GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 26, 2023

Jorge Garcia
Aion Pineview LLC
11681 Whitehall Dr.
Sterling Heights, MI 48313

RE: License #: AS630412937
Investigation #: 2024A0611002
Pineview Manor

Dear Mr. Garcia:

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:

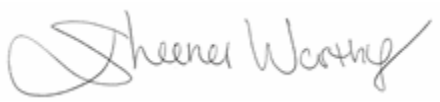
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 (248) 975-5053.

Sincerely,



Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630412937
Investigation #:	2024A0611002
Complaint Receipt Date:	10/11/2023
Investigation Initiation Date:	10/13/2023
Report Due Date:	12/10/2023
Licensee Name:	Aion Pineview LLC
Licensee Address:	11681 Whitehall Dr. Sterling Heights, MI 48313
Licensee Telephone #:	(248) 342-9015
Administrator:	Jorge Garcia
Licensee Designee:	Jorge Garcia
Name of Facility:	Pineview Manor
Facility Address:	2888 S Baldwin Rd Orion Township, MI 48360
Facility Telephone #:	(248) 342-9015
Original Issuance Date:	05/03/2023
License Status:	TEMPORARY
Effective Date:	05/03/2023
Expiration Date:	11/02/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There are concerns with inadequate meals.	Yes
There are concerns regarding restrictions on visiting hours.	No
The medication administration should be reviewed for the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/11/2023	Special Investigation Intake 2024A0611002
10/13/2023	Special Investigation Initiated - Telephone A return phone call was received from the reporting source. The allegations were discussed.
10/18/2023	Inspection Completed On-site I completed an unannounced onsite. I interviewed staff member, Taylor Harney and William Gross. I reviewed and received copies of all the residents MAR for the month of October. I observed all of the resident's medications. I observed the menu in the kitchen. I observed assistive devices in the basement.
10/19/2023	Contact - Telephone call made I made a telephone call to the AFC group home. I spoke to staff member, Jenny. Jenny provided the name of the medication listed to be discontinued on Resident M's MAR but, the name is covered up. Jenny confirmed that the menu has been updated for this week.
10/19/2023	Contact - Document Sent I emailed the licensee designee, Jorge Garcia and requested a copy of medication trainings for every staff member along with their start dates.
10/23/2023	Contact – Document Received I received the start dates and medications trainings for six employees.
10/24/2023	Contact – Face to Face I completed another unannounced onsite. I interviewed Resident M, Resident D, and staff member Linda Esckelson. I attempted to interview Resident B. I observed Resident J and Resident P. I

	reviewed Resident M and Resident J's file. I observed the food in the refrigerator and the menu. I also observed the assistive devices in the home. I contacted Resident J's guardian and spoke to them about Resident J.
10/24/2023	Exit Conference I completed an exit conference with the licensee designee, Jorge Garcia via telephone.

ALLEGATION:

There are concerns with inadequate meals.

INVESTIGATION:

On 10/13/23, a complaint was received and assigned for investigation alleging a family member having concerns based on multiple observations of inadequate balanced meals and meal planning. This has been brought to the administrator's attention but has been observed again. Family members are restricted to visitation except for the hours of 10am-7pm. Medication administration should be reviewed also.

On 10/13/23, I received a return phone call from the reporting source. Regarding the allegations, the reporting source stated at times the residents are fed limited meals. The reporting source described an instance where the residents had three fish sticks each and a tablespoon of soup on their plates. There was another instance where the residents were served a bowl of chunky soup and water for dinner. These concerns were brought to the owner of the home, William Gross and his response was “OK thank you”. The reporting source stated on Tuesday (10/10/23) a relative was visiting the home and witnessed the staff member not having enough food to put a meal together for dinner. The staff member contacted the home manager regarding no food in the home for dinner. The relative volunteered and ordered a pizza for the residents to eat dinner.

On 10/18/23, I completed an unannounced onsite. I interviewed staff member, Taylor Harney and the owner, William Gross. I observed the menu in the kitchen.

