GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 22, 2023

James Maxson
Grand Vista Properties, LLC
13711 Lyopawa Island
Coldwater, MI 49036

RE: License #: AL120406800
Investigation #: 2023A1030049
Grand Vista Properties

Dear Mr. Maxson:

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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Nile Khabeiry, LMSW

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL120406800
Investigation #:	2023A1030049
Complaint Receipt Date:	08/07/2023
Investigation Initiation Date:	08/07/2023
Report Due Date:	10/06/2023
Licensee Name:	Grand Vista Properties, LLC
Licensee Address:	13711 Lyopawa Island Coldwater, MI 49036
Licensee Telephone #:	(517) 227-5225
Administrator/ Licensee Designee:	James Maxson
Name of Facility:	Grand Vista Properties
Facility Address:	99 Vista Drive Coldwater, MI 49036
Facility Telephone #:	(517) 227-5225
Original Issuance Date:	12/29/2020
License Status:	REGULAR
Effective Date:	06/29/2023
Expiration Date:	06/28/2025
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Narcotic medications were taken from the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/07/2023	Special Investigation Intake 2023A1030049
08/07/2023	Special Investigation Initiated - Telephone Interview with complainant
08/07/2023	APS Referral
08/08/2023	Contact - Face to Face Interview with DCSM #1
08/08/2023	Contact - Face to Face Interview with DCSM #2
08/08/2023	Contact - Face to Face Interview with Jim Maxson
08/09/2023	Contact - Document Received Received Pharmacy delivery invoices.
08/09/2023	Contact - Telephone call made Interview with DCSM #3
08/09/2023	Contact - Telephone call made Interview with DCSM #5
08/09/2023	Contact - Telephone call made Interview with DCSM #6
08/09/2023	Contact - Document Received Received screen shots for DCSM #5
08/10/2023	Contact - Telephone call made Interview with Meggie Segura RN

08/10/2023	Contact - Telephone call made Interview with Resident A DPOA
08/11/2023	Contact - Telephone call made Interview with Dawn Heisler RN
08/15/2023	Contact - Telephone call made Interview with Monica Clark
08/17/2023	Contact - Telephone call made Interview with DCSM #5
08/17/2023	Contact - Telephone call made interview with DCSM #5
08/17/2023	Contact - Face to Face Interview with DCSM #1
08/17/2023	Contact - Document Received Received and reviewed Resident A's MAR for July 2023
08/17/2023	Contact - Telephone call made Interview with Sherry Labonski
08/18/2023	Contact - Telephone call made Interview with Officer Greg Morick
08/24/2023	Contact - Document Received Received and reviewed documents sent by Monica Clark
08/25/2023	Contact - Telephone call made interview with Jim Maxson and Monica Clark Interview with Complainant
08/31/2023	Contact - Face to Face Interview with Jim Maxson Interview with Monica Clark
09/08/2023	Contact - Telephone call made Interview with DCSM #7 by phone.
9/26/2023	Exit Conference by phone

ALLEGATION:

Narcotic medications were taken from the home.

INVESTIGATION:

On 8/7/23, I interviewed the complainant by phone. The complainant reported the issue came to light on 7/31/23 when the hospice nurse noted there was only one bottle of liquid morphine at the home when on 7/24/23 there were two bottles of liquid morphine in addition to ten prefilled syringes of morphine. The complainant reported they did an additional investigation and went back to April 2023 and compared the home's medications with the delivery records from the pharmacy. The complainant reported the pharmacy delivered 60 Norco tablets on 4/21/23 and only 30 Norco tablets made it into the medication cart. On 5/11/23 the pharmacy delivered 90 Norco tablets and only 30 made it into the medication cart. On 7/25/23 the pharmacy delivered 90 Norco tablets and only 60 made it into the medication cart.

