GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 20, 2023

Sarah Sease
Chandler Pines, LLC
1435 Coit Ave NE
Grand Rapids, MI 49505

RE: License #: AS410411560
Investigation #: 2024A0583012
Care Cardinal Belmont B

Dear Ms. Sease:

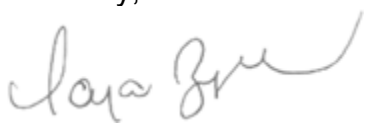
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. Failure to submit an acceptable corrective action plan will result in disciplinary action. The corrective action plan is due 15 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.

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 (616) 356-0183.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410411560
Investigation #:	2024A0583012
Complaint Receipt Date:	12/12/2023
Investigation Initiation Date:	12/15/2023
Report Due Date:	01/11/2024
Licensee Name:	Chandler Pines, LLC
Licensee Address:	1435 Coit Ave NE Grand Rapids, MI 49505
Licensee Telephone #:	(616) 450-1279
Administrator:	Sarah Sease
Licensee Designee:	Sarah Sease
Name of Facility:	Care Cardinal Belmont B
Facility Address:	7555 Chandler Dr. NE Belmont, MI 49306
Facility Telephone #:	(616) 204-7598
Original Issuance Date:	05/18/2022
License Status:	REGULAR
Effective Date:	11/18/2022
Expiration Date:	11/17/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility staff did not immediately obtain needed medical care for Resident A's femur fracture.	Yes
Residents do not receive their medications as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/12/2023	Special Investigation Intake 2024A0583012
12/13/2023	APS Referral
12/13/2023	Special Investigation Initiated - Letter
12/14/2023	Inspection Completed On-site
12/20/2023	Exit Conference Licensee Designee Sarah Sease

ALLEGATION: Facility staff did not immediately obtain needed medical care for Resident A's femur fracture.

INVESTIGATION: On 12/12/2023 complaint allegations were received from the BCH online complaint system. The complaint alleged that "EMS called, and resident taken to ER", where it was discovered that the resident sustained a broken leg. The complaint further stated that, "home is assuming it was an unwitnessed fall" and the facility staff, "can't keep residents safe".

On 12/13/2023 I emailed the complaint allegations to adult Protective Services centralized intake.

On 12/14/2023 I completed an unannounced onsite investigation at the facility and interviewed Licensee Designee Sarah Sease, staff Jelaine Naffziger, and staff Guadalupe Perez each privately.

Licensee Designee Sarah Sease stated that Resident A has been diagnosed with dementia and her son, Relative 1, is her activated Durable Power of Attorney. Ms. Sease stated that from 12/08/2023 7:00 PM until 12/09/2023 7:00 AM staff Angela Wilber worked independently at the facility and from 12/09/2023 7:00 AM until 7:00 PM staff Guadalupe Perez worked at the facility independently. Ms. Sease stated that on 12/09/2023 at 4:05 PM she received a telephone call from Ms. Perez and Ms. Perez stated that Resident A was complaining of pain and she observed a

“bump” and a bruise on Resident A’s head and a bruise on Resident A’s left hand. Ms. Sease stated that she instructed Ms. Perez to take Resident A’s vitals, complete an incident report, call Resident A’s “DPOA”, and send Resident A “out for evaluation” for medical care. Ms. Sease stated that Ms. Perez did contact emergency medical services who transported Resident A to Butterworth hospital where Resident A was diagnosed with a fracture in her left leg which required surgical repair and the insertion of “two or three pins”. Ms. Sease stated that due to Resident A’s dementia, Resident A is unable to provide information related to the origination of her injuries. Ms. Sease stated that the remaining five residents residing at the facility cannot provide interviews due to their dementia. Ms. Sease stated that no one saw a presumed fall which may have caused Resident A’s injuries. Ms. Sease stated that staff complete “rounds” every two hours to verify residents’ wellbeing and Ms. Wilber documented that she completed rounds with no indications of a fall. Ms. Sease stated that Resident A can verbalize pain by stating words such as “ow”. Ms. Sease stated that Resident A is currently hospitalized.