On 10/18/23, I interviewed staff member, Taylor Harney. Ms. Harney has worked at the AFC group home for three months. Ms. Harney works the dayshift from 7:00am to 3:00pm. Regarding the allegations, Ms. Harney stated the menus are printed at another AFC group home (Silverbell Manor) and brought to this AFC group home by the home manager, Blanca Bolanos. Ms. Bolanos is currently on vacation for two weeks. I observed the menu on the refrigerator and saw the menu is dated for last week (10/9/23 –10/14/23). Ms. Harney stated today for lunch she served the residents a cold cut sandwich with strawberries and grapes, and the residents were given either chips or pretzels to eat with the sandwiches. The residents were given apple juice to drink

except for Resident D as she is given protein drinks. Ms. Harney stated even if the menu was updated for this week, she probably would not have followed it depending on what was listed on the menu. Ms. Harney does not like to cook the same things that the residents eat at Silverbell Manor because everyone eats differently.

Ms. Harney stated yesterday she worked a double shift. Ms. Harney stated yesterday for lunch she served the residents fish sticks, french fries, a scoop of applesauce, and water. Ms. Harney stated for dinner yesterday she served meatballs, mashed potatoes, and a vegetable medley.

On 10/18/23, I interviewed the owner, William Gross. Mr. Gross stated the menus are in place and the staff follow them unless the residents request to eat something different. Mr. Gross did not mention that the staff write substitutions on the menu when they choose to deviate from it. Mr. Gross stated the home manager is responsible for ensuring the menus are up to date. Mr. Gross stated when the home manager is not available, he makes sure the menus are up to date. Mr. Gross denies receiving any complaints regarding what the residents are being fed. Mr. Gross stated he or his fiancé grocery shop for the AFC group home.

On 10/24/23, I completed another unannounced onsite. I interviewed Resident M, Resident D, and staff member Linda Esckelson. I attempted to interview Resident B. However, she could not comprehend well. I observed Resident J and Resident P. I reviewed Resident M and Resident J's file. I observed the food in the refrigerator and the menu. I contacted Resident J's guardian and spoke to them about Resident J.

On 10/24/23, I interviewed Resident M. Resident M was observed in his wheelchair in his bedroom. Regarding the allegations, Resident M would not provide an answer stating whether or not he likes living at the AFC group home. Resident M stated he chooses to “stay mute” regarding that question. Resident M stated everyone in the AFC group home is loosing weight. Resident M stated for lunch they are fed peanut butter sandwiches or tuna and for dinner they are fed soup. Resident M stated he did not eat breakfast, today nor was he asked if he wanted breakfast. Resident M stated for breakfast they are usually served waffles or oatmeal. Resident M stated the staff are not feeding them three nutritious meals a day. The snacks that are provided consist of cookies, cakes, and other sugary foods. Resident M stated the major problem at the AFC group home is the diet which needs to change. Resident M pointed out that he has boxes of food in his bedroom to eat.

On 10/24/23, I interviewed Resident D in her bedroom. Resident D was observed laying in bed. Resident D was fully dressed. Resident D stated she is not feeling too good as she has trouble using the bathroom. Resident D stated things are not as bad now, but she has been dealing with blood in her stool for a long time. Resident D stated it has been a while since she saw a doctor. Resident D stated she does not like the food at the AFC group home as it is not that good. Resident D stated for breakfast she had two slices of toast with jelly. Resident D could not remember what she ate for dinner yesterday but, she stated often she is fed goulash. Resident D stated she is fed three

meals a day, but they are not big meals. Resident D stated the staff does not provide a variety of meals. Resident D is always given water to drink and was told if she wants something else, she has to ask for it. Resident D stated she doesn't think the staff buys anything else to drink and if they do, she thinks the AFC group home will raise the price which will make it harder for people to afford to live there.

On 10/24/23, I observed Resident B, Resident J, and Resident P in the living room watching TV. I attempted to engage Resident B however; she kept saying "what" to my questions. Resident J was observed to have significant bruising on her face and forehead. Resident J's bruises were dark purple and green. Staff member, Linda Esckelson stated Resident J fell a couple weeks ago directly on her face. Ms. Esckelson stated Resident J has fallen more than once. I observed an alarm on the back of Resident J's wheelchair.

I spoke to Resident J separate from Ms. Esckelson. Resident J stated she does not know how she hurt her face. Resident J stated staff did not hurt her. I asked Resident J if she fell, and she stated yes. Resident J stated she fell one time. Resident J stated she does not know where she was when she fell. Resident J stated she did not go to the doctor when she fell. I asked Resident J a second time if staff had hurt her and she stated no. I observed Resident J's file. I did not see any medical records regarding treatment for Resident J falling. I did observe progress notes regarding that Resident J fell.

