GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 14, 2024

Connie Clauson
Baruch SLS, Inc.
Suite 203
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL410375718
Investigation #: 2024A0357026
Fountain View of Lowell South

Dear Mrs. 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 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 (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor,
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL410375718 |
| | |
| **Investigation #:** | 2024A0357026 |
| | |
| **Complaint Receipt Date:** | 04/11/2024 |
| | |
| **Investigation Initiation Date:** | 04/12/2024 |
| | |
| **Report Due Date:** | 05/11/2024 |
| | |
| **Licensee Name:** | Baruch SLS, Inc. |
| | |
| **Licensee Address:** | Suite 203, 3196 Kraft Avenue SE<br>Grand Rapids, MI 49512 |
| | |
| **Licensee Telephone #:** | (616) 285-0573 |
| | |
| **Administrator:** | Kimberly Vagnetti |
| | |
| **Licensee Designee:** | Connie Clauson |
| | |
| **Name of Facility:** | Fountain View of Lowell South |
| | |
| **Facility Address:** | 11537 E. Fulton<br>Lowell, MI 49331 |
| | |
| **Facility Telephone #:** | (616) 897-8413 |
| | |
| **Original Issuance Date:** | 02/06/2019 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/06/2023 |
| | |
| **Expiration Date:** | 08/05/2025 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED, AGED,<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A did not receive her nighttime medications on 04/03/2024. | Yes |
| Resident A's oral swabs were delivered on 03/13/24 but were unable to be located. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 04/11/2024 | Special Investigation Intake<br>2024A0357026 |
| 04/12/2024 | Special Investigation Initiated - Telephone |
| 05/06/2024 | Inspection Completed On-site<br>Unannounced inspection. Met with Katie Elders, Activity Director, and Alyssa Knowlton Resident Care Manager. |
| 05/06/2024 | Contact - Face to Face<br>With Katie Elders, Activity Director, and Alyssa Knowlton, Resident Care Manager for 1st shift. |
| 05/06/2024 | Contact - Document Received<br>Received two pages of New Pharmacy Check In History, dated 03/07/2024- 05/06/2024 for Resident A, Active Medications for Resident A, Discharge information from Trinity Health Grand Rapids (SMGR) Psych Unit Charge Nurse. |
| 05/06/2024 | Contact - Telephone call made,<br>Kimberly Vagnetti |
| 05/06/2024 | Contact – Telephone made to Resident A's, Psychiatrist Dr. Mon Poulose at Pine Rest. Left message to return my call. |
| 05/07/2024 | Contact - Telephone call made.<br>To Amber Try-Hall LMSW, from Area Agency on Aging of Western MI. Conducted a telephone interview. |
| 05/07/2024 | Contact - Telephone call made.<br>To Family Member 1 for Resident A. |
| 05/07/2024 | Contact - Telephone call made.<br>Conducted telephone interview with facility PA, Karin Schmottlach. |

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|---|---|
| 05/07/2024 | Contact - Telephone call received,<br>From Family Member 1, Conducted interview with her. |
| 05/07/2024 | Contact - Telephone call made, interview,<br>With Kathy Seese, Resident Care Manager for 2nd shift. |
| 05/07/2024 | Contact - Document Received<br>Three delivery sheets with medications for Resident A. |
| 05/08/2024 | Contact – Telephone received from Pine Rest.<br>Erin Hanes, Psy Support Staff for Psychiatrist Mon Poulose. |
| 05/08/2024 | Contact - Face to Face<br>Interview with Jason Hendges, Pharm D, Long Term Care Pharmacy Manager for HomeTown Pharmacy, Rockford Long-Term Care. |
| 05/10/2024 | Contact – Telephone call made to<br>Kimberly Vagnetti, Administrator. Telephone interviews with Katie Elders, Alyssa Knowlton. |
| 05/13/2024 | Contact – Telephone call made to<br>Kimberly Vagnetti, Administrator. Telephone call from Victoria Morris and conducted an interview. |
| 05/14/2024 | Telephone exit conference conducted with Connie Clawson, Licensee Designee. |

