GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 15, 2025

Syed Shah
56565 Senior Care Solutions LLC
2498 Tranquil Dr.
Troy, MI 48098

RE: License #: AS630398556
Investigation #: 2025A0991005
Blossom Hill #1-AS

Dear Syed Shah:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 (248) 975-5053.

Sincerely,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS630398556 |
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| **Investigation #:** | 2025A0991005 |
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| **Complaint Receipt Date:** | 11/18/2024 |
| | |
| **Investigation Initiation Date:** | 11/19/2024 |
| | |
| **Report Due Date:** | 01/17/2025 |
| | |
| **Licensee Name:** | 56565 Senior Care Solutions LLC |
| | |
| **Licensee Address:** | 56565 10 Mile Rd<br>South Lyon, MI 48178 |
| | |
| **Licensee Telephone #:** | (248) 264-6497 |
| | |
| **Licensee Designee:** | Syed Shah |
| | |
| **Name of Facility:** | Blossom Hill #1-AS |
| | |
| **Facility Address:** | 56565 10 Mile Rd<br>South Lyon, MI 48178 |
| | |
| **Facility Telephone #:** | (248) 264-6497 |
| | |
| **Original Issuance Date:** | 12/23/2019 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 02/13/2023 |
| | |
| **Expiration Date:** | 02/12/2025 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
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| Medication is not being locked up. A resident overdosed on medication and was given expired medication. | Yes |
| The home does not have sufficient staff on duty. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

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|---|---|
| 11/18/2024 | Special Investigation Intake<br>2025A0991005 |
| 11/19/2024 | Special Investigation Initiated - Telephone<br>Referred to Adult Protective Services (APS) Centralized Intake |
| 11/19/2024 | APS Referral<br>Referred to APS Centralized Intake |
| 11/20/2024 | Contact - Telephone call received<br>From Marcie Fincher, APS- assigned to Sarah Peoples |
| 11/21/2024 | Inspection Completed On-site<br>Unannounced onsite inspection- interviewed licensee designee and Relative 1A, observed residents |
| 11/21/2024 | Contact - Telephone call made<br>To APS worker, Sara Peoples |
| 11/21/2024 | Contact - Document Received<br>Medication records, hospice notes, prescription list, assessment plan, care agreement |
| 11/26/2024 | Contact - Telephone call made<br>Left message for hospice nurse |
| 12/09/2024 | Contact - Telephone call made<br>Left message for hospice nurse |
| 12/26/2024 | Contact - Document Received<br>Additional allegations received |

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| 12/26/2024 | Contact - Telephone call made<br>Left message for complainant |
| 01/06/2025 | Contact - Document Received<br>Incident Report- Resident A passed away on hospice |
| 01/09/2025 | Contact - Telephone call made<br>Left message for complainant- received return call- wrong number |
| 01/09/2025 | Contact - Telephone call made<br>To licensee designee, Syed Shah |
| 01/09/2025 | Contact - Document Received<br>Staff schedule and staff list |
| 01/09/2025 | Contact - Telephone call made<br>Left message for Resident A's hospice nurse |
| 01/09/2025 | Contact - Telephone call made<br>Left message for APS worker, Sara Peoples |
| 01/13/2025 | Contact - Telephone call made<br>Left message for direct care worker, Sheri Sarnowski |
| 01/13/2025 | Contact - Telephone call made<br>Left message for Resident A’s hospice nurse |
| 01/14/2025 | Inspection Completed On-site<br>Interviewed licensee designee, staff, and Resident B |
| 01/14/2025 | Exit Conference<br>Face to face with licensee designee |

**ALLEGATION:**

**Medication is not being locked up. A resident overdosed on medication and was given expired medication.**

**INVESTIGATION:**

On 11/19/24, I received an anonymous complaint regarding Blossom Hill #1- AS. The complaint indicated that medication is not being locked up. An unnamed resident overdosed on medication last week and was given expired medication. I initiated my investigation on 11/19/24 by making a complaint to Adult Protective Services (APS)

Centralized Intake. The complaint was assigned to APS worker, Sarah Peoples, for investigation.

