GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 27, 2025

Achal Patel & Vivek Thakore
Divine Nest of Perry 1 Inc
2045 Birch Bluff Dr
Okemos, MI 48864

RE: License #: AL780418811
Investigation #: 2025A1033028
Divine Nest of Perry 1 Inc

Dear Mr. Patel & Mr. Thakore:

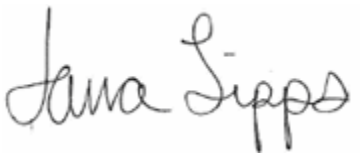
Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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) 335-5985.

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 #:	AL780418811
Investigation #:	2025A1033028
Complaint Receipt Date:	04/02/2025
Investigation Initiation Date:	04/02/2025
Report Due Date:	06/01/2025
Licensee Name:	Divine Nest of Perry 1 Inc
Licensee Address:	2045 Birch Bluff Dr Okemos, MI 48864
Licensee Telephone #:	(517) 898-2431
Administrator:	Cheri Lynn Weaver
Licensee Designee:	Achal Patel & Vivek Thakore
Name of Facility:	Divine Nest of Perry 1 Inc
Facility Address:	521 E. First St, Bldg 1 Perry, MI 48872
Facility Telephone #:	(517) 625-5650
Original Issuance Date:	01/27/2025
License Status:	TEMPORARY
Effective Date:	01/27/2025
Expiration Date:	07/26/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED/AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A experienced a fall in his bedroom, suffering significant injury, and direct care staff did not provide for his supervision, protection, and safety in responding to this medical event.	Yes
Resident A's medications were not administered correctly during the month of February 2025.	No
Additional Findings	Yes

III. METHODOLOGY

04/02/2025	Special Investigation Intake- 2025A1033028
04/02/2025	APS Referral- Currently assigned to Adult Services Worker, Rebecca Schalow.
04/02/2025	Contact - Document Sent- Email correspondence sent to APS, Rebecca Schalow.
04/02/2025	Special Investigation Initiated – Letter- Email correspondence received from APS, Rebecca Schalow.
04/08/2025	Inspection Completed On-site- Interviews conducted with direct care staff/Home Manager, Sandy Stelle, and direct care staff/Assistant home manager, Mellissa Knerr. Review of Resident A's resident record and direct care staff schedule initiated.
04/08/2025	Contact - Document Received- Email correspondence received from Relative A1.
04/18/2025	Contact - Telephone call made- Interview conducted with Relative A1, via telephone.
04/24/2025	Contact – Telephone call made- Interview conducted with Administrator, Cheri Lynn Weaver, via telephone.
04/28/2025	Contact – Document Received- Email correspondence with Ms. Weaver.
04/29/2025	Contact – Document Received- Email correspondence with Ms. Weaver.

05/02/2025	Contact – Document Sent- Email correspondence with Ms. Weaver.
05/12/2025	Contact – Telephone call made- Interview conducted with Guardian A1.
05/16/2025	Contact – Document received Email correspondence with Ms. Schalow.
05/16/2025	Exit Conference Conducted via telephone with licensee designee, Achal Patel.
05/19/2025	Contact – Document Received Email correspondence received from Administrator, Cheri Lynn Weaver.
05/20/2025	Contact – Document Received Email correspondence received from licensee designee, Achal Patel.
05/22/2025	Contact – Telephone call made Interview conducted with direct care staff, Anna Loomis, via telephone.

ALLEGATION: Resident A experienced a fall in his bedroom, suffering significant injury, and direct care staff did not provide for his supervision, protection, and safety in responding to this medical event.

INVESTIGATION:

On 4/2/25 I received an online complaint regarding the Divine Nest of Perry 1 Inc, adult foster care facility (the facility). The complaint alleged that Resident A experienced a fall in his bedroom at the facility, suffered a significant injury to his head, and was left bleeding on the floor of his room for multiple hours, before direct care staff checked on him. The complaint alleged direct care staff had not checked on Resident A for multiple hours as Resident A was bleeding extensively from his injury. On 4/2/25 I had email correspondence with Adult Protective Services, adult services worker, Rebecca Schalow. Ms. Schalow reported that she has been assigned to this investigation and is currently investigating these allegations. She reported that Guardian A1 had a video of Resident A's fall and she was making attempts to obtain this video as evidence.

On 4/8/25 I had email correspondence with Ms. Schalow. She reported that Resident A is still hospitalized at U of M Health Sparrow Hospital in Lansing, MI. She reported Guardian A1 was able to send her a copy of the video file and she had watched the

video. Ms. Schalow reported that after viewing the video she has adequate evidence to substantiate the allegations as neglect.