The complainant reported she spoke with the homeowner, Jim Maxson and the main "medication technician" Monica Clark regarding the medication discrepancies. The complainant reported Ms. Clark indicated she received the medication deliveries, and that the pharmacy did not deliver all the Norco medications documented on the delivery sheets but did not bring it to anyone's attention. Regarding the liquid morphine, Ms. Clark reported "the bottle was leaking" and again did not report it to anyone. The complainant reported Mr. Maxson seemed upset about the situation but did not believe Ms. Clark did anything improper or illegal. The complainant reported she made police report #23- 6357 with the Coldwater Police Department.

On 8/8/23, I interviewed direct care staff member (DCSM) #1 at the home. DCSM #1 reported she has worked at the home for one year and passed medications during day shift. DCSM #1 reported she is aware of the situation with medications missing from the home but denied doing anything improper. DCSM #1 reported she was involved in a meeting with several staff members, Jim Maxson and hospice staff members and was informed that a bottle of liquid morphine was missing as well as other Opiate pain medication. DCSM #1 reported the home receives deliveries of medications from Hometown Pharmacy in the evening, but she does not receive or account for the deliveries. DCSM #1 reported the home keeps medications in their medication cart but keeps overstock in another location in Mr. Maxson's office. DCSM #1 reported lead worker, Monica Clark was the main medication person at the home and is the only person who deals with the overstocked medications kept in Mr. Maxson's office.

DCSM #1 reported she knows the procedure when destroying narcotic medications as she and Ms. Clark have destroyed medications a "couple of times." DCSM #1 reported she witnessed Ms. Clark crush up a pill and then dispose of it and signed a document. DCSM #1 reported she was aware that Ms. Clark and Mr. Maxson are in a dating relationship. Ms. Hurst also reported she spoke with another DCSM who indicated Ms.

Clark asked her for her child's ADHD medications and has observed test messages sent by Ms. Clark asking for the medication.

On 8/8/23, I interviewed DCSM #2 at the home. DCSM #2 reported she has worked at the home for seven months. DCSM #2 reported she does not pass medications, nor does she receive deliveries of medications from the pharmacy. DCSM #2 reported she is aware of the problems but does not have any information about what happened to the missing medications. DCSM #2 indicated Monica Clark was "in charge of medications."

On 8/8/23, I interviewed licensee Jim Maxson at the home. Mr. Maxson acknowledged the problem of missing medications and indicated Monica Clark is one of the medication technicians at the home and asked me to speak with her about the missing medications. Mr. Maxson reported she explained what happened to him, but he did not fully understand the details. Mr. Maxson reported Ms. Clark has been having some medical and personal problems but could not explain everything to me. Mr. Maxson reported he has "no idea what happened to the missing liquid morphine." Mr. Maxson reported he keeps some of the extra narcotic medications in his office behind a locked door because he does not want to keep all of them in the medication cart. Mr. Maxson also reported he disposes of all unused medication at the local police department but does not keep a record of the medications he takes to the police department and "thinks" some of them may be the missing Norco pills. I informed Mr. Maxson that there needs to be an accurate record of all medications passed or destroyed.

On 8/9/23, I received and reviewed delivery invoices from Hometown Pharmacy documenting medication deliveries to the home on 5/8/23, 6/2/23, 6/23/23 and 7/25/23. It should be noted that there was a check mark by all medications delivered and the invoices were signed by DCSM #3, DCSM #4 and DCSM #5.

On 8/9/23, I interviewed DCSM #3 by phone. DCSM #3 reported she was fired by Mr. Maxson on Friday "for no reason." DCSM #3 reported there have been issues with medications since April 2023. DCSM #3 reported there is another DCSM named Monica Clark who was the person in charge of the medications and was supposed to sign the "Narcotics book" every time she passed medication and would often not sign it and they were supposed to count mediations together during shift changes and she would not count with her. DCSM #3 provided a copy of the work schedule for July 2023, and it was noted Ms. Clark was scheduled throughout the entire month.

