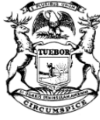


GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

March 6, 2024

Connie Clauson
Suthern Adult Care, LLC
617 Riverview Ct.
Gladwin, MI 48624

RE: License #: AL650308159
Investigation #: 2024A0360009
The Horizon Senior Living III

Dear Connie Clauson:

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 (866) 865-0006.

Sincerely,

Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
931 S Otsego Ave Ste. 3
Gaylord, MI 49735
(989) 370-8320

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

I. IDENTIFYING INFORMATION

License #:	AL650308159
Investigation #:	2024A0360009
Complaint Receipt Date:	01/09/2024
Investigation Initiation Date:	01/10/2024
Report Due Date:	03/09/2024
Licensee Name:	Suthern Adult Care, LLC
Licensee Address:	617 Riverview Ct. Gladwin, MI 48624
Licensee Telephone #:	(989) 343-9404
Administrator:	Connie Clauson
Licensee Designee:	Connie Clauson
Name of Facility:	The Horizon Senior Living III
Facility Address:	613 Progress St. West Branch, MI 48661
Facility Telephone #:	(989) 343-9404
Original Issuance Date:	02/11/2011
License Status:	REGULAR
Effective Date:	09/16/2023
Expiration Date:	09/15/2025
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident medications were not disposed of after resident death.	Yes
Additional Findings	No

III. METHODOLOGY

01/09/2024	Special Investigation Intake 2024A0360009
01/10/2024	APS Referral online
01/10/2024	Special Investigation Initiated - Letter APS
01/18/2024	Inspection Completed On-site Paula Cassiday Regional Director, DCS Alexis Brewer, DCS Hanna Hathcock, DCS Starlett Shea, Home manager Chasity Gorno
3/06/2024	Exit Conference With Connie Clauson

ALLEGATION:

Resident medications were not disposed of after resident death.

INVESTIGATION:

On 1/18/24, I conducted an unannounced onsite inspection at the facility. The regional director Paula Cassiday stated she was at the home due to a concern about medications not disposed of properly. Ms. Cassiday and I interviewed direct care staff (DCS) Alexis Brewer. Ms. Brewer stated the medication disposal procedures are that they will dispose of resident narcotic medications onsite and return any discontinued non-narcotic to the pharmacy. Ms. Brewer stated the most recent resident death was Resident A. She stated Resident A died on 11/26/23. Ms. Cassiday logged into the electronic medication administration records which noted Resident A’s Tramadol was disposed of on 1/18/23.

We then interviewed DCS Hanna Hathcock. Ms. Hathcock stated she does not usually dispose of any medications. She stated the home manager Chasity Gorno typically does that. She stated she was not aware of any medications that have not been disposed of properly.

We then interviewed DCS Starlett Shea. Ms. Shea stated she does not have any medication responsibilities and has not witnessed any medication disposal.

We then reviewed all of the medications in the medication cart and cross referenced them with the current residents. We found Loperamide 2mg tabs prescribed to deceased Resident A. We also found Hydrocortisone Cream prescribed to deceased Resident A.

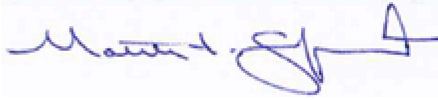
We then interviewed the home manager Chasity Garno. Ms. Garno stated the medications for deceased residents are typically disposed of immediately upon the death of a residents. She stated she would dispose of medications left in the medication cart for Resident A.

APPLICABLE RULE	
R 400.15312	**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:	The complaint alleges resident medications were not disposed of after resident death. While interviews with Ms. Brewer and Ms. Garno resulted in them stating medications are disposed of after a resident death. When reviewing the medication cart with Ms. Cassiday, medications from deceased Resident A were observed to not be disposed of.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/6/24 I conducted an exit conference with the licensee designee Connie Clauson. Ms. Clauson concurred with the findings and stated she will submit a corrective action plan for approval.

IV. RECOMMENDATION

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



3/6/24

Matthew Soderquist Date
Licensing Consultant

Approved By:

3/6/24

Russell B. Misiak Date
Area Manager