**ALLEGATION: Resident A did not receive her nighttime medications on 04/03/2024.**

**INVESTIGATION:** The complaint came to us from our BCAL Online Complaints and reported Resident A was readmitted to the facility on 04/03/2024 following a psychiatric hospitalization. It was found on 04/04/2024, by comparing hospital discharge information with that which was provided by the facility as her active med list, that her discharge medications, including psychiatric medications, were not updated in the facility record or received from the pharmacy to be administered. Per the facility internal investigation, it was found that the medications had been called into the wrong pharmacy where her medications were awaiting pick up. This matter was resolved by having the medications transferred to the proper pharmacy that delivered them to the facility for staff to then administer. Resident A's record was said to have been updated to reflect the proper pharmacy moving forward. Additionally, it was found that oral swabs that had been purchased and delivered on 03/13/24, were unable to be located within Resident A's possessions.

On 05/06/2024, I made an unannounced inspection at the facility. I met with Katie Elders (Activity Director) and Alyssa Knowlton (1st shift Resident Care Manager). They explained that the new Administrator was at a conference. I explained the complaint to them and requested Resident A's records. They both explained that Resident A had been in a nursing home and was admitted to Fountain View of Lowell, North on 03/07/2024. Ms. Elders explained that Kimberly Vagnetti, their new administrator had difficulty in receiving Resident A's medication list from the nursing home. Ms. Elders explained that Resident A exhibited difficult behaviors, and they recommended she be moved to the facility next door, a memory care unit at Fountain View of Lowell, South. The family agreed to this move, and it took place on 03/12/2024. Shortly after this move, they found she had a UTI and her altered mental status might be related to the UTI. Resident A was admitted to Trinity hospital on 03/15/2024. Ms. Elders explained that Resident A returned to the facility on 04/03/2024 at 12:40 pm. Ms. Elders reported that they found out (no date provided) that the hospital had sent her prescriptions to HomeTown Pharmacy in Grand Rapids on Kalamazoo Ave and not to HomeTown Pharmacy in Rockford which is the pharmacy they use for their residents' medications. Ms. Elders stated that they had sent Resident A's "face sheet" with her to the hospital, and it recorded that HomeTown Pharmacy in Rockford was her pharmacy and she said the telephone number was listed. I asked to see Resident A's discharge information from the hospital, which they provided to me. Discharge information from Trinity Health Grand Rapids (SMGR) Psych Unit Charge Nurse. "*Diagnosis: Your principal diagnosis at the time of discharge: Schizoaffective Disorder, Bipolar Type."* This discharge document contained three pages of Resident A's medication, with the following:

Contained on the discharge three pages were the list of Resident A's regular 11 medications which Resident A had been taking while living in the AFC homes. These were all indicated with the word "Continue." Then there were three medications that were noted with the word "Changed" and one new medication that was indicated with the word "Start."

One medication was changed: **divalproex** 500 mg 24 hr tablet commonly know as DEPAKOTE ER. Take 2 tablets (1,000 mg total) by mouth at bedtime. The last time this was given: April 2, 2024, at 8:25 PM. Take for: mania associated with bipolar disorder.

The second medication that was changed: **risperDONE** 2mg tablet. Take1 tablet (2mg total) by mouth at bedtime. Last time this was given: April 2, 2024, at 8:25 PM. Taken for schizophrenia.

The third medication that was changed: **traZODONE** 50 mg tablet, commonly known as DESYREL. Take 1 tablet (50mg total) by mouth at bedtime as needed for sleep. Last time this was given: April 2, 2024, at 8:25 AM, Taken for: insomnia associated with depression.

The new medication to “Start,” was **melatonin** 3 mg tablet. Take 3 mg tablets (9mg total) by mouth at bedtime. Last time this was given: April 2, 2024, at 8:25 PM. Take for difficulty falling asleep.

“*Pick up these medications at Hometown Pharmacy #51 Grand Rapids, MI 4252 Kalamazoo Ave.,:*
*divalproex 500 mg 24 hr tablet,*
*melatonin 3 mg tablet*
*5isperidone 2 mg tablet*
*traZODONE 50 mg tablet.”*

Ms. Elders stated that they never received the scrips for these changes or the new medications. The problem was that the pharmacy (since it was the wrong pharmacy) did not enter the medications into their computer to their ECP system. She said they can’t pass medications that they do not have orders for. Ms. Elders reported that Resident A had been on Sertraline (Zoloft) 100mg once daily when she went into the hospital. She reported that according to their active medication list for Resident A it had been discontinued by Cathy Seese, Resident Care Manager for 2nd shift and Ms. Elders could not explain why. This medication was also not on the discharge medication list from the hospital.

