conclude a rule violation. Resident A relies on Cardinal Care staff for medication compliance per her IPOS. Resident A ran out of some of her medication (Benztropine, Olanzapine, Prozac, and Trazadone) in June 2023, and this was documented on Resident A's medication administration sheets. Staff did not ensure the medications were in the home or that Resident A had adequate refills for the medication to be filled by the pharmacy. According to home manager, Jasmine Tillman, the home was not sure who to call or the process of ensuring medications are in the home and that there are refills available. There is a preponderance of evidence to conclude Resident A's was not administered her medication as prescribed by her doctor.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On June 30, 2023, I conducted an unannounced on-site inspection at Cardinal Care. I reviewed the medication book and Resident A's medication administration sheets. There were several instances where medications were not signed with staff initials indicating medication was administered to Resident A including June 22, 2023, June 27, 2023, June 28, 2023, and June 29, 2023.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	On June 30, 2023, I conducted an unannounced on-site inspection at Cardinal Care. I reviewed the medication book and Resident A's medication administration sheets. There were several instances where medications were not signed with staff initials indicating medication was administered to Resident A including June 22, 2023, June 27, 2023, June 28, 2023, and June 29, 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

On August 10, 2023, I conducted an Exit Conference with Licensee Designee, Thomas Hart. I advised Licensee Designee Hart I would be requesting a corrective action plan for the cited rule violation.

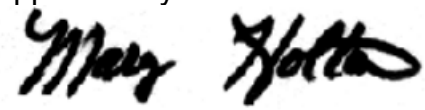
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the license status.

8/10/2023

Christina Garza Date
Licensing Consultant

Approved By:



8/10/2023

Mary E. Holton Date
Area Manager