GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 1, 2024

Jody Josephson
7415 Dexter Pinckney Rd
Dexter, MI 48130

RE: License #: AF810377402
Investigation #: 2024A0122026
Clara's House II

Dear Ms. Josephson:

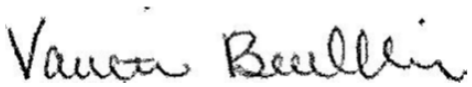
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9720.

Sincerely,



Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF810377402
Investigation #:	2024A0122026
Complaint Receipt Date:	06/04/2024
Investigation Initiation Date:	06/05/2024
Report Due Date:	08/03/2024
Licensee Name:	Jody Josephson
Licensee Address:	7415 Dexter Pinckney Rd Dexter, MI 48130
Licensee Telephone #:	(517) 206-7815
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Clara's House II
Facility Address:	7415 Dexter Pinckney Rd Dexter, MI 48130
Facility Telephone #:	(734) 391-5783
Original Issuance Date:	06/17/2015
License Status:	REGULAR
Effective Date:	12/17/2023
Expiration Date:	12/16/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED ALZHEIMERS

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 05/30/2024, Resident A was left unsupervised, fell, and suffered injury.	No
Resident A is not receiving his medication as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/04/2024	Special Investigation Intake 2024A0122026 APS Referral
06/05/2024	Special Investigation Initiated - Telephone Completed interview with Relative A1.
06/05/2024	Contact - Telephone call made. Completed interview with Relative A2.
06/06/2024	Inspection Completed Onsite Completed interviews with Jody Josephson, Licensee, and Resident B. Requested Resident A's file.
06/07/2024	Contact – Telephone call made. Completed interview with Megan Morger, staff member.
06/10/2024	Contact – Telephone calls made. Completed interview Jayden Frazier, staff member. Jody Josephson discussed Resident A's file.
06/13/2024	Contact – Document received. Jody Josephson submitted pictures of required admission paperwork. Pictures of Resident A's medication provided.
06/17/2024	Exit Conference Discussed findings with Jody Josephson, Licensee.

ALLEGATION: On 05/30/2024, Resident A was left unsupervised, fell, and suffered injury.

INVESTIGATION: On 06/05/2024, I completed an interview with Relative A1. Relative A reported on 05/30/2024 he contacted the facility at 9:30 a.m. and spoke to staff member, Meagan Morger, to inform her that he would arrive at 11:30 a.m. to pick up Resident A for an outing. Per Relative A1, Ms. Morger informed him that Resident A had fallen, had an accident of incontinence, and she was changing him. Relative A1 stated initially Ms. Morger told him that Resident A was not in pain, nor had he suffered injury but as the discussion continued, Ms. Morger did report that Resident A appeared to be in pain.

Relative A1 stated he responded by directing Ms. Morger not to change Resident A and that he would arrive as soon as possible. Relative A1 arrived at the facility, went into Resident A's bedroom and observed, Resident A in a wheelchair with Ms. Morger and Resident B in present in the room. Resident B informed Relative A1 that he assisted in getting Resident A off the floor into the wheelchair. Resident B reported to Relative A1 that Resident A was difficult to lift and cried out in pain. Relative A1 stated he assessed that Resident A was in pain and needed to be transported to the hospital using an ambulance. Relative A1 stated he contacted the ambulance; Resident A was transported to the hospital for a medical assessment and diagnosed with a broken hip.

According to Relative A1, when discussing Resident A's fall with Ms. Morger, she reported that she arrived at the home at 8:00 a.m. and observed staff member, Jayden Frazier, outside of the facility waiting for her. Ms. Morger informed Relative A1 that she found Resident A in his bedroom on the floor and obtained assistance from Resident B to lift Resident A off the floor.

On 06/05/2024, I completed an interview with Relative A2. Relative A2 reported the same as Relative A1. It was reported to Relative A2 that Mr. Frazier was observed outside of the facility by Ms. Morger when she arrived at work. Ms. Morger found Resident A on the floor in his bedroom once she entered the facility and began checking on the residents. No staff person can state specifically how Resident A fell out of his bed onto the floor.

On 06/06/2024, I completed an interview with Jody Josephson, Licensee, regarding Resident A's fall on 05/30/2024. Ms. Josephson stated that she was not present, therefore, she did not have any information to give regarding the incident. Ms. Josephson stated that staff member, Megan Morger, was present and her contact information was given.

On 06/06/2024, I interviewed Resident B. Resident B confirmed that he was present on 05/30/2024. Resident B reported the following: On 05/30/2024, he observed Resident A laying on the floor. He stated Ms. Morger asked for help, both of them assisted with getting Resident A off the floor and placed him in the wheelchair.

