GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 14, 2024

Barbara Frazier
Welcome Home, Inc.
P. O. Box 40
Grand Ledge, MI 48837

RE: License #: AL230256414
Investigation #: 2024A1033057
Fairview AFC

Dear Ms. Frazier:

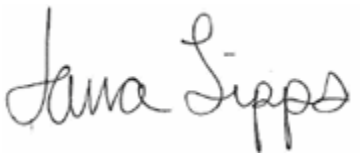
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

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

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

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

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL230256414
Investigation #:	2024A1033057
Complaint Receipt Date:	08/30/2024
Investigation Initiation Date:	09/04/2024
Report Due Date:	10/29/2024
Licensee Name:	Welcome Home, Inc.
Licensee Address:	11656 S. Hartel Road Grand Ledge, MI 48837
Licensee Telephone #:	(517) 290-3107
Administrator:	Barbara Frazier, Administrator
Licensee Designee:	Barbara Frazier, Designee
Name of Facility:	Fairview AFC
Facility Address:	11656 S. Hartel Road Grand Ledge, MI 48837
Facility Telephone #:	(517) 622-1009
Original Issuance Date:	01/26/2004
License Status:	REGULAR
Effective Date:	04/24/2023
Expiration Date:	04/23/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents are not being provided adequate personal care and are being left in soiled incontinence briefs.	No
Direct care staff have caused serious resident injuries which required surgical interventions.	No
Medications are being administered to residents without orders.	No
Residents are not being offered food. There are residents being left in their rooms during mealtimes without being offered meals.	No
Additional Findings	Yes

III. METHODOLOGY

08/30/2024	Special Investigation Intake 2024A1033057
09/04/2024	Special Investigation Initiated - On Site Interviews conducted with direct care staff, Joseph Frazier & Rose Briggs. Review of Resident A's resident record initiated. Request for additional documentation submitted to Mr. Frazier.
09/04/2024	Contact - Document Sent Email correspondence sent to the facility email address requesting additional documentation for this investigation. Awaiting response.
10/04/2024	Contact – Telephone Call Received Interview conducted with direct care staff, Gwen Schelter, via telephone.
10/04/2024	Contact – Telephone Call Made Attempt to interview Guardian A1, via telephone. Voicemail message left and awaiting response.
10/08/2024	Contact – Telephone Call Received Interview conducted with direct care staff, Wendy Kenney, via telephone.
10/08/2024	Contact – Telephone Call Made Attempt to interview direct care staff, Katelynn Gingrich, on 10/4/24 and 10/8/24. No answer and no way to leave a voicemail message.
10/08/2024	Contact – Telephone Call Received

	Interview conducted with Guardian A1, via telephone.
10/08/2024	Contact – Document Sent Email correspondence sent to Ms. Briggs, requesting further documentation.
10/10/2024	Contact – Telephone Call Made Follow up interview conducted with Guardian A1, via telephone.
10/10/2024	Contact – Telephone Call Made Follow up interview with Ms. Briggs, via telephone.
10/14/2024	Exit Conference Conducted via telephone with licensee designee, Barbara Frazier.

ALLEGATION: Residents are not being provided adequate personal care and are being left in soiled incontinence briefs.

INVESTIGATION:

On 8/30/24 I received an anonymous complaint regarding Fairview AFC, adult foster care facility (the facility). The complaint alleged that residents at the facility are not being provided adequate personal care and will be left in soiled incontinence briefs for hours without being changed. The complaint did not name an individual resident being left in their briefs. There was no specific information in this allegation to identify any of the current residents at the facility. On 9/4/24 I conducted an unannounced on-site investigation at the facility. I interviewed direct care staff, Joseph Frazier. Mr. Frazier reported that residents who are incontinent are on a schedule for their brief changes. He reported that direct care staff are directed to document in the electronic medical record when they conduct incontinence brief changes for residents. Mr. Frazier reported that the facility has a camera system installed in the common areas which can also monitor if a direct care staff member has entered a resident room. He reported that if there is any concern that a direct care staff member is not tending to resident's personal care needs, including brief changes, he can watch the footage from these cameras and determine how frequently direct care staff are entering resident bedrooms during their shifts. Mr. Frazier reported that he does not have cameras in private areas, such as bathrooms and bedrooms. Mr. Frazier reported that he does not have a current concern that residents are not being offered and provided their regular incontinence brief changes.

