GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 7, 2020

James Hoeberling
J&W Ventures, Inc.
10686 Wacousta Road
DeWitt, MI 48820

RE: License #: AM190338087
Investigation #: 2020A0565006
A Family Affair

Dear Mr. Hoeberling:

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

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

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

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

Sincerely,

Dawn Campbell, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-9724

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM190338087
Investigation #:	2020A0565006
Complaint Receipt Date:	11/13/2019
Investigation Initiation Date:	11/14/2019
Report Due Date:	01/12/2020
Licensee Name:	J&W Ventures, Inc.
Licensee Address:	10686 Wacousta Road DeWitt, MI 48820
Licensee Telephone #:	(810) 922-2938
Administrator:	James Hoeberling
Licensee Designee:	James Hoeberling
Name of Facility:	A Family Affair
Facility Address:	8990 E. M-78 Haslett, MI 48840
Facility Telephone #:	(517) 339-8968
Original Issuance Date:	04/09/2013
License Status:	REGULAR
Effective Date:	03/25/2018
Expiration Date:	03/24/2020
Capacity:	12
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was taken to the hospital due to the facility not properly caring for her diabetes.	No
Two days prior to her death the facility stopped feeding Resident A by mouth.	No
Resident A was given morphine despite being allergic to morphine.	No
Additional Findings	Yes

III. METHODOLOGY

11/13/2019	Special Investigation Intake 2020A0565006
11/14/2019	Special Investigation Initiated - Telephone Spoke with the complainant to get additional information and verify the facility the resident was residing.
11/15/2019	Inspection Completed – BCAL Sub. Compliance.
11/19/2019	Contact – Document received Received written health care appraisal for Resident A.
11/20/2019	Contact – Document received Received *Patient Care Report from Lansing Mercy Ambulance* regarding Resident A.
12/10/2019	Contact - Telephone call made Left a telephone message for Guardian A1 to return telephone call regarding the complaint allegations.
12/12/2019	Contact - Telephone call made Interviewed Guardian A1 regarding the complaint allegations.
12/16/2019	Exit Conference Conducted exit conference with Licensee Designee, James Hoeberling.

ALLEGATION:

- **Resident A was taken to the hospital due to the facility not properly caring for her diabetes.**

- **Two days prior to her death the facility stopped feeding Resident A by mouth.**

INVESTIGATION:

On 11/14/2019, I interviewed Complainant who stated facility staff did not know Resident A was a diabetic and was not properly caring for her diabetes. Complainant stated over a month ago Resident A was taken to the hospital because her blood sugar was too high, and the facility was giving her regular food. The complainant stated Resident A's blood sugar was so high that it took 4-5 days in the hospital for the blood sugar level to return to normal. Complainant stated when Resident A returned from the hospital, she was placed on hospice care. Complainant stated Resident A was getting the proper care because Resident A went to the hospital twice only because family members called 911 not facility staff members. Complainant stated Resident A would not have received medical care if the family had not called 911. Complainant stated facility direct care staff members stopped feeding Resident A by mouth two days before she died. Complainant stated Resident A died on 11/12/2019.

On 11/15/2019, I conducted an unannounced onsite investigation and interviewed facility manager Cindy Ahrens who stated Resident A was admitted to the facility in May 2019. Ms. Ahrens stated she was aware Resident A had a diabetes diagnosis, took medication for her diabetes and had her blood sugar levels were taken twice per day. Ms. Ahrens stated due to Resident A's medical condition Resident A often refused meals which made it difficult for Resident A to maintain a normal blood sugar level. Ms. Ahrens stated Resident A was admitted to the hospital twice in September 2019. Ms. Ahrens stated the first time Resident A was taken to the hospital (09/17/2019) due to a fall and at that time, Resident A's blood sugar and blood pressure were high. Ms. Ahrens stated on 09/30/2019 Resident A was admitted to the hospital because of low sodium, low magnesium and a urinary tract infection not because her blood sugar was too high. Ms. Ahrens stated after Resident A's first hospitalization her health began to decline rapidly, and Resident A was regularly refusing to eat. Ms. Ahrens stated Resident A received a pureed diet and was fed by facility staff. Ms. Ahrens stated after Resident A's second hospitalization, she returned to the facility on hospice services. Ms. Ahrens stated Resident A received hospice services from Heartland Home Health & Hospice. Ms. Ahrens stated Resident A's health continued to decline rapidly once she began to receive hospice services. Ms. Ahrens stated shortly before her death, Resident A was having trouble swallowing and refused food. Ms. Ahrens stated as Resident A's health continued to decline, the hospice nurse gradually discontinued Resident A's medications until she was not given any medication at all. Ms. Ahrens stated Resident A died on 11/12/2019.