On 4/8/25 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/home manager, Sandy Steele. Ms. Steele reported that, to her knowledge, Resident A was currently at the Ingham County Medical Care Facility for rehabilitation services. Ms. Steele reported that Resident A experienced a fall in his bedroom on 3/30/25. She reported that she had arrived at the facility that morning around 9am. She reported the direct care staff on shift that morning were, Jordynn Young and Amber Schultz. Ms. Steele reported that Ms. Young and Ms. Schultz were scheduled to work at the facility from 5am to 1pm on 3/30/25. Ms. Steele reported that the previous shift was from 9pm to 5am and that shift was covered by direct care staff, Kathleen Barrows and Michelle Hanuscak. Ms. Steele reported that on 3/30/25 around 4:30am, Resident A was taken to his bedroom and direct care staff got him into his bed. She reported direct care staff did not go back to check on Resident A until around 9am the following morning. She reported that when direct care staff checked on him, they found him lying face down, on the floor of his bathroom, in a puddle of blood. She reported that she asked Resident A if he was “okay” and told him that the ambulance was coming. Ms. Steele reported that she sat with Resident A until the ambulance arrived and told him he was going to be okay. Ms. Steele reported that she observed Resident A had blood loss during the night and there were three large pools of blood on the carpet between the bedroom and the bathroom. She reported that there was also blood found on his chair, which she interpreted as if he had sat down in the chair after he had fallen. Ms. Steele reported that Resident A had a gash to the mid to back region of his head and this wound was bleeding. Ms. Steele reported all direct care staff are required to conduct hourly checks for safety and incontinence purposes throughout the night. She reported that Resident A does wear an incontinence brief that would require checking throughout the night. Ms. Steele reported that Ms. Schultz and Ms. Young both reported that they had not checked on Resident A between their shift starting at 5am and 9am when Resident A was found on the floor. Ms. Steele reported that Ms. Young and Ms. Schultz have been terminated due to not following protocol to conduct safety checks on Resident A on 3/30/25.

During the on-site investigation on 4/8/25, I interviewed direct care staff/assistant home manager, Mellissa Knerr. Ms. Knerr was present in the room when I interviewed Ms. Steele. Ms. Knerr agreed with all of Ms. Steele’s statements regarding Resident A’s injury. Ms. Knerr reported that hourly safety checks are documented on the Quick MAR system. She reported that this is an expectation for all direct care staff to follow this directive.

During the on-site investigation on 4/8/25, I reviewed the following documentation:

- Admin History for [Resident A] – Every 2 Hours Bathroom Check. I observed the following:
    - On 3/29/25 the document had scheduled checks for 12am, 2am, 4am, 6am, 8am, 10am, 12pm, 2pm, 4pm, 6pm, 8pm, 10pm.

    - On 3/30/25 the document had scheduled checks for 12am, 4am, 12pm, 2pm, 4pm, 6pm, 8pm, 10pm. There was not an entry for a 2am, 6am, or an 8am check on this document.
    - Ms. Young recorded that she administered the 3/30/25 4am check at 10:20am.
- *Medication Administration Record* (MAR) for Resident A for the Month of March 2025 was provided. I observed the following information in this document:
    - Aspirin Low Dose 81MG, Take 1 tablet by mouth daily. Prescribed on 12/24/24. This medication functions as an anticoagulant.
    - Clopidogrel Tab 75mg, Take 1 tablet by mouth daily. Prescribed on 3/11/25. This medication functions as an anticoagulant.
- *Health Care Appraisal* for Resident A, dated 9/5/24. Under section, *7. Diagnoses*, it reads, "Dementia, Insomnia". Under section, *11. Mental/Physical Status and Limitations*, it reads, "A&O x 1, limited insight and judgment, slow speech."
- *McLaren Greater Lansing Emergency Department, Discharge Instructions*, for Resident A, dated 2/25/25. Under the section, *Final Diagnosis*, it reads, "Lightheaded".
- *Assessment Plan for AFC Residents* for Resident A, dated 9/6/24. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *A. Moves Independently in Community*, it reads, "Needs supervision. Memory issues."
- *Resident Care Agreement,* for Resident A, dated 9/5/24.
- *Employee Termination,* document dated 3/31/25, for Ms. Schultz. This document states, "Your employment has been terminated due to: Not following company procedure which led to Resident endangerment." This document is signed by Ms. Schultz, Ms. Steele, and Ms. Knerr.
- *Employee Termination,* document dated 3/31/25, for Ms. Young. This document states, "Your employment has been terminated due to: Not following company procedure which led to Resident endangerment." This document is signed by Ms. Young, Ms. Steele, and Ms. Knerr.
- *AFC Licensing Division Incident – Accident Report* for Resident A, dated 3/30/25. This document was completed by Ms. Schultz. Under the section, *Explain What Happened/Describe Injury*, it reads, "[Resident A] was on the floor by the bathroom bleeding all over his room." Under the section, *Action Taken by Staff/Treatment Given*, it reads, "Usually he sleep good and walks normal." Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "I thought you supposed to do checks every 2 hours if them are people normal need…" (The rest of this sentence was not legible).
- *AFC Licensing Division Incident – Accident Report* for Resident A, dated 3/30/25. This document was completed by Ms. Young. Under the section, *Explain What Happened/Describe Injury*, it reads, "I got to work at 3am, [Resident A] was up all night in the living room, went and toileted him and put him to bed around 5am. [Ms. Schults] went in to get him up at around 9am and he was on the floor blood everywhere, hit his head. Called 911, called [Guardian A1]. Not sure when he fell or how long he was there for. Manager was here. Under the section, *Corrective Measures Taken to Remedy and/or Prevent*

