GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 1, 2023

Vashu Patel
Hudson's Country Manor, Inc.
9842 Oakland Dr.
Portage, MI 49024

RE: License #: AL390292582
Investigation #: 2023A0581055
Hudson's Country Manor, Inc.

Dear Vashu Patel:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390292582
Investigation #:	2023A0581055
Complaint Receipt Date:	09/11/2023
Investigation Initiation Date:	09/12/2023
Report Due Date:	11/10/2023
Licensee Name:	Hudson's Country Manor, Inc.
Licensee Address:	9842 Oakland Dr. Portage, MI 49024
Licensee Telephone #:	(269) 323-9752
Administrator:	Almetta Whitley
Licensee Designee:	Vashu Patel
Name of Facility:	Hudson's Country Manor, Inc.
Facility Address:	9842 Oakland Dr. Portage, MI 49024
Facility Telephone #:	(269) 323-9752
Original Issuance Date:	08/29/2008
License Status:	REGULAR
Effective Date:	07/26/2023
Expiration Date:	07/25/2025
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS

	Violation Established?
Background checks are not being conducted on direct care staff.	No
Home manager, Dani Gritten, told direct care staff not to change Resident A's incontinence briefs.	No
Direct care staff are not trained.	No
Home manager, Dani Gritten, treats residents poorly and has belittled and embarrassed Resident A in front of direct care staff and residents.	Yes
Home manager, Dani Gritten, has taken all the facility's food away and has made it inaccessible to direct care staff and residents.	No
Home manager, Dani Gritten, took Resident B's oxygen away from her because there was no prescription for it.	No
Home manager, Dani Gritten, is not logging controlled medications in resident's Medication Administration Records.	No
Home manager, Dani Gritten, is not adhering to the facility's menu.	No

III. METHODOLOGY

09/11/2023	Special Investigation Intake 2023A0581055
09/11/2023	APS Referral APS received the allegations but denied investigating.
09/11/2023	Referral - Recipient Rights Confirmed with Integrated Services of Kalamazoo (ISK) they also received allegations and are investigating.
09/12/2023	Special Investigation Initiated - Face to Face Via MiTeams, interviews with staff and Resident A, in conjunction with ISK RRO.
09/19/2023	Contact - Document Received Email from APS specialist, Lauren Crock.
09/20/2023	Contact - Telephone call made Interview with Ms. Crock.
09/26/2023	Inspection Completed On-site Interviewed residents, staff, and reviewed documentation.

10/03/2023	Contact - Document Sent Email to Ms. Gritten
10/03/2023	Contact - Document Received Email from Ms. Gritten
10/03/2023	Contact - Telephone call made Interview with Ms. Gritten
10/06/2023	Contact - Document Received Email from Ms. Gritten.
10/18/2023	Contact – Telephone call made Interview with licensee designee, Vashu Patel.
10/19/2023	Contact – Document Sent Email sent to Ms. Gritten.
10/20/2023	Contact – Telephone made Left voicemail with Bridgeways case manager, Lisa Way.
10/31/2023	Contact – Telephone call made Interview with direct care staff, Cierra Foley, via telephone.
10/31/2023	Contact – Document Sent Email to Ms. Crock.
10/31/2023	Contact – Telephone call made Interview with Ms. Crock.
11/01/2023	Exit conference with licensee designee, Vashu Patel, via telephone.

ALLEGATION: Background checks aren't being conducted on direct care staff.

INVESTIGATION:

On 09/11/2023, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The compalint alleged direct care staff, Dani Gritten, who is also the facility's identified home manager, is hiring staff without first conducting background checks.

On 09/12/2023, I conducted a MiTeams video interview with Ms. Gritten in conjunction with Integrated Services of Kalamazoo (ISK) Recipient Rights Officer

(RRO), Michele Schiebel. Ms. Gritten denied direct care staff didn't have background checks completed, as required. She stated all the facility's direct care staff had obtained fingerprints through the Workforce Background Check (WBC).

During the MiTeams video, I also interviewed direct care staff, Michael Prevatte, Joyce McCoy, and Grace McCoy. All three staff stated they had received background checks and were not aware of any staff working in the facility without background checks being conducted.

On 09/26/2023, I conducted an unannounced inspection at the facility. I reviewed employee files for direct care staff, Dani Gritten, Michael Prevatte, Sophia Lawrence, Quandra Armstrong, Grace McCoy, Deon Daniel, and Brian Daniel. Upon my review of all the staff files, I determined all direct care staff had verification of background checks except Ms. McCoy.