On 11/15/2019, I interviewed direct care staff Sarah Wiles who stated Resident A was a diabetic and the facility was providing care to Resident A according to doctor and hospice orders. Ms. Wiles stated Resident A stopped getting anything by mouth the Friday before she died. Ms. Wiles stated Resident A could not swallow and was unable to eat and that is why the facility stopped giving her food.

On 11/15/2019, I reviewed the resident file of Resident A. Resident A's diagnoses include type 2 diabetes, bi-polar disorder, hypersensitivity lung disease, COPD, anxiety, dementia, hypertension, A-fib and pulmonary nodular amyloidosis. Resident A used a walker for assistance with walking. On 11/10/2019, Heartland Home Health & Hospice *Medical Practitioner's Orders* for Resident A stated, "DC all routine meds d/t patient difficulty with swallowing and decline in condition."

On 11/15/2019, I reviewed the September 2019, October 2019 and November 2019 medication administration records (MAR) for Resident A. Resident A was prescribed insulin aspart and insulin detemir to treat her diabetes. On 10/05/2019, Heartland Hospice RN, Melinda Brown instructed staff to discontinue all Resident A's insulin. Resident A's MAR's documented that she was given medication according to physician's orders.

On 12/12/2019, I interviewed Guardian A1 (GA1) who stated her agency has been a guardian for Resident A since 2016. GA1 stated Resident A had a great deal of medical problems and was in fragile health. GA1 stated Resident A's family has a history of making false allegations against adult foster homes where Resident A lived which has caused her to be discharged from two prior placements. GA1 stated the facility was aware that Resident A was diagnosed as diabetic and was giving her medication according to physician's orders. GA1 stated family members called paramedics to this facility on more than one occasion. GA1 stated Resident A was transported to the hospital on one occasion because her blood sugar was too high. GA1 stated due to her medical condition it was difficult for Resident A to eat and her blood sugar fluctuated. GA1 stated facility staff kept her informed about Resident A's medical condition and she believed facility staff provided the appropriate care to Resident A.

APPLICABLE RULE	
R 400.14305	**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 on the above statements and interviews and a review of the files, Resident A was being treated for her diabetes. Facility records indicated Resident A was given medication to treat her diabetes until the medication was discontinued on 10/05/2019. Facility direct care staff members reported Resident A did not receive anything by mouth approximately two days before she died because of the decline in her medical condition and difficulty with swallowing. Resident A also refused meals just prior to her death as well. Hospice notes for Resident A documented Resident A's difficulty with swallowing and the decline in her medical condition leading up to her death. Consequently, Resident A's protection and safety needs were attended to in accordance with hospice physician orders until her death.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Resident A was given morphine despite being allergic to morphine.

INVESTIGATION:

On 11/14/2019, Complainant stated facility direct care staff members gave Resident A morphine so she would sleep at night. Complainant stated the morphine turned Resident A into a "zombie." Complainant stated Resident A was allergic to morphine. Complainant stated as a result Resident A's throat swelled up so she could not eat or breathe, and Resident A died a few days later. Complainant stated he told facility direct care staff members that Resident A was allergic to morphine, but facility staff continued to give Resident A morphine. Complainant stated the family called 911 due to their concerns about Resident A getting morphine, but the facility turned the ambulance away because Resident A had a "do not resuscitate" order.