On 11/21/24, I conducted an unannounced onsite inspection at Blossom Hill. I interviewed the licensee designee, Syed Shah. Dr. Shah stated that the home is going through a transitional period. He stated that he is listed as one of the licensee designees for the facility, but he was more hands-off, as Drita Aliatim was acting as the primary licensee designee for the home. Ms. Aliatim recently opened a new facility in Northville, and she is no longer involved with Blossom Hill. Dr. Shah stated that he had to take over her responsibilities at Blossom Hill effective 11/01/24 on very short notice, and things were left in a very disorganized and chaotic state. He stated that he is trying to get everything in order at this time, and much of the documentation is missing from the home. Dr. Shah stated that Resident A was recently placed on hospice care within the last week or so. He stated that when Resident A started receiving hospice services, they were making several medication changes. He stated that Resident A's hospice nurse gave her Morphine when she already received Norco.

On 11/21/24, I interviewed Relative A1 who was at the home visiting with Resident A. Relative A1 stated that Resident A had a near fall when she was being transferred by staff at the home. She used to be able to stand and swivel for transfers, but she twisted her leg and cannot stand now. This happened a little over a week ago. Following this incident, Resident A was placed on hospice on 11/08/24. Relative A1 stated that there was an incident about a week ago, when Resident A's oxygen dropped down to 64. Her hands were blue, and her face was pale. Resident A was in respiratory distress. The daughter of another resident in the home, who is a registered nurse, noticed that Resident A's coloring was bad, and put her on oxygen. Relative A1 stated that he believed Resident A received a double dose of Norco, as she had Norco in her regular medication blister pack and in her care pack from hospice. He stated that staff then gave Resident A liquid morphine for pain because they were going to move her. They were not supposed to administer liquid morphine, as she was supposed to receive a morphine pill. He stated that Resident A's medication log was not updated when hospice made changes to her medications. An hour and a half later, Resident A's hospice nurse gave her regular morphine. This is when Resident A's breathing got low. He stated that they went into the medication room and checked Resident A's medication bubble packs. Norco pills had been popped out of the regular medication blister pack and from a second pack that was in a bin because it was discontinued and needed to be disposed of. Relative A1 did not recall the date of this incident. He stated that he believed staff, Rosie, was working at the time and administered the medication. Relative A1 stated that the medication room, which also serves as the pantry, is not always locked. He stated that it is unlocked more often than it is locked. He stated that the family members like to have access to the medication administration records (MARs), as staff have not been consistently initialing the MAR to show which medications are being passed.

During the onsite inspection, I observed that medications were being stored in the walk-in pantry area of the home. The door to the room was not locked. The medication bubble packs were hanging from hooks on the wall. There were several controlled substances in the unlocked room, including Resident A's morphine solution. I did not observe any expired medications. The licensee designee, Syed Shah, stated that the room has a biometric lock, but it needs to be reprogrammed, so the room is not currently locked. Dr. Shah stated that he would immediately obtain a locked medication cart to store the medications instead of keeping them in an unlocked pantry. Dr. Shah stated that Rosie was a temporary staff and is no longer working in the home.

During the onsite inspection, I reviewed Resident A's medication administration records (MARs) and medications. Resident A's MAR was dated 11/14/24-12/01/24. The licensee designee stated that hospice changed Resident A's medications, and they received an updated MAR from the pharmacy. He did not have a copy of the previous MAR. The 11/14/24-12/01/24 MAR indicated that Resident A is prescribed Morphine Sulfate 15mg XR- take one tablet by mouth twice daily at 8:00am and 8:00pm. She was also prescribed the PRN (as needed) medications- APAP 325mg/hydrocodone 10 (Norco)- Take one table by mouth every 4 hours as needed for pain and Morphine Sulfate 20mg/ml Solution- Take .25mL (5mg) by mouth every 1 hour as needed for pain/shortness of breath. The MAR was not initialed to show that the PRN Norco had been administered at all since 11/14/24. The MAR was initialed to show the PRN Morphine Sulfate 20mg/ml Solution was administered on 11/14/24, 11/15/24 (administered twice), 11/16/24, and 11/18/24.