Ms. Elders provided me with a copy of Resident A’s Check in Pharmacy Meds. On 04/04/2024, the medications Trazone 50 mg tablet, Divalproex ER 500 mg tablet, Risperidone 2mg tablet and Melatonin 3mg tablet. Therefore, the facility had received the three medications that the hospital had changed and one that had been added on 04/04/2024. It also means the facility could not have given Resident A these four nighttime medications on 03/03/2024 because the hospital had sent them to the wrong pharmacy. She also reported that Resident A’s medication Melatonin had been received on 04/04/2024, but not administered until 04/11/2024.

On 05/07/2024, I conducted a telephone interview with Family Member 1 (FM1). She stated that Resident A had been in a skilled facility receiving care when they reduced her psychiatric medications. Then she said they moved Resident A to Fountain View of Lowell, North. She said that Resident A had become very confused and was not doing well and the home asked her to move to Fountain View, South. She said the staff told her that Resident A was discovered with a UTI, so she said she waited a few days. Then she said they told her she had to go to the emergency room immediately. She stated that the hospital was treating the UTI and she remained on the med unit for a week where they ruled out other things and then transferred her to the Psych-med unit. She said Resident A was in the hospital for three weeks. She was aware that the hospital sent the orders for her medications to the wrong HomeTown Pharmacy. She explained that Resident A has seen the same psychiatrist Dr. Mon Poulose at Pine Rest for many years. She reported that she took Resident A for an appointment on 04/11/2024, and when he looked at Resident A he could tell that she had not been receiving her medication Zoloft. FM1 said that she had been receiving the Zoloft at 100 mg for quite some

time. She said Dr. Mon Poulose did not know she was off the medication, and he said she needs to be back on it. She also reported that in front of them he called the facility and told them that he was re-ordering the Sertraline (Zoloft) and he would start her at 25mg for two weeks and then have it prescribed at 50mg. She said he confirmed with her that HomeTown Pharmacy in Rockford was where her prescriptions should be sent to, and he called it in. She expressed her disappointment in the care Resident A received, especially at the nursing home. I explained that this investigation will not address her concerns related to the nursing home. She stated he was aware of that and had been provided with the agency in authority over licensed nursing homes.

On 05/07/2024, I conducted a telephone interview with Cathy Seese, Resident Care Manager on 2nd shift. I asked her about the discontinuation of Resident A's medication Sertraline, and she explained that this medication was not listed on the discharge information from the hospital so she just D/C'd it. I asked her about Resident A's new medications of Melatonin, which she had been prescribed when she returned from the hospital. She said she looked on their ECP system MAR for Resident A and confirmed the medication had been received and administrated as prescribed. She denied missing any of Resident A's medications when she administered her medications. She explained that the Regional Director, Chris Milowe was there when Resident A returned from the hospital, and he left to drive to HomeTown Pharmacy in Grand Rapids when they were notified that HomeTown Pharmacy Rockford would be delivering the medications that night. The medications were delivered late, which was after bedtime medications, therefore, Resident A did not receive her new night-time medications because they did not have them to administer because the hospital had sent Resident A's prescriptions to the wrong pharmacy.

On 5/07/2024, I conducted telephone interview with facility PA, Karin Schmottlach. She stated that she had prescribed Sertraline 50 mg. for Resident A on 04/16/2024. She was certain that Resident A had started to receive the medication on 04/17/2024.

On 05/07/2024, Ms. Seese had their secretary send me the delivery sheets dated 04/11/2024. There were three pages for Resident A all signed by Victoria Morris, direct care staff. On the first page was listed: Amlodipine 10 mg x 2, second pager Amlodipine 10 mg, and Acetic Acid Irrig, 0.25% and on the third page was listed as Amlodipine 10 mg, Trazodone 50 mg. and Sertraline 50mg.