During the on-site investigation on 9/4/24 I interviewed direct care staff/Director of Nursing, Rose Briggs. Ms. Briggs reported that residents who require assistance are scheduled for every two to three hour "toilet checks". She reported that direct care

staff follow a schedule and will check on residents and change their incontinence briefs during these two-to-three-hour checks. Ms. Briggs reported direct care staff are directed to document these “toilet checks” in the electronic medical record. She reported that she is aware that there are issues with the direct care staff remembering to document that the “toilet checks” were completed and she has provided reminders and training to this facility requirement. Ms. Briggs reported she does not have any concerns that residents are not being provided personal care, just the concern about direct care staff forgetting to document that personal care was provided. Ms. Briggs noted that the form direct care staff document brief changes on is called the *TAR* or *Task Administration Record.*

On 9/4/24 I requested that Mr. Frazier and Ms. Briggs provide me, via email, a copy of the *TAR* for the month of August 2024 for Residents A, B, C, & D. I received these documents, via email, from Mr. Frazier on 9/10/24. I reviewed the following documents:

- *Care History for [Resident A]* dated 8/1/24 thru 8/31/24. This document reported individual, daily tasks that direct care staff managed for Resident A through the month of August 2024. Notations of incontinence care were found on this log. The notations were sporadic and did not seem to follow a schedule. I observed anywhere between one hour and eleven hours in between incontinence checks that were documented on this log. There did not appear to be consistency in documenting these incontinence checks.
- *TAR* for August 2024, for Resident B. Under the section, *Toileting*, it notes, “As needed assistance”. Under the section, *Bathing*, it reads, “Full Assistance”. It is documented that Resident B is offered a bath every two to six days. Twice during the month of August 2024, it is documented that Resident B refused the bath that was offered.
- *TAR* for August 2024, for Resident C. Under the section, *Toilet Check*, it reads “Scheduled. Follow their toileting schedule and assist in monitoring and assisting. Resident has Crohns: Failure to follow schedule ould result in a BM mess”. Resident C is scheduled to have toileting checks completed at 12am, 4am, 6am, 10am, 12pm, 2pm, 5pm, and 8pm. I observed at least 90 entries that were left blank and not initialed by direct care staff that the toilet checks for Resident C were completed. Under section, *Personal Care*, it reads, “Perform mini bath 2x daily washing face and hands with warm wash cloth and soap. Wash under resident arms as well as peri area (Do not use baby wipes for the bath). Warm wash cloth and soap must be used. Change and date soiled brief as needed”. The personal care is listed as being scheduled for 7am and 7pm daily. I observed at least 22 entries that were left blank and not initialed by direct care staff that the personal care was provided to Resident C. Under the section, *bathing*, I observed that it has been documented that Resident C has received a bath at least every 2-3 days.
- *TAR* for August 2024 for Resident D. Under section, *Bathing*, it reads, “Full Assistance”. I observed that Resident D is documented as receiving a bath at least every 2 – 3 days. Under the section, *Toilet Check*, it reads, “Scheduled. Follow their toileting schedule and assist in monitoring and assisting”.

Resident D is scheduled to receive toilet checks at 2am, 5am, 10am, 2pm, 5pm, 10pm. I observed at least 80 entries that were left blank and not initialed by direct care staff that the toilet checks for Resident D were completed.

On 10/4/24 I interviewed direct care staff, Gwen Schelter, via telephone. Ms. Schelter reported that she has worked at the facility since 2013. She reported that she currently works the overnight shift, 6pm to 6am. Ms. Schelter reported that she has no current concerns about residents not receiving personal care from direct care staff. She reported that residents who are incontinent and require the use of incontinence briefs are placed on a schedule of every two hours where direct care staff check on them and change their brief if needed. Ms. Schelter reported that she has not received any complaints from direct care staff, visitors, or residents that the incontinence briefs have not been changed for residents. Ms. Schelter reported that direct care staff are to document in the electronic record for the residents who receive brief changes. She reported that she feels this is being completed by the direct care staff, most of the time.

On 10/8/24 I interviewed direct care staff, Wendy Kenney, via telephone. Ms. Kenney reported that she has worked at the facility for at least 19 years. She reported that she works the day shift from 4am to 12pm. Ms. Kenney reported that she has no current concerns about residents not being provided adequate personal care. She reported that residents who are incontinent are placed on a schedule for regular incontinence brief changes which is usually every one to two hours. She reported direct care staff can see this schedule in the computer and know to check on the resident during these increments and provide brief changes as needed. She reported that she feels the residents are actually receiving more incontinence brief changes than they are scheduled for in the computer as the direct care staff will also change the resident any time they notice a soiled brief. Ms. Kenney reported direct care staff also have a policy to date the incontinence briefs so that it can be identified when the last brief change was performed. She reported that this policy was instituted about two years ago and seems to be working. Ms. Kenney reported that direct care staff are supposed to document in the computer when they provide incontinence brief changes to residents. She reported that she is not aware of whether there are any issues with this being completed as she does not ever look at the completed printout to know. She reported that Ms. Briggs is the one who oversees this task.

