GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 24, 2021

Marva Townsend
Trinity 30/60/100 dba Living Well-Adult Living Fac
1001 Lafayette SE
Grand Rapids, MI 49507

RE: License #: AL410380788
Investigation #: 2021A0467010
Living Well-Adult Living Facility

Dear Ms. Townsend:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Anthony Mullins

Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410380788
Investigation #:	2021A0467010
Complaint Receipt Date:	08/13/2021
Investigation Initiation Date:	08/13/2021
Report Due Date:	10/12/2021
Licensee Name:	Trinity 30/60/100 dba Living Well-Adult Living Fac
Licensee Address:	1001 Lafayette SE, Grand Rapids, MI 49507
Licensee Telephone #:	(616) 633-8284
Administrator:	Marva Townsend
Licensee Designee:	Marva Townsend
Name of Facility:	Living Well-Adult Living Facility
Facility Address:	1001 Lafayette SE, Grand Rapids, MI 49507
Facility Telephone #:	(616) 633-8284
Original Issuance Date:	11/21/2016
License Status:	1ST PROVISIONAL
Effective Date:	08/03/2021
Expiration Date:	02/02/2022
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED, ALZHEIMERS, MENTALLY ILL, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The staff are not giving Resident A his medication as scheduled and he consistently has high blood sugar, which resulted in him being hospitalized from 7/18/21 through 7/18/21.	Yes

III. METHODOLOGY

08/13/2021	Special Investigation Intake 2021A0467010
08/13/2021	Special Investigation Initiated - Telephone Telephone call made to the assigned APS worker, Bryan Kahler
08/13/2021	Contact - Document Sent Ed Wilson, Network 180
08/13/2021	Inspection Completed On-site
08/13/2021	Contact - Telephone call made Telephone call made to InterAct of Michigan
08/17/2021	Contact - Document Received Medical Records received from InterAct of Michigan
08/24/2021	Exit Conference Completed with licensee, Marva Townsend

ALLEGATION: The AFC staff are not giving Resident A his medication as scheduled and he consistently has high blood sugar, which resulted in him being hospitalized from 7/18/21 through 7/18/21.

INVESTIGATION: On 8/13/21, I received a complaint from Adult Protective Services (APS) stating that Resident A was hospitalized from 7/18/21 through 7/21/21 for high blood sugar. It stated that Resident A consistently has high blood sugar, which resulted in him going into circulatory shock and being hospitalized in the intensive care unit (ICU). It was alleged that the facility staff are not completing Resident A's Medication Administration Record (MAR) regularly and are not documenting a reason for missed dosages.

On 8/13/21, I sent an email to Ed Wilson (Recipient Rights at Network-180) to see if he will be assigning a recipient rights worker to investigate this matter. Mr. Wilson responded stating that Melissa Gekeler will be assigned to the case.

On 8/13/21, I initiated the investigation by calling the assigned APS worker, Bryan Khaler. Mr. Khaler and I agreed to meet at the facility at 11:00 a.m. to address the allegations jointly.

On 8/13/21, assigned APS worker Mr. Khaler and I made an unannounced onsite investigation to the facility. We made entry into the home and staff member Catina Thomas introduced us to Resident A and he agreed to speak. Resident A confirmed that he was recently hospitalized due to high blood sugar levels as he is diabetic. Resident A stated that he takes insulin four times per day and staff always provide him with his medication as scheduled. Resident A stated that he has refused his insulin in the past as "I have the right to do that." Resident A was unable to specify when the last time was that he refused his insulin. Although Resident A admitted to refusing his insulin in the past, Resident A stated that he never refuses his blood sugar checks. Resident A stated that he has issues with his blood sugar levels due to drinking pop, approximately 12-16 ounces "once in a while." Resident A denied any issues receiving his medication within the facility.

After speaking with Resident A, Ms. Thomas was asked if she could provide us with Resident A's MAR. Ms. Thomas stated that the facility's owner/licensee, Marva Townsend had the key and Ms. Townsend arrived shortly thereafter. Ms. Townsend was asked to provide Mr. Khaler and I with Resident A's MAR from July and August, to which she did. While reviewing the requested records, I noticed that the documentation indicated Resident A did not have any blood sugar test completed at 5:00 p.m. on July 2nd and July 4th through 31st as ordered. The documentation also indicated that Resident A did not receive his Novolog injection from July 8th through 15th, as well as other missed days and there was nothing documented on the MAR to explain why. According to the MAR, Resident A did not receive his Novolog injection on August 7thth at 12:00 p.m. and none of his 5:00 p.m. and 8:00 p.m. blood sugar checks from August 1st through August 13th. Ms. Townsend stated that if Resident A's blood sugar log is incomplete, it's likely due to him being in the community. Ms. Townsend stated that Resident A is in the community a lot during medication passes and staff try to find him or wait for him to return. Ms. Townsend stated that Resident A usually misses a medication pass daily due to being in the community although he knows he needs to take his medications. Despite Resident A being in the community during medication passes, Ms. Townsend acknowledged that his MAR should accurately reflect that.