DCSM #3 reported they use a medication cart for the resident's medication but keep extra medication in Mr. Maxson's office in a small room that is locked. DCSM #3 reported the only people who ever went into that room was Ms. Clark and Mr. Maxson. DCSM #3 reported she was unaware that Resident A had liquid morphine and she has never passed it to him. DCSM #3 denied ever taking any of the residents' medication or using drugs of any kind. DCSM #3 took a ten-panel drug screen when this came up and provided a copy indicting, she was negative for all substances. DCSM #3 reported she did receive delivery of medications form Hometown Pharmacy and would go over all medications to ensure the ones they received matched the invoices and they were

always accurate. DCSM #3 reported she was very upset about this situation and suggested that all staff who pass medications take a drug screen including Ms. Clark and Mr. Maxson responded by saying “you’re overstepping your boundaries” and did not require her to take a drug screen. DCSM #3 reported Mr. Maxson is “covering” for Ms. Clark because they are dating.

On 8/9/23, I interviewed DCSM #4 by phone. DCSM #4 reported she has worked at the home for seven years and works third shift. DCSM #4 reported she passes medications and is aware that some medications have come up missing. DCSM #4 denied any knowledge of what happened to the Norco pills or the liquid morphine. DCSM #4 denied ever going in the locked room inside of Mr. Maxson’s office where the extra medications are stored. DCSM #4 reported DSCM Monica Clark is the main person in charge of the medications. DCSM #4 reported she has received deliveries of medications form Hometown pharmacy and always counts them to ensure they receive the current medications. DCSM #4 acknowledged knowing that Mr. Maxson and Ms. Clark are in a dating relationship.

On 8/9/23, I interviewed DCSM #5 by phone. DCSM #5 reported she has worked at the home for seven months. DCSM #5 reported she provides personal care for the residents while her coworker, Monica Clark takes care of the medications. DCSM #5 reported she was aware that some medications came up missing and denied knowing how that occurred. DCSM #5 reported the overstocked medications are kept in a locked room inside of Mr. Maxson’s office and the only people who ever go into that room are Mr. Maxson and Ms. Clark. DCSM #5 reported she was very upset about this situation and took it upon herself to get drug tested to prove she is not the person stealing the medication. DCSM #5 reported that several of her co-workers also took 10 panel drug screens, and they all were negative. DCSM #5 reported Ms. Clark did not get herself drug tested and expressed some concerns about her behavior regarding prescriptions medication. DCSM #5 reported her son takes ADHD medication and Ms. Clark asked her to divert some of his Vyvanse and Adderall for her personal use. DCSM #5 reported she never gave her any of her son’s medication and provided a screen shot of a text message from DCSM #5 asking, “did you get your sons by chance?” DCSM #5 provided another screen shot of a conversation between her and Ms. Clark with Ms. Clark texting “wish I could find an Adderall I’m struggling.” DCSM #5 reported Ms. Clark has asked other DCSM to give or sell her ADHD medications and even witnessed her purchasing medication from one of the third shift DCSM. DCSM #5 reported it was common knowledge that Mr. Maxson and Ms. Clark are romantically involved.

On 8/9/23, I interviewed DCSM #6 by phone. DCSM #6 reported she works first shift “most of the time” as a fill in staff member as she has another full-time job. DCSM #6 reported she gets scheduled when Monica Clark leaves for the day. DCSM #6 reported she also receives text messages from Ms. Clark to cover her shift because she does not “feel good.” DCSM #6 reported she is aware of the concerns with medications at the home. DCSM #6 reported she has never been in the back room inside of Mr. Maxson’s

office where the overstock medication was stored. DCSM #6 reported Ms. Clark is the DCSM who oversees medications and has access to the locked room. DCSM #6 denied knowing how the medications disappeared. DCSM #6 reported it is common knowledge that Ms. Clark and Mr. Maxson are dating, and she was told by Ms. Clark herself about the relationship. DCSM #6 expressed concerns about Ms. Clark as she asked her and other DCSM to give or sell her their medications. DCSM #6 reported Ms. Clark "begged and begged" her for Vyvanse but she would not give it to her. DCSM #6 reported she felt so uncomfortable about the situation that she told Mr. Maxson about the situation "about 2 weeks ago" and Ms. Clark has now stopped asking her for the medication.