On 10/8/24 I interviewed Guardian A1, via telephone, regarding the allegations. Guardian A1 reported that Resident A resided at the facility from June 2014 through July 2024. She reported that she was initially impressed with the care provided at the facility but after the COVID-19 pandemic the care decreased in quality, and she felt Resident A was not receiving quality care any longer. She reported visiting Resident A at least four to five times per week and finding Resident A in soiled incontinence briefs on multiple occasions. She reported that she brought this to the attention of Mr. Frazier and Ms. Briggs and was told that Resident A is being changed about 8-10 times per day. Guardian A1 reported that she found this unlikely

because she would be the one ordering Resident A's incontinence briefs and putting them away in her room. Guardian A1 reported that there was a surplus of incontinence briefs building up in Resident A's closet because the direct care staff were not gong through them as quickly as the new inventory would arrive. She reported that she would order about 120 incontinence briefs per month for Resident A. This quantity would have provided for about four brief changes per day and there was still excess supply in Resident A's closet. Guardian A1 reported that she feels Resident A may have only been changed twice per day, but she could not prove this as fact.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based upon interviews conducted with Mr. Frazier, Ms. Briggs, Ms. Schelter, Ms. Kenney, & Guardian A1, as well as review of the *TAR* document for the month of August 2024 for Resident A, B, C, & D, it can be determined that there is not adequate evidence to suggest residents are not being provided and offered personal care by direct care staff. Although, it was noted in reviewing the *TAR* documents that there are multiple entries missing where direct care staff should have initialed that they provided incontinence care to these residents, Ms. Briggs also reported that it has been difficult getting the direct care staff to comply with this facility required documentation. Each direct care staff interviewed reported that they have no concern about the current level of personal care being provided to the residents and noted systems in place, such as dating incontinence briefs, the use of cameras in common areas to monitor direct care staff entering resident rooms, and scheduling incontinence brief changes in the electronic record for reminders. Although, Guardian A1 reported that she had found Resident A soiled on several occasions, it cannot be determined if Resident A was due for a brief change prior to this and it's difficult to determine whether the incontinence briefs being provided by Guardian A1 were the only briefs used for Resident A. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff have caused serious resident injuries which required surgical interventions.

INVESTIGATION:

On 8/30/24 I received an anonymous, online complaint regarding the facility. The complaint alleged that the direct care staff have caused resident injuries and referenced one resident being injured to the point that they required surgical intervention. The complaint did not name any specific resident. The complaint further alleged that management at the facility have been covering up resident injuries. On 9/4/24 I conducted an unannounced, on-site investigation at the facility. I interviewed Mr. Frazier on this date. Mr. Frazier reported that the only resident injury he recalls, which required surgical intervention, was for Resident A. He reported that Resident A no longer resides at the facility as her family had moved her from the facility about one week prior to this interview. Mr. Frazier reported that Resident A's family had hired a private duty caregiver to spend time with Resident A to provide her more attention and stimulation at the facility. Mr. Frazier reported that he could not recall the date of the injury, but it was identified by a direct care staff member (name unknown), on a Monday morning that they felt something happened with Resident A over the weekend as her leg/foot appeared swollen. Mr. Frazier reported that no one seemed to know why Resident A's leg/foot appeared this way. He reported that Resident A is transported by means of a Broda chair and it was assumed that potentially someone pushed the chair into a wall or door jamb which caused the injury. Mr. Frazier reported that it was not able to be determined whether a direct care staff member or Resident A's hired caregiver caused the injury. Mr. Frazier reported that after this injury a policy was instituted in the facility whereby residents are only transported backward in their wheelchair, Broda chair, or Geri chairs, to prevent another resident from hitting their feet on a wall, or door jamb. Mr. Frazier reported that Resident A was sent for evaluation of the injury and was offered either a cast or surgery to correct the injury. He reported that Guardian A1 chose to have surgery.

During the on-site investigation on 9/4/24 I interviewed Ms. Briggs regarding the allegation. Ms. Briggs reported that the only resident incident in the past year, which caused injury requiring surgery was for Resident A. Ms. Briggs reported that this incident occurred in the Fall 2023, but she could not recall the exact date. She reported that Resident A was observed to have pain and swelling in her leg/foot but when questioned about this none of the direct care staff members knew what had caused the injury. Ms. Briggs reported that Resident A does have a private duty caregiver who was hired by the family to make visits to Resident A, bring Resident A's mother to visit, and provide additional support and companionship to Resident A. Ms. Briggs reported that once direct care staff noticed the injury, her medical provider, Dr. Harold Roth, ordered a mobile x-ray for Resident A. Ms. Briggs reported that the x-ray identified a fracture and Guardian A1 took Resident A to the emergency department for treatment. Ms. Briggs reported that the initial recommendation from the emergency department was for Resident A to wear a boot

to immobilize her foot to promote healing, but this was not proving to be successful as the injury was not demonstrating signs of healing. Ms. Briggs reported that it was then recommended that Resident A could have her foot/leg put in a cast or she could have surgery. Ms. Briggs reported that Guardian A1 chose the option of surgery for Resident A.