On 10/24/23, I observed Resident I sitting at the kitchen table eating cereal. I attempted to engage Resident I, but she could not answer any questions.

On 10/24/23, I interviewed staff member Linda Esckelson. Ms. Esckelson started working for the AFC group home in September 2023. Ms. Esckelson stated she was fully trained by the home manager Ms. Bolanos. Ms. Esckelson mainly works the day shift from 7:00am to 3:00pm. Ms. Esckelson stated today she served two slices of toast and cereal for breakfast. Ms. Esckelson stated Resident I and Resident B sleep late which is why they eat breakfast after the other residents. Ms. Esckelson stated everyone ate breakfast today except Resident M. Ms. Esckelson stated Resident M often refuses to eat because his son often visits the home and brings him food. Resident M's son will bring him food such as steak and potatoes. Ms. Esckelson stated she tries to follow the menu unless the meal provided on the menu is not available in the home. Ms. Esckelson stated if that happens, she crosses out what is on the menu and documents what she serves the residents. Ms. Esckelson states she has had to write substitutions on the menu this week. Ms. Esckelson stated the owner's fiancé (Anna) does the grocery shopping for the home. I observed Ms. Esckelson making goulash with bread on the side for lunch for the residents. The residents were given apple juice to drink. Resident M did not eat lunch because he was outside with his family who brought him food.

On 10/24/23, I made a telephone call to Resident J's guardian. Regarding the allegations, the guardian stated Resident J fell two weeks ago and hurt her arm.

Resident J fell a second time last Sunday. As a result, an alarm was placed on Resident J's bed and her wheelchair. Resident J is currently in hospice. Resident J is often agitated. The guardian stated Resident J fell because she was trying to climb over her bed rails, and she landed on her face. Resident J also fell six months ago when she was living in an apartment, which caused her to be hospitalized for a broken nose. Since Resident J has been admitted into the AFC group home, her behavior has worsened as she is more agitated and gets up at nighttime. The guardian stated they are trying to sedate her at nighttime to ensure she will sleep through the night. The guardian stated he is not concerned with the staff not properly supervising Resident J. The guardian handed the phone to his wife in order for me to receive additional information.

The guardian's wife stated Resident J's bed rails were added after she fell the second time. The guardian's wife visits the AFC group home at least twice a week to assist Resident J with adjusting to the new home. Resident J was admitted into the home on 09/09/23. Resident J has Dementia, and her health is declining. The guardian's wife does not have any concerns with the staff as they are wonderful. However, the guardian's wife has a concern with staff member, Jennifer Lewis as she has health issues and has trouble walking. The guardian's wife stated Ms. Lewis could not stand up for more than five minutes to talk to her. The guardian's wife stated she is not sure but, she thinks each time Resident J fell Ms. Lewis was on duty and she would like to know if she was how did she help Resident J off the floor. The guardian's wife stated when Resident J fell, she saw a doctor from Home MD and the second time she saw a doctor from hospice.

The guardian's wife stated on 10/18/23, she and her husband were at the AFC group home. Resident J fell from her wheelchair in the hallway in between the living room and back entrance. The guardian and his wife were in the kitchen and did not see Resident J fall. Ms. Lewis asked the guardian to help get Resident J back into her wheelchair. The guardian's wife does not know where Ms. Lewis was when Resident J fell as Ms. Lewis stated she did not see her fall. The guardian spoke to the owner, William Gross about their concerns about Ms. Lewis being able to perform her job duties. Mr. Gross stated he will look into it. The guardian's wife reiterated that she thinks the staff and the AFC group home is wonderful and she doesn't want to see anybody get into trouble. The guardian's wife stated she has never been to the home during mealtime, but she has spoken to Ms. Harney who has told her she is going to cook pork chops and green beans for the residents. The guardian's wife thinks the residents are being fed nutritious meals. The guardian's wife often brings bake goods to the home because she likes to bake.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form,

	consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on my investigation and the information gathered, there is sufficient evidence to support the allegations. On 10/18/23, Resident M stated the staff do not provide three nutritious meals on a daily basis. Resident M stated for lunch they are fed peanut butter sandwiches or tuna, for dinner they are fed soup, and for breakfast they are usually served waffles or oatmeal. The snacks that are provided consist of cookies, cakes, and other sugary foods. Resident D stated she does not like the food at the AFC group home as it is not that good. Resident D stated for breakfast she had two slices of toast with jelly. Resident D could not remember what she ate for dinner yesterday but stated she is often fed goulash. Resident D stated she is fed three meals a day, but they are not big meals. Resident D stated the staff does not provide a variety of meals.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	On 10/18/23, I observed that a current menu was not posted on the refrigerator. There was only a menu dated from last week available. Staff member, Taylor Harney was not aware that she is expected to write any changes or substitution on the menu when it is not followed. The owner of the AFC group home, William Gross was also unaware that staff are expected to write substitutions on the menu when they choose to deviate from it.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There are concerns regarding restrictions on visiting hours.

INVESTIGATION:

On 10/13/23, the reporting source confirmed that the visiting hours are from 10:00am to 7:00pm daily. It was explained to the reporting source that the visiting hours are acceptable and not a rule violation.

On 10/18/23, I completed an unannounced onsite. Upon entering the home, I observed a sign on the door that indicates visiting hours are from 10:00am to 6:30pm. Mr. Gross stated the visiting hours are from 10:00am to 6:30pm and the visitors have no later than 7:00pm to leave the AFC group home. Mr. Gross stated no family members have requested any exceptions to the visiting hours due to their work schedules.

APPLICABLE RULE	
R 400.14304	**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 of the following resident rights: **(k) The right to have contact with relatives and friends and receive visitors in the home at a reasonable time. Exceptions shall be covered in the resident's assessment plan. Special consideration shall be given to visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.**
ANALYSIS:	Based on the information gathered and observed, the AFC group home is not in violation of this rule. There is a sign located at the front entrance that indicates the visiting hours are from 10:00am to 6:30pm. The owner of the AFC group home, William Gross stated the visiting hours are from 10:00am to 6:30pm and the visitors have no later than 7:00pm to leave the AFC group home. The reporting source confirmed that he is able to visit the home between the hours of 10:00am and 7:00pm.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The medication administration should be reviewed for the home.

INVESTIGATION:

On 10/13/23, the reporting source stated they were informed by a different relative that a resident was given the wrong medication. The reporting source stated they do not know if the above statement is true or not. The reporting source was adamant about not giving any specific details and/or information such as names or dates because he did not want his relative to be discharged from the home. The reporting source does not have a specific complaint regarding the resident's medications.

On 10/18/23, I reviewed and received copies of all the residents' MAR for the month of October. I observed all of the residents' medications. Prior to observing the resident's medications, I observed the medication cabinet was unlocked. I observed Resident J's medications. Resident J started being administered a Lidocaine patch for her hand since yesterday (10/17/23). This medication was not listed on Resident J's MAR. Resident J is prescribed Polyethylene Glycol however, this medication was not observed in her medication bin. There were no staff initials for the morning medications that were administered on 10/18/23. Furthermore, there were missing initials for the following medications:

- Lubricant eye drops on 10/11/23
- Doxylamine Succinate on 10/15/23
- Prednisone on 10/15/23

Resident J is prescribed Ketoconazole 2% shampoo every 72 hours. The last time she was administered this medication was on 10/7/23 and there are no staff initials 72 hours later on 10/10/23. Resident J's Lubricant eye drops is a PRN. Resident J was administered this medication from 10/1/23 to 10/10/23 and 10/12/23 to 10/14/23, and 10/16/23. The staff did not document the reason and/or the result each time the Lubricant eye drops were administered.

I observed Resident M's medications. There was Lorazepam gel 1 mg in Resident M's medication bin however; this medication expired on 10/16/23 and it was not listed on his MAR. On 10/13/23, a prescription for Nitrofurantoin 100mg was filed and the instructions were to take one pill twice a day for five days. There was only one pill left in the bubble packet for 10/15/23. The only staff initials on the MAR for this medication are on 10/14/23 for 8:00am and 8:00pm, and 10/16/23 for 8:00pm. Resident M is prescribed artificial tear eye drops every two hours as needed. This medication was observed in Resident M's bin. However, there was a second box entitled dry eye relief as a PRN that was not listed on Resident M's MAR. Resident M is prescribed Diazepam every six hours (12:00am, 6:00am, 12:00pm, 6:00pm) I observed a bubble packet for this medication for 12:00am, 6:00am, 12:00pm, and 6:00pm. There was a fifth bubble packet also listed for 12:00am and the pills were missing for each day of the month. Resident M is prescribed Polyethylene Glycol. It is written on the MAR to not administer this medication. There was no date on the MAR indicating when this medication was discontinued. A discontinue order from a physician was not located in the file.