Recurrence, it reads, “Do more frequent checks. I was letting him sleep and should’ve checked more.”
- *Divine Living of Perry Work Schedule*. This document identifies Ms. Young and Ms. Schultz as scheduled to work 5am to 1pm on 3/30/25.

On 4/8/25 I received email correspondence from Citizen 1. She sent a link to the video footage from Resident A’s bedroom on 3/30/25. I watched this video and made the following observations:

- At 4:26am a direct care staff member (name unknown) is seen on camera escorting Resident A to his bed. He walks himself to the bed and she helps arrange his blankets. She turns off the lights, shuts the door and leaves the bedroom at 4:27am.
- At 4:29am Resident A sits up in bed, uncovers himself, stands up, and begins walking toward the door on the opposite side of the room. He stumbles backward, regains his momentum, and walks quickly with an unsteady gait, forward again. He then turns around, feels for his chair, appears to trip on the foot of the chair, and falls forward hitting his head on what appears to be the windowsill next to his chair. Resident A lets out a slight moan when he hits his head. There is a noise when he hit the windowsill. The fall occurred at 4:30am. He then gets himself off the ground and sits in his chair, holding his head.
- The camera then zooms in to show a horizontal gash on Resident A’s head, that is bleeding, just above the hairline on the scalp on the left side of his head.
- At 4:59am, 5:04am, 5:11am the camera is too dark to see where Resident A is located, but there are noises heard on the video footage that sound like Resident A was moving around in the room.
- At 5:37am Resident A can be seen crawling/scooting along the floor near his bed.
- At 9:06am a direct care staff member enters Resident A’s bedroom and exclaims, “Um, oh my God! I need help. [Resident A] fell.” “There’s blood all over.”
- At 9:08am Ms. Steele is seen entering Resident A’s bedroom. Ms. Steele appears to be observing the blood stains that are visible on the carpet, side table by the bathroom, Resident A’s chair. At one point she looks down and says, “Is this skin?” She does not go into the bathroom and assess Resident A or provide him any verbal comfort.
- At 9:09am Ms. Steele walks back by the bathroom, where Resident A is lying, and does not attend to Resident A. Ms. Steele states, “I want 911 right now. He’s been laying here for way too long.” She then exits Resident A’s bedroom and the direct care staff exit as well, leaving Resident A on the bathroom floor, alone. There are slight moans heard during this section of the video. (Resident A cannot be visualized in this video, as the camera captures the resident living area, hallway to the bathroom and the main entrance to the room).
- At 9:11am Ms. Steele and two direct care staff re-enter Resident A’s bedroom. They proceed to discuss how Resident A may have fallen. One direct care staff (name unknown) asks, “Should we just leave him there?” to which Ms. Steele replies, “Yeah, don’t move him.” Ms. Steele then sits on the armrest of Resident

A's chair and states, "No one cared to check him hourly." Resident A mumbles something that could not be heard clearly, and one of the direct care staff states, "Hang on buddy, we got someone coming for you." At this point I do not see any direct care staff who have entered the bathroom to sit with Resident A or provide any first aid/care.