On 11/09/24, Resident A's hospice nurse wrote a note in the Hospice Visit Log stating, "received a call, medications need to be reconciled. Staff gave MS (morphine sodium) tab, MS concentration, Norco, pt was (illegible). O2 70%. Write d/c MS tab, renew order Norco 10mg 32mg." The rest of the note is illegible.

There was a "physician's interim order form" dated 11/10/24 and a hospice home medication record dated 11/09/24, which listed all of Resident A's prescribed medications. Morphine Sulfate 15mg XR tablet was not listed on either list; however, the medication was still listed on Resident A's 11/14/24-12/01/24 MAR. Staff initialed the MAR indicating that Morphine Sulfate 15mg XR tablet was administered at 8:00am and 8:00pm from 11/14/24-11/18/24 and 11/20/24. The Morphine Sulfate tablets were not present in the home at the time of the onsite inspection.

While reviewing Resident A's 11/14/24-12/01/24 MAR and medications, I noted the following:

- The label instructions for Resident A's Omeprazole 20mg CAP states- Take one capsule every other day oral route for 30 days. Staff initialed Resident A's MAR for four days in a row on 11/15/24,11/16/24, 11/17/24, and 11/18/24 when the medication was only being administered every other day.
- The instructions on the MAR and bubble pack for Resident A's Omeprazole 20mg CAP state- Take one capsule every other day. The physician orders for the

medication state- Take once daily. The bubble pack only contained pills to be given every other day.

- The label instructions for Resident A's Metoprolol Tar 25mg TAB states- Take one tablet twice a day by oral route, hold for heart rate < 55. Staff were measuring Resident A's blood pressure, pulse, and pulse ox. The record sheet for Resident A's vitals was not being consistently filled out by staff, with fields being left blank on 11/07/24, 11/08/24, 11/09/24, 11/10/24, 11/15/24, 11/16/24, and 11/19/24.
- The label instructions for Resident A's PRN Lactulose solution 10g state take 30ml orally as needed- take every three days if no bowel movement. Staff were not consistently tracking Resident A's bowel movements. There was a laminated calendar in the bathroom that did not have the dates written it, other than "1st" being written on the first Friday of the month. No bowel movements were noted except on the second Thursday of the month (presumably 11/14/24), where it was noted "1pm 1am-small." The MAR shows Resident A received the PRN lactulose on 11/16/24, which would have been less than three days from her last bowel movement. The chart notes "massive bm" on the third Saturday of the month (presumably 11/16/24).
- The label on Resident A's Hydrocodone/APAP 10-325mg Tab- Take one tab by mouth every four hours for pain, indicates that the medication was filled on 11/10/24. There were pills punched out of the bubble pack on the blisters labeled 10, 11, 12, and 19. Pills remained in the bubble pack from the 13-18th. Resident A's MAR dated 11/14/24-12/01/24 was not initialed to show that this medication was passed at all, including on 11/19/24. The MAR for 11/01/24-11/13/24 was not available to review, so it is unknown when the pills were passed.
- Resident A's 11/14/24-12/01/24 MAR was not initialed for the 8:00am dose of Bisacodyl 5mg, Citalopram 10mg, Cranberry 450mg tablet, Omeprazole 20mg, Sodium Chloride 1000mg, Metoprolol Tartrate 25mg, Quetiapine 25mg, Gabapentin 100mg, Amlodipine 5mg, or Artificial Tears eyedrops on 11/14/24.
- Resident A's 11/14/24-12/01/24 MAR was not initialed for the 8:00pm dose of Magnesium Oxide 400mg or Temazepam 15mg on 11/14/24.
- Resident A's 11/14/24-12/01/24 MAR was not initialed for the 8:00pm dose of Temazepam 15mg or Artificial Tears eyedrops on 11/15/24.
- Resident A's 11/14/24-12/01/24 MAR was not initialed for any of her AM or PM medications on 11/19/24.
- Resident A's 11/14/24-12/01/24 MAR was not initialed for any 8:00am medications at the time of the onsite inspection at 1:00pm on 11/21/24.