There were no staff initials for the morning medications that were administered on 10/18/23. Furthermore, there were missing initials for the following medications:

- Aspirin on 10/11/23, 10/12/23, 10/14/23 -10/16/23
- Diazepam on 10/11/23, 10/14/23-10/16/23
- Morphine on 10/11/23-10/16/23
- Omeprazole on 10/11/23, 10/12/23, 10/14/23-10/17/23
- Oxycodone on 10/11/23, 10/15/23, 10/17/23
- Metoprolol on 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/14/23-10/17/23
- Cholestyramine on 10/1/23-10/17/23
- Nitrofurantion on 10/15/23-10/17/23

I observed Resident D's medications and noticed there were three loose pills in a Ziploc bag. There was AP325 imprinted on the pills. Resident D's PRN's were not observed in her medication bin. There were no staff initials for the morning medications that were administered on 10/18/23. Furthermore, there were missing initials for the following medications:

- Levothyroxine on 10/5/23, 10/7/23, 10/8/23, 10/12/23, 10/15/23, 10/16/23
- Lisinopril on 10/3/23, 10/5/23, 10/8/23, 10/12/23, 10/15/23, 10/16/23
- Risperidone on 10/3/23, 10/5/23, 10/8/23, 10/10/23, 10/15/23

I observed Resident I's medications. There was D3 25mcg observed in Resident I's medication bin but, this medication was not listed on her MAR. There were no staff initials for the morning medications that were administered on 10/18/23. Furthermore, there were missing initials for the following medications:

- Amlodipine on 10/15/23, 10/16/23
- Atorvastatin on 10/15/16, 10/16/23
- Levothyroxine on 10/15/23, 10/16/23
- Losartan on 10/15/23, 10/16/23
- Omeprazole on 10/15/23, 10/16/23
- Quetiapine on 10/8/23, 10/14/23
- Trazodone on 10/8/23, 10/14/23

I observed Resident P's medications. Resident P is prescribed Polyethylene Glycol, Preparation H rapid-lido, and Fluoxetine hcl. However, these medications were not observed in her medication bin. There were no staff initials for the morning medications that were administered on 10/18/23. Furthermore, there were missing initials for the following medications:

- Calcium on 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23
- CO Q-10 on 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23
- Donepezil on 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23

- Fluoxetine on 10/4/23, 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23
- Hydroxyzine on 10/3/23, 10/5/23, 10/8/23, 10/15/23
- Lisinopril on 10/7/23 -10/9/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23
- Magnesium on 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23
- Memantine on 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23
- Vitamin D3 on 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23

I observed Resident B's medications. Resident B is prescribed Metoprolol 25 mg once a day. The pill for 10/17/23 was still in the bubble packet. A bubble packet for Memantine was observed. The 8:00am pills for 10/17/23 and 10/18/23 were still in the bubble packet. Resident B is prescribed Olmesartan Medoxomil in the morning if her systolic blood pressure is greater than 130 or diastolic blood pressure is greater than 80. There is no documentation indicating that Resident B's blood pressure is being checked on a daily basis. There were no staff initials for the morning medications that were administered on 10/18/23. Furthermore, there were missing initials for the following medications:

- Metoprolol on 10/5/23, 10/7/23, 10/8/23, 10/12/23, 10/15/23, 10/16/23
- Potassium on 10/5/23, 10/7/23, 10/8/23, 10/12/23, 10/15/23, 10/16/23
- Sertraline on 10/5/23, 10/7/23, 10/8/23, 10/12/23, 10/15/23, 10/16/23
- Vitamin on 10/4/23, 10/5/23, 10/7/23, 10/8/23, 10/12/23, 10/15/23, 10/16/23

On 10/18/23, Mr. Gross could not explain why there is a fifth bubble packet for Resident M's Diazepam for 12:00am.

On 10/23/23, I received the start dates and medications trainings for six employees. I received a medication training for one staff member who name is illegible. The start date for this employee is 09/12/23. I received a medication training for Blanca Bolanos whose start date was 06/15/23. I received a medication training for Taylor Samone H. whose start date was 07/30/23. I received a medication training for Tai Terry whose start date was 07/29/23. I received a medication training for Jennifer L. whose start date was 07/03/23. I received a medication training for Jesenia Flores whose start date was 09/12/23.