During the inspection, I interviewed direct care staff, Deon Daniel. He stated both he and his relative, Brian Daniel, were recently hired and stated they both received background checks.

On 10/06/2023, Ms. Gritten emailed me a copy of Ms. McCoy's eligibility letter through the WBC confirming she had a background check completed. Additionally, Ms. Gritten provided the WBC eligibility letter for Clipboard Health contracted staff, Cierra Foley, confirming she also had a background check completed upon working in the facility.

On 10/18/2023, I interviewed the facility's Licensee Designee, Vashu Patel, via telephone. Ms. Patel denied the allegation direct care staff do not have background checks. She stated all direct care staff have background checks at time of hire, including direct care staff who were contracted with outside agencies like Clipboard Health.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal

	history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Based on my investigation, which included interviews with multiple direct care staff and my review of direct care staff files, there is no evidence supporting the licensee is not obtaining background checks through the Workforce Background Check on all direct care staff, including contracted staff through outside agencies like Clipboard Health.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Home manager, Dani Gritten, told direct care staff not to change Resident A's incontinence briefs.

INVESTIGATION:

The complaint alleged Resident A wears "depends" and has a "care plan", which documents direct care staff are to change his depends regularly; however, the complaint alleged the facility's home manager, Dani Gritten, who started approximately two weeks ago, told direct care staff to stop changing his depends.

The complaint alleged Ms. Gritten told direct care staff he was able to change himself.

Ms. Gritten stated she's worked in the facility for approximately four weeks. She stated Resident A requires "prompting" in changing in his incontinence briefs between 12 pm -1 pm, 4 pm – 5 pm, and 8 pm – 9 pm. She stated direct care staff should be giving Resident A verbal prompts or ask if he needs assistance in changing. Ms. Gritten stated staff should be documenting on his "charting notes" if they've offered him assistance with toileting. Ms. Gritten denied telling any direct care staff they weren't to assist with changing him or to stop assisting him with changing. She stated direct care staff were not supposed to stop changing him until his plan was updated to reflect a change in care. Ms. Gritten stated Resident A reported to her that staff didn't change him the weekend of 08/25-08/27. She stated Resident A can't always feel if he needs to go to the bathroom and is unable to reach around his body to attach the incontinence briefs tabs in order to secure them. Ms. Gritten stated Resident A's *Individual Plan of Service* (IPOS) identifies the information on toileting assistance from staff.

Resident A stated he's resided in the facility since late spring 2023. He stated he needs physical assistance from direct care staff in attaching the tabs on his incontinence briefs, which is documented in his Integrated Services of Kalamazoo (ISK) plan. Resident A stated when Ms. Gritten first started working in the home, she told direct care staff she talked to Resident A's case manager and determined direct care staff didn't need to assist him. Resident A stated he didn't have the specific dates and didn't recall the specific direct care staff, but he stated direct care staff stopped assisting and prompting him with his personal care for several days in August. He stated when he brought this to staff's attention, they told him Ms. Gritten checked with his case manager who told them not to help him anymore. Resident A stated Ms. Gritten checking with his case manager was "impossible" because she was on vacation the week he didn't receive direct care staff's assistance and his treatment plan never changed to reflect not getting the personal care assistance. Resident A stated direct care staff are supposed to document when they've prompted or assisted him, but he stated he believes direct care staff forge these documents. Resident A also stated Ms. Gritten told him to his face that he didn't need assistance with changing his incontinence briefs.

Direct care staff, Mike Prevatte, denied ever being told by Ms. Gritten that direct care staff were to stop prompting or assisting Resident A with toileting or following his care plan. He stated he's observed direct care staff checking in with Resident A and assisting him as needed.

Direct care staff, Joyce McCoy, stated Resident A requires the assistance of direct care staff in changing his incontinence briefs. She approximately 4-5 days after Ms. Gritten started working in the facility she asked direct care staff if any of the residents required hands on assistance from staff. Ms. Joyce McCoy initially stated she had been told by Ms. Gritten not to assist Resident A with brief changes, but

later indicated she had been told by other direct care staff this had been Ms. Gritten's directions. Ms. Joyce McCoy stated she worked 08/25 and 08/27 and continued to prompt Resident A and assist him with brief changes. She stated she also worked with Ms. Grace McCoy during that time frame and Ms. Grace McCoy also prompted and assisted Resident A with brief changes.

