GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 18, 2019

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

RE: License #: AS390080967
Investigation #: 2019A0578042
8038 Interlochen 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,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390080967
Investigation #:	2019A0578042
Complaint Receipt Date:	05/22/2019
Investigation Initiation Date:	05/23/2019
Report Due Date:	07/21/2019
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:	8038 Interlochen AFC
Facility Address:	8038 Interlochen Road Kalamazoo, MI 49009
Facility Telephone #:	(269) 353-6941
Original Issuance Date:	08/01/1998
License Status:	REGULAR
Effective Date:	02/14/2019
Expiration Date:	02/13/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A went several days without medications.	Yes

III. METHODOLOGY

05/22/2019	Special Investigation Intake 2019A0578042
05/23/2019	Special Investigation Initiated - Face to Face
05/23/2019	Special Investigation Completed On-site -Interview with staff members Emily Taylor, Megan Beers and Gina Varconie.
05/24/2019	Special Investigation Completed On-site -Interview with Resident A
06/20/2019	Exit Conference -With the licensee, Barry Bruns.
07/15/2019	Contact -Telephone -Interview with KCMHSAS recipient rights officer Suzie Suchyta.
07/16/2019	Contact – Telephone -Interview with Ms. Petra Witkowksi of Kalamazoo Long Term Care Pharmacy.
07/16/2019	APS Referral Completed.

ALLEGATION:
Resident A went several days without medications.

INVESTIGATION:
On 05/22/2019, I completed an intake for this facility based on a telephone call from Complainant. Complainant stated Resident A was a new resident at this facility and only had medications for one week before running out of medications and not receiving her prescribed medications for several days. Complainant stated Resident A's previous pharmacy did not provide the appropriate prescriptions to Resident A's new pharmacy at this facility. Complainant stated the old prescriptions had handwritten numbers on them, which was not acceptable by the new pharmacy as a legitimate prescription.

On 05/23/2019, I completed an unannounced special investigation at this facility with Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) recipient rights officer Suzie Suchyta and we interviewed staff member Emily Taylor regarding the allegations. Ms. Taylor explained that Resident A was admitted to this facility on 05/10/2019 with only one week of medications and copies of prescribed medication orders. Ms. Taylor explained that these copies of prescriptions were not accepted by Kalamazoo Long Term Care, the pharmacy that provides prescription refills to this facility. Ms. Taylor reported the staff of this facility were in communication with the pharmacy regarding obtaining continuing medications for Resident A, but the current pharmacy was not receiving the correctly completed prescriptions and transfer of information from the previous pharmacy. Ms. Taylor reported a portion of the medications were delivered to the facility on 05/17/2019 but mistakenly stored in an office area for several days before being noticed by staff trainer Nick Burell on 05/20/2019. Ms. Taylor stated the pharmacy was able to obtain these medications by requesting them directly from the prescribing physician. Ms. Taylor acknowledged that attempts to obtain new prescriptions for Resident A's medications were only made through the pharmacy and not directly through Resident A's physician. Ms. Taylor reported that while missing medications, Resident A did not report any abnormal symptoms. Ms. Taylor reported Kalamazoo Long Term Care Pharmacy was consulted regarding these missing medications but could not identify any instructions provided. Ms. Taylor reported it was a company policy to notify the pharmacy regarding medication errors.

While at the facility, I interviewed direct care staff member Gina Varconie, who serves as the referral coordinator for this facility. Ms. Varconie acknowledged that Resident A was admitted to the facility with only a week of medications and handwritten prescriptions that were not accepted by Kalamazoo Long Term Care Pharmacy, resulting in Resident A missing medications for several days.

While at the facility, I interviewed direct care staff member Megan Beers, who serves as the home manager for the facility. Ms. Beers acknowledged that Resident A had missed several doses medications as a result of being admitted to the facility with only one week of medications and handwritten prescriptions that were not accepted by Resident A's new pharmacy. Ms. Beers acknowledged that a portion of the medications were delivered to the facility on 05/17/2019 but mistakenly stored in an office area for several days before being noticed by staff on 05/20/2019.

While at the facility, I reviewed the *Routine Medication* sheets for Resident A. Beginning 05/16/2019 and continuing until 05/20/2019, Resident A missed the following medications: Aspirin 81MQ QD, Levothyroxine 75MCG QD, Meloxicam 15MG QD, Sertraline HCL 100MG BID, Prazosin 2MG TID, Benzonatate 200MQ TID, and Calcium 600MQ QD. Nurse's notes for Resident A beginning on 05/16/2019 record that Resident A did not receive daily medications due to them not being in the facility until 05/20/2019.

While at the facility, I reviewed the *Assessment Plan for AFC Residents* for Resident A, completed on 05/09/2019. This plan states that direct care staff are to monitor and administer Resident A's medications.

While at the facility, I reviewed the following case notes for Resident A relating to the allegations.

