RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

September 18, 2018

Barry Bruns
HomeLife Inc
PMB #360
5420A Beckley Rd.
Battle Creek, MI 49015

RE: License #: AS390078924
Investigation #: **2018A0581053**
10713 South 12th Street AFC

Dear Mr. Bruns:

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 (616) 356-0183.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390078924
Investigation #:	2018A0581053
Complaint Receipt Date:	08/10/2018
Investigation Initiation Date:	08/13/2018
Report Due Date:	10/09/2018
Licensee Name:	HomeLife Inc
Licensee Address:	3 Heritage Oak Lane Battle Creek, MI 49015
Licensee Telephone #:	(269) 660-0854
Administrator:	Barry Bruns
Licensee Designee:	Barry Bruns
Name of Facility:	10713 South 12th Street AFC
Facility Address:	10713 South 12th St Portage, MI 49087
Facility Telephone #:	(269) 372-4820
Original Issuance Date:	11/06/1997
License Status:	REGULAR
Effective Date:	08/11/2018
Expiration Date:	08/10/2020
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A's medication, Metoprolol, had not been passed according to physician instructions.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/10/2018	Special Investigation Intake 2018A0581053
08/13/2018	Special Investigation Initiated - Telephone Interview with Recipient Rights Officer, Michele Schiebel
08/16/2018	Inspection Completed On-site Unannounced onsite inspection. Interviewed direct care staff. Obtained documentation.
08/16/2018	Contact - Face to Face Obtained information from the Long-Term Care Pharmacy
08/17/2018	Contact - Telephone call made Interview with RRO, Michele Schiebel
08/17/2018	Contact - Telephone call received Voicemail from LTC Pharmacy receptionist
08/21/2018	Contact – Document Received Facility home manager, Jessica Cummins, emailed and faxed Resident A's updated prescription order from his physician.
09/14/2018	Contact – Telephone call made Left voicemail with direct care staff, Shakira Bonds.
09/14/2018	Exit conference with licensee designee, Barry Bruns.

ALLEGATION:

Resident A's medication, Metoprolol, had not been passed according to physician instructions.

INVESTIGATION:

On 08/10/2018, I received this complaint through the BCHS online complaint system. The complaint alleged direct care staff, Lillian Kaye, reviewed Resident A's July 2018 medication administration records (MAR) and noticed Resident A's Metoprolol medication had been passed on 07/09/2018 when it should have been held. The complaint alleged the doctor's orders state the medication should be held if Resident A's pulse is less than 60 and according to the MAR Resident A's pulse was 55 on 07/09/2018.

On 08/13/2018, I interviewed Kalamazoo's Recipient Rights Officer, Michele Schiebel. Ms. Schiebel confirmed she was aware of the allegations and was already investigating the complaint; therefore, a referral to Recipient Rights was not needed. Ms. Schiebel reported she had already contacted Resident A's doctor who informed her Resident A was placed at a risk of harm for receiving his Metoprolol medication when his blood pressure was below 60. Ms. Schiebel reported Resident A's doctor reported to her the risk could have included a drop in heart rate that could have caused dizziness or a fall, which would have caused injury.

On 08/16/2018, I conducted an unannounced onsite at the facility as part of my investigation. The facility's home manager, Jessica Cummins, was present, as well as, direct care staff, Lillian Kaye, both of whom I interviewed. Ms. Kaye reported she had been reviewing Resident A's blood pressure and pulse tracking sheet on 08/02/2018 when she noticed Resident A's pulse had been recorded as 55 on 07/09/2018. I reviewed the blood pressure and pulse tracking sheet used by the facility and confirmed what Ms. Kaye was reporting. Ms. Kaye reported when she reviewed Resident A's MAR, it showed Resident A's Metoprolol was still administered by direct care staff, Shakira Bonds. I reviewed Resident A's July MAR and was again able to confirm what Ms. Kaye reported to me.

During the onsite investigation, Ms. Cummins reported to me direct care staff, Shakira Bonds, who administered the Metoprolol to Resident A when she shouldn't have had been disciplined for not following medication instructions. She advised Ms. Bonds was not administering medications to any of the residents until she completed a remedial medication training and passed accordingly. Ms. Cummins provided me with copies of Ms. Bonds written warning regarding the incident. It was noted under the "Expectations" section the following:

> "It is expected that you follow the 5 R's when passing all medication. It is also expected that you complete a self-check of all the medication packs and med sheets. As

> Shift Supervisor, you are expected to ensure that proper medication passing protocols are being followed, including checking your own work."

Under the "Consequences" section, the following was noted:

> "Due to this medication error you are receiving a written warning. Further, this serves as a notice of the above expectations, and to notify you that careful adherence to the 5 R's and self/buddy check system are expected. You will be required to attend remedial medication training with the SLS. During your time off of medications you will still be required to act as the medication "buddy-checker" for your fellow staff. Future infractions will result in further disciplinary action including, further remedial medication trainings, suspensions, and demotion up to termination from HomeLife, Inc."

