GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 1, 2021

Cynthia Duzenbury
Altam Inc
6300 Douglas Road
Riverdale, MI 48877

RE: License #: AM590091656
Investigation #: 2021A1030012
Pine Point

Dear Ms. Duzenbury:

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,

Nile Khabeiry, LMSW

Nile Khabeiry, 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 #:	AM590091656
Investigation #:	2021A1030012
Complaint Receipt Date:	06/01/2021
Investigation Initiation Date:	06/01/2021
Report Due Date:	07/31/2021
Licensee Name:	Altam Inc
Licensee Address:	6300 Douglas Road Riverdale, MI 48877
Licensee Telephone #:	(989) 560-0292
Administrator:	Cynthia Duzenbury
Licensee Designee:	Cynthia Duzenbury
Name of Facility:	Pine Point
Facility Address:	6300 Douglas Road Riverdale, MI 48877
Facility Telephone #:	(989) 833-5274
Original Issuance Date:	03/01/2000
License Status:	REGULAR
Effective Date:	02/05/2020
Expiration Date:	02/04/2022
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Pine Point AFC direct care staff members failed to follow the recommendations of Resident A's primary care physician.	Yes
Resident A went without prescribed medication for a period of 49 days.	Yes
Two different medications were placed in the same bottle.	No

III. METHODOLOGY

06/01/2021	Special Investigation Intake 2021A1030012
06/01/2021	Special Investigation Initiated – Telephone call made with Complainant.
06/02/2021	Contact - Telephone call made to with Faith Simison
06/04/2021	Contact – Face to Face- Interview with Cynthia Duzenbury
06/04/2021	Inspection Completed On-site
06/04/2021	Contact - Face to Face- Interview with Michelle Barber-Button
06/04/2021	Contact - Face to Face- Interview with Resident A
06/23/2021	Contact - Telephone call- Interview with Natalie Short
06/23/2021	Contact - Telephone call- Interview with Shannon Sequin
06/25/2021	Exit Conference by phone with licensee designee Cynthia Duzenbury.

ALLEGATION:

Pine Point AFC direct care staff members failed to follow the recommendations of Resident A's primary care physician.

INVESTIGATION:

On 6/1/20201, I interviewed Complainant regarding the allegations. Complainant reported Resident A stopped taking her blood thinner and the facility direct care staff members were responsible for rescheduling an appointment with Resident A's cardiologist. Direct care staff members did not reschedule an appointment despite

three requests to do so. Complainant reported resident A did have a psychiatric appointment for a medication review on May 25, 2021.

On 06/02/2021, I interviewed Resident A's guardian, Guardian A1, regarding the allegations. Guardian A1reported Resident A was unable to afford the blood thinner ($400.00) per month, so it had to be discontinued. Guardian A1 reported Resident A refused to attend her last cardiology appointment but instructed the AFC to reschedule to appointment. To her knowledge, the appointment has not been rescheduled. Guardian A1 reported Resident A just had a psychiatric appointment last week and believes Resident A's mental health needs are being addressed.

On 06/04/2021, I interviewed licensee designee and administrator, Cynthia Duzenbury. Ms. Duzenbury reported Resident A was taking a blood thinner however the medication was discontinued by Resident A's legal guardian, Guardian A1 due to the exorbitant cost. Ms. Duzenbury reported Resident A refused to attend her last cardiology appointment on March 25, 2021 and contacted Guardian A1about Resident A's refusal to attend the medical appointment. Ms. Duzenbury reported that Resident A's PCP, Dr. Bahn is supposed to reschedule the cardiologist appointment. Ms. Duzenbury reported Resident A attended a psychiatric appointment on May 25, 2021.

On 6/4/2021, I conducted an on-site investigation at Pine Point AFC and interviewed direct care staff member Michelle Barber-Button regarding the allegations. Ms. Barber - Button reported she has worked in the AFC since November 2020. Ms. Barber-Button reported Resident A refused to attend her last cardiology appointment. Ms. Barbara-Button reported licensee designee Cynthia Duzenbury transports residents to their medical appointments. Ms. Barbara-Button reported she has no knowledge of the cardiology appointment being rescheduled.