Direct care staff, Ms. Grace McCoy, statement to me regarding the personal care assistance required by Resident A was consistent with Ms. Gritten's and Ms. Joyce McCoy's statements to me. Ms. Grace McCoy stated Ms. Gritten told her she planned to talk to Resident A's case manager about his assistance from staff in prompting and changing his incontinence briefs. Ms. Grace McCoy did not recall Ms. Gritten telling her to stop changing Resident A's incontinence briefs. Ms. Grace McCoy stated she continued to prompt and assist Resident A when she worked 08/25-08/27.

On 09/20/2023, I interviewed Adult Protective Services (APS) specialist, Lauren Crock. Ms. Crock stated Resident A reported similar concerns to her about direct care staff not changing his incontinence briefs; however, she also indicated a lot of hearsay amongst direct care staff.

During my inspection, I attempted to interview Resident C, D, E and F regarding Resident A's care; however, none of them were aware of what kind of personal care Resident A required of direct care staff.

I interviewed direct care staff, Deon Daniel, who's statement to me was consistent with Mr. Prevatte's statement to me. He stated Resident A will report to staff if he needs assistance with having his incontinence briefs changed.

I reviewed Resident A's *ISK Individual Plan of Service* (IPOS), with a plan effective date of 08/01/2023. According to his IPOS, an objective to Resident A's goal to "have a life worth living" was identified as the following:

> "[Resident A] will "have a life worth living" by working with case management and AFC staff to appropriately address [Resident A's] needs, as evidenced by staff and self-report of increased independence, ADL prompting, staff check ins with polite verbiage from both staff and client regarding hygiene and grooming practices including discussion regarding incontinence needs between 12-1pm, 4-5pm, and 8-9pm, and as needed to encourage engaging in hobbies and self care time, communicating laundry needs as appropriate, communicating sensory overstimulation and using coping skills during times of sensory distress, and communicating food preferences to AFC staff over the next 12 months."

Ms. Gritten provided Resident A's *Person Centered Plan* tracking sheet from 08/21 through 08/27, which documented staff encouraged Resident A to change his soiled incontinence supplies each shift on 08/25 through 08/27.

On 10/31/2023, Ms. Crock stated she substantiated for abuse based on Resident A's report of direct care staff not prompting or assisting him with brief changes.

On 10/31/2023, I interviewed former contracted direct care staff through Clipboard Health, Cierra Foley, via telephone. Ms. Foley stated after Ms. Gritten worked for several days she reported to Ms. Foley that after observing Resident A for several days, she didn't believe he required assistance from staff in changing his incontinence briefs as documented in his IPOS. Ms. Foley stated Ms. Gritten initially told her not to assist Resident A with brief changes, but when Ms. Foley told her he needed the assistance Ms. Gritten then told her she could continue assisting him, which Ms. Foley stated she continued to do. Ms. Foley stated Ms. Gritten reported to her she planned to get Resident A's care plan changed so female staff wouldn't feel uncomfortable changing him. Ms. Foley stated she continued providing Resident A with changing his incontinence briefs while she worked, which also included the weekend of 08/25-08/27. She stated if any of the other female staff were working, like Ms. Joyce or Grace McCoy, then they also would have prompted or aided Resident A as she had observed these staff also providing care to him in the past.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.

ANALYSIS:	Based on my investigation, which included interviews with Resident A, the facility's home manager, Dani Gritten, direct care staff, Michael Prevatte, Joyce McCoy, Grace McCoy, Deon Daniel, and Cierra Foley, and my review of Resident A's IPOS, effective date of 08/01/2023, and his IPOS tracking sheet from 08/21 through 08/27, there is insufficient evidence supporting the allegation of Ms. Gritten telling staff to no longer assist Resident A with prompting and assisting him in changing his incontinence briefs during the weekend of 08/25 through 08/27. Additionally, there is no supporting evidence staff followed the alleged direction from Ms. Gritten even if she gave the direction to no longer prompt or assist Resident A with his brief changes. Subsequently, I am unable to establish supporting evidence Resident A's IPOS was not implemented on or around 08/25-08/27, as alleged.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff are not trained.

INVESTIGATION:

The complaint alleged home manager, Ms. Gritten, is hiring staff without training them.