- At 9:13am three individuals, one of which is Ms. Steele, are observed in the bedroom, walking around, looking at the room. There is conversation that is difficult to decipher. Ms. Steele makes a comment about the reasoning for hourly checks is so incidents like this don't go unnoticed.
- At 9:18am the paramedics arrive to provide care for Resident A.
- At 9:19am the paramedics inquire whether Resident A is on a blood thinner (anticoagulant) medication. The direct care staff respond that Resident A takes Aspirin. The paramedic inquires about Eliquis, and it was not decipherable what the answer to this question was from direct care staff.
- At 9:20am the paramedic asks for a pillow, which is retrieved by a direct care staff member, who then stated that Resident A had fallen about 25 minutes prior.
- At 9:22am the paramedic is heard stating to Resident A, "We're wrapping you up buddy, you're bleeding badly."
- At 9:25am additional paramedics arrive through the fire department to assist with carrying Resident A out of the bathroom to the stretcher.
- At 9:37am a direct care staff (name unknown) is seen beginning to clean the blood in Resident A's bedroom.

On 4/18/25 I interviewed Citizen 1, via telephone. Citizen 1 reported that they are a relative to Guardian A1. Citizen 1 reported that a video camera was placed in Resident A's bedroom by Guardian A1 for observation of Resident A's care. Citizen 1 reported that she has access to this video footage and was able to view what occurred during the early morning hours of 3/30/25. Citizen 1 reported that there are two different times seen on the video as she lives in Central Time Zone, so her video feed is one hour behind but noted that the actual Eastern Time Zone is also seen on the video in the lower right corner. Citizen 1 reported that the video shows Resident A being tucked into bed around 4:30am (Eastern Standard Time) by a direct care staff member. She reported that after he was tucked in, the lights were turned off, the door was closed and Resident A got himself out of bed, within minutes of the direct care staff member leaving the bedroom. Citizen 1 reported that shortly after Resident A gets out of bed, he stumbles, falls and hits his head on what appears to be the windowsill or the wall. She reported that Resident A then begins bleeding and is not checked on again until around 9am, when a direct care staff member enters the bedroom and can be heard exclaiming, "Oh my God!" Citizen 1 reported that she has watched the video footage multiple times and does not see any evidence that any of the direct care staff, including Ms. Steele (who is seen in the video), attempted to perform first aid or even sat with Resident A to provide comfort. She reported that until the paramedics arrived, the direct care staff walked around the room, or sat on the edge of furniture and debate what may have occurred. She further reported that she heard one of the direct care staff note to the paramedics, when they arrived, that Resident A had only been on the floor for about 25 minutes. Citizen 1 reported that on this date, Resident A is still hospitalized due to

the injury sustained. She reported that when he arrived at the hospital his blood pressure was 70/30, his hemoglobin count was at a 6 (normal range for men is 14 to 17.5 per the Cleveland Clinic website), and he required four uncross matched units of blood. She reported that Resident A has a large horizontal gash just above the hairline on his scalp which required sutures. Citizen 1 reported that Resident A did not have a subdural hematoma from the fall but is now experiencing behavioral disturbances which is holding up his ability to be transferred to a rehabilitation center. She reported that he has been placed in restraints at the hospital, and he has a safety sitter with him for his own protection. Citizen 1 reported that the direct care staff did know Resident A had a video camera in his bedroom, as one of the direct care staff spoke directly to the camera while they were waiting for the paramedics to arrive.

On 4/24/25 I interviewed the Administrator, Cheri Lynn Weaver, via telephone regarding the allegations. Ms. Weaver reported that she is aware of the injury Resident A sustained due to falling at the facility. She reported that the direct care staff working that day have been terminated. She confirmed that this includes Ms. Young, Ms. Schultz, and Ms. Steele. Ms. Weaver reported that a plan of correction is already being formulated and discussed putting video cameras in place to be able to check on direct care staff to ensure they conduct regular safety checks on resident bedrooms during sleeping hours. She reported that these video cameras will be placed in the hallways of the facility to provide for view of resident bedroom doors. Ms. Weaver reported that direct care staff training will also be conducted regarding resident supervision, protection, and safety.

On 4/24/25 Ms. Weaver provided documentation of cardiopulmonary resuscitation training for Ms. Young, Ms. Steele, and Ms. Schultz. I observed the following:

- Ms. Schultz held a current certification in CPR/First Aid with a renewal date of 11/2025.
- Ms. Young held a current certification in CPR/First Aid with a renewal date of 2/20/25.
- Ms. Steele’s certification in CPR/First Aid expired on 6/16/24.

On 4/28/25 Ms. Weaver provided documentation for review, via email. This documentation included the *Resident Register* for the facility. I observed the following information:

- In section, License Number, the document reads, “AL7804188811”.
- Resident A’s name does not appear on this document.
- Resident B through Resident K have an admission date of 10/4/24.
- Resident L has an admission date of 12/9/24.
- Resident M has an admission date of 12/10/24.
- The license effective date is 1/27/25.