On 11/15/2019, Ms. Ahrens stated Resident A was prescribed morphine by the hospice nurse in October of 2019 and Resident A began to receive morphine on an as needed basis at the time it was prescribed. Ms. Ahrens stated Resident A never showed any signs or symptoms of being allergic to morphine. Ms. Ahrens stated the family called EMT's this past weekend (11/10/2019) to report that Resident A was having an allergic reaction to morphine and needed to be taken to the hospital. Ms. Ahrens stated when paramedics came arrived at the facility, Resident A was assessed, and paramedics did not find any signs of an allergic reaction to morphine. Ms. Ahrens stated Resident A was not taken to the hospital as paramedics

determined she did not need to be transported to the hospital and that she was actively dying.

On 11/15/2019, Ms. Wiles stated Resident A was given morphine as needed for pain and to keep her comfortable as she was dying. Ms. Wiles stated Resident A never showed any signs of being allergic to morphine. Ms. Wiles stated she continued to give Resident A the morphine as it was prescribed to her.

On 11/15/2019, I reviewed Resident A's resident file. Resident A's medical documentation did not indicate that Resident A had an allergy to morphine. I reviewed the September 2019, October 2019 and November 2019 medication administration records (MAR) for Resident A. Resident A's MA's indicated she was given morphine on an as needed basis since it was prescribed by Heartland Hospice on 10/04/2019.

On 11/19/2019, I reviewed the *Patient Care Report* from Lansing Mercy Ambulance Service dated 11/10/2019. The *Patient Care Report* indicates that Resident A was assessed by paramedics on 11/10/2019 for an allergic reaction to morphine. The *Patient Care Report* stated there were no indications that Resident A was having an allergic reaction to morphine. The report stated Resident A was in the end stages of life, actively dying but appeared to be very comfortable. The report stated that the assessing paramedic saw no indication that Resident A needed to be transported to a hospital.

On 12/12/2019, GA1 stated Resident A did not have a history of having an allergy to morphine. GA1 stated on 11/10/2019, she was contacted by facility direct care staff members and informed that Resident A's son had contacted emergency personnel and reported that Resident A was having an allergic reaction to morphine. GA1 stated facility direct care staff members informed her paramedics assessed Resident A and determined that she showed no signs of having any type of allergic reaction to morphine. GA1 stated the decision was made for Resident A to remain at the facility as emergency personnel did not find it necessary to transport Resident A to the hospital.

On 12/16/2019, I conducted an exit conference with Licensee Designee, James Hoeberling. Mr. Hoeberling stated he would submit a corrective action plan for the rule violation cited in this report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	According to the above statements and a review of Resident A's resident file Resident A was prescribed morphine by hospice staff on 10/04/2019 and began receiving morphine on an as needed basis. Facility staff report Resident A was given the morphine as prescribed and showed no signs of having an allergic reaction to the morphine. Resident A was assessed by medical personnel on 11/10/2019 and showed no signs of having an allergic reaction to morphine. Facility staff report Resident A continued to receive the morphine as prescribed. There is insufficient evidence to support this complaint allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/15/2019, I reviewed the resident file of Resident A. Resident A's resident file did not contain a written health care appraisal despite Resident A being admitted in May 2019. On 11/19/2019, Ms. Ahrens submitted a written health care appraisal for Resident A dated 10/21/2019.

APPLICABLE RULE	
R 400.14301	**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:	On 11/15/2019, Resident A’s resident file was reviewed. Resident A’s resident file did not contain a written health care appraisal despite Resident A being admitted in May 2019.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/16/2019, I conducted an exit conference with Licensee Designee, James Hoeberling. Mr. Hoeberling stated he would submit a corrective action plan for the rule violation cited in this report.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

01/06/2020

Dawn Campbell Date
Licensing Consultant

Approved By:

01/07/2020

Dawn N. Timm Date
Area Manager