Staff Jelaine Naffziger stated that she is the facility’s “house manager” and was not working on 12/09/2023. Ms. Naffziger stated that she received a telephone call from Ms. Perez on 12/09/2023 at approximately 9:08 AM. Ms. Naffziger stated that Ms. Perez reported that Resident A presented with bruises of an unknown origin on her head. Ms. Naffziger stated that she instructed Ms. Perez to complete Resident A’s “vitals” and call “Home MD” for instructions and to follow the directions of “Home MD”. Ms. Naffziger stated that Ms. Perez agreed to follow her directions and Ms. Naffziger did not receive another phone call from Ms. Perez that day.

Staff Guadalupe Perez stated that she has worked at the facility for approximately seven months. Ms. Perez stated that she worked at the facility independently on 12/09/2023 from 7:00 AM until 7:00 PM. Ms. Perez stated that when she arrived at the facility at 7:00 AM she met briefly with staff Angela Wilber. Ms. Perez stated that at 7:00 AM she and Ms. Wilber counted medications and completed resident room checks together. Ms. Perez stated Ms. Wilber left the facility right after the medication count and room checks. Ms. Wilber stated that during the 7:00 AM room check Resident A was sitting in her chair and presented with no bruising. Ms. Perez stated that she brought Resident A’s breakfast to her in her bedroom at 8:00 AM and observed no bruising on Resident A’s head or arm. Ms. Perez stated that at approximately 9:00 AM she observed Resident A sitting in her bedroom chair with a bump that was bruising the size of a “quarter” and two smaller bruises on Resident A’s forehead. Ms. Perez stated she telephoned staff Amanda Wilber to discuss Resident A’s bruises, but Ms. Wilber did not answer her telephone. Ms. Perez stated that she subsequently telephoned Ms. Naffziger and informed Ms. Naffziger of Resident A’s bruises. Mr. Perez stated that she asked Ms. Naffziger if anyone had reported a previous incident that may have caused Resident A’s bruises and Ms. Naffziger stated that no one had reported a previous incident. Ms. Perez stated that Ms. Naffziger did not offer guidance except to monitor the situation. Ms. Perez stated that Ms. Naffziger never instructed Ms. Perez to complete Resident A’s vitals during their telephone conversation. Ms. Perez stated that she provided Resident A

lunch in her bedroom at approximately 12:30 PM because Resident A did not come out of her room to the lunch table. Ms. Perez stated that Resident A complained of pain when Ms. Perez brought her lunch by stating “ow”. Ms. Perez stated that Resident A complained that the pain was in her lower hip area. Ms. Perez stated Resident A had a recent history of complaining of constipation and therefore Ms. Perez suspected Resident A was complaining of constipation pain. Ms. Perez stated that she attempted to reposition Resident A in her recliner chair around lunch time and Resident A would complain of pain. Ms. Perez stated that at approximately 4:00 PM she attempted to reposition Resident A and Resident “screamed” in pain. Ms. Perez stated that while repositioning Resident, Ms. Perez observed multiple bruises on Resident A’s lower right back area and multiple bruises on Resident A’s right wrist and arm. Ms. Perez stated that she telephoned Licensee Designee Sarah Sease who directed Ms. Perez to telephone emergency medical staff. Ms. Perez stated that she contacted 911 shortly before 5:00 PM and Resident A was sent to the hospital where she was diagnosed with a leg fracture. Ms. Perez stated that at no time did she observe Resident A fall on 12/09/2023.

While onsite I observed Resident A’s bedroom which presented as appropriately clean and free of clutter.

On 12/14/2023 I interviewed staff Angela Wilber via telephone via telephone. Ms. Wilber stated that she worked independently at the facility on 12/08/2023 at 7:00 PM until 12/09/2023 at 7:00 AM. Ms. Wilber stated she observed Resident A from 7:00 PM until 9:00 PM and Resident A did not display any signs of distress. Ms. Wilber stated that she assisted Resident A to bed at 9:00 PM without issue and then completed rounds every two hours during the night. Ms. Wilber stated that at 5:30 AM she went into Resident A’s bedroom and observed Resident A was dressed and sitting in her chair. Ms. Wilber stated that she did not observe any bruises or signs of distress from 5:30 AM until 7:00 AM. Ms. Wilber stated staff Guadalupe Perez arrived at the facility at 7:00 AM and Ms. Wilber provided a brief update. Ms. Wilber stated that she and Ms. Perez completed resident rounds together briefly and then Ms. Wilber left the facility. Ms. Wilber stated that Resident A does not have a history of complaining of constipation pain and rarely complains of pain.