During the on-site investigation on 9/4/24, I reviewed the following documents:

- *Incident Report*, for Resident A, dated 11/25/23, and completed by direct care staff, Brandi Casler. Under the section, *Briefly Describe What Occurred*, it reads, “Resident had a Xray of left foot from swelling. The Xray has shown that the left foot is displaced and fractured. [Guardian A1] was contacted to transfer resident to sparrow ER.”
- *Incident Report,* for Resident A, dated 12/28/23, and completed by direct care staff, Dasia Thrush. Under the section, *Briefly Describe What Occurred*, it reads, “When counting medication during shift report resident was being brought over from the mess side after music. Staff heard a loud bang then the door open and [Resident A] scream “ow” really loudly. Came to the conclusion that family personal paid caregiver had ran her leg into the door, resident became very upset and was banging on her tray. No visible injuries were seen at this time.”
- *Incident Report,* for Resident A, dated 12/28/23, and completed by direct care staff, Sue Metzger. Under the section, *Briefly Describe What Occurred*, it reads, “I witnessed family paid personal caregiver taking resident to her room when I was coming around the corner she had run resident into the metal trashcan and the can was on top of resident.”
- I reviewed a physician’s order for Resident A’s Broda chair, signed by Dr. Roth on 12/14/20.
- Trident Care Imaging document for Resident A, dated 11/25/23. On page two, under section, *History of Present Illness*, it reads, “Ankle swelling [Hx of: Reports Trauma; Char.: Reports redness, Pain; Assoc. Sx: Reports Bruising; Free text: Pt is special needs and not able to communicate. Lives in an assisted living. Foot was possibly hit today. There is some bruising swelling around ankle/foot. Not sure date/time of injury.]” On page three, under the section, *Assessment/Plan*: “Unspecified fracture of lower end of left tibia, initial encounter for closed fracture (S82.302A) – Complicated.” Under paragraph two of this section it reads, “You’ve elected to receive your fracture care @ Lansing Urgent Care. At ANY time if you decide you want to see an orthopedic surgeon we will be happy to refer your care to a local orthopedist for consult and assumption of your care.”
- Lansing Urgent Care document dated 11/25/23 for Resident A. Under the section, *Clinical History*, it reads, “PT is unable to communicate due to disability, significant edema with ecchymosis over the lateral ankle/foot. R/O Fx.” Under the section, *Findings*, it reads, “There is an oblique fracture of the distal tibial shaft with soft tissue swelling. There are no erosive changes seen. The ankle mortise is intact. Under the section, *Impression*, it reads, “Tibial fracture.”

- *Health Care Appraisal* for Resident A, dated 1/10/23. Under the section, Mental/Physical Status & Limitations, it reads, “Wheelchair confined.”

On 10/4/24 I interviewed Ms. Schelter via telephone. Ms. Schelter reported that she has no knowledge of a resident injury which required surgical interventions. She reported that she recalls Resident A as a previous resident of the facility but does not recall an injury she sustained which required surgical intervention. Ms. Schelter reported that she has no knowledge of resident injuries that have been attempted to be ignored or hidden. She reported that she has no reason to believe this is accurate information.

On 10/8/24 I interviewed Ms. Kenney, via telephone, regarding the allegations. Ms. Kenney reported that she is not aware of any resident injury which may have required surgical interventions. She reported that she does not recall the extent of Resident A’s injury as this occurred several months ago and she was not able to review Resident A’s record in the computer to refresh her memory. Ms. Kenney reported that she does not feel the management at the facility is covering up any resident injuries and reported that Mr. Frazier, Ms. Briggs, and licensee designee, Barbara Frazier, all report injuries to family members when they occur.