Resident B stated that Resident A was in “bad shape,” in that he was yelling and screaming while he was on the floor as if he was in pain. Resident B reported that emergency personnel eventually arrived and transported Resident A to the hospital. Resident B stated Resident A probably “slipped off the bed.” He also reported that Relative A1 thanked him for his assistance with Resident A. Resident B could give no information regarding Mr. Frazier’s whereabouts on 05/30/2024.

On 06/07/2024, I completed an interview with staff member, Meagan Morger. Ms. Morger reported on 05/30/2024 she observed Resident A on the floor tangled in blankets. Ms. Morger stated initially she was concerned about moving him, so she sat on the floor speaking with him trying to assess his condition. Per Ms. Morger, as she was speaking with Resident A, Relative A1 called stated he was coming over. Ms. Morger decided to put Resident A in the wheelchair and asked Resident B to assist her with the movement of Resident A. Ms. Morger stated that Relative A1 arrived, medical personnel was called, and when they arrived Resident A was transported to the hospital.

Ms. Morger stated that when she arrived at work on 05/30/2024, staff member Jayden Frazier was in the facility kitchen. Per Ms. Morger, they spoke briefly, and Mr. Frazier left. Ms. Morger stated that she found Resident A on the floor as she was checking on the residents for the morning. Ms. Morger could give no explanation as to why Relative A1 stated that Mr. Frazier was waiting outside of the facility, she denied reporting that to him.

On 06/10/2024, I completed an interview with staff member, Jayden Frazier. Mr. Frazier reported he worked from 8:30 p.m. until 8:30 a.m. on 05/30/2024. Mr. Frazier stated on 05/30/2024 he checked on Resident A at approximately 7:15 a.m., observed Resident A to be in his bed sleeping. Per Mr. Frazier, upon Ms. Morger arrival, he gave a brief update on the residents, and left the facility. Mr. Frazier stated he did not observe Resident A on the floor and therefore can give no additional information. Mr. Frazier denied being outside of the facility on 05/30/2024 when Ms. Morger arrived.

APPLICABLE RULE	
R 400.1410	**Resident protection.**
	A licensee or responsible person shall always be on the premises when a resident is in the home.

ANALYSIS:	On 06/05/2024, Relative A1 reported that staff member, Meagan Morger reported that staff member, Jayden Frazier was outside of the facility the day that Resident A fell, 05/30/2024, thereby leaving Resident A unattended. On 06/06/2024, Resident B could give no information regarding Mr. Frazier's whereabouts on 05/30/2024. On 06/07/2024, staff member, Meagan Morger reported that Jayden Frazier was inside the facility when she arrived onsite on 05/30/2024. Ms. Morger denied reporting to Relative A1 that Mr. Frazier was outside of the facility on 05/30/2024. Ms. Morger reported she found Resident A on the floor on 05/30/2024. On 06/10/2024, staff member, Jayden Frazier reported that he was inside of the facility on 05/30/2024, when Ms. Morger arrived. Per Mr. Frazier, he left the facility after he gave Ms. Morger an update on the residents. Based upon my investigation I find there is not enough evidence to support the allegation that staff member, Jayden Frazier was not on the premises when Resident A fell on 05/30/2024.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A is not receiving his medication as prescribed.

INVESTIGATION: On 06/05/2024, I completed an interview with Relative A2. Relative A2 stated upon Resident A's admission to the Clara's House II adult foster care family home, he was no longer prescribed the medication, Flomax 4mg 2 caps by mouth daily. Relative A2 stated staff members of Clara's House II adult foster care home began giving Resident A, Flomax, without her consent or physician's order.

On 06/06/2024, I completed an interview with Jody Josephson, Licensee. Ms. Josephson stated that all resident medications are packaged by her pharmacist using bubble packs and she administers medications to her residents, which included Resident A's medications as prescribed by their physicians.

Ms. Josephson could not give specific details regarding Resident A's medication. She did not know if he was prescribed the medication, Flomax, but stated that Relative A2 did not want Resident A to take it.

I requested to review Resident A's resident file and medication administration records, to which Ms. Josephson replied that she did not have a file for Resident A. Ms. Josephson stated that Relative A2 took Resident A's file, including his medication administration records. I requested that Ms. Josephson obtain copies of Resident A's physician prescriptions and submit them to me.

On 06/10/2024, Jody Josephson stated she had found some of Resident A's paperwork and would like to submit them for review. I explained that I would review the paperwork, however the integrity of the documents is in question as several days have passed since my initial request of Resident A's file to be reviewed.