On 5/12/25 I interviewed Guardian A1, via telephone, regarding the allegations. Guardian A1 reported that Resident A is still hospitalized as a new placement has not been located for him due to his behavioral disturbances. She reported that the family did keep a video recording camera in Resident A’s bedroom at the facility and the direct

care staff were aware of the presence of this camera. She reported that they put a sign on the wall of the bedroom to report the presence of the camera and to remind the direct care staff to not unplug the camera. Guardian A1 reported that on 3/30/25 she woke up and went to review the night's camera footage as she did most mornings. She reported that she observed the direct care staff enter Resident A's bedroom around 9am and find Resident A had fallen and was bleeding on the ground. Guardian A1 reported that she called the facility around 945am to ask what had occurred and was told that Resident A was sent to the hospital. Guardian A1 reported that the direct care staff had not called her prior to this to report the incident. She reported that she was made to pay Resident A's room and board charges for the month of April 2025 due to the fact that she was not able to provide a 30-Day Notice of discharge. Guardian A1 reported that she has not received any contact from any person affiliated with the facility to check on the status of Resident A since the incident.

On 5/16/25 I had email correspondence with Ms. Schalow. Ms. Schalow reported that she continues to have an open APS case for Resident A due to Resident A remaining hospitalized. She reported that she attempted to interview Ms. Schultz and Ms. Young and neither returned her telephone calls.

On 5/16/25 I conducted an exit conference with licensee designee, Achal Patel. Mr. Patel reported that he understands that the direct care staff did not complete their required safety checks for Resident A on 3/30/25. Mr. Patel reported that three direct care staff have been terminated because of this oversight and the failure to attend to Resident A's injury in a timely manner. Mr. Patel reported that he does not feel the direct care staff should have performed first aid to Resident A prior to emergency medical services arriving on-site as Resident A had a head injury and the direct care staff could have caused further injury by attempting to administer first aid. He reported that the company has a policy about this protocol that he would email for my review.

On 5/20/25 I received email correspondence from Mr. Patel. Attached to this email was a document titled, *Fall Protocol*. This document reported the following steps for direct care staff to follow in the event of a witnessed or unwitnessed fall:

- Ask the resident if they hit their head during the process of falling down.
- Check for any visible injuries by scanning open areas, gently touching covered body parts. Avoid excessive movement of any extremities/the resident. Ask for pain, take a full set of vitals, complete skin assessment form.
- Call 911 if major injury or head trauma is visible/suspected. Give a copy of the facesheet to EMS or to the family (if the family is transporting).
- Call & inform manager/DRS.
- Call the Doctor's office/Hospice.
- Inform family.
- Fill out the incident report.

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 conducted with Ms. Schalow, Ms. Steele, Ms. Knerr, Citizen 1, Guardian A1, Mr. Patel, and Ms. Weaver, as well as a review of video footage from Resident A's bedroom camera, and documentation provided on-site and via email, it can be concluded that the direct care staff did not provide adequate supervision for Resident A's protection and safety on 3/30/25. Resident A's fall may not have been preventable, however, had Ms. Young and Ms. Schultz conducted the required safety checks on Resident A, they would have identified his injury, and been able to call for emergency medical services sooner. Since this did not occur, Resident A was left alone and injured in his room for up to 4.5 hours. This entire time he was bleeding extensively from his head, leaving him in a compromised medical status, requiring a prolonged hospitalization. Resident A was taking two medications that act as anticoagulant agents, which caused his blood to not clot resulting in a significant bleed. Resident A's *Health Care Appraisal* notes that he has limited insight, poor judgement, and Insomnia. The direct care staff should have been aware of these factors and provided better supervision during sleeping hours for this resident. Even though the direct care staff involved in this incident were terminated and the facility is actively working on a plan of correction, a violation stands as the direct care staff were not adequately supervised to ensure they were following protocol to ensure resident safety. In reviewing the *Fall Protocol* document provided by Mr. Patel, it can also be identified that the direct care staff did not follow all the steps on this document as they did not appear to check Resident A's vital signs while they awaited emergency medical services to arrive. Additionally, the lack of supportive response from the direct care staff, provided to Resident A, while he awaited paramedic arrival, demonstrated an inefficiency of the direct care staff to handle this emergency situation in a caring and effective manner for Resident A. As a result, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's medications were not administered correctly during the month of February 2025.

INVESTIGATION:

On 4/18/25 I interviewed Citizen 1 regarding Resident A's fall at the facility. Citizen 1 reported that she had additional concerns that Resident A's medications had not been administered as prescribed during the month of February 2025. She reported that it was discovered there was an issue obtaining medications for Resident A from the pharmacy and that Resident A was hospitalized due to experiencing withdrawal symptoms from not having his routine medications administered for multiple days and even weeks.