On 05/07/2024, I conducted telephone interview with Amber Try-Hall Case Manager from Agency on Aging of Western Michigan. She reported that she was at the facility on 03/04/2024 and requested Resident A's medication list, and after her comparison it did not match what the hospital had provided to her. She said the new psych meds prescribed by the hospital were not on the list and therefore Resident A had not received them on her return to the facility at the required bedtime on 03/03/2024. She then learned of the mix-up with the pharmacies. She

also learned that the hospital had discontinued Resident A's Zoloft. She explained that before her admission to the AFC home the nursing home had reduced her Psych meds through GRD's (Gradual dose reduction). She said when they did this Resident A decompensated psychiatrically. She said Resident A had been on Risperdal, Depakote and most recently Zoloft for years. She said she thought it was very important that Resident A's history and the changes at the nursing home had caused her to have religious conversations that often did not make sense along with problem behaviors. She was convinced that this caused Resident A to decline so rapidly and subsequently having to go into the hospital for three weeks soon after her admission to the AFC home. She did not believe that the care at the AFC homes had caused any issues with Resident A. She was aware of Resident A's psychiatrist ordering the Sertraline (Zoloft) 25 mg for two weeks to titrate the medication and she said the staff did not administer the prescribed medication. She stated that the facility staff had missed the medication and she confirmed it had been delivered to the facility late on 04/11/2024. She also learned that the PA for the facility had prescribed the Sertraline for Resident A at 50mg. later.

On 05/08/2024, I received a telephone call from Pine Rest, Erin Hanes, who identified as the Psych. Support Staff for Psychiatrist Mon Poulose. He said he was returning a telephone call to me when I had telephoned on 05/06/2024. He stated he could confirm that Psychiatrist Mon Poulose had prescribed Resident A with Sertraline 25 mg. for two weeks on 04/11/2024, and then 50 mg at the end of the two weeks. He reported that they wanted the Sertraline to titrate up and then go to the 50 mg dose at the end of two weeks.

On 05/08/2023 I conducted a face-to-face interview with Jason Hendges, Pharm D, Long Term Care Pharmacy Manager for HomeTown Pharmacy, Rockford Long-Term Care. He confirmed that they do provide medications to the residents of Fountain View of Lowell, South. Mr. Hendges explained that when Resident A was in the nursing home and on Sertraline and the State of Michigan requires them to do GDR (Gradual Dose Reduction), meaning a tapering a dose to determine if symptoms, conditions or risks can be managed by a lower dose or the medication can be discontinued. He explained they also have to do a Risk to Benefit analysis. He was unsure what had happened to Resident A's medication of Sertraline, but it appeared that her dose of this medication had been decreased which he reported can cause her to have adverse consequences. He explained that they send all of the resident's medications who reside in the AFC homes in a cellophane roll, and it only includes 7 days of medications, to Fountain View of Lowell, South. He said they also send a fax to the facility which contains the order for any new medication(s). He reported that the new Administrator, Kimberly Vagnetti had notified him (date not provided) that they have a fax machine in a locked office so their staff could not access the fax information. He reported that she was immediately fixing this so the fax could go to their medication room. I asked him about Resident A's prescription medications from the Psych-med at Trinity hospital and he said they sent the medication orders to the wrong HomeTown Pharmacy in Grand Rapids instead to their pharmacy HomeTown Pharmacy Rockford. He said it

then it became a “logistics thing”. He explained that they did receive the orders late and they sent the medications to the facility late and probably not in time for the bedtime dose. He provided me with an “After Visit Summary”, with dates of 03/22/2024 -04/03/2024 from Trinity Health. This document said to pick up your medications at Grand Rapids Kalamazoo Ave: “Divalpropex, Melatonin, RsiperiDONE and TraZODONE. The report also read to stop taking benztropine 0.5 tablet (Cogentin), nitrofurantoin (microcrystal-monohydrate) 100 mg and Sertraline 100 mg tablet (Zoloft). He said the medications were ordered “STAT,” which met right away. He reported that they sent the four new medications to the facility on 03/04/2024. I asked him about Resident A’s prescription of Sertraline on 04/11/2024 from her psychiatrist and he reported that Pine Rest had e-scripted the medication to them. He confirmed it was sent out on 04/11/2024 late in the evening. He stated that they sent the fax to the facility for this new order. He also explained that the medication comes in 50mgs., so the pharmacy cut the Sertraline in half for the staff to administer it as the physician had prescribed.