On 06/13/2024, I reviewed Resident A's paperwork. I observed that Ms. Josephson submitted a Resident Care Agreement and Assessment Plan both dated 03/10/2024. I also reviewed pictures of Resident A's pharmacy packaged medication, Flomax 0.4mg, with the directions of take 2 capsules by mouth daily was part of his medications. I reviewed Resident A's medication administration sheets, prefilled by the pharmacist, dated 05/01/2024 – 05/31/2024. The sheets showed staff initials on the dates of 05/01/2024 – 05/29/2024, also the medication Flomax 0.4mg was listed, with the directions of take 2 capsules by mouth daily was printed on the sheet.

On 06/14/2024, Ms. Josephson submitted text communication with Relative A2 dated 06/07/2024. In the communication, Relative A2 stated that Resident A should not be taking the medication Flomax, and acknowledged that the pharmacy "must have gotten mixed up when transferring his prescriptions…"

On 06/172024, I completed an exit conference with Jody Josephson where my findings were discussed with her. Ms. Josephson did not agree with my findings, stating that she was unable to accommodate my request to review Resident A's file as it was not in her possession but taken from her. Ms. Josephson feels that the paperwork she submitted on 06/13/2024 should be considered as honoring the request to review Resident A's file.
Let's discuss.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(1) Prescription medication, including tranquilizers, sedatives, dietary supplements, or individual special medical procedures, shall be given, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy container which shall be labeled for the specific 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.

ANALYSIS:	On 06/05/2024, Relative A2 reported that Resident A was no longer prescribed the medication**,** Flomax 4mg 2 caps by mouth daily and staff members were administering it to him. On 06/06/2024, I completed an interview with Jody Josephson, Licensee. Ms. Josephson stated that Resident A's medications were packaged by her pharmacist using bubble packs and she administered Resident A's medications as prescribed by his physician, which are included in the bubble pack. On 06/06/2024, my request to review Resident A's Medication Administration Records was denied as Jody Josephson reported that she did not have the forms, nor did she have Resident A's file. On 06/13/2024, I reviewed pictures of Resident A's pharmacy packaged medications, bubble packs, and observed that the medication Flomax 4 mgs, was packaged with the rest of his medication and the information was listed on the medication administration sheets. On 06/14/2024, text communication with Relative B shows that she acknowledged that the pharmacy must have made a mix up and sent the medication Flomax to be administered to Resident A in error. Based upon my investigation I find Resident A did not receive his medication as prescribed, including the medication Flomax. Ms. Josephson submitted forms, Resident A's administration medication sheets, 7 days after the initial request to review Resident A's file, therefore the integrity of the forms are in question.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 06/06/2024, I completed an onsite inspection. I requested to review Resident A's file, Jody Josephson, Licensee reported that she did not have a file for me to review. Ms. Josephson stated that Relative A2 had taken Resident A's paperwork from her.

On 06/10/2024, Jody Josephson stated she had found some of Resident A's paperwork and would like to submit them for review. I explained that I would review the paperwork, however the integrity of the documents is in question as several days have passed since my initial request of Resident A's file to be reviewed.

On 06/17/2024, I completed an exit conference with Jody Josephson where my findings were discussed with her. Ms. Josephson did not agree with my findings, stating that she was unable to accommodate my request to review Resident A's file as it was taken from her. Ms. Josephson feels that the paperwork she submitted on 06/13/2024 should be considered as honoring the request to review Resident A's file.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply wit the following provisions: (a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.
ANALYSIS:	On 06/06/2024, I requested to review Resident A's Medication Administration Records. On 06/06/2024, Jody Josephson reported that did not have a file on Resident A as it was no longer in her possession. On 06/13/2024, Jody Josephson submitted Resident A's Medication Administration Records dated May and June 2024. Based upon my investigation I find that Licensee, Jody Josephson, did not maintain a file on Resident A for a period of not less than 2 years. Ms. Josephson submitted Medication Administration Records (MARS) 7 days after the initial request to review Resident A's MARS, therefore the integrity of the forms is in question.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
400.1422	**Resident records.**
	(2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from home.
ANALYSIS:	On 06/06/2024, I requested to review Resident A's File. On 06/06/2024, Jody Josephson reported that did not have a file on Resident A as it was no longer in her possession. On 06/13/2024, Jody Josephson submitted documents, Assessment Plan and Resident Care Agreement, stating they were from Resident A's file. Based upon my investigation I find that Licensee, Jody Josephson, did not maintain a file on Resident A for 2 years after the date of his discharge from the home. Ms. Josephson submitted forms 7 days after the initial request to review Resident A's file, therefore the integrity of the forms is in question.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend no change to the status of the license.

Vanita C. Bouldin Date: 06/25/2024
Licensing Consultant

Approved By:

Ardra Hunter Date: 07/01/2024
Area Manager