On 12/18/2023 I interviewed staff Guadalupe Lopez via telephone. Ms. Lopez stated that when she arrived at the facility in the morning at 7:00 AM Resident A was sitting in her bedroom chair and at 9:00 AM she checked to see if Resident A was dry. Ms. Perez stated that Resident A doesn’t ever ask to use the restroom therefore staff check her adult briefs every two hours. Ms. Perez stated that at 9:00 AM she checked to see if Resident A was dry by touching the outside of Resident A's clothing. Ms. Perez stated she couldn’t check Resident A’s adult brief under her clothing because, “she was in pain” and “every time she moved she was in pain” as evidenced by yelling “ow”. Ms. Perez stated that from 7:00 AM until 5:00 PM, Resident A was not escorted to the restroom and her adult briefs were not changed. Ms. Perez stated that before dinner she transferred Resident A from her chair to her bed. Ms. Perez stated that Resident A stayed in her bed until emergency personnel

arrived and transferred Resident A to a stretcher. Ms. Perez stated that after Resident A was moved from her bed, Ms. Perez observed that Resident A's bed pad was wet with urine.

On 12/18/2023 I interviewed Relative 2 via telephone. Relative 2 stated that Resident A is currently at a "rehab" following surgical repair of Resident A's femur fracture. Relative 2 stated that on 12/09/2023 she received a telephone call from staff Guadalupe Lopez. Relative 2 stated that Ms. Lupe informed Relative 2 that Resident A was in pain and had bruises that required emergency medical treatment. Relative 2 stated that Ms. Perez reported that on 12/09/2023 Resident A had been walking while at the facility in the morning but by the afternoon Resident A refused to get out of her lazy boy chair.

On 12/20/2023 I completed an Exit Conference with Licensee Designee Sarah Sease via telephone. Ms. Sease stated that she agreed the licensing violation occurred and agreed medical care should have been sought in a more expedient manner. Ms. Sease stated that she would consult with her administrative staff before accepting or rejecting the issuance of a Provisional License. Ms. Sease stated that a Corrective Action Plan will be completed and submitted quickly.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	On 12/09/2023, Resident A sustained a fractured femur while at the facility from unknown origin. Resident A first expressed to staff Guadalupe Perez that she was in pain at 9:00 AM by yelling "ow" when she was moved. Despite the discovery of Resident A's injuries as early as 9:00 AM, medical treatment was not sought by staff until approximately 5:00 PM. A preponderance of evidence was discovered during the course of the special investigation to establish a violation of the applicable rule. Facility staff failed to obtain needed medical care in a timely manner for Resident A's broken femur.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents do not receive their medications as prescribed.

INVESTIGATION: On 12/12/2023 complaint allegations were received from the BCH online complaint system. The complaint alleged that, **"**residents are missing their meds".

On 12/14/2023 I completed an unannounced onsite investigation at the facility and interviewed Licensee Designee Sarah Sease. Ms. Sease stated that to her knowledge, all residents are receiving their medications as prescribed.

While onsite I reviewed the facility's Medication Administration Records. My review indicated that on 12/02/2023 Resident B did not receive her Olanzapine TAB 7.5MG due to the medication, "not being in the med cart, was waiting for med to arrive" and "did not arrive tonight".

On 12/14/2023 I interviewed staff Tarina Garza via telephone. Ms. Garza stated that she worked at the facility on 12/02/2023 and oversaw administering residents' medications. Ms. Garza stated that on 12/02/2023 Resident B's Olanzapine TAB 7.5MG was not in the medication cart because the medication had not arrived at the facility for a refill. Ms. Garza stated that Resident B did not receive the medication and no medical professional was notified of the incident.