> "05/16/2019-Nick (Burell) from Homelife spoke with Danielle at KLTC (Kalamazoo Long Term Care) pharmacy asking about scripts of meds. Danielle stated the original pharmacy had not sent over the correct transfer paperwork so KLTC could not refill the meds legally. Nick Burell asked about the scripts Anthony (LKU) had sent on 05/15/5019 to KLTC. Danielle stated that since HomeLife's scripts were just copies, that KLTC couldn't legally use those either. Danielle then stated our (HomeLife) only options were to wait until the previous pharmacy sent over the correct transfer or attempt to have all the physicians fill new scripts."
>
> "05/16/2019- Nick Burell from HomeLife called IPSG (Pharmacy) to check on status of transferring scripts to KLTC (Pharmacy) unknown name confirmed she was currently working on it and was going to transfer the scripts to KLTC today on 05/16/2019."
>
> "05/16/2019- Nick Burell contacted Danielle from KLTC (Pharmacy) letting her know the original pharmacy would be sending scripts to KTLC tonight."
>
> "05/16/2019-Cindy from KLTC (Pharmacy) called saying they had received some of the transfer scripts but not all of them. Cindy said KLTC will send out as many as they received tonight 05/16/2019 and will keep us updated on the rest as the come in."

On 05/23/2019, I interviewed Resident A regarding the allegations at a community agency. Resident A acknowledged that she did not receive her medications for several days. Resident A stated she experienced headaches during this time and attributed it to missing her medications. Resident A acknowledged that she was receiving all her medications currently without any concerns.

On 06/20/2019, I reviewed the details of the allegations with the licensee, Mr. Barry Bruns. Mr. Bruns stated he had reviewed the medication error with representatives from Kalamazoo Long Term Care. Mr. Bruns reported that prescription medications for Resident A were unavoidably missed due to the prescriptions provided from Resident A's previous pharmacy having handwritten quantities on them. Mr. Bruns stated a representative from the pharmacy informed him this was a rare occurrence and a fluke. Mr. Bruns reported that he was told by the pharmacy there was no way that a primary physician would have released a physical or electronic prescription to his staff had they requested it directly. Mr. Bruns was provided consultation on involving guardians when coordinating medication prescriptions if necessary and

contacting an appropriate health care professional for medication errors and following and recording instructions given. Mr. Bruns clarified that direct care staff are contacting the pharmacy during missed medications and errors to review these occurrences with a pharmacist.

On 07/15/2019, I reviewed the details of the allegations with KCMHSAS recipient rights officer Suzie Suchyta. Ms. Suchyta stated a risk assessment for Resident A was completed by Dr. Chudoba, stating that Resident A would experience increased pain due to missing her Meloxicam. Ms. Suchyta acknowledged that medications were delivered but remained on a desk until they were noticed by staff. Ms. Suchyta stated for these reasons her department substantiated Neglect II against this facility.

On 07/16/2019, I interviewed Ms. Petra Witkowski of Kalamazoo Long Term Care Pharmacy. Ms. Witkowski identified “Danielle” and “Cindi” as “service technicians” and not pharmacists.

On 07/16/2019, I interviewed Stephanie (LKU) of Kalamazoo Long Term Care Pharmacy. Stephanie confirmed that “Danielle” and “Cindi” are “service technicians” and any missed medications or medication errors would need to be addressed with the pharmacist.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	During an unannounced on-site investigation, I interviewed direct care staff members Emily Taylor, Megan Beers and Gina Varconie, who acknowledged that Resident A did not receive her fully prescribed daily dosage of medications from 05/16/2019 until 05/20/2019. While at the facility I reviewed *Routine Medication* sheets for Resident A, which documented that Resident A’s Aspirin, Levothyroxine, Meloxicam, Sertraline, Prazosin, Benzonatate, and Calcium were not in the facility and unable to be administered from 05/16/2019 and continuing until 05/20/2019. As such, there is enough evidence to support that Resident A did not receive her daily medications as prescribed by a physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	During interviews, staff member Emily Taylor and the licensee, Barry Bruns reported that Resident A's missed medications were reviewed with Kalamazoo Long Term Care Pharmacy. During an unannounced on-site investigation, I reviewed case notes documenting several pharmacy communications related to the allegations that occurred on 05/16/2019 with "Danielle" and "Cindy" of Kalamazoo Long Term Care Pharmacy. During an interview, Ms. Petra Witkowski of Kalamazoo Long Term Care Pharmacy identified "Danielle" and "Cindy" as service technicians and not pharmacists. As such, Resident A's missed medication was not reported to an appropriate health care professional, and no additional instructions from an appropriate health care professional relating to these medication errors were obtained.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

07/16/2019

Eli DeLeon Date
Licensing Consultant

Approved By:

07/18/20/19

Dawn N. Timm Date
Area Manager