On 10/8/24 I interviewed Guardian A1, via telephone. Guardian A1 reported that Resident A did suffer a broken leg during November of 2023 at the facility. She reported that it was relayed to her that Resident A was injured by a direct care staff member at the facility, but she could not recall this individual’s full name. She reported that after this direct care staff member communicated the injury to her, that Ms. Briggs also called and communicated the injury and the need for Resident A to be taken to the hospital for treatment. Guardian A1 reported that she did take Resident A to the urgent care where she was diagnosed with a fracture. Guardian A1 reported that it was never confirmed what caused Resident A’s fracture, but she has her suspicions of how it occurred. She reported she has no evidence to support these suspicions. Guardian A1 inquired why she did not find documentation of this injury on the LARA website where facility reports are located. It was explained to Guardian A1 that incident reports are not uploaded to the LARA website, and this is not a requirement for facilities.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based upon interviews with Mr. Frazier, Ms. Briggs, Ms. Schelter, Ms. Kenney, & Guardian A1, as well as review of resident records during the on-site investigation it can be determined that there is not adequate evidence to suggest that the direct care staff are not treating residents with dignity by attending to their personal needs, including protection and safety. Resident A did experience an injury of unknown origin, but the direct care staff documented that they addressed the injury as soon as it was identified, had the medical provider order an X-ray, and then Resident A was sent to the hospital for treatment of this injury. There were no other residents identified in this investigation who had received an injury requiring surgical interventions. There is not adequate information to determine that Resident A's safety and protection were not being provided for by direct care staff members. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Medications are being administered to residents without orders.

INVESTIGATION:

On 8/30/24 I received an anonymous, online complaint regarding the facility. The complaint alleged that residents are being administered medications without physicians' orders. The complaint did not specify a specific resident but did note that morphine was being administered without consent. On 9/4/24 I completed an unannounced investigation at the facility. I interviewed Mr. Frazier on this date. Mr. Frazier reported that all resident medications are administered by trained direct care staff and ordered by licensed physicians or nurse practitioners. Mr. Frazier reported that the direct care staff document the administration of medications in an electronic Medication Administration Record (MAR) for each resident. Mr. Frazier reported having no knowledge of direct care staff administering medications to residents that were not prescribed.

On 9/4/24 I interviewed Ms. Briggs regarding the allegation. Ms. Briggs reported that the direct care staff use the electronic MAR system to administer resident medications. Ms. Briggs reported that all resident medications that are administered are ordered by a licensed practitioner. Ms. Briggs reported that she has no concerns that direct care staff would be "overmedicating" residents. She reported that she tries to encourage direct care staff to use "as needed" or PRN medications for residents for their comfort and she has found it challenging to get direct care staff members comfortable with administering PRN medications. She does not feel that any of the residents' medications are being mismanaged or overused.

During the on-site investigation on 9/4/24 I requested to review the August 2024 MARs for Residents A, B, C, & D. I received these documents via email from Mr. Frazier and reviewed them on 9/10/24. I did not observe any information recorded on the MAR that would indicate direct care staff were administering medications not ordered by a licensed practitioner. I observed that the PRN medications ordered on these MARs were rarely administered to the residents. Resident C was the only resident ordered morphine. The morphine for Resident C was ordered on a PRN basis and only initialed as being administered two times in the month of August 2024.

On 10/4/24 I interviewed Ms. Schelter via telephone regarding the allegation. Ms. Schelter reported that she has no knowledge of any allegations that resident medications are being mismanaged at the facility. She reported that there is a strict medication practice and that medications, especially narcotics and controlled substances are counted at the beginning and the end of each shift. She reported that she feels it would be very difficult for a direct care staff member to administer too much of a medication or a medication that was not ordered for a resident. Ms. Schelter reported that she has no knowledge of any direct care staff who have administered medications that were not ordered or attempted to administer too much of a medication to a resident.

On 10/8/24 I interviewed Ms. Kenney, via telephone, regarding the allegation. Ms. Kenney reported that she has no knowledge of any direct care staff members administering medications to residents that were not ordered for the residents. She reported that she has no concerns about mismanagement of resident medications. She reported that when direct care staff administer a PRN or as needed medication to a resident, they usually contact Ms. Briggs, via telephone, to discuss the administration and the symptoms they are observing, prior to administering the medication. Ms. Kenney reported that she has no concerns, nor has she heard any complaints that a direct care staff member has been administering resident medications inappropriately.

On 10/8/24 I interviewed Guardian A1, via telephone, regarding the allegation. Guardian A1 reported that she feels Resident A did not receive her prescribed Cannabis Chocolate as it was ordered to be administered routinely once per day. She reported that she felt direct care staff were taking the medication themselves and not administering the medication to Resident A. Guardian A1 had no evidence to support this allegation. This is the only complaint Guardian A1 had regarding medication administration at the facility.

On 10/8/24 I reviewed the MAR for Resident A for the month of August 2024. On the MAR I noted that Resident A was scheduled to receive, “Cannabis Chocolate, one chocolate daily and 4 times a day as needed for anxiety and behaviors (hitting, throwing items, insomnia)”. This medication was scheduled to be administered at 2pm daily and also PRN. This medication is noted as being placed on hold and initialed by “RB” for the entire month of August 2024.