On 05/10/2024, I spoke by telephone with Ms. Vangettil and Ms. Elders. They reported that they had pulled up Resident A’s MAR. and found that on 4/10/2024, the Omeprazole Dr 20 mg had not been administrated and the explanation was “temporarily out of stock.” They reported that Resident A’s, Amlodipine 10 mg had not been administered on 04/10 and 04/11/2024 with the explanation of, “temporarily out of stock.” They reported that Resident A’s, Metformin ER, 500 Mg had not been administered on 04/28/2024 and the message was written that they were “temporarily out of stock.” Ms. Elders apologized that she had reported to me on 05/06/2024 that Resident A’s Melatonin had not been administered for several days but when she went back and looked it had been administered.

On 05/07/2024, I conducted a telephone interview with Alysa Knowlton, Resident Care Manager. She explained that when Resident A came from the skilled facility she had “Blister packs” which are large carboard with a punch out on the back, and their med cart did not accommodate them, so she said they were laid down in Resident A’s drawer while their weekly cellophane was in a roll on the other side of the drawer. She said she learned that Resident A’s, Omeprazole 20 mg was not administered on 04/10/2024, and she found the medication in the blister pack, so she administered it but has no way of showing that she had administered the medication on Resident A’s MAR. She said the staff forgot that there were blister packs of Resident A’s medication in her drawer, so they did not look at them first. She reported that the medication Amlodipine 10mg had not been administered on 04/10/ or on 04/11/2024 and that Resident A’s, Metformin ER 500 mg had not been administered on 04/28/2024. I asked her about letting the pharmacy know that Resident A was in the hospital, for three weeks and the pharmacy was still sending her prescribed medications and she explained that they had it on the ECP system that she said the pharmacy staff could see what they had written. I explained that I had met with the pharmacist Jason Hendges, Pharm D, Long Term Care Pharmacy Manager for HomeTown Pharmacy, Rockford and he reported, that he does not have access to the ECP on Resident A or any other resident.

I asked her about Resident A's, Sertralne (Zoloft) that had been sent on 04/11/2024 from HomeTown Pharmacy and was signed by Direct Care Staff, Victoria Morris on 04/11/2024, as received. She had no knowledge of this new prescription. I told her that FM1 was with Resident A on 04/11/2024 when she heard the psychiatrist call the facility and he had spoken to a staff (name unknow) and told them he had ordered Sertraline at 25mg for two weeks and then it would go to 50mg. I explained that on 05/08/2024 the staff Erin Hanes, Psych Support Staff for Psychiatrist Mon Poulose, had returned my call and confirmed he worked with Dr. Mon Poulose, and the order for the Sertraline was for 25mg for two weeks and then 50mgs after the two weeks was the actual order. I also told her I had met Jason Hendges, Pharm D, Long Term Care Pharmacy Manager for HomeTown Pharmacy Rockford on 05/08/2024, and he also had confirmed that he had received the same order from Resident A's physiatrist, Mon Poulose, of 25mg for two weeks and then 50mg after that which was the same order. She explained that the fax order comes from the pharmacy and goes to the fax machine in the front office. I explained that Mr. Hendges had reported to me that he had spoken to Kimberly Vagnetti who told him the staff were not able to access the fax machine. Ms. Vagnetti had reported to him that the fax machine was in a locked room and the staff could not get at it. He reported that he had faxed the order for the Sertraline 25 mg to the facility. Ms. Knowlton reported that she did not receive the fax order from the pharmacy, and she had no idea what had happened to the Resident A's prescribed Sertraline. She also reported that she had not been made aware of the new medication Sertraline for Resident A. She also reported that the staff who signed the Delivery Sheet, Victoria Morris, 3rd shift med passer dated 04/11/2024 was fairly knew and she only passed a few Tylenols, on the third shift so probably did not understand what to do with the medication. I asked her what she was required to do with it, and she said to look up on their computer system ECP and verity that the medication was on Resident A's prescribed MAR. If it was not there, she should have called the pharmacy and reported it to the first shift staff or to her know right away in the morning. She acknowledged that Resident A had not received her prescribed medication of Sertraline 25 mg for two weeks. I asked her to look at her sheets that indicated that the medication had been destroyed and she reported there was no destruction of Resident A's, Sertraline. She said sometimes the staff put the medications in the red box designated for sharps, such as needles. She had no idea what had happened to Resident A's, Sertraline.

