GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 21, 2020

Kevin Kalinowski
890 N. 10th Street, Suite 110
Kalamazoo, MI 49009

RE: License #: AM030353416
Investigation #: 2020A0350014
691 W. Bridge Street AFC

Dear Mr. Kalinowski:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030353416
Investigation #:	2020A0350014
Complaint Receipt Date:	01/02/2020
Investigation Initiation Date:	01/02/2020
Report Due Date:	02/01/2020
Licensee Name:	HomeLife Inc
Licensee Address:	890 N. 10th Street, Suite 110 Kalamazoo, MI 49009
Licensee Telephone #:	(269)
Licensee Designee:	Kevin Kalinowski
Administrator:	Melissa Williams
Name of Facility:	691 W. Bridge Street AFC
Facility Address:	691 W. Bridge Street Plainwell, MI 49080
Facility Telephone #:	(269) 225-1021
Original Issuance Date:	02/04/2014
License Status:	REGULAR
Effective Date:	11/04/2019
Expiration Date:	11/03/2021
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The home is not keeping resident medications in stock, causing residents to frequently miss their medications.	Yes

III. METHODOLOGY

01/02/2020	Special Investigation Intake 2020A0350014
01/02/2020	Special Investigation Initiated - Telephone I arranged to meet Mandy Padget, Recipient Rights Officer, at this home on 01/03/2020 at 11 a.m.
01/03/2020	Contact - Face to Face I met with Ms. Padget, Kelsey Newsome, Recipient Rights Officer, and Amber Kelley and Kayla Bielein, staff at this home
01/14/2020	Contact – Telephone call made I called and spoke with Rebecca Rogalski, Home Manager
01/21/2020	Exit conference – Held with Kevin Kalinowski

ALLEGATION: The home is not keeping resident medications in stock, causing residents to frequently miss their medications.

INVESTIGATION: On 01/02/2020, I spoke with Mandy Padget, Recipient Rights Officer, and made arrangements to meet at this home the following day at 11 a.m., along with another Recipient Rights Officer, Kelsey Newsome. Ms. Padget said she would email me several Incident Reports (IR) from this home pertaining to residents not getting their medications.

On 01/02/2020, I received 45 IRs from Ms. Padget via email. Through my review, I noted that that each of these IRs pertained to resident medications not being administered as prescribed because the medications were not available in the home.

On 01/03/2020, I conducted an onsite inspection and met with the Recipient Rights Officers and staff members Amber Kelley and Kayla Bielein. Ms. Padget provided me with several more Incident Reports regarding residents not getting their medications. Ms. Padget and Ms. Newsome informed me that Resident A was recently in the hospital for breathing trouble and that he has two inhalers, but neither was available in the home. Ms. Padget stated that Resident A had to be intubated. Ms. Padget reported that they have received about 100 IRs from this home since

October (2019). Ms. Bielein stated that Resident A's Klonopin patch was also "out-of-facility," a phrase this home uses to mean a medication is not available in the home. Ms. Kelley explained that Resident A often "overuses" his inhalers (inhaling more than twice) causing the inhalers to become empty several days before they are due to be refilled. Ms. Kelley also said that she is the one who orders the medications for all the residents. Ms. Bielein stated that Resident B's Haldol and Klonopin were also documented as being "out-of-facility," and that Resident C had missed doses of his medication recently because they were not put in the drawer where they usually go. It was also revealed that Resident B's Klonopin count was off without an explanation as to why. The count went from 46 to 30 within just 3 days, but she only takes two a day. Also, Resident B's Flonase was currently out-of-facility. Ms. Bielein stated that the controlled substance count sheet was "confusing" to use. In addition, according to Ms. Kelley and Ms. Bielein, Resident A's Biotine, which is like a mouthwash that helps with dry mouth, is often out-of-facility. Resident B was hospitalized for having trouble breathing from 12/09 to 12/11 and then again from 12/15 to 12/17. Ms. Bielein informed the Recipient Rights Officers and me that she spoke with Rebecca Rogalski, the Home Manager, about the many issues regarding medications, but stated "she doesn't follow up" on them.

On 01/14/2020, I reviewed all of the IRs that Ms. Padget had sent me on 01/02/2020. I noted that between 10/02/2019 and 12/17/2019, the home did not have Resident A's Biotine 13 times; his Wixella inhaler 6 times; Hydralazine 2 times; and his Oyster Calcium and Sodium Chloride 1 time each. I also observed that Resident B was not given her Fluticasone 7 times; her Clonazepam 2 times; and 1 dose each of Ranitidine, Gabapentin, Folic Acid, and one illegible medication was not given between 10/06 and 12/18/2019 because they were not in the facility. I also noticed that other than these just mentioned, medications were not administered to Resident A or Resident B because either the medications were not delivered by the pharmacy or the resident refused them.

On 01/14/2020, I called and spoke with Rebecca Rogalski, Home Manager. I informed Ms. Rogalski that I found many medication errors, especially medications not being available in the home to administer to the residents. I asked Ms. Rogalski what she thought was the reason for this and she stated that the lead supervisor, Kayal Bienlein, was waiting for the pharmacist to call her to have medications filled, which sometimes meant the resident had to see his or her Primary Care Physician or Psychiatrist. This waiting for the pharmacy to call and requiring the residents to see their doctors for prescriptions caused substantial delays in prescriptions being filled. This, in turn, caused many days when several of the residents' medications were not in stock at this home and the residents missed getting them. Ms. Rogalski informed me that she provided Ms. Bienlein a "script refill calculator, but she refused to use it so Ms. Rogalski wrote her up and she will be demoted. Ms. Rogalski told me that Tiffany Allen is now in charge of ordering medications.

On 01/21/2020, I sent an email to Ms. Rogalski, asking her about the times that Resident B went into the hospital from 12/09 to 12/11 and then again from 12/15 to

12/17 for having trouble breathing. I inquired as to whether Resident B had been out of the medication she uses for her breathing issues just prior to those hospitalizations; and if so, what medication(s) she takes for her breathing issues.

On 01/21/2020, I received an email from Ms. Rogalski, responding to my questions above She stated that, "(Resident A) had her inhalers in the facility during the time of her hospitalizations. She had one instance on 12/17 that she refused her inhaler (Atrovent HFA 17mcg). The only medication that was unavailable in the facility during those times was her allergy nasal spray (Flonase). This information was consistent with the IRs I received and reviewed as previously summarized in this report.

On 01/21/2020 I conducted an exit conference with Kevin Kalinowski, Licensee Designee. I informed Mr. Kalinowski that I was citing a violation of this rule and recommending a modification of the license to provisional status. Mr. Kalinowski stated that they were already making changes at this home, including putting a new person in charge of ordering medications. He added that he would reply to this recommendation after thoroughly reviewing this report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident medications are not being ordered in a timely manner, often causing the residents to miss their prescribed doses. Rebecca Rogalski, Home Manager, stated that Kayla Bienlein, Lead Supervisor, was in charge of ordering medications, but she often waited too long to order the medications, causing residents to not get them because they hadn't been refilled in time. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

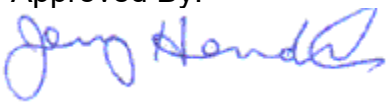
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend a 6-Month Provisional License for the above summarized quality of care violations.

January 21, 2020

Ian Tschirhart — Date
Licensing Consultant

Approved By:



January 21, 2020

Jerry Hendrick — Date
Area Manager