On 10/24/23, Resident M stated last night he was not administered his 12:00am medications on time (Morphine, Diazepam, Oxycodone). Resident M stated at 12:55am he slammed his bedroom door and shortly after the staff came in and gave him his medications. Resident M would not identify the name of the staff member. Resident M stated he has said too much, and he will deny everything that he has told me. Resident M stated he has to live here and does not want to say anything else.

On 10/24/23, I observed Ms. Esckelson preparing to administer Resident M's noon medications at 12:30pm. Ms. Esckelson was getting ready to initial the MAR before she administered Resident M's medications. I explain to Ms. Esckelson that she is not supposed to initial the MAR until after the medications are given. When Ms. Esckelson

finished administering Resident M's medications, she noticed that a different staff had already initialed the MAR for Resident M's noon medications. Ms. Esckelson stated it must have been staff member Taylor Harney who initialed the MAR because she worked the midnight shift yesterday.

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:	On 10/18/23, I observed the medication cabinet to be unlocked. Resident J is prescribed Polyethylene Glycol however; this medication is not being kept in a locked cabinet as it was not present in the medication cabinet and, it was not located by staff. Resident D had three loose pills in a Ziploc bag inside of her medication bin. The name of these medications are unknown and; it is unknown how long these medications were removed from there original pharmacy-supplied container.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident J's Polyethylene Glycol is not being administered as prescribed as it was not observed in the AFC group home. Resident D's PRN's were not observed in the AFC group home. Resident J is prescribed Ketoconazole 2% shampoo every 72 hours however; she was not given the shampoo on the prescribed date of 10/10/23. Resident P is prescribed Polyethylene Glycol, Preparation H rapid-lido, and Fluoxetine HCL however; these medications

	were not observed in her medication bin. Resident B is prescribed Metoprolol 25 mg once a day. The pill for 10/17/23 was still in the bubble packet. A bubble packet for Memantine was observed for Resident B and the 8:00am pills for 10/17/23 and 10/18/23 were still in the bubble packet. Resident B is prescribed Olmesartan Medoxomil in the morning if her systolic blood pressure is greater than 130 or diastolic blood pressure is greater than 80. There is no documentation indicating that Resident B's blood pressure is being checked on a daily basis. On 10/18/23, I observed that on 10/13/23, Resident M's prescription for Nitrofurantoin 100mg was filled and the instructions were to take one pill twice a day for five days. There was only one pill left in the bubble packet for 10/15/23. Resident M is prescribed Diazepam every six hours (12:00am, 6:00am, 12:00pm, 6:00pm) I observed a bubble packet for this medication for 12:00am, 6:00am, 12:00pm, and 6:00pm however; there was a fifth bubble packet also listed for 12:00am and the pills were missing for each day of the month.
CONCLUSION:	**VIOLATION ESTABLISHED**

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.**
ANALYSIS:	On 10/18/23, staff member Taylor Harney admitted to administering all of the morning medications without initialing the resident's MAR. Additional staff initials were observed missing for the following residents: Resident J: • Lubricant eye drops on 10/11/23 • Doxylamine Succinate on 10/15/23

	• Prednisone on 10/15/23 Resident M: • Aspirin on 10/11/23, 10/12/23, 10/14/23 -10/16/23 • Diazepam on 10/11/23, 10/14/23 – 10/16/23 • Morphine on 10/11/23 – 10/16/23 • Omeprazole on 10/11/23, 10/12/23, 10/14/23 – 10/17/23 • Oxycodone on 10/11/23, 10/15/23, 10/17/23 • Metoprolol on 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/14/23 – 10/17/23 • Cholestyramine on 10/1/23 – 10/17/23 • Nitrofurantion on 10/15/23 – 10/17/23 Resident D: • Levothyroxine on 10/5/23, 10/7/23, 10/8/23, 10/12/23, 10/15/23, 10/16/23 • Lisinopril on 10/3/23, 10/5/23, 10/8/23, 10/12/23, 10/15/23, 10/16/23 • Risperidone on 10/3/23, 10/5/23, 10/8/23, 10/10/23, 10/15/23 Resident I: • Amlodipine on 10/15/23, 10/16/23 • Atorvastatin on 10/15/16, 10/16/23 • Levothyroxine on 10/15/23, 10/16/23 • Losartan on 10/15/23, 10/16/23 • Omeprazole on 10/15/23, 10/16/23 • Quetiapine on 10/8/23, 10/14/23 • Trazodone on 10/8/23, 10/14/23 Resident P: • Calcium on 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23 • CO Q-10 on 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23 • Donepezil on 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23 • Fluoxetine on 10/4/23, 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23 • Hydroxyzine on 10/3/23, 10/5/23, 10/8/23, 10/15/23 • Lisinopril on 10/7/23 -10/9/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23 • Magnesium on 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23