On 05/13/2024, I conducted a telephone interview with Direct Care Staff and med passer Victoria Morris. I asked her how long she has worked in the facility, and she reported only two or three months. I reviewed with her the three Delivery Sheets from HomeTown Pharmacy that she had signed on 04/11/2024 for receipt of Resident A's medications. She acknowledged that she had signed the delivery sheets. I asked her what she had done with Resident A's medications that had been delivered and she said she put them in Resident A's drawer in the medication cart. She said she made sure that the medications matched up with the rows of medications. I asked her if she had checked their ECP, MAR for the listing of her medications especially the Sertraline for Resident A and she reported she had not.

She did not remember if she told anyone about the medications for Resident A. She said she had not been told that a new medication was coming for Resident A, so she was not looking for it. She said normally Ms. Seese would tell her to be looking for a resident's new medication but she had not been told anything. I asked her if she had been trained in medication administration and she reported that she had worked for Hope Network, and they had trained her. She reported that Hope used the Blister Packs, and this facility has the cellophane rolls and she had to learn this new system of administration of medications from the rolls. I asked her if she had any idea what had happened to Resident A's, Sertraline and she had no idea.

On 05/14/2024, I conducted a telephone exit conference with the Licensee Designee, Connie Clawson and she agreed with my findings.

| **APPLICABLE RULE** | |
|---|---|
| **R 400. 15312** | **Resident medications** |
| | **(2) Medications shall be given, taken, or applied pursuant to label instructions.** |
| | It was discovered on 04/04/2024 that Resident A's medication list was not updated in the facility record and Resident A did not receive her nighttime psychiatric medications on 04/03/2024. During this investigation it was also discovered that Resident A had not received several of her medications.<br><br>Resident A was discharged from Trinty Health hospital on 03/04/2024. The facility staff discovered that Resident A's change of medications and a new medication were sent to HomeTown Pharmacy in Grand Rapids and not to HomeTown Pharmacy in Rockford. HomeTown in Rockford received a STAT order for the medications: "Divalpropex, Melatonin, RsiperiDONE and TraZODONE and then sent them to the facility late in the evening which had missed bedtime for Resident A. She did not receive her nighttime medications on 03/03/2024.<br><br>Ms. Vangetti Administrator and Katie Elders, Activity Director confirmed that Resident A's, Amlodipine 10 mg was not administered on 04/10 & 11/2024. Medformin 500 mg was not administered on 04/28/2024. On 04/11/2024 Resident A's Psychiatrist prescribed Sertraline, 25mg for two weeks then 50mg. Pharmacy Manager received the prescription and sent a fax to the facility but had been informed by the Administrator that the fax went to the fax machine in a locked office and not accessible to staff. Staff reported they did not receive the fax. On 04/11/2025 Direct Care staff Victoria Morris signed for |

| | |
|---|---|
| | Resident A's medications including Sertraline and it was put in her drawer in the med cart and the medication was never administered.<br><br>Resident A's medication Amlodipineas 10 mg was not administered on 04/10/2024 and 04/11/2024 and Metformin ER, 500 Mg was not administered on 04/28/2024. Resident A's Sertraline 25 mg was not administered at 25 mg daily for two weeks followed by 50mg. They did not follow the label instructions. There is a violation to this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION: Resident A's oral swabs were delivered on 03/13/24 but were unable to be located.**

**INVESTIGATION:** On 05/06/2024, I made an unannounced inspection at the facility. I met with Katie Elders, Activity Director, and Alyssa Knowlton, Resident Care Manager. They both reported that the deliveries that come to the facility are usually dropped off at their main door. I asked if they had policy/procedure on who picks up the deliveries and who delivers them to the right individual, staff or resident, and is this recorded anywhere, and they said there was no policy/procedures. I asked if they had any knowledge of what had happened to Resident A's oral swabs, and they had no idea. Ms. Elders explained that when Resident A was admitted the facility had found some swabs available and she gave them to Resident A to use. They both believed that Resident A currently has the correct swabs because they have seen green swabs on her nightstand, and they thought that the additional boxes are in her closet. They were unable to provide the date that Resident A had received her oral swabs. Ms. Elders reported that Resident A is receiving support from AAA Medicaid waiver program and someone, probably the case manager from there had called the facility (no date provided) to ask where Resident A's oral swabs were. They did not know the outcome.