On 4/28/25 Ms. Weaver sent, via email, Resident A's *Medication Administration Record* (MAR) for the month of February 2025 for my review. I made the following observations in reviewing this document:

- Aspirin Low Dose 81mg (p), take 1 tablet by mouth daily. This medication is marked as not being administered on the following dates, 2/4/25, 2/5/25, 2/15/25 – 2/24/25.
- Atorvastatin Tab 10mg, Take 1 tablet by mouth daily. This medication is marked as not being administered on the following dates, 2/15/25 – 2/24/25.
- Buspirone Tab 5mg, Take 1 tablet by mouth twice daily. This medication is marked as not being administered 2/11/25 - 2/26/25 8am.
- Donepezil Tab 10m, Take 1 tablet by mouth at bedtime. This medication is marked as not being administered on the following dates, 2/12/25, 2/14/25 - 2/25/25.
- Escitalopram Tab 10mg, take 1 tablet by mouth daily. This medication is marked as not being administered on the following dates, 2/4/25 – 2/26/25.
- Loratadine Tab 10mg, Take 1 tablet by mouth daily. This medication is marked as not being administered on the following dates, 2/1/25 – 2/28/25.
- Lorazepam Tab 0.5mg, Take 1 tablet by mouth every 12 hours. This medication is marked as not being administered on the following dates, 2/1/15 – 2/28/25
- Losartan Potassium 100 mg tabs, Administer 1 tab daily. This medication is marked as not being administered on the following dates, 2/15/25 – 2/24/25.
- Memantine Tab HCL 10mg, Take 1 tablet by mouth twice daily. This medication is marked as not being administered on the following dates, 2/12/25 (8pm), 2/14/25 (8pm), 2/15/25 – 2/20/25. There is a notation that this medication was stopped on 2/20/25.
- Mirtazapine Tab 7.5mg, Take 1 tablet by mouth at bedtime. This medication is marked as not being administered on the following dates, 2/1/15 – 2/25/25.
- Quetiapine Tab 25mg, Take 1 tablet by mouth at bedtime. This medication is marked as not being administered on the following dates, 2/1/25 – 2/20/25. There is a notation that this medication was stopped on 2/20/25.
- Rexulti Tab 0.5mg, Take 1 tablet by mouth daily. This medication is marked as not being administered on the following dates, 2/15/25 – 2/24/25.
- There is a notation on the MAR which reads, "Resident out of facility 18 Feb 2025 to 24 Feb 2025".

- There are notations in the "*Exceptions*" section of the MAR for the medications that were not administered which read, "Waiting on Pharmacy to Fill" (2/1/25-2/14/25, 2/25/25-2/28/25) "Out of facility" (2/14/25-2/18/25, 2/25/25), "Resident Refused" (2/12/25).

On 4/28/25 I sent email correspondence to Ms. Weaver requesting information on why Resident A had so many missed medication administrations for the month of February 2025. Ms. Weaver responded to this email on 4/29/25 and reported that she was informed by direct care staff that Guardian A1 was supposed to be supplying the medications and delivering them to the facility. She reported that she was informed that Guardian A1 would state that the medications would be delivered and were not supplied. Ms. Weaver reported that at this time she is not aware of any written documentation from the direct care staff to support this evidence in their efforts to obtain Resident A's medications. I provided response to Ms. Weaver's email communication on 4/29/25 and requested to review any written documentation and to have the telephone number of the direct care staff member responsible for communications with Resident A's family. I did not receive a response to this request. On 5/2/25 I sent another email correspondence to Ms. Weaver again asking for any written documentation of the efforts to obtain medications for Resident A, during the month of February 2025. I have not received a response to this request as of 5/12/25.

On 5/12/25 I interviewed Guardian A1, via telephone. Guardian A1 reported that Resident A went almost the entire month of February 2025 without many of his medications due to the direct care staff not being able to order his medications correctly. She reported that she was working with a direct care staff by the name of Anna (last name unknown) and this individual was trying to assist in ordering Resident A's medications through an external pharmacy for Guardian A1. Guardian A1 reported that the reason they were going through this process was because if they ordered Resident A's medications through the pharmacy used by the facility, then there was a charge for Resident A's medications, but if she ordered them through Walgreens, there was no charge. Guardian A1 reported that the individual she was working with at the facility had requested scripts for Resident A's medications through two different medical providers (primary care physician and neurologist) and both sent the same scripts to Walgreens on the same date which caused a "red flag" in the system and they would not fill the prescriptions. Guardian A1 reported that there were many back and forth conversations about the medications which resulted in both medical providers noting they would no longer communicate with Anna at the facility due to the confusion she was causing in this process. Guardian A1 reported that she asked Anna routinely about the status of Resident A's medications because she made daily visits to the facility. Guardian A1 reported that Anna never sought out Guardian A1 with updates regarding the status of the medications. She reported that the result was the medications were ordered to be filled through the pharmacy the facility uses, and Resident A was charged for the medications.