On 10/8/24 I sent email correspondence to Ms. Briggs, inquiring as to why the cannabis chocolate is marked as being on hold for the month of August 2024 and if the initials “RB” were her initials. Ms. Briggs reported, “I put the cannabis on hold mid July”. She confirmed it was her initials on the MAR and stated the reason it was placed on hold is because the family was supposed to provide the cannabis medication and had not provided a refill. On 10/8/24 I replied to Ms. Briggs and requested a copy of the physician’s order for the cannabis and documentation of attempts to refill the cannabis.

On 10/10/24 I received a follow up email from Ms. Briggs and she provided a written physician’s order for the cannabis and Resident A’s MARs for the months of June 2024 and July 2024. I reviewed these documents and noted the following:

- Physician’s order, for Resident A, from Dr. Harold Roth, dated 3/3/20, reads, “May use marijuana PRN”.
- Resident A’s MAR June 2024. Cannabis chocolate is marked as being administered 6/1/24 through 6/30/24, every day at 2pm, and as needed on 6/1/24, 6/2/24, 6/6/24, 6/12/24, 6/26/24, & 6/28/24 – 6/30/24.
- Resident A’s MAR July 2024. Cannabis chocolate is marked as being administered, at 2pm daily from 7/1/24 through 7/10/24. The medication is marked by Ms. Briggs as being on hold from 7/11/24 through 7/31/24.

On 10/10/24 I conducted a follow up interview with Guardian A1, via telephone. I inquired about how the cannabis chocolate was ordered, administered, and provided to the facility. Guardian A1 reported that she had wanted the cannabis to be administered to Resident A as a substitute to Lorazepam. She reported that she had asked if Dr. Roth would write an order for the cannabis, and this was completed. She reported that it was her responsibility to provide the cannabis to the facility to administer. Guardian A1 reported that around June 2024 she stopped providing the cannabis as she felt it was being misused by the direct care staff, but she could not confirm that this was factual.

On 10/10/24 I conducted a follow up interview with Ms. Briggs, regarding the cannabis order for Resident A. Ms. Briggs reported that Guardian A1 wanted Resident A to use the cannabis and she provided it to the facility to administer. Ms. Briggs reported that Dr. Roth wrote the initial order for the cannabis and that this was the only order on file. She reported that Resident A's MAR does not match the order, which read, "May use marijuana PRN" because Guardian A1 had requested that it be added as a daily/routine medication for Resident A. Ms. Briggs was advised that the prescribing physician must be involved in changing the order for the cannabis and the order for the prescription must match what is written on the MAR. Ms. Briggs reported that she opted to place the cannabis on hold when Guardian A1 stopped delivering the cannabis to the facility as there was no way for the direct care staff to administer the medication to Resident A.

APPLICABLE RULE	
R 400.15312	**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:	Based upon interviews with Mr. Frazier, Ms. Briggs, Ms. Schelter, Ms. Kenney, & Guardian A1, as well as review of resident MARs for the month of August 2024, it can be determined that there is not adequate evidence to conclude that resident medications are not being administered as prescribed or that resident medications are being mismanaged by direct care staff. Regarding Resident A's cannabis chocolate and Guardian A1's concerns about whether this medication was administered as directed, it appears that while the direct care staff had the cannabis on hand, they were administering it as ordered and documenting this on the resident MAR. Guardian A1 reported that she was responsible to deliver the cannabis to the facility and that she stopped delivering this medication in June 2024. The direct care staff could not administer the cannabis as it was not available on-site to be administered. I found no additional evidence to support these allegations during this investigation. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Residents are not being offered food. There are residents being left in their rooms during mealtimes without being offered meals. There is concern residents are losing weight due to lack of nutrition.

INVESTIGATION:

On 8/30/24 I received an anonymous, online complaint regarding the facility. The complaint alleged that the residents at the facility are not being offered food. It specifically reported that residents who are bedbound are being left in their rooms during mealtimes and not offered food and noting this is causing weight loss for an unidentified resident. On 9/4/24 I conducted an unannounced, on-site investigation at the facility. I interviewed Mr. Frazier regarding the allegations. Mr. Frazier reported that the only time he has heard complaints about residents having issues with receiving their meals was for Resident A. He reported that Resident A's mother would frequently visit Resident a during mealtimes and the direct care staff would report that Resident A's mother would eat from her meal. He reported that this was an ongoing issue with Resident A. Mr. Frazier reported that Resident A was a picky eater and at times would not eat for certain direct care staff members. Mr. Frazier reported that Resident A would eat better when Guardian A1 was present as she was more instant about Resident A finishing her food. Mr. Frazier reported that direct care staff members cannot force a resident to eat and finish their entire meal. Mr. Frazier reported that Resident A ate 95% of her meals in the main dining room. He reported that occasionally she would eat her meals in her room.