I left messages for Resident A's hospice nurses at Residential Hospice on 11/26/24, 12/09/24, 01/09/25, and 01/13/25. I did not receive a return phone call.

On 01/14/25, I conducted a follow-up onsite inspection at Blossom Hill #1-AS. I observed that the licensee designee obtained a medication cart to store the residents' medications, which was locked. Narcotics were double locked in a box within the

medication cart, and staff were completing a medication count for the narcotic medications. I reviewed the medications and MARs for Resident B and Resident C. During the onsite inspection at 11:30am on 01/14/25, I noted that Resident B's January 2025 MAR had not been initialed for that morning's 8:00am dose of Pilocarpine 4% OP solution eyedrops, Potassium CL Micro tab 20MEQ, and Timolol Mal Sol 0.5% eyedrops.

| **APPLICABLE RULE** | |
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| **R 400.14312** | **Resident medications.** |
| | **(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.** |
| **ANALYSIS:** | During my onsite inspection on 11/21/24, I observed medications were being stored in a room that also served as a walk-in pantry. The door to the room was not locked. Medications, including controlled substances, were hung from hooks on the wall, and were not in a locked cabinet or drawer. The licensee designee stated that there is a biometric lock on the door that needed to be reprogrammed. Resident A's relative stated that the medication room is unlocked more often than it is locked, and family members have access to the room.<br><br>The licensee designee did obtain a locked medication cart, which was in use during a follow-up onsite inspection on 01/14/25. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED (BUT CORRECTED) Reference Renewal Licensing Study Report dated 03/23/23; CAP dated 04/01/23** |

| APPLICABLE RULE | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.** |
| **ANALYSIS:** | Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A did not receive her medications as prescribed. Resident A transitioned to hospice care on 11/08/24. The licensee designee and Resident A's relative stated that there was confusion regarding medication changes that were made shortly after Resident A began receiving hospice services. A note from the hospice nurse on 11/09/24 indicated that Resident A's medications needed to be reconciled, as staff administered Morphine Sodium tablet, Morphine Sodium concentration, and Norco to Resident A. Resident A's MAR for the beginning of November was not available to review and the MARs were not being initialed consistently, so it is unknown what medications she received. The Morphine Sulfate 15mg XR tablet was not listed on Resident A's list of prescribed medications from hospice dated 11/09/24, and there was a note from the hospice nurse indicating this medication was discontinued. However, the medication was still listed on Resident A's 11/14/24-12/01/24 MAR. Staff initialed the MAR indicating that Morphine Sulfate 15mg XR tablet was administered at 8:00am and 8:00pm from 11/14/24-11/18/24 and 11/20/24, although the medication was not in the home during the onsite inspection on 11/21/24. In addition, staff were not consistently maintaining a log to document Resident A's vitals and bowel movements when she was prescribed medications that were contingent on this information. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| APPLICABLE RULE | |
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| **R 400.14312** | **Resident medications.** |
| | **(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:**<br>**(b) Complete an individual medication log that contains all of the following information:**<br>**(i) The medication.**<br>**(ii) The dosage.** |

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| | **(iii) Label instructions for use.**<br>**(iv) Time to be administered.**<br>**(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**<br>**(vi) A resident's refusal to accept prescribed medication or procedures.** |
| **ANALYSIS:** | Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not complete or maintain a medication administration record (MAR). Staff were not initialing the MAR at the time medications were administered, and the medication logs did not contain accurate information that matched the prescription information. During the onsite inspection on 11/21/24, Resident A's MARs prior to 11/14/24-12/01/24 could not be located and were not available to review. At the time of the onsite inspection on 11/21/24, Resident A's MAR had not been initialed for the morning medications that were passed earlier that day. Her 11/14/24-12/01/24 MAR was missing initials on several dates as outlined above. The 11/14/24-12/01/24 MAR listed Morphine Sulfate 15mg XR tablet and indicated that this medication was administered at 8:00am and 8:00pm from 11/14/24-11/18/24 and 11/20/24, when the medication was discontinued on 11/09/24. During the onsite inspection at 11:30am on 01/14/25, Resident B's January 2025 MAR had not been initialed for that morning's 8:00am dose of Pilocarpine 4% OP solution eyedrops, Potassium CL Micro tab 20MEQ, and Timolol Mal Sol 0.5% eyedrops. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br>**Reference Renewal Licensing Study Report dated 03/23/23; CAP dated 04/01/23**<br>**Renewal Licensing Study Report dated 07/28/2020; CAP dated 08/13/2020** |