A review of the LARA file indicates that on 06/28/2023 the facility was found to have violated R 400.14312 (1). Special Investigation 2023A0583033 documents that according to the Medication Administration Records, Resident A did not receive her prescribed Acetaminophen 500 MG on 06/01/2023, 06/02/2023, 06/03/2023, 06/04/2023, 06/05/2023, 06/06/2023, 06/07/2023, and 06/08/2023 at midnight and 6:00 AM and on 06/10/2023, 06/11/2023, 06/12/2023, 06/13/2023, 06/14/2023, and 06/15/2023 at 6:00 AM and Midnight. In addition, Resident B did not receive her prescribed Crest Pro Health Rinse, Clyndamycin Phosphate Gel, Seroquel 25 MG, Systane Complete Solution .6% each at 8:00 PM on 06/04/2023 or her prescribed Lantus Solostar 100 UNITS/M, Melatonin 5MG, and Olanzapine 7.5 MG on 06/02/2023.

On 12/19/2023 I interviewed Licensee Designee Sarah Sease via telephone. Ms. Sease stated that Resident B's Olanzapine TAB 7.5MG was delivered to the facility on 11/29/2023 and placed in a tote located in a locked office. Ms. Sease stated that on 12/02/2023 staff Tarian Garza did not have a key to unlock the office to retrieve Resident B's Olanzapine TAB 7.5MG. Ms. Sease stated that Ms. Garza should have telephoned Ms. Sease and Ms. Sease would have told Ms. Garza where the office key was located to retrieve this medication.

On 12/20/2023 I completed an Exit Conference with Licensee Designee Sarah Sease via telephone. Ms. Sease stated that she agreed that this licensing violation occurred. Ms. Sease stated that she has reeducated facility staff regarding

medication administration responsibilities. Ms. Sease stated that a Corrective Action Plan will be completed and submitted quickly.

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 S333.1101 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:	The facility's Medication Administration Records indicate that on 12/02/2023 Resident B did not receive her Olanzapine TAB 7.5MG due to the medication not being in "med cart". Staff Tarina Garza stated that she worked at the facility on 12/02/2023 and oversaw administering residents' medications. Ms. Garza stated that on 12/02/2023 Resident B's Olanzapine TAB 7.5MG was not in the medication cart because the medication had not arrived at the facility for a refill. Ms. Garza stated that Resident B did not receive the medication and no medical professional was notified of the incident. A preponderance of evidence was discovered during the course of the special investigation to establish a violation of the applicable rule. Resident B did not receive her prescribed medication, Olanzapine 7.5MG, on 12/02/2023.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **2023A0583033 06/28/2023**

ADDITIONAL FINDINGS: The facility fails to maintain a daily staff schedule with job titles, hours worked, and scheduling changes.

INVESTIGATION: While onsite on 12/14/2023, I reviewed the facility's December 2023 staff schedule. I observed that the staff schedule lacked staffs' job titles, hours worked, and scheduling changes.

On 12/19/2023 I interviewed Licensee Designee Sarah Sease via telephone. Ms.

Sease stated that the facility does not have the required staff schedule information in any other document.

On 12/20/2023 I completed an Exit Conference with Licensee Designee Sarah Sease via telephone. Ms. Sease stated that she agreed that this licensing violation occurred. Ms. Sease stated that a Corrective Action Plan will be completed and submitted quickly.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	The facility's December 2023 staff schedule lacked staffs' job titles, hours worked, and scheduling changes. Licensee Designee Sarah Sease stated that the facility does not have the required staff schedule information. A preponderance of evidence was discovered during the course of the special investigation to establish violation of the applicable rule; the licensee failed to maintain a daily schedule of work assignments that includes job titles, hours worked, and scheduling changes.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Facility staff failed to complete Resident A's Assessment Plan at admission.

INVESTIGATION: While onsite on 12/14/2023, I requested to review Resident A's Assessment Plan. Licensee Designee Sarah Sease stated that Resident A was admitted to the facility on 12/04/2023 from Chandler Pines Unit A which is located in the same building. Ms. Sease acknowledged that a new/updated Assessment Plan had not been created prior to or after this move occurred. Ms. Sease stated that she was unaware that a new Assessment Plan was required to be completed.