On 8/10/23, I interviewed Meggie Segura RN who is Resident A's Hospice Nurse. Ms. Segura reported she has been working with Resident A since January 2023. Ms. Segura identified DCSM Monica Clark as the staff in charge of medications. Ms. Segura reported these issues with medication first came to light on 7/31/23 when she noted a full bottle of liquid morphine was missing from the back room where the overstock medications are kept in Jim Maxson's office. Ms. Segura reported she and Monica Clark were together when it was discovered. Ms. Segura reported the medication was present on 7/24/23 when she and Ms. Clark worked together. Ms. Segura reported she contacted Mr. Maxson immediately, and they looked throughout the backroom, and the medication cart however could not find the morphine. Ms. Segura reported she contacted her supervisor who contacted the pharmacy to obtain records of the deliveries of medication to the home over the last several months.

Ms. Segura reported she has had concerns about Ms. Clark's behavior such as when Ms. Clark acted "erratic or manic" and at least one time when she seemed "high" like she could not keep her eyes open and was "just out of it." Ms. Segura reported there were also times when Ms. Clark seemed "well put together" and other times where she looked like she was out all night long. Ms. Segura reported she is also concerned that Mr. Maxson may be covering for Ms. Clark as they are in an intimate relationship. Ms. Segura reported there are "orange sheets" that come with narcotic medications, that initially were missing. However, later Mr. Maxson allegedly had some of them in his binder and showed them to her from a distance without letting her get a close look at them. Ms. Segura reported the orange sheets had writing on them and they should not have any writing which she thinks may indicate they were "forged." Ms. Segura reported she was also aware that Ms. Clark has asked other DCSM to give her prescription medications that belong to their children or themselves.

On 8/10/23, I interviewed Relative A1's DPOA by phone. Relative A1 reported she was aware of the "lost or stolen" medications. Relative A1 reported she is concerned but was informed that Resident A never went without his medications as the missing medications were extra medications. Relative A1 reported she was satisfied with the care Resident A receives as he has been there over four years and she visits often.

On 8/15/23, I interviewed Monica Clark by phone. Ms. Clark reported she has worked at the home for eight or nine years and works first shift. Ms. Clark reported she is

charge of medications at the home and is aware of the problem with medications. Ms. Clark reported the extra narcotic medications were kept in a locked room inside Jim Maxson's office. Ms. Clark reported she was concerned with the large number of medications in the locked room and informed hospice of those concerns.

Concerning the liquid morphine, Ms. Clark reported she noted a full bottle was missing when she and the hospice nurse were counting medications on 7/31/23 and she was "the who found it was missing." While trying to determine a timeline for when the medication was taken from the home I asked if she and the hospice counted the morphine on 7/24/23. Ms. Clark reported that she was off on 7/24/23 and did not participate in a medication count. Ms. Clark reported she was dealing with a medical problem and was off of work starting 7/10/23 and returned on 7/31/23. When asked again about counting the medication on the 7/24/23 and 7/31/23 Ms. Clark stated several times that she did not count the medication on 7/24/23 as she was off since 7/10/23 and would not have been at the home during those days.

Concerning the Norco medication, Ms. Clark offered several explanations. Ms. Clark reported Resident A had a nurse named Penny Walman RN that was caring for him prior to entering Hospice services in March or April of 2023 and she destroyed his medications. Ms. Clark denied having a record of the medications being destroyed and was unsure if she had a record or if she "remembers destroying the medication." I informed Ms. Clark that Resident A entered Hospice care in January 2023 and inquired why Ms. Walman would destroy his medications after Hospice took over his medical care. Ms. Clark reported she was unsure of the date Resident A entered Hospice care and could not explain why or how she would have access to medication prescribed by hospice. Ms. Clark reported Hometown pharmacy did not deliver all the medications documented on the invoices and blamed the discrepancy on the pharmacy. I informed Ms. Clark that I received several invoices with the signatures from various DCSM that the medications on the invoice were received and that the DCSM all reported that they counted the medications, and they matched the invoices. Ms. Clark reported she did not believe they actually counted the medications. Ms. Clark reported she has proof that the medications were not delivered and had the narcotic sheets she could show me in person.