**ALLEGATION:**

**The home does not have sufficient staff on duty.**

**INVESTIGATION:**

On 12/26/24, I received additional allegations stating that the home does not have enough staff on shift, as there are many residents who use a Hoyer lift or require a two-person assist. I attempted to contact the complainant on 12/26/24 and 01/09/25. I

received a return phone call stating that it was the wrong number. On 01/09/25, interviewed the licensee designee, Syed Shah via telephone. Dr. Shah stated that they currently have only two residents in the home. They have one or two staff on each shift, with an overlapping staff in the morning and evening, and he goes out to the home at least three to four times a week. I reviewed copies of the staff schedules, which showed one staff working from 8:00am-8:00pm and one staff working from 8:00pm-8:00am. There are some dates with a second overlapping staff working from 2:00 or 3:00pm-8:00pm or 8:00am-8:00pm. Dr. Syed stated that neither of the residents require a two-person assist. Resident B uses a Hoyer lift, but one person is able to transfer her. All of the staff are trained on how to operate the Hoyer lift. Resident C is mobile with a walker and requires standby staff assistance. Resident C sometimes has difficulty balancing, so staff give her a hand to hold while she grabs onto her walker. Staff are able to safely evacuate the residents. Dr. Shah stated that since he took over the home, he has been practicing fire drills. He then stated that they practice “tabletop” fire drills, where he gives staff a scenario and discusses how they would respond. He stated that they have not been fully evacuating for fire drills due to the weather. I advised Dr. Shah of the licensing requirements for all residents to fully evacuate the home for fire drills during daytime, evening, and sleeping hours each quarter. He expressed an understanding. He stated that he will also conduct a thorough evaluation of any new residents who are being admitted to the home, to ensure that the residents are a good fit and that the staffing levels are appropriate to meet their needs.

On 01/14/25, I conducted an onsite inspection at Blossom Hill #1- AS. I observed two staff working in the home, as well as Dr. Shah. I interviewed Resident B. Resident B stated that she has lived in the home for almost five years. She requires staff assistance and a Hoyer lift to be transferred from her bed to her wheelchair. She stated that one staff person is able to transfer her safely to her wheelchair, and she has never been injured or felt unsafe with one staff in the home. They typically move her to the bed to change her briefs during the day. She has never been left sitting in a soiled brief. She stated that some of the new staff are still learning how to transfer her on their own, but they do not work alone. She did not have any concerns about the staff in the home or any other issues.

I observed Resident C ambulating through the home with the use of a walker. She was unable to participate in an interview due to limited cognitive/verbal abilities.

On 01/14/25, I interviewed direct care worker, Sylvia Viray. She stated that she has worked in the home since last month. There are currently two residents living in the home. Resident B is the only resident who uses a Hoyer lift. She stated that typically the midnight staff person stays and helps transfer Resident B out of bed in the morning and the night shift also overlaps to transfer her back to bed. She stated that staff are able to transfer Resident B on their own, and they could safely evacuate her in an emergency. Resident C is able to walk on her own. She stated that one staff on shift is sufficient with the two residents in the home, but they might need more staff if additional residents move in.

On 01/14/25, I interviewed direct care worker, Emerenciana (Mercy) Najera. Ms. Najera stated that she has worked in the home for two weeks. She stated that she always works with another staff in the home, and she has never worked alone. She stated that Resident B needs two staff to help transfer her out of bed. The night staff typically stay and help the morning shift and vice versa. She stated that staff can safely evacuate the residents from the home, but they have not practiced. She did not have any concerns about the home.