On 9/4/24 during the on-site investigation I interviewed Ms. Briggs regarding the allegations. Ms. Briggs reported that most residents eat their meals in the main dining room. She reported that there are some bed bound residents who eat in their resident rooms. She reported that Resident C, Resident E, and Resident F do eat in their rooms. She reported that they are capable of feeding themselves and will, at times, choose to eat in their rooms due to how they are feeling on that day. Ms. Briggs reported that she has not received any complaints from visitors, family members or these residents about a resident not being, fed, offered food, or losing weight. Ms. Briggs reported Guardian A1 had concerns about Resident A losing weight. Ms. Briggs reported Resident A was easily distracted during meals. She reported direct care staff found it difficult for Resident A to maintain focus on her meals. Ms. Briggs reported Guardian A1 wanted Resident A to be served two hotdogs for lunch each day, regardless of what was on the menu. Ms. Briggs reported that there were days when Resident A would refuse to eat the hotdogs. Ms. Briggs reported that she did not have any knowledge of any resident being left in their room during mealtimes and not offered food to eat.

During the on-site investigation on 9/4/24 I reviewed the following documents:

- *Health Care Appraisal* for Resident A, dated 1/10/23. Under section, 2. Weight, it read, “100”.
- *Health Care Appraisal* for Resident A, dated 1/16/24. Under section, 2. Weight, it read, “95”.

During the on-site investigation on 9/4/24 I observed residents in the dining room eating their noon meal. I observed a healthy offering of food at this time, and I observed direct care staff assisting residents with eating their meal.

On 9/10/24 I received and reviewed the following documents, via email, from Mr. Frazier:

- Resident A’s monthly weight record report from 1/2/24 through 8/6/24. The following weights were recorded:
  - 1/2/24: 95
  - 2/6/24: 97
  - 3/5/24: 95.9
  - 4/2/24: 95
  - 5/7/24: 93
  - 6/4/24: 95
  - 7/2/24: 95
  - 8/6/24: 93
- Resident B’s monthly weight record report from 1/3/24 through 8/1/24. The following weights were recorded:
  - 1/3/24: 150.3
  - 2/1/24: 146.6
  - 3/7/24: 149
  - 4/4/24: 142
  - 5/2/24: 140

    - 6/6/24: 145
    - 7/2/24: 146.6
    - 7/4/24: 146.6
    - 7/17/24: 146.8
    - 8/1/24: 145
- Resident C's monthly weight record report from 1/11/24 through 8/6/24. The following weights were recorded:
    - 1/11/24: 115.4
    - 2/6/24: 113.5
    - 3/5/24: 115.3
    - 4/2/24: 115.8
    - 5/8/24: 110.8
    - 6/4/24: 106
    - 7/2/24: 109
    - 8/6/24: 110.3
- Resident D's monthly weight record report from 6/5/24 through 8/6/24. The following weights were recorded:
    - 6/5/24: 133
    - 7/2/24: 133.6
    - 8/6/24: 135

On 10/4/24 I interviewed Ms. Schelter, via telephone, regarding the allegation. Ms. Schelter reported that most of the residents at the facility eat their meals in the dining room. She reported that there are some residents who choose to eat their meals in their bedrooms, and this is accommodated by the direct care staff. Ms. Schelter reported that she has never received a complaint that a resident was not being offered their regularly scheduled meals and she has no knowledge of residents being forgotten at mealtimes.

On 10/8/24 I interviewed Ms. Kenney, via telephone, regarding the allegation. Ms. Kenney reported that residents are encouraged to go to the dining room for their meals, but if a resident chooses, they may eat in their own room. She reported that it is the responsibility of the "lead caregiver" on the shift to ensure that residents who choose to eat in their rooms are offered their meal tray. She reported that the lead caregiver takes on this task as well as administering resident medications. Ms. Kenney reported that she has never received a complaint from a resident or their family member that a resident's meal was forgotten.