On 12/20/2023 I completed an Exit Conference with Licensee Designee Sarah Sease via telephone. Ms. Sease stated that she agreed that this licensing violation occurred. Ms. Sease stated that a Corrective Action Plan will be completed and submitted quickly.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	While onsite on 12/14/2023, I requested to review Resident A's Assessment Plan. Licensee Designee Sarah Sease stated that Resident A was admitted to the facility on 12/04/2023 from Chandler Pines Unit A which is located in the same building. Ms. Sease acknowledged that a new/updated Assessment Plan had not been created prior to or immediately after this move occurred. A preponderance of evidence was discovered during the course of the special investigation to establish a violation of the applicable rule. The licensee failed to complete an assessment plan for Resident A upon her admission of 12/04/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Facility staff failed to complete Resident A's Resident Care Agreement at admission.

INVESTIGATION: While onsite on 12/14/2023, I requested to review Resident A's Resident Care Agreement. Licensee Designee Sarah Sease stated that Resident A was admitted to the facility on 12/04/2023 from Chandler Pines Unit A which is located in the same building. Ms. Sease acknowledged that a new/updated Resident Care Agreement had not been created prior to or immediately after Resident A's move. Ms. Sease stated that she was unaware that a new Resident Care Agreement would be required to be completed.

On 12/20/2023 I completed an Exit Conference with Licensee Designee Sarah Sease via telephone. Ms. Sease stated that she agreed that this licensing violation

occurred. Ms. Sease stated that a Corrective Action Plan will be completed and submitted quickly.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.** **(c) A description of additional costs in addition to the basic fee that is charged.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.** **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.** **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.14315.**

	(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met. **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.**
ANALYSIS:	While onsite on 12/14/2023, I requested to review Resident A's Resident Care Agreement. Licensee Designee Sarah Sease stated that Resident A was admitted to the facility on 12/04/2023 from Chandler Pines Unit A which is located in the same building. Ms. Sease acknowledged that a new/updated Resident Care Agreement had not been created prior to or immediately after Resident A's move. A preponderance of evidence was discovered during the course of the special investigation to establish a violation of the applicable rule. The licensee failed to complete a Resident Care Agreement for Resident A upon her admission of 12/04/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Facility staff failed to document the administration of Resident B's medications.

INVESTIGATION: While onsite on 12/14/2023, I reviewed the facility's Medication Administration Records. According to the records, on 12/03/2023 Resident B did not receive her Acetamin TAB 325MG, Carvedilol TAB 6.25MG, Furosemide TAB 20MG, Furosemide TAB 40MG, Omeprazole CAP 20MG, POT CL Micro TAB 20MEQ ER, Vitamin D3 TAB 1000Unit due to "Awaiting med arrival from pharmacy".

On 12/14/2023 I interviewed Staff Guadalupe Perez. Ms. Perez stated that she worked independently at the facility on 12/03/2023 from 7:00 AM until 7:00 PM. Ms. Perez stated that she could not initially locate Resident B's medications in the medication cart but subsequently located the medications in the facility's office. Ms. Perez stated she administered the medications as prescribed but did not document their administration in the Medication Administration Record.

A review of the LARA file indicates that on 09/27/2023 the facility was found to have violated R 400.14312 (4) (b). Special Investigation 2023A0583045 stated that the facility's Medication Administration Records indicated that on 08/26/2023 Resident B did not receive her prescribed medication, Torvastin 10MG, which is to be administered daily. The MAR is not initialed by a staff member, with no note indicating if the medication was unavailable or refused. Staff Rachell Robinson stated that on 08/26/2023 she was tasked with medication administration duties.

Ms. Robinson stated that she passed Resident B's Torvastatin 10 MG but forgot to initial the Medication Administration Record.