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my review of Resident A's medication administration record, the facility's blood pressure and pulse tracking sheet, the instructions on Resident A's medication labels and disciplinary action documentation, direct care staff member Shakira Bonds administered the medication, Metoprolol, to Resident A when it should have been held.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 08/16/2018, during my unannounced onsite at the facility, I requested to review Resident A's July MAR. Upon further inspection of Resident A's July's MAR, I observed a handwritten instruction under Resident A's Metoprolol medication. The instruction read, "*hold if pulse <60 or SBP <110*". Direct care staff, Lillian Kaye confirmed she had handwritten the instruction onto the MAR. When I observed the actual medication pack for Metoprolol, I also observed the same handwritten instructions as observed on the MAR. Ms. Kaye also confirmed she handwrote the instructions on all the medication packs. She reported to me she handwrote the instructions because the pharmacy didn't put the instructions on them, but the order

for the medication included this instruction. I requested the physician's order for Metoprolol while at the facility; however, Ms. Cummins and Ms. Kaye could not locate it, stating it was possible it had been archived due to how long it'd been since it was originally written. They also did not have available for review any kind of contact sheet stating a current verbal order had been obtained regarding the instruction of the administration for the Metoprolol.

Later in the day on 08/16/2018, I received a fax from Ms. Cummins containing a physician's order for Resident A's Metoprolol prescription. The documentation stated the order was given as a phone order, which was given on12/20/2013. The order stated the following:

> METOPROLOL 25MG TAB
> TAKE ONE TAB BY MOUTH ONCE DAILY IN THE AM
> (HOLD IF PULSE <60 OR <110)
> #30 REFILL X6

According to this physician's order, Resident A's Metoprolol prescription would have only been valid until 06/20/2014.

On 08/16/2018, I requested all Resident A's prescription orders from Long Term Care Pharmacy (LTC). LTC Pharmacy fills all Resident A's medications. They provided me with all Resident A's orders relating to Metoprolol since 12/19/2016. According to the prescription orders, the doctor who originally prescribed Resident A's Metoprolol was Dr. Bahram Elami. The last prescription renewal provided by Dr. Elami was written on 03/27/2017. Effective 07/31/2017, a new prescription was sent to LTC Pharmacy by Dr. Imran Shafqat for Metoprolol. The only direction on the new order was "Take 1 tablet (25 mg total) by mouth daily". According to this order, there were 5 refills meaning the order was valid until 12/31/2017. Effective 01/09/2018, another new prescription order was sent to LTC Pharmacy by Leslie Price, physician's assistant (PA). The only direction on this order was "1 tab(s) PO(oral) qDay". According to this order, there were again 5 refills making the order valid until 06/09/2018. The final prescription order I received by LTC Pharmacy was written by Dr. John Bradtke on 07/11/2018. The only directions on this order were "1 tab(s) PO (oral) qday". Five refills were also noted on this order meaning the order would be valid until 12/11/2018.

On 08/20/2018, I received a fax of Resident A's newest prescription order for Metoprolol from the facility. The order was dated 08/20/2018 by Leslie Price, PA with the instruction of "Hold medication if pulse less then 60bpm OR SBP less than 110". This order was noted to have 5 refills making it valid until 01/20/2019.

APPLICABLE RULE	
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: **(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 on my interview with direct care staff, Lillian Kaye, she acknowledged she had handwritten instructions, which included parameters, for how Resident A's medication, Metoprolol, should be administered to him. She and home manager, Jessica Cummins, also acknowledged these instructions were from a 2013 order for Metoprolol. Since 2017, Resident A has had different doctors prescribe Metoprolol with new orders being made; however, instructions for how it should be administered according to Resident A's pulse were not included in these new orders. Subsequently, direct care staff continued to handwrite the original and invalid instructions on the medication packets and medication administration records without having Resident A's physician update the instructions either through a physical or verbal order. Therefore, direct care staff were adjusting or modifying the instructions for how Resident A's medication for Metoprolol should be administered to him without a current physician order.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/14/2018, I conducted the exit conference with licensee designee, Barry Bruns, to provide him with an opportunity for questions or comments. Mr. Bruns agreed with the findings regarding the first violation where direct care staff administered Resident A's medication when it should have been held. In regard to the second violation, Mr. Bruns reported he would discuss with managers at an upcoming meeting the importance of continuing medication instructions when new orders are created.

IV. RECOMMENDATION

Upon receipt of a corrective action plan, I recommend the current license status continue.

09/14/2018

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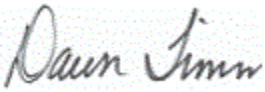
Cathy Cushman Date
Licensing Consultant

Approved By:



09/18/2018 

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Dawn N. Timm Date
Area Manager