On 8/17/23, I interviewed DCSM #5 by phone. DCSM #5 reported she recently switched shifts but worked first shift the month of July and worked mostly with Monica Clark. Ms. Clark indicated Ms. Clark took a few full days off in July due to sickness but did not take July 10th through July 30th off. DCSM #5 reported she usually left early when she did work but assured me that she worked most of July.

On 8/17/23, I conducted an unannounced inspection and interviewed DCSM #1. DCSM #1 reported the home has changed the way they keep track of the narcotic medications since the investigation began. I observed the locked area where the overstock medication was kept prior to this investigation and noted there were no medications in the room. DCSM #1 reported all narcotic medications are now stored in a locked compartment in the medication cart and are counted by DCSM at the beginning and

ending of each shift. DCSM #1 reported she is unsure why the overstock medications were never counted along with the medications in the medication cart. I counted all the narcotic medications for all residents and noted they were medications matched the narcotic medication sheets.

DCSM #1 reported she and Ms. Clark work the same shift but not on the same day and usually did not see her at the home. DCSM #1 reported she and Ms. Clark make the weekly work schedule and confirmed that the schedule for July 2023 I showed her was accurate. DCSM #1 provided me with a copy Resident A's *Medication Administration Record* (MAR) from July 2023. The MAR indicated Ms. Clark passed medications on July 3, 4, 8, 9, 10, 12, 13, 14, 17, 22, 23, 26, 27, and 31.

On 8/18/23, I interviewed Greg Morick from the Coldwater Police Department. Officer Morick reported he was investigating the complaint made regarding the possible theft of medications at the home. Officer Morick reported he interviewed owner James Maxson about the medications, and it appeared "the right hand does not know what the left hand is doing." Officer Morick indicated he asked about the home's safety measures and it's "best practices" to account for the narcotic medication and Mr. Maxson responded, "I'm totally perplexed as to how this could have happened." Officer Morick reported his investigation is ongoing and still needs to interview several staff members.

On 8/24/23, I received documents from Mr. Maxson via email including invoices from Hometown Pharmacy, prescription for Roxanol (Morphine), medication list, fax to Hometown Pharmacy from the home (Monica Clark) indicating she was trying to get refills for Resident A dated 7/8/23, Hospice Comprehensive Assessment and Plan of Care Update Report, physician's orders regarding medication change of Norco from twice a day as needed for pain to twice a day at 8:00am and 8:00pm dated 3/23/23, electronic transmitted prescription sheets dated 5/2/23, 5/7/23, 5/19/23 and Norco ~~(~~MAR~~)~~ for March, April and May 2023.

On 8/25/23, I interviewed Mr. Maxson and Ms. Clark by phone regarding the documents received. Mr. Maxson reported they have been going through all their records and documents and believe they determined out what happened. Mr. Maxson reported Ms. Clark will explain their position on the missing medication. Ms. Clark reported she figured out the misunderstanding with the Morphine. Ms. Clark reported there are ten prefilled syringes which equals one bottle of Morphine and another full bottle of Morphine. Ms. Clark was asked for additional clarification as the original referral indicated there was a partial bottle along with the ten prefilled syringes and a full unopened bottle of Morphine. Ms. Clark reported the prefilled syringes are prefilled by Hospice staff and are filled .275ML equals one bottle of Morphine. Ms. Clark reported there was never a full bottle, partial bottle and ten prefilled syringes. Ms. Clark reported she kept a book of Narcotic medication stored in the back room inside Mr. Maxson office and asked Ms. Segura if she wanted to count that medication, but she said, "it's fine" and never counted the Norco.

It should be noted that Mr. Maxson and Ms. Clark continued to “locate” documents while they were interviewed and still had information pertaining to the investigation, they needed to put together to share with me. Based on the incomplete information provided we scheduled a face-to-face interview on 8/31/23. I called back after reviewing my initial interview with Ms. Clark to discuss some inconsistencies however Ms. Clark left the home, and I interviewed Mr. Maxson. I asked about Ms. Clark indicating she was the person who discovered the bottle of Morphine missing and today she said there was no Morphine missing. Mr. Maxson reported Ms. Clark has been missing a lot of work due to illness and blamed her mistake on her illness and being absent. Mr. Maxson admitted it being his responsibility to run the home but indicated “my main person” was not able to manage things due to her personal and medical problems which is the reason this situation is so confusing.