Home manager, Ms. Gritten, and staff, Mr. Prevatte, Ms. Joyce McCoy, Ms. Grace McCoy and Mr. Deon Daniel all stated they received training since they started working in the facility. She stated she hadn't been formally trained on Resident A's BSP by Resident A's case manager, but she did look it over and was aware of his goals.

I confirmed all staff were trained, as required, after reviewing their staff files and reviewing documentation provided by Ms. Gritten via email. Additionally, Ms. Gritten provided confirmation staff, Ms. Foley, who was contracted with the outside agency Clipboard Health, had also received the required trainings and was competent prior to performing her assigned tasks within the facility.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before

	performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	There is no evidence supporting direct care staff are not competent before performing their assigned tasks, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Home manager, Dani Gritten, treats residents poorly and has belittled and embarrassed Resident A in front of direct care staff and residents.

INVESTIGATION:

There was no additional information provided in the complaint other than the identified allegations.

Ms. Gritten denied the allegations; however, she indicated Resident A didn't like her. She stated she'd worked at the facility for approximately one month and had limited interaction with Resident A. She described a recent incident where Resident A was screaming at her in front of his ISK case manager, Lisa Way; however, Ms. Gritten denied saying anything to Resident A that could have been misconstrued as rude, belittling, or embarrassing. Ms. Gritten also described an incident where she talked to a female staff about the staff feeling uncomfortable in assisting Resident A with his incontinence briefs changes; however, Ms. Gritten stated this conversation took place in the facility's office rather than in the facility's common areas or in front of Resident A.

Mr. Prevatte's statement was consistent with Ms. Gritten's statement to me. He stated he hadn't been physically present or witnessed Ms. Gritten treat any of the residents, including Resident A, poorly or belittle and/or engage in a behavior that could have been construed as embarrassing to them. Mr. Prevatte also described an incident between Resident A and Ms. Gritten where they were both "loud" and Resident A was telling Ms. Gritten he didn't like her; however, Mr. Prevatte stated Ms. Gritten's tone was only loud. He stated he did not recall Ms. Gritten acting inappropriately.

Ms. J. McCoy, Ms. G. McCoy, and Mr. D. Daniel all stated they did not personally witness or observe Ms. Gritten treat any of the residents poorly or embarrass/belittle residents in front of other residents or staff, including Resident A.

Resident A did not have any information as to how Ms. Gritten treats the other residents poorly, but he described incidences where Ms. Gritten made him feel embarrassed and belittled. He stated Ms. Gritten compared him to her past boyfriends where she referred to these boyfriends as slobs and didn't contribute to society, which he indicated hurt his feelings. Resident A was unable to recall if any residents or other staff were present when this incident occurred.

Resident A stated he also overheard Ms. Gritten tell staff she had wanted to hire her daughter to work in the facility, but he overheard Ms. Gritten report there was "no way in hell" she was going to have her daughter work with Resident A. Resident A stated this also hurt his feelings.

Residents C, D, E and F all denied Ms. Gritten being rude or impolite to any of the residents, including Resident A. They all reported Resident A keeps to himself by staying in his bedroom a lot; therefore, he had limited interaction with the other residents.

On 10/20/2023, I Interviewed Resident A's ISK case manager, Lisa Way, via telephone. Ms. Way stated she conducted a meeting at the facility on 08/28/2023 with Ms. Gritten and Resident A. She stated during this meeting, Resident A reported how Ms. Gritten compared him to an ex-boyfriend and referred to him as lazy. Ms. Way stated Ms. Gritten reported she had been talking to staff about Resident A and asking questions rather than making these statements about Resident A. Ms. Way stated Ms. Gritten's voice was raised during the meeting and appeared defensive of her statements and questions concerning Resident A. Ms. Way indicated Resident A was upset during the meeting.

On 10/31/2023, Ms. Crock stated she substantiated her case for the abuse and neglect of Resident A for how he was treated by Ms. Gritten.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**

	(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.
ANALYSIS:	Based on my investigation, which included interviews with the home manager, Dani Gritten, direct care staff, multiple residents, including Resident A, APS specialist, Lauren Crock, and Resident A's Integrated Services of Kalamazoo (ISK) case manager, Lisa Way, Resident A's and Ms. Way's statements to me were consistent with how Ms. Gritten spoke to or about Resident A in front of him that could have been perceived as belittling and/or embarrassing. Subsequently, Ms. Gritten did not treat Resident A with respect or personal dignity on or around 08/28/2023, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Home manager, Dani Gritten, has taken all the facility's food away and has made it inaccessible to direct care staff and residents.