Ms. Townsend shared that Resident A is non-compliant with his diet as he likes to eat candy and drink 2-liters of pop, causing his blood sugar levels to increase. Ms. Townsend stated she has discussed her concerns with Resident A and he has told her that he has "free will" to do as he pleases. Ms. Townsend stated she is aware that she will be cited for the lack of documentation with Resident A's MAR.

On 8/13/21, A phone call was made to facility staff Ruby Boultrece. Ms. Boultrece confirmed that during her shifts at the facility, she always has access to the residents' MAR's and completes them after giving residents' their medication. Ms.

Boultrece stated she did not know why Resident A's MAR was not completed accurately.

On 8/13/21, I spoke to Carly Dietrich, from Resident A's case management agency, Interact of Michigan. Ms. Dietrich stated that Resident A's case manager, Zachary Stepanovich is out of the office and she will obtain information regarding Resident A's hospitalization and medical records and relay this information to me next week.

On 8/17/21, I received Resident A's medical record from his case management agency, InterAct of Michigan. Records indicated that Resident A was admitted to Mercy Health hospital Intensive Care Unit (ICU) for diabetic ketoacidosis (DKA) on 7/18/21 and discharged on 7/21/21. Resident A was started back on a lower dose of lantus and his sugars were controlled, which supports Resident A was noncompliant with his medicine, leading to DKA.

After reviewing resident A's discharge records from Mercy Health hospital, I compared his MAR from Living Well AFC to his admission dates in the hospital. This comparison made it clear that there were some obvious discrepancies on Resident A's MAR from Living Well AFC between 7/18-7/21. Resident A's MAR indicates that he received his 8:00 a.m. Pantoprazole, Aspirin, Amlodipine and Lisinopril on 7/19. His MAR also indicated that he had his blood sugar level tested at 8:00 a.m., 12:00 p.m. and 8:00 p.m. on 7/19. Resident A's MAR states that he received his Atorvastatin at 8:00 p.m. on 7/19 and 7/20. Resident A's blood sugar log listed levels for him three times on 7/19. Based on Resident A's medical record from Mercy Health, it's evident that his MAR and blood sugar log in the facility was falsified on the days listed above as he was in the hospital those same days.

On 8/18/21, I spoke with Ms. Thomas via phone. Ms. Thomas stated that she took a leave of absence during the time period that Resident A was in the hospital. Ms. Thomas reportedly returned to work on the day that Resident A was discharged from the hospital. Ms. Thomas was adamant that she gives residents their medications individually and completes their MAR immediately after. Ms. Thomas stated she has no knowledge as to why Resident A's MAR was not completed accurately.

On 8/18/21, Ms. Townsend sent me an addendum to Resident A's nighttime blood sugar log for July and August. On the addendum for July's blood sugar log, it states that Resident A was in the hospital from the night of 7/18 through 7/21. However, the original facility blood sugar log that I received from Ms. Townsend while at the facility, provided three blood sugar levels for Resident A on 7/19.

On 8/18/21, I contacted Ms. Townsend via phone to inquire about the discrepancy in Resident A's MAR and blood sugar log. Ms. Townsend stated that sometimes while passing medication, she and her staff use a notepad to document what medications were given to residents. Ms. Townsend stated that dates on Resident A's MAR may have gotten mixed-up when transferring information from the notepad to his MAR. Ms. Townsend acknowledged that "it is kind of difficult" to document everything while

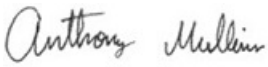
passing the medications. Ms. Townsend also stated that she thought Resident A's blood sugars only needed to be documented on his blood sugar log and not his MAR, although his log had missing documentation as well. Ms. Townsend stated that her staff would not intentionally falsify documentation for any resident. Ms. Townsend did not have an explanation as to why some dates on Resident A's MAR and blood sugar log were blank. She did, however, state that she takes full responsibility for the errors identified in Resident A's MAR and blood sugar log.

On 8/24/21, licensing consultant Megan Aukerman and I completed an exit conference with licensee, Ms. Townsend. We informed Ms. Townsend of the investigative findings and she stated she understands that it is being recommended that the facility's license be revoked due to being cited for a quality-of-care rule violation while operating under a provisional license for similar concerns. Ms. Townsend is aware that a compliance conference will be scheduled with the disciplinary action unit (DAU) to address the concerns further. All of Ms. Townsend's questions were answered during this exit conference.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A MAR's from July and August confirmed that there were multiple days that he did not have his blood sugars checks and multiple days that his insulin was not documented as being administered as prescribed. Resident A's MAR also indicated that he received morning and/or afternoon and evening medication and blood sugar test on 7/19/ and 7/20, which is inaccurate as he was in the hospital those days. Based on the investigative findings, there is a preponderance of evidence to support that staff at Living Well AFC did not provide Resident A with his medication pursuant to the label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

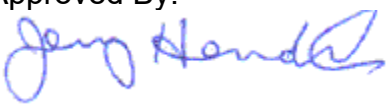
The facility was previously placed on a provisional license effective 08/03/2021 due to quality-of-care and physical plant violations. The corrective action plan was approved on 07/21/21. As a result of this investigation, the facility is being cited for the above-referenced quality-of-care violation, which has resulted in a recommendation of license revocation.



08/24/2021

Anthony Mullins Date
Licensing Consultant

Approved By:



08/24/2021

Jerry Hendrick Date
Area Manager