On 8/25/23, I interviewed the complainant to get additional information about the liquid morphine. The complainant reported the home had one full bottle of Morphine, one partial bottle and ten prefilled syringes. The complainant reported the syringes were prefilled from the partial bottle and were filled at the starting dose which is .25ML and the bottle is a 30ML bottle. The complainant reported there are 120 doses per 30ML bottle of Morphine at .25ML per dose. The complainant reported the syringes were prefilled by Hospice staff as there are no RN’s on staff at the home.

On 8/31/23, I interviewed Jim Maxson at the home. Mr. Maxson reported he thought he had the “silver bullet” with the documents he and Ms. Clark found regarding the liquid morphine however after reviewing the documents several times he found some inconsistencies. Mr. Maxson produced 31 spiral notebook pieces of paper that had been ripped out of a notebook. The documents appeared to be handwritten in ink and documented the narcotic medications kept in the back office for Resident A and other residents. It should be noted the dates begin on 4/1/23 and end on 6/29/23 and that the medications were counted sporadically throughout the months. It should also be noted there was no indication who was counting the medications and there was white-out used and medications crossed off the list.

Concerning Resident A, it is documented on 4/1/23 he had 60 Norco tablets in “backstock” and 30 in the medication cart. On 5/15/23 Resident A had 30 Norco tablets in “backstock.” On 5/9/23 it was documented Resident A had 30 Norco tablets in “backstock” and there were 90 tablets that were destroyed because the prescription was written by the “wrong provider and it was the wrong script.” It should be noted that there were no initials or documentation as to who destroyed the medication. Regarding the liquid morphine, it is documented on 4/1/23 that Resident A had a bottle and ten prefilled syringes. On 4/16/23 it was again documented the identical amount of liquid morphine as on 4/1/23. On 4/18/23, it was documented Resident A had two full bottles of morphine and ten prefilled syringes. It should be noted that no morphine was given to Resident A or delivered to the home between 4/5/23 and 7/31/23. On 5/2/23 it was documented Resident A had one full bottle, one partial bottle and 10 prefilled syringes which was the correct count.

Mr. Maxson was asked about the accuracy of the documents, and acknowledged they were not maintained in a professional or accurate manner. Mr. Maxson reported Ms. Clark is the DCSM who was supposed to be maintaining the documents and was unable to explain how the count was so inaccurate. Mr. Maxson advised I speak with Ms. Clark to get additional information. Mr. Maxson was asked several times if the DCSM most responsible for ensuring medications are maintained, passed and secured safely at the home was most likely the person who is taking the medications based on this totality of my investigation. Mr. Maxson denied Ms. Clark would have done anything improper and that she "didn't work much in July" so could not be the person who took the Norco tablets or morphine. Mr. Maxson did however agree that one full bottle of liquid morphine was missing.

On 8/31/23, I interviewed Monica Clark at the home. Ms. Clark acknowledged the documents Mr. Maxson provided of the medications kept in the back office was created by her and that some of the writing in the documents was her handwriting. Ms. Clark reported that she was not the only one who had written in the documents however was unsure who the other person was who counted medication or made notes in the documents. Ms. Clark indicated several times that she encouraged Ms. Segura to count the medications with her but she refused. I pointed out several inconsistencies in the dates, amounts of medications and that there were no initials or signatures in the documents which Ms. Clark acknowledged but had not explanation as to how and why she did not keep a better record of the medications in the back office.

Ms. Clark acknowledged there was a full bottle of morphine missing from the home, however denied the Norco medications were missing. Ms. Clark was reminded that it was confirmed the pharmacy delivered the medication and that it was counted by the DSCM who received the deliveries. Ms. Clark provided several explanations including the DCSM did not count the medications, the pharmacy had a shortage of Norco and did not deliver it or that his medications were destroyed by a nurse who worked with Resident A several months before he entered Hospice. Ms. Clark also indicated Mr. Maxson's daughter is a registered nurse and works at the home from time to time and may have destroyed the medications. Ms. Clark reported there was no record of the medications being destroyed and was asked why Mr. Maxson's daughter would come into the home and destroy medications without documenting it. Ms. Clark then indicted that she would not do that.