On 6/4/2021, I interviewed Resident A regarding the allegations during an on-site visit. Resident A reported she used to take blood thinners but does not believe she needs them anymore. Resident A reported she refused to go to her last cardiologist appointment because she had "not showered in 5 days" and preferred to have a couple days' notice before an appointment. Resident A reported she is willing to attend the next scheduled appointment if she has notice. Resident A reported she attends all of her psychiatric appointments.

On 06/04/2021, I received and reviewed Resident A's *Medication Administration Record* (MAR) for March 2021. Resident A's MAR indicated that Eliquis was discontinued by her guardian. There was no physician's order discontinuing the medication noted on Resident A's MAR.

On 06/23/2021, I interviewed direct care staff member Natalie Short regarding the allegations. Ms. Short reported she works part-time at Pine Point AFC. Ms. Short reported Resident A has been known to refuse medications and refuse to go to medical appointments and direct care staff members cannot force her to go to appointments or

take medications. Ms. Short reported, licensee designee Cindy makes medical appointments for the residents and usually takes them to the appointments.

On 06/23/2021, I interviewed Shannon Sequin RN from Resident A's PCP office. Ms. Sequin reported Dr. Rabh scheduled the initial appointment for Resident A to see her cardiologist on March 25, 2021, but it's the responsibility of the facility to schedule any follow up appointments. Ms. Sequin reported their office is not regularly informed if patients miss appointments and the facility should have rescheduled if the appointment was missed.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Based on my investigation which included my observations of the facility, review of Resident A's Medication Administration Record and interviews with direct care staff members Michelle Barber-Button and Natalie Short, licensee designee Cynthia Duzenbury, Guardian A1 and RN Shannon Sequin there is evidence to substantiate Pine Point AFC did not follow the recommendations of Resident A's PCP by rescheduling an appointment with Resident A's cardiologist after Resident A refused to attend the first appointment. Dr. Bahn scheduled a cardiology appointment for Resident A on March 25, 2021, which Resident A did not attend. Pine Point AFC has not rescheduled the appointment despite instructions from Resident A's legal guardian and the initial request from Resident A's physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Resident A went without prescribed medication for a total of 49 days.**

- **Two different medications were placed in the same bottle.**

INVESTIGATION:

On 6/1/20201, I interviewed Complainant regarding the allegations. Complainant reported she spoke with direct care staff member Michelle Barber-Button about Resident A's medication change to confirm the medication had been delivered and that she was receiving Cymbalta rather than Zoloft. Complainant reported direct care staff member Michelle indicated the Cymbalta was put in the wrong medication bottle with another medication. Complainant reported the medication change occurred on 04/13/2021 and the online pharmacy was informed of the change that day. Complainant reported it takes 10 days for medications to be delivered to the facility. Complainant reported the facility is responsible for sending medication bills to Resident A's guardian/payee however there have been two occasions that the bills from the pharmacy were not forwarded to the guardian, therefore the pharmacy refused to fill the prescription.

On 06/02/2021, I interviewed Resident A's guardian, Guardian A1 regarding the allegations. Guardian A1 reported she is unaware of any medication errors involving Resident A's anti-depressants. Guardian A1 reported she is aware that the AFC is having difficulty getting medications from the mail-order pharmacy as direct care staff are not allowed to receive information about the client's medications. Guardian A1 reported there have been times when the pharmacy will not deliver medication if there is an outstanding balance owed to the pharmacy. Guardian A1 reported that Pine Point has neglected to send her the bill on a couple of occasions. Guardian A1 reported Resident A has private medical insurance which mandates they use Opti-Med instead of the local pharmacy.

On 06/04/2021, I interviewed licensee designee/administrator, Cynthia Duzenbury. Ms. Duzenbury reported the facility has difficulty getting medication in a timely manner from Resident A's mail order pharmacy. Ms. Duzenbury reported medications are delivered 10-14 days after they are ordered. Ms. Duzenbury reported Resident A's medication was changed from Zoloft to Cymbalta in April 2021 which they ordered from the pharmacy. Ms. Duzenbury reported the Cymbalta was delivered on May 20, 2021. Ms. Duzenbury acknowledged Resident A ran out of Zoloft at the end of March 2021 prior to the medication switch and reported she called Resident A's legal guardian about the need for medication. Ms. Duzenbury denied any two medications were ever in the same bottle.