On 12/20/2023 I completed an Exit Conference with Licensee Designee Sarah Sease via telephone. Ms. Sease stated that she agreed that the licensing violation occurred. Ms. Sease stated that a Corrective Action Plan will be completed and submitted quickly.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	The facility's Medication Administration Records indicated that on 12/03/2023 Resident B did not receive her Acetamin TAB 325MG, Carvedilol TAB 6.25MG, Furosemide TAB 20MG, Furosemide TAB 40MG, Omeprazole CAP 20MG, POT CL Micro TAB 20MEQ ER, Vitamin D3 TAB 1000 Unit due to "Awaiting med arrival from pharmacy". Staff Guadalupe Perez stated that she worked independently at the facility on 12/03/2023 from 7:00 AM until 7:00 PM. Ms. Perez stated that she could not initially locate Resident B's medications in the medication cart but subsequently located the medications in the facility's office. Ms. Perez stated she administered the medications as prescribed but did not document the administration of the medications in the Medication Administration Record A preponderance of evidence was discovered during the course of the special investigation to establish a violation of the applicable rule. Facility staff failed to document the administration of Resident B's medications on 12/03/2023.

CONCLUSION:	**REPEAT VIOLATION ESTABLISHED 2023A0583045 09/27/2023**

ADDITIONAL FINDINGS: Facility staff failed to notify an appropriate health care professional after Resident B did not receive a prescribed medication.

INVESTIGATION: While onsite on 12/14/2023, I reviewed the facility's Medication Administration Records. My review indicated that on 12/02/2023 Resident B did not receive her Olanzapine TAB 7.5MG due to "not in med cart, was waiting for med to arrive" and "did not arrive tonight".

On 12/14/2023 I interviewed staff Tarina Garza via telephone. Ms. Garza stated that she worked at the facility on 12/02/2023 and oversaw administering residents' medications. Ms. Garza stated that on 12/02/2023 Resident B's Olanzapine TAB 7.5MG was not in the medication cart because the medication had not arrived at the facility for a refill. Ms. Garza stated that Resident B did not receive the medication and no medical professional was notified of the incident.

On 12/20/2023 I completed an Exit Conference with Licensee Designee Sarah Sease via telephone. Ms. Sease stated that she agreed that the licensing violation occurred. Ms. Sease stated that a Corrective Action Plan will be completed and submitted quickly.

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: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	The facility's Medication Administration Records indicated that on 12/02/2023 Resident B did not receive her Olanzapine TAB 7.5MG. Ms. Garza stated that on 12/02/2023 Resident B's Olanzapine TAB 7.5MG was not in the medication cart because the medication had not arrived at the facility for a refill. Ms. Garza stated that Resident B did not receive the medication and no medical professional was notified of the incident.

	A preponderance of evidence was discovered during the course of the special investigation to establish violation of the applicable rule. The facility failed to contact an appropriate health care professional after Resident B was not administered her medication on 12/02/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: A facility egress door is equipped with a 15-second delay specifically designed to prevent the door from opening immediately.

INVESTIGATION: While onsite I observed a facility egress door was equipped with a 15-second delay specifically designed to prevent the door from opening immediately when an individual attempts to exit. Licensee Designee Sarah Sease stated that she was unaware of the date that the 15-second delay was added to the door because it has been utilized since she started employment at the facility.

A review of the LARA file indicates that on 10/20/2022 the facility was found to have violated R 400.14507 (2). Special Investigation 2023A0583004 stated that two facility egress doors were equipped with a 15-second delay specifically designed to prevent the door from opening immediately when an individual attempts to exit.

On 12/20/2023 I completed an Exit Conference with Licensee Designee Sarah Sease via telephone. Ms. Sease stated that she agreed that the licensing violation occurred. Ms. Sease stated that a Corrective Action Plan will be completed and submitted quickly.

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(2) A means of egress shall be arranged and maintained to provide free and unobstructed egress from all parts of a small group home.
ANALYSIS:	While onsite I observed a facility egress door was equipped with a 15-second delay specifically designed to prevent the door from opening immediately when an individual attempts to exit. A preponderance of evidence was discovered during the course of the special investigation to establish violation of the applicable rule; the facility door blocks egress.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED 2023A0583004 10/20/2022**

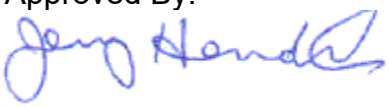
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license be modified to Provisional due to the above-cited quality of care and physical plant violations.

12/20/2023

Toya Zylstra Date
Licensing Consultant

Approved By:



12/20/2023

Jerry Hendrick Date
Area Manager