On 10/8/24 I interviewed Guardian A1, via telephone, regarding the allegations. Guardian A1 reported that the meals at the facility were "excellent." She reported that she did have concerns about residents not being fed who required assistance with their meals. She reported direct care staff would take their food if they did not finish. She reported that she felt some of the residents were not finishing because they required assistance with eating their meals. Guardian A1 did not have any evidence to support this allegation.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based upon interviews with Mr. Frazier, Ms. Briggs, Ms. Schelter, Ms. Kenney, & Guardian A1, as well as review of resident weight records over the past eight months for Resident A, B, C, & D, it can be determined that evidence was not found to suggest that residents are not being offered and provided 3 regular nutritious meals daily. During the on-site investigation I observed the noon meal being provided to residents and direct care staff members assisting residents by feeding them this meal. Direct care staff interviewed reported having no knowledge of residents who had not been provided meals or any complaints from family members or visitors to the facility of a resident not receiving a meal. Due to this lack of evidence, no violation will be cited at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/8/24 I interviewed Guardian A1, via telephone, regarding the allegation. Guardian A1 reported that she feels Resident A did not receive her prescribed Cannabis Chocolate as it was ordered to be administered routinely once per day. She reported that she felt direct care staff were taking the medication themselves and not administering the medication to Resident A. Guardian A1 had no evidence to support this claim. This is the only complaint Guardian A1 had regarding medication administration at the facility.

On 10/8/24 I reviewed the MAR for Resident A for the month of August 2024. On the MAR I noted that Resident A was scheduled to receive, “Cannabis Chocolate, one chocolate daily and 4 times a day as needed for anxiety and behaviors (hitting, throwing items, insomnia)”. This medication was scheduled to be administered at 2pm daily and also PRN. This medication is noted as being placed on hold and initialed by “RB” for the entire month of August 2024.

On 10/8/24 I sent email correspondence to Ms. Briggs, inquiring as to why the cannabis chocolate is marked as being on hold for the month of August 2024 and if the initials “RB” were her initials. Ms. Briggs reported, “I put the cannabis on hold mid July”. She reported that it was her initials on the MAR and that the reason it was

placed on hold is because the family was supposed to provide the medication and had not provided a refill. On 10/8/24 I replied to Ms. Briggs and requested a copy of the physician's order for the cannabis and documentation of attempts to refill the cannabis.

On 10/10/24 I received a follow up email from Ms. Briggs and she provided a written physician's order for the cannabis and Resident A's MARs for the months of June 2024 and July 2024. I reviewed these documents and noted the following:

- Physician's order, for Resident A, from Dr. Harold Roth, dated 3/3/20, reads, "May use marijuana PRN".
- Resident A's MAR June 2024. Cannabis chocolate is marked as being administered 6/1/24 through 6/30/24, every day at 2pm, and as needed on 6/1/24, 6/2/24, 6/6/24, 6/12/24, 6/26/24, & 6/28/24 – 6/30/24.
- Resident A's MAR July 2024. Cannabis chocolate is marked as being administered, at 2pm daily from 7/1/24 through 7/10/24. The medication is marked by Ms. Briggs as being on hold from 7/11/24 through 7/31/24.

On 10/10/24 I conducted a follow up interview with Guardian A1, via telephone. I inquired about how the cannabis chocolate was ordered, administered, and provided to the facility. Guardian A1 reported that she had wanted the cannabis to be administered to Resident A as a substitute to Lorazepam. She reported that she had asked if Dr. Roth would write an order for the cannabis, and this was completed. She reported that it was her responsibility to provide the cannabis to the facility to administer. Guardian A1 reported that around June 2024 she stopped providing the cannabis as she felt it was being misused by the direct care staff, but she could not confirm that this was factual.

On 10/10/24 I conducted a follow up interview with Ms. Briggs, regarding the cannabis order for Resident A. Ms. Briggs reported that Guardian A1 wanted Resident A to use the cannabis and she provided it to the facility to administer. Ms. Briggs reported that Dr. Roth wrote the initial order for the cannabis and that this was the only order on file. She reported that Resident A's MAR does not match the order, which read, "May use marijuana PRN" because Guardian A1 had requested that it be added as a daily/routine medication for Resident A. Ms. Briggs was advised that the prescribing physician must be involved in changing the order for the cannabis and the order for the prescription must match what is written on the MAR. Ms. Briggs reported that she opted to place the cannabis on hold when Guardian A1 stopped delivering the cannabis to the facility as there was no way for the direct care staff to administer the medication to Resident A.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the**

	resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.
ANALYSIS:	Based upon interviews with Guardian A1 & Ms. Briggs, as well as review of Resident A's resident record, it can be determined that Resident A's physician, Dr. Roth, prescribed Resident A marijuana as needed as based on his physician ordered dated 3/3/20. Resident A's MAR for June, July, August 2024 all list Resident A as receiving her cannabis chocolate once per day and as needed. Ms. Briggs was not able to provide an updated physician's order for this change in frequency of the cannabis chocolate. She reported that Guardian A1 had requested this change. Based upon this information it has been concluded that Resident A's cannabis frequency was modified without instructions from a physician. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

10/10/24

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Jana Lipps Date
Licensing Consultant

Approved By:

10/11/2024

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Dawn N. Timm Date
Area Manager