On 6/4/2021, I conducted an onsite investigation at Pine Point AFC and interviewed Michelle Barber-Button regarding the allegations. Ms. Barber-Button reported she has worked in the AFC since November 2020. Ms. Barber-Button reported Resident A's medication was switched from Zoloft to Cymbalta on April 14, 2021. Ms. Barber-Button reported the Cymbalta was received by mail from an "out-of-town" pharmacy but was unsure when it was delivered. Ms. Barber-Button reported it can take up to 14 days for medications to be delivered by mail. Ms. Barber-Button reported she was checking Resident A's medication because the Cymbalta had not been received and noted that "someone put it in a different medication bottle." Ms. Barber-Button reported she does

not know who put the Cymbalta in with another medication and is unsure of which medication bottle it was put into.

On 6/4/2021, I interviewed Resident A regarding the allegations during an on-site visit. Resident A reported she knows she missed some of her medication and attributes that to the pharmacy not delivering the medication in a timely fashion. Resident A reported she was without her medication for two weeks. Resident A is unaware if any of her medications were put in the wrong bottle and indicated that she is satisfied with the facility and wants to continue to live at Pine Point AFC.

On 06/04/2021, I reviewed Resident A's *Medication Administration Record* (MAR) dated March 2021, April 2021, May 2021, and June 2021 and noted Resident A was prescribed Cymbalta on April 14, 2021, and her Zoloft was discontinued. Resident A was to continue the Zoloft until the Cymbalta was delivered. Resident A's March 2021 MAR indicated she was given Zoloft daily as prescribed. Resident A's April 2021 MAR indicated she was not given any dosages of Zoloft during the month on any date. Resident A's May 2021 MAR indicated she was not given any Zoloft in May 2021 and began taking Cymbalta on May 20, 2021. Resident A's June 2021 MAR indicated Resident A was given Cymbalta daily as prescribed. I reviewed the MAR's and the medication for Resident B, Resident C and Resident D and noted that all medications were being dispensed as prescribed.

On 06/23/2021, I interviewed direct care staff member Natalie Short regarding the allegations. Ms. Short reported she works part-time at Pine Point AFC. Ms. Short reported Resident A gets her medications delivered from an on-line pharmacy and it takes at least two weeks for the medication to be delivered after it has been ordered. Ms. Short reported she "heard of two different medications being put in the same bottle." by a former staff member but was unsure which medications were put in the same bottle.

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

ANALYSIS:	Based on my investigation which included my observations of the facility, review of Resident A's March, April, May and June 2021 Medication Administration Records and interviews with direct care staff Michelle Barber-Button and Natalie Short, licensee designee Cynthia Duzenbury, Guardian A1 and RN Shannon Sequin there is evidence to substantiate that Resident A went 49 days without her prescription anti-depressant. Resident A's MAR indicated the last dose of Zoloft passed was on 03/31/2021 and the first dose of Cymbalta was passed on 05/20/2021. There was no evidence that Pine Point placed two different medications in the same bottle.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications**
ANALYSIS:	Based on my investigation which included my observations of the facility, review of Resident A's Medication Administration Record and interviews with direct care staff Michelle Barber-Button and Natalie Short, licensee designee Cynthia Duzenbury, Guardian A1 and RN Shannon Sequin, facility direct care staff members and/or licensee designee Cynthia Duzenbury did not follow Resident A's physician order changing Resident A's anti-depressant medications. Resident A was to continue taking Zoloft until the new prescription for Cymbalta was delivered. However, despite direct care staff members and licensee designee Cynthia Duzenbury all being aware that Resident A's mail order pharmacy takes up to 14 days to deliver medication, the proper steps were not taken to assure the medication was ordered timely so there were no gaps between Resident A's last dose of Zoloft on 03/31/2021 and the arrival of the Cymbalta medication. Due to the lack of follow-through, Resident A did not have any anti-depressant medication for 49 days which was not in line with her physician's order.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

06/30/2021

_____

Nile Khabeiry Date
Licensing Consultant

Approved By:

07/01/2021

_____

Dawn N. Timm Date
Area Manager