INVESTIGATION:

The complaint alleged that in addition to Ms. Gritten taking all the facility's food from the pantry it was also unknown where Ms. Gritten was storing the food. The complaint alleged the food was inaccessible to direct care staff and they couldn't give food to residents when they were hungry.

Ms. Gritten stated the facility's food is ordered weekly. She stated the facility's pantry is kept locked because direct care staff will gather items for the upcoming week's meal preparation. She stated residents have access to the facility's freezer and fridge in the kitchen and in the back of the house where there are extra freezers and refrigerators. She stated the kitchen cupboards are not locked. Ms. Gritten stated fresh fruit like bananas and oranges are kept out for residents for snacks.

Direct care staff, Mr. Prevatte's, Ms. J. McCoy's, Ms. G. McCoy's, and Mr. D. Daniels' statements to me were consistent with Ms. Gritten's statement to me. All four staff stated food is accessible to residents and staff with snacks always available, as well. They denied withholding food from residents. They all stated the pantry is kept locked as the week's prearranged meals are kept in the pantry, in addition to, knives and sharp objects.

During my inspection, I observed an abundance of food in the pantry. I observed an accessible refrigerator and freezer in the facility's kitchen as well as in a back room of the facility. I also observed snack items like chips, crackers, and fruit available in the cupboards and on the kitchen counters. The facility's pantry was observed locked; however, I observed such items as fresh fruit and vegetables, canned fruit,

canned vegetables, muffin mixes, pancake mixes, oats, soups, sauces, applesauce, condiments, rice, and hamburger helper mix.

Residents A, C, D, E, F, and G all stated there is food accessible and available in the facility. They all stated food was not withheld from them and three meals were served per day.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(e) Withhold food, water, clothing, rest, or toilet use.**
ANALYSIS:	There is no supporting evidence any direct care staff, including the identified home manager, Dani Gritten, is withholding food from residents or making it inaccessible to staff so that residents are unable to have it.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Home manager, Dani Gritten, took Resident B's oxygen away from her because there was no prescription for it.

INVESTIGATION:

The complaint alleged Resident B went two weeks without having her oxygen tank because home manager, Dani Gritten, took it away from her since there was no prescription for Resident B to use it. The complaint alleged it took Ms. Gritten two weeks before she was able to get a prescription for oxygen.

Ms. Gritten stated she started working in the facility on or around 08/21/2023 and on or around 08/23/2023, she discovered Resident B had an oxygen concentrator in her room; however, there was no prescription for Resident B to have the oxygen and/or oxygen concentrator so she removed it from her room. Ms. Gritten stated Resident B was not utilizing any oxygen either.

Ms. Gritten stated it was her understanding Resident B brought the oxygen concentrator with her to the facility after she was discharged from a nursing home; however, Ms. Gritten stated she was not working in the facility at that time. Ms. Gritten stated the concentrator was discovered when staff were deep cleaning the facility. Ms. Gritten stated despite Resident B having an oxygen concentrator, there was no physician's order for it; therefore, she contacted Airlink to pick up the concentrator from the facility. She stated there was an Airlink tag on the

concentrator, which is how she knew what agency to contact about it. She stated she also had Mr. Prevatte contact Resident B's physician to confirm Resident A didn't have an active order for it, which she did not. Ms. Gritten stated a prescription had since been received from Resident B's physician ordering the oxygen concentrator.

Mr. Prevatte's statement to me was consistent with Ms. Gritten's statement to me. He stated Resident B hadn't been using the oxygen concentrator and it was only being stored in the facility. He confirmed calling Resident B's physician about the oxygen concentrator and confirmed there was not an active order for it.

Both Ms. J. McCoy and Ms. G. McCoy stated they hadn't observed Resident B utilizing the oxygen concentrator in her bedroom. They both stated the concentrator had been picked up from the facility by Airlink.

During my inspection, I attempted to interview Resident B; however, she stated she didn't want to talk to me.

On 10/20/2023, I confirmed with Adult Protective Services (APS) specialist, Thomas Larthridge, that he was not citing any facility staff for any abuse or neglect of Resident B. He stated it was his understanding that while the oxygen concentrator was in her room there hadn't ever been an order for it and Resident B wasn't using it. Mr. Larthridge documented the oxygen concentrator was just being stored until Ms. Gritten discovered it and had Airlink pick it up.