I reviewed Resident B and Resident C's assessment plans. Resident B's assessment plan dated 12/13/24 notes that she uses a wheelchair and Hoyer lift. She needs assistance with all activities of daily living. It does not note that she requires a two-person assist for transfers. Resident C's assessment plan notes that she uses a walker and requires stand by assistance. It does not note that she requires a two-person assist.

| **APPLICABLE RULE** | |
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| **R 400.14206** | **Staffing requirements.** |
| | **(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.** |
| **ANALYSIS:** | Based on the information gathered through my investigation, there is insufficient information to conclude that the facility does not have sufficient direct care staff on duty to meet the needs of the residents. There are currently two residents living in the home. The facility has one staff on shift, with some overlap during shift changes. The assessment plans for Resident B and Resident C did not indicate that they require a two person assist. Resident B stated that one staff can transfer her to and from her wheelchair and bed. She felt safe and did not have any concerns about the staffing in the home. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

| **APPLICABLE RULE** | |
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| **R 400.14318** | **Emergency preparedness; evacuation plan; emergency transportation.** |
| | **(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.** |

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| **ANALYSIS:** | Based on the information gathered through my investigation, there is sufficient information to conclude that staff are not practicing emergency evacuation procedures as required. The licensee designee, Syed Shah, stated that they do “tabletop exercises” where he discusses evacuation scenarios with staff to ensure they know the procedure. He stated that residents are not being fully evacuated from the home due to the weather. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

During the onsite inspection on 01/14/2025, I reviewed the training verification forms on file for employees Sylvia Viray, Nicholas Allen, Sheri Sarnowski, and Rosemary (Rosie) Mendez. The certificate of training completion only indicated that staff completed medication administration training. There was no verification on file for training with regards to reporting requirements, first aid, CPR, personal care, supervision and protection, resident rights, safety and fire prevention, or prevention and containment of communicable diseases, with the exception of Nicholas Allen who did have CPR/First Aid certificates on file. The licensee designee, Syed Shah, stated that all of the staff work as in-home caregivers for other agencies or in the medical field in some capacity, so they are trained and qualified; however, the training verification was not completed.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14204** | **Direct care staff; qualifications and training.** |
| | **(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:**<br>**(a) Reporting requirements.**<br>**(b) First aid.**<br>**(c) Cardiopulmonary resuscitation.**<br>**(d) Personal care, supervision, and protection.**<br>**(e) Resident rights.**<br>**(f) Safety and fire prevention.**<br>**(g) Prevention and containment of communicable diseases.** |
| **ANALYSIS:** | During the onsite inspection on 01/14/2025, there was no verification on file for staff training with regards to reporting requirements, first aid, CPR, personal care, supervision and protection, resident rights, safety and fire prevention, or |

| | |
|---|---|
| | prevention and containment of communicable diseases, except for Nicholas Allen who did have CPR/First Aid certificates on file. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

During the onsite inspection on 01/14/25, I reviewed employee files and noted that direct care workers, Sheri Sarnowski and Rosemary Mendez, had medical clearance request forms on file; however, they were not fully completed or signed by the physician.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14205** | **Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.** |
| | **(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.** |
| **ANALYSIS:** | During the onsite inspection on 01/14/25, the employee files for Sheri Sarnowski and Rosemary Mendez did not contain a statement that signed by a physician attesting to their physical health. The medical clearance forms on file were not fully completed or signed. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

During the onsite inspection on 01/14/25, I reviewed employee files and noted that direct care workers, Sheri Sarnowski and Rosemary Mendez, had medical clearance request forms on file with a box checked for TB skin test; however, the forms did not indicate the date the TB test was administered or the results.