On 05/06/2024, Ms. Elders provided me with two copies of the Packing List from Zylstra Medical Supply Inc. for the oral swabs. The first one was shipped on 03/12/2024 for 6 packs of 10 each for Swab, Oral Dentips, treated, Green 10/pk. The second list was shipped on 04/08/2024 with the same information. The customer was listed as Resident A.

On 05/07/2024, I conducted a telephone interview with Resident A's Family Member 1 (FM1). I asked her about Resident A's oral swabs. She reported that Amber Try-Hall, her case manager had ordered them for her. She said there was confirmation that the swabs had been delivered to the facility, but they had not made it to Resident A's room. She said staff accessed other ones for Resident A to use. She reported that the facility did not have a procedure for who takes care of the

packages delivered to the facility. She said that Ms. Try-Hall had gone to the facility to see if Resident A had them and the swabs were not there (no date provided). She said on 04/18/2024 she had taken a picture of the oral swabs in Resident A's room and there were some green oral swabs in her bedroom. She reported that she used to have dentures, but they were gone, and her lips and mouth were dry and that was why AAA had ordered the oral swabs for her.

On 05/07/2024, I conducted a telephone interview with Amber Try-Hall LMSW, from Area Agency on Aging of Western MI. She reported that Resident A does not have teeth or dentures and therefore she uses sponge swabs for her oral care to clean her gums. She reported that she ordered the oral swabs through the waiver program for Resident A. She said she ordered them on 04/04/2024. She said she contacted the vender and they confirmed they had been delivered to Fountain View of Lowell. She said on her visits to see Resident A no one knew where they were. She stated she ordered them again. She said she spoke to Ms. Vagnetti who explained to her that the delivery personnel just leave the packages at the front door. She said Ms. Vagenetti asked her to change the name to be in care of Ms. Vagenitti so she would receive the package and know whom to deliver it to. She reported she ordered them again in care of Ms. Vagenetti. She said the swabs were green and flavored with mint. She reported this will help Resident A with oral hygiene. She said she ordered it again on 04/15/2024 and confirmed deliver on 04/18/2024, for six packs of ten for a total of 60. She had asked FM1 to take a picture of them when she visited Resident A. Ms. Try-Hall learned that Resident A had finally received the swabs. She had no confirmation that the first order had been provided to Resident A.

On 05/10/2024 I conducted a telephone interview with the Administrator, Kimberly Vagnetti. She stated that she has only been at the facility for three months when she learned that the deliveries are dropped off at the front door and that there was no policy or procedure for the process of delivering these packages to the intended recipient. She reported that when she learned that Resident A had not received her oral swabs, she asked Ms. Try-Hall if she would put on the order "in care of Kimberly Vagnetti," and that way she would receive the package and could deliver it to the appropriate individual. She said she is working to have this communicated to all the companies that deliver to the facility, but that will take some time. She did not know if Resident A had received her personal oral swabs, but she assumed she had at some point because staff reported that she had green oral swabs in her room.

On 05/14/2024 I conducted a telephone exit conference with the Licensee Designee, Connie Clawson and she agreed with my findings.

| **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: (j) The right of reasonable access to and use of his or her personal clothing and belongings.**<br>**(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.** |
| **ANALYSIS:** | Resident A's oral swabs that had been purchased and delivered on 03/13/24, were unable to be located within Resident A's possessions.<br><br>During the investigation it was confirmed that Resident A did not initially receive her own treated oral swabs that had been delivered to the facility. No one could find them. Therefore, there is a violation to the rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

I recommend the license provide us with an acceptable plan of correction.

Arlene B. Smith 05/14/2024

Arlene B. Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 05/14/2024

Jerry Hendrick Date
Area Manager