On 10/20/2023, Ms. Gritten forwarded me the oxygen prescription for Resident A, which had 09/07/2023 as a "Date of Service" with Harmony Cares Medical Group. The order documented Resident A has a diagnosis of chronic obstructive pulmonary disease (COPD) and the services ordered from the date of service were "Oxygen Concentrator and Gaseous Portables Tanks".

APPLICABLE RULE	
R 400.15310	**Resident health care.**
ANALYSIS:	**(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following:** **(a) Medications.** **(b) Special diets.** **(c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate.** **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
	Based on my investigation, which included interviews with home manager, Dani Gritten, and direct care staff, Michael Prevatte, Joyce McCoy and Grace McCoy, and Adult Protective Services Specialist, Thomas Larthridge, and my review of the prescription for Resident A's oxygen concentration and gaseous tanks, there is no evidence supporting the licensee wasn't following the instructions or recommendations of Resident B's health care professional regarding her use of oxygen. Resident B came to the facility with an oxygen concentrator after being discharged from a nursing home; however, she was sent back to the facility without a physician's order or a prescription for it. Upon staff discovering the oxygen concentrator without a prescription it was removed from the facility and returned to Airlink. Direct care staff, Michael Prevatte, then obtained a prescription, dated 09/07/2023, for Resident B's use of an oxygen concentrator and gaseous portables tanks. There is also no supporting evidence Resident B was utilizing the oxygen concentrator when there was no active prescription.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Home manager, Dani Gritten, is not logging controlled medications in residents' Medication Administration Records.

INVESTIGATION:

There was no additional information provided in the complaint other than the identified allegations.

Ms. Gritten denied the allegations. She stated all controlled and/or narcotic medication are logged on resident Medication Administration Records (MARs), as required.

Direct care staff, Mr. Prevatte's, Ms. J. McCoy's, Ms. G. McCoy's, and Mr. D. Daniels' statements to me were consistent with Ms. Gritten's statement to me.

Residents A, C, D, E, F, and G all stated they receive their medications, as required.

During my inspection, I requested to review the MARs for all residents who received controlled and/or narcotic medications. According to Mr. Prevatte, Residents A, B, D, E, and H all received controlled medications; however, upon review of their MARs, all their medications, including the controlled medication, were being documented. I observed no issues on the MARs indicating staff were not properly documenting the administration of medications to residents.

APPLICABLE RULE	
R 400.15312	**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:	There was no evidence supporting any direct care staff, including home manager, Dani Gritten, is not logging controlled and/narcotic medication on resident's MARs, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Home manager, Dani Gritten, is not adhering to the facility's menu.

INVESTIGATION:

The complaint alleged Ms. Gritten was not adhering to the facility's menu, which was confusing and upsetting the residents.

Ms. Gritten stated staff post the facility's weekly menu for all the residents to see; however, staff also keep a blank menu below the weekly menu to add any substitutions or changes made to the original menu.

Direct care staff, Mr. Prevatte's, Ms. J. McCoy's, Ms. G. McCoy's, and Mr. D. Daniels' statements to me were consistent with Ms. Gritten's statement to me.

During my inspection, I observed the facility's weekly menu posted in the kitchen and in other common areas of the facility. I also observed a substitution menu, which identified several days where substitutions had been made.

Resident A, C, D, E, F, and G all stated menus are posted within the facility. Additionally, none of the residents indicated they were confused or upset about the facility's menu or staff not adhering to it.

APPLICABLE RULE	
R 400.15313	**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:	There is no supporting evidence establishing the licensee is not creating menus at least one week in advance and posting it. Additionally, there is no evidence the licensee is not ensuring menu changes or substitutions aren't considered part of the facility's original menu, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 11/01/2023, I conducted the exit conference with the licensee designee, Vashu Patel, via telephone. Ms. Patel stated she addressed Ms. Gritten's interaction with Resident A immediately after the incident took place on or around 08/28/2023. She stated she meets and/or communicates with Ms. Gritten at least weekly and is regularly providing Ms. Gritten with coaching on non-verbal communication, as well, as communication style. She agreed with my other findings and stated she would provide an acceptable plan of correction.

IV. RECOMMENDATION

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

11/01/2023

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Cathy Cushman — Date
Licensing Consultant

Approved By:

11/07/2023

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Dawn N. Timm — Date
Area Manager