	• Memantine on 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23 • Vitamin D3 on 10/7/23, 10/8/23, 10/11/23, 10/12/23, 10/15/23, 10/16/23 Resident B: • Metoprolol on 10/5/23, 10/7/23, 10/8/23, 10/12/23, 10/15/23, 10/16/23 • Potassium on 10/5/23, 10/7/23, 10/8/23, 10/12/23, 10/15/23, 10/16/23 • Sertraline on 10/5/23, 10/7/23, 10/8/23, 10/12/23, 10/15/23, 10/16/23 • Vitamin on 10/4/23, 10/5/23, 10/7/23, 10/8/23, 10/12/23, 10/15/23, 10/16/23 Furthermore, the following medications were being administered however; the medication, dosage, label instructions for use, and time to be administered were not listed on the MAR: • Resident J started being administered a Lidocaine patch for her hand since 10/17/23. This medication was not listed on Resident J's MAR. • Resident M had Lorazepam gel 1 mg in his medication bin however; this medication was not listed on his MAR. There was also a second box entitled dry eye relief as a PRN that was not listed on Resident M's MAR. • Resident I had D3 25mcg in her medication bin but, this medication was not listed on her MAR.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**

ANALYSIS:	Resident J's Lubricant eye drops is a PRN. Resident J was administered this medication from 10/1/23 to 10/10/23 and 10/12/23 to 10/14/23, and 10/16/23. The staff did not document the reason and/or the result each time the Lubricant eye drops were administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	According to Resident M's MAR, he is prescribed Polyethylene Glycol. It is written on the MAR to not administer this medication. There was no date on the MAR stating when this medication was discontinued. A discontinue order from a physician was not located in the file.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**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:	On 10/18/23, I observed Lorazepam gel 1 mg in Resident M's medication bin however; this medication expired on 10/16/23 and was not properly disposed of.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/18/23, I observed four shower chairs and one commode in the basement that is not prescribed to any current resident in the home.

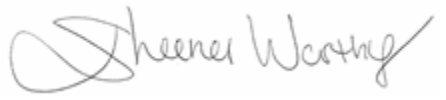
On 10/24/23, I observed the assistive devices in the home and Resident M's file. I observed two shower chairs in the shower. Ms. Esckelson stated one shower chair belongs to Resident M and the second chair doesn't belong to anyone but is used by the residents. I observed a durable medical equipment (DME) request form from hospice for Resident M to receive a motorized wheelchair, oxygen back up tank, oxygen concentrator, bedside table, and an electric hospital bed. I did not observe a doctor's order for a shower chair. According to Resident M's assessment plan dated 06/23/23, his assistive devices consist of a wheelchair and a hospital bed.

On 10/24/23, I completed an exit conference with the licensee designee, Jorge Garcia via telephone. Mr. Garcia admitted that he is not hands on with the day-to-day operations of the AFC group home as he has taken a step back and allowed William Gross to be more involved. Mr. Garcia was informed about which allegations will be substantiated and why a provisional license is being recommended. Mr. Garcia understood the recommendation.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	The four shower chairs and commode that was observed in the basement of the AFC group home are not prescribed to any current residents in the home therefore; these assistive devices are not included in any of the current residents assessment plans. According to Resident M's assessment plan, a shower chair is not documented as one of his assistive devices.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

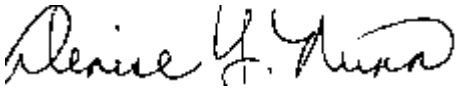
Contingent upon the receipt of an acceptable corrective action plan, I recommend the issuance of a six-month provisional license.



Sheena Worthy
Licensing Consultant

10/24/23
Date

Approved By:



10/26/2023

Denise Y. Nunn
Area Manager

Date