On 5/19/25 I received email correspondence from Ms. Weaver. Ms. Weaver sent documentation for my review of the attempts direct care staff, Anna Loomis, made to

obtain Resident A's medication refills. The documentation I reviewed identified the following information:

- On 12/17/24 Ms. Loomis sent a fax transmittal to Resident A's medical providers, Dr. Habtamu Handro and Dr. Steven Simensky, which included Resident A's medication list for their review.
- On 1/7/25 Ms. Loomis sent a fax transmittal to Dr. Handro's office requesting refills of Resident A's Lexapro, Namenda, Remeron, Seroquel, and Ativan medications. This request also noted that the medication refills should be sent to the Walgreens pharmacy (it did not identify which Walgreens pharmacy to send the refills).
- On 1/18/25 Ms. Loomis sent a fax transmittal to Dr. Simensky's office requesting a medication list for Resident A due to some potential medication discrepancies for this resident.
- On 1/20/25 Ms. Loomis received a fax transmittal from Dr. Simensky's office which included Resident A's medication list with hand written notes regarding which medications should be continued, modified, or discontinued.
- On 1/23/25 Ms. Loomis received a fax transmittal from McLaren. This transmittal included Resident A's medication list, but it did not identify who was sending the medication list.
- Ms. Weaver sent screenshots of a text message exchange dated 2/13/25, between the facility management and direct care staff members at the facility, discussing Resident A's medications not being available for administration. The text messages indicated that the direct care staff were still awaiting Guardian A1 to pick up the medications from the Walgreens pharmacy.

On 5/22/25 I interviewed direct care staff, Anna Loomis, regarding the allegations. Ms. Loomis reported that Resident A was running out of his medications at the facility due to his physicians, Dr. Handro and Dr. Simensky, not agreeing on what prescriptions Resident A should be taking. Ms. Loomis reported that she spent multiple days on the phone with the two providers and even sent fax transmittals trying to coordinate which medications would be refilled for Resident A. Ms. Loomis reported that she called the providers' offices about twice per week for a period of 1.5 to 2 months, trying to resolve the issue. Ms. Loomis reported that she would leave voicemail messages and had telephone conversations with the medical assistants and nurses in these provider offices trying to figure out the issue with refilling Resident A's medications. Ms. Loomis reported that she also made telephone calls to the Walgreens pharmacy to see if the prescriptions had been filled. She reported that she transferred from the facility to another licensed adult foster care facility at the end of February 2025 and the issue with Resident A's medications had not been resolved at that point. She reported that throughout this process she was working with Guardian A1, who was also attempting to communicate with the physicians regarding Resident A's medications. Ms. Loomis reported that Resident A was hospitalized in February 2025 and it was reported to her that his hospitalization was due to medication withdrawal as he had not been receiving his regularly prescribed medications for a prolonged period. Ms. Loomis reported that she did have a telephone conversation with a family member (name she could not recall) of Guardian A1, in February 2025, who noted that the family was going to speak

with Guardian A1 about using the medical provider who makes visits to the facility for Resident A. This transition in care was discussed to eliminate the issues with the prescriptions not being refilled in a timely manner.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon interviews conducted and *Medication Administration Records* reviewed during this on-site investigation it can be determined that the direct care staff were not able to administer all Resident A's medications as prescribed during the month of February 2025. Ms. Weaver reported that there were issues in obtaining Resident A's medications from Guardian A1, who was the person responsible for delivering medications to the facility. Guardian A1 reported that a direct care staff member at the facility was taking charge of ensuring the medications were ordered through an outside pharmacy and that she had to request repeated updates from this individual as to the status of the prescriptions and whether they were sent to the pharmacy, correctly, for refill. Ms. Loomis reported that she was making regular telephone calls and sending fax transmittals to the providers offices in attempts to refill the prescription medications for Resident A. Due to the conflicting statements from Ms. Weaver, Ms. Loomis, and Guardian A1, as well as documentation reviewed demonstrating the direct care staff efforts to obtain prescription refills for Resident A, it can be determined that there is not adequate evidence to suggest that the direct care staff were not actively attempting multiple courses of communication in attempts to secure Resident A's medications. Based upon this information, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on 4/8/25 I reviewed the following documents:

- *Health Care Appraisal* for Resident A, dated 9/5/24.
- *Assessment Plan for AFC Residents* for Resident A, dated 9/6/24.
- *Resident Care Agreement,* for Resident A, dated 9/5/24.