| APPLICABLE RULE | |
|---|---|
| **R 400.14205** | **Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.** |
| | **(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.** |
| **ANALYSIS:** | During the onsite inspection on 01/14/25, the employee files for Sheri Sarnowski and Rosemary Mendez did not contain verification of current TB testing. The medical clearance form was not fully completed to show the date of TB testing or the results. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

During the onsite inspection, I reviewed Resident A's resident file. The assessment plan on file was dated 03/12/2021. It was not updated annually and had not been updated to include her transition to hospice care and current needs.

| APPLICABLE RULE | |
|---|---|
| **R 400.14301** | **Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.** |
| | **(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.** |

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| **ANALYSIS:** | Resident A's assessment plan was not updated annually and had not been updated to include her transition to hospice care. The assessment plan on file was dated 03/12/21. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

During the onsite inspection, I reviewed Resident A's resident file. The resident care agreement on file was dated 03/12/2021. It was not updated or reviewed annually.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14301** | **Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.** |
| | **(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.** |
| **ANALYSIS:** | Resident A's resident care agreement was not updated annually. The resident care agreement on file was dated 03/12/21. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br>**Reference Renewal Licensing Study Report dated 03/23/23; CAP dated 04/01/23** |

**INVESTIGATION:**

During the onsite inspection on 01/14/25, I reviewed Resident B's assessment plan dated 12/13/24. It did not specify the use of bed rails or a shower chair. I reviewed Resident C's assessment plan dated 11/24/2024. The assessment plan did not include a shower chair or bed rails, which are used by Resident C.

| **APPLICABLE RULE** | |
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| **R 400.14306** | **Use of assistive devices.** |
| | **(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.** |

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| **ANALYSIS:** | Resident B's assessment plan dated 12/13/24 and Resident C's assessment plan dated 11/24/24 did not specify the use of bed rails or a shower chair. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

During the onsite inspection on 01/14/25, I reviewed Resident B and Resident C's files. There was no authorization on file for Resident B's Hoyer lift, bed rails, or shower chair. There was no physician authorization on file for Resident C's walker, bed rails, or shower chair. Resident C's health care appraisal noted that she uses a wheelchair for mobility, but she only uses a walker.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14306** | **Use of assistive devices.** |
| | **(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.** |
| **ANALYSIS:** | During the onsite inspection on 01/14/25, Resident B's file did not contain a physician authorization for her Hoyer lift, bed rails, or shower chair. Resident C's file did not contain a physician authorization for her walker, bed rails, or shower chair. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

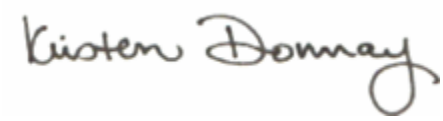
During the onsite inspection, I reviewed Resident A's resident file. Resident A's weight was not recorded from March-June 2023. Her weight was not recorded from August 2023-November 2024. The last weight recorded was 07/24/23. During the onsite inspection on 01/14/25, I reviewed the Resident B's resident file. There were no weights recorded for Resident B. The licensee designee, Syed Shah, stated that they do not have a scale that can be used to weigh Resident B since she is in a wheelchair and cannot stand on her own.

On 01/14/25, I conducted an exit conference in person with the licensee designee, Syed Shah, and reviewed my findings. I informed Dr. Shah that I would be recommending a provisional license due to the numerous violations and repeat violations. Dr. Shah stated that he would submit a corrective action plan and a signed statement as to whether or not he accepts the provisional license after reviewing the report and considering his options for the future of the home.

| APPLICABLE RULE | |
|---|---|
| **R 400.14310** | **Resident health care.** |
| | **(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.** |
| **ANALYSIS:** | Weights were not recorded monthly for Resident A and Resident B. The last weight recorded for Resident A was on 07/24/23. Resident B did not have any weights on file. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend the issuance of a six-month provisional license.



01/15/2025

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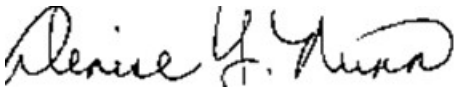
Kristen Donnay Date
Licensing Consultant

Approved By:



01/15/2025

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Denise Y. Nunn Date
Area Manager