On 9/8/23, I interviewed DCSM #7 by phone. DCSM #7 contacted me regarding the investigation. DSCM 7 reported she had worked at the home a year ago and has been back for about a month and worked third shift. DSCM #7 reported she "heard some Norco pills and Morphine walked off" and indicated she does not know how that happened. DSCM #7 reported she does have concerns about something that occurred about a week ago involving Ms. Clark. DSCM #7 reported she was getting ready to leave for the day at 7:00am and asked Ms. Clark who had come in at 7:00am to count the Narcotic medications with her so she could go home. DSCM #7 reported Ms. Clark "ignored" her, so she asked again at 7:30am and Ms. Clark responded that "someone

told her that they did not have to court the narcotic medications" but she insisted and counted the medication with Ms. Clark before she left for the day.

DSCM #7 reported she is unsure who is supposed to be in charge of the medications but was unaware that there was a backstock of medications in a locked room in Mr. Maxson's office. DSCM #7 denied ever going into the room or counting any of those medication in a separate book from the medications in the medication cart. DSCM #7 reported she has taken deliveries from Hometown pharmacy during her shift and she and the delivery driver go over the medications on the invoice to ensure everything is accurate. DSCM #7 reported she was told by another DCSM that Ms. Clark has asked for her prescription medications (Adderall) but has not ever seen the text messages or spoke with Ms. Clark directly about obtaining medications.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	It was alleged narcotic medications were taken from the home. Based on interviews with all DCSM, the licensee, medical professionals and review of documentation this violation will be established. Resident A was receiving Hospice services and prescribed Norco and Morphine among other medications. A bottle of liquid morphine was discovered to be missing from the home on 7/31/23 which prompted an investigation by Promedica Hospice which discovered a large amount of Norco tablets missing beginning in April 2023. Upon my investigation into this matter, it was confirmed that Ms. Clark oversaw medications in the home and one of the policies was to keep extra narcotic medications in a locked room in Mr. Maxson's office. It was also confirmed that Ms. Clark created a medication log for those medications which was maintained in an inaccurate and unprofessional manner and could not be used to track these medications. Mr. Maxson and Ms. Clark provided several explanations, however none of these explanations fully accounted for the missing morphine and Norco tablets.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I interviewed Jim Maxson several times throughout the course of the investigation, and he denied having a full understanding of how a large amount of narcotic medication was unable to be accounted for and admitted to destroying medications without proper documentation. In addition, Mr. Maxson was interviewed by law enforcement, and he admitted to being "perplexed as to how this could happen" and did not have a system in place to maintain the medications safely in the home.

APPLICABLE RULE	
R 400.15201	**Qualifications of administrator.**
	(9) A licensee and the administrator all of the following qualifications: **(c) Be capable of assuring program planning, development, and implementation of services to residents consistent with the home's program statement and in accordance with the resident's assessment plan and care agreement.**
ANALYSIS:	Jim Maxson was interviewed on 8/8, 8/25 and 8/31 and it was apparent he did not have an adequate system in place to safeguard the narcotic medications in the home. In addition, Mr. Maxson was aware that Ms. Clark was having medical and personal problems and did not make appropriate arrangements to have her duties covered by either himself or another staff member. While it is not known for sure how the medications became missing, Mr. Maxson was negligent in assuring oversite of a safe, accountable, and transparent resident medication program.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

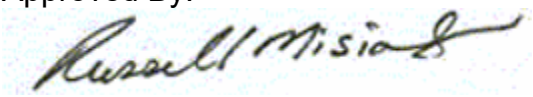
Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to six provisional license.

Nile Khabeiry, LMSW

9/22/23

Nile Khabeiry Date
Licensing Consultant

Approved By:



9/22/23

Russell B. Misiak Date
Area Manager