I asked Ms. Steele if these were the current resident forms for Resident A. Ms. Steele reported that they are in the process of updating the resident forms since the new license was issued on 1/27/25, but these forms have not been updated yet and these are the current documents for Resident A.

On 4/28/25 Ms. Weaver provided documentation for review, via email. This documentation included the *Resident Register* for the facility. I observed the following information:

- In section, License Number, the document reads, “AL7804188811”.
- Resident A’s name does not appear on this document.
- Resident B through Resident K have an admission date of 10/4/24.
- Resident L has an admission date of 12/9/24.
- Resident M has an admission date of 12/10/24.
- The license effective date is 1/27/25.

APPLICABLE RULE	
R 400.15301	**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.
ANALYSIS:	Based upon review of the available *Assessment Plan for AFC Residents* for Resident A, it can be determined that this document was dated 9/6/24, and therefore not updated when the new license was issued for this facility on 1/27/25. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following:

ANALYSIS:	Based upon review of the available *Resident Care Agreement* for Resident A, it can be determined that this document was dated 9/5/24, and therefore not updated when the new license was issued for this facility on 1/27/25. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Based upon review of the available *Health Care Appraisal* for Resident A, it can be determined that this document was dated 9/5/24, and therefore not updated when the new license was issued for this facility on 1/27/25. This document was not completed within 90 days of admission to the facility. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15210	**Resident register.**
	Rule 210. A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(a) Date of admission.** **(b) Date of discharge.** **(c) Place and address to which the resident moved, if known.**

ANALYSIS:	Based upon review of the *Resident Register* document provided by Ms. Weaver, it can be determined that Resident A's information is not recorded on this document. It was further identified that Resident B through M had listed dates of admission that were prior to the issuance of the license on 1/27/25. Therefore, a violation has been established due to the *Resident Register* not containing accurate information regarding dates of admission, or resident's admission and discharge information.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 4/24/25 Ms. Weaver provided documentation of cardiopulmonary resuscitation training for Ms. Young, Ms. Steele, and Ms. Schultz. I observed the following:

- Ms. Schultz held a current certification in CPR/First Aid with a renewal date of 11/2025.
- Ms. Young held a current certification in CPR/First Aid with a renewal date of 2/20/25.
- Ms. Steele's certification in CPR/First Aid expired on 6/16/24.

APPLICABLE RULE	
R 400.15204	**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: **(b) First aid.** **(c) Cardiopulmonary resuscitation.**
ANALYSIS:	Based upon the cardiopulmonary resuscitation certificates reviewed for the direct care staff, Ms. Schultz, Ms. Young, and Ms. Steele, it can be determined that Ms. Steele did not hold an active cardiopulmonary resuscitation/First Aid certification at the time of Resident A's injury. Therefore, a violation has been established at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

EXIT CONFERENCE

On 5/16/25 I conducted an exit conference with licensee designee, Achal Patel, via telephone. Mr. Patel was informed of the rule violations cited in this special investigation report. Mr. Patel reported that he wants additional time provided for him to

evaluate Resident A's medications and the reasoning why the medications were not administered as ordered during the month of February 2025. Mr. Patel reported that he disagrees with the rule violation regarding resident admission paperwork as he was instructed by adult foster care licensing consultant, Candace Coburn, that he would have a period of six months to complete new paperwork for the existing residents since the issuance of the original license on 1/27/25. Mr. Patel reported that this facility was purchased and licensed with the existing residents from the previous owner/license number. He reported he did not know that he had to complete the new documentation for residents immediately and that he was verbally told he had up to six months to get this paperwork in order. Mr. Patel reported that he agrees with the finding regarding the citation of Rule 305.3 as the direct care staff members did not complete the required safety checks for Resident A and could have attended to his injury sooner. Mr. Patel reported that these direct care staff members have had their employment terminated. He reported that he has taken immediate action in terminating the direct care staff involved and feels that the resident's fall may not have been avoidable. He reported that he is unsure what first aid could have been provided due to the resident having a head injury and he does not feel that there is adequate evidence to suggest that the direct care staff could have offered adequate first aid prior to the arrival of the emergency medical services team without the prospect of potentially causing additional injury to Resident A.

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of the license remains unchanged.

5/27/25

_____

Jana Lipps Date
Licensing Consultant

Approved By:

05/27/2025

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Dawn N. Timm Date
Area Manager