GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 4, 2021

Robert McDaniel
Lakeshore Caring Corp.
4851 Lakeshore, Bldg A
Fort Gratiot, MI 48059

RE: License #: AL740007429
Investigation #: 2021A0604010
Lakeshore Woods

Dear Mr. McDaniel:

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.

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.

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 (248) 975-5053.

Sincerely,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL740007429
Investigation #:	2021A0604010
Complaint Receipt Date:	06/04/2021
Investigation Initiation Date:	06/04/2021
Report Due Date:	08/03/2021
Licensee Name:	Lakeshore Caring Corp.
Licensee Address:	4851 Lakeshore, Bldg A Fort Gratiot, MI 48059
Licensee Telephone #:	(810) 385-3185
Administrator:	Robert McDaniel
Licensee Designee:	Robert McDaniel
Name of Facility:	Lakeshore Woods
Facility Address:	4851 Lakeshore Road Fort Gratiot, MI 48059
Facility Telephone #:	(810) 385-3185
Original Issuance Date:	03/30/1992
License Status:	REGULAR
Effective Date:	03/14/2020
Expiration Date:	03/13/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Pharmacy reported that 60 Norco pills were delivered to facility. Pills are missing. It was discovered when the home called for a refill, that the pills had already been delivered.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/04/2021	Special Investigation Intake 2021A0604010
06/04/2021	Contact - Document Received Received an email indicating that Jamie Saueri from Lakeshore Woods left a message on the Detroit phone line on 06/03/2021, to report a suspected drug diversion.
06/04/2021	Special Investigation Initiated - Telephone Returned call from Regional Director, Jamie Saueri
06/04/2021	Contact - Document Sent Email to and from Licensee Designee, Robert McDaniel
06/07/2021	Inspection Completed On-site Completed onsite investigation. Interviewed Rob McDaniel, Vicky Fulton, Jamie Saurei, Denise Kunkelman, Katie Schef and Resident A. Received copies of staff written statements, Resident Information Record and pharmacy records.
06/08/2021	APS Referral Adult Protective Services (APS) referral made and assigned to APS Worker, Marine DeBell.
06/08/2021	Contact- Document Sent Email to Robert McDaniel
06/08/2021	Contact - Telephone call received Received Resident A's medication administration records and staff statement from Rob McDaniel by email.
06/08/2021	Contact - Telephone call made TC to Nurse Practitioner, Alex Joji

06/08/2021	Contact- Document Received Received copies of mediation logs from Rob McDaniel
06/08/2021	Contact - Document Received Emails from APS Worker, Marnie Debell. Sent return email.
06/22/2021	Contact - Document Received Email from Relative 1
06/22/2021	Contact - Document Sent I sent return email to Relative 1
06/22/2021	Contact - Telephone call made Left message from Jamie Saueri
06/24/2021	Contact - Document Received Received copy of police report from Rob McDaniel
06/24/2021	Contact - Document Sent I sent return email to Rob McDaniel.
07/14/2021	Contact - Document Received Email form Marnie DeBell. Sent return email.
08/03/2021	Exit Conference Left messages for Licensee Designee, Robert McDaniel and Regional Director, Jamie Saueri. Informed that Mr. McDaniel is out entire week. Sent email to Mr. McDaniel with findings are recommendation for provisional license.

ALLEGATION:

Pharmacy reported that 60 Norco pills were delivered to facility. Pills are missing. It was discovered when the home called for a refill, that pills had already been delivered.

INVESTIGATION:

On 06/04/2021, I received an email regarding a message left about Lakeshore Woods. On 06/03/2021, Jamie Saueri from Lakeshore Woods left a message on the Detroit phone line to report a suspected drug diversion.

On 06/04/2021, I contacted Jamie Sauri to clarify if the incident took place at Lakeshore Woods adult foster care (AFC) or Homes for the Aged. It was confirmed that the incident took place at Lakeshore Woods AFC. Ms. Sauri stated that she is the Regional

Director. She stated that there is a suspected drug diversion at facility. There were 60 tablets of Norco delivered on 05/06/2021. They are not in the building and unable to be located. It was discovered that the pills were missing when they asked for a refill and nurse practitioner said a prescription was already filled. She stated that staff, Vicki, in the business office signed for the pills and put them in the medication office. The pharmacy does not package controlled substances separately. They will be switching pharmacies. Ms. Sauri stated that they have taken statements from staff, however, they do not know what happened to the medication. No one remembers seeing medication in the office.

On 06/07/2021, I completed an onsite investigation at Lakeshore Woods. I interviewed Licensee Designee Robert McDaniel, RN, Vicky Fulton, Jamie Sauri, Denise Kunkelman and Resident A. I received copies of written statements, Resident A information record and pharmacy records.

On 06/07/2021, I interviewed Licensee Designee, Robert McDaniel. He stated that a bag of medication was delivered by the pharmacy. The bag had medication for three residents. The medication allegedly was delivered on 05/06/2021 and included 60 Norco pills for Resident A. Resident A was scheduled to take two per day, however, the nurse gave a verbal order to change mediation to a PRN. They do not have a written order. Mr. McDaniel stated that Staff, Vicki Fulton, signed for medications when they were delivered by the pharmacy. He believes she put them in the medication office and locked the door. That is their standard protocol. Mr. McDaniel stated that he does not remember seeing the medications that were delivered in the medication office. Mr. McDaniel stated both cards of Norco are missing (30 pills each). It was discovered that the medication was missing when they tried to reorder. Mr. McDaniel stated that he never put both cards out at same time. The backup medications are locked up in a separate cabinet and need a different key. He, Vicki Fulton and Staff, Katie Schef, are the only staff who have a key. Mr. McDaniel stated that he does not remember ever putting the pills out. He stated that the day after the pills were delivered, he came in the around 5:30 am. Katie was not at work that day. Typically when he arrives to work, he sorts the new medications in the office. He stated that Vicki did have access to the medication room. There are no other staff who would have access to both the medication room and back up cabinet where extra medications are kept. Mr. McDaniel stated that he has been doing this for 10 years and he always locks up one pill pack in back up if there are more than one card. After he sorts medications, they are put on medication carts on units where residents reside. Mr. McDaniel provided copies of receipts and signatures that were provided by the pharmacy. He did have concerns regarding the appearance and placement of the signatures. However, Ms. Sauri called the pharmacy to confirm that they were scanned into the system once signed for and she believed them to be accurate.

On 06/07/2021, I interviewed Vicki Fulton, Business Office Coordinator. She stated that she did sign for medications that were delivered on 05/06/2021. The pharmacy handed her a clipboard and told her to sign. She stated that the pharmacy does not give you bag of medication until you are done signing on clipboard and then they give you

receipts. She trusted she was signing for what they gave her. She did not compare medications in the bag to what she was signing for on the clipboard. She stated that pharmacy rips receipts off medication bags. She does not recall if there were any loose receipts that were not attached to the bags. She does not recall seeing the barcodes that are on copies of receipts provided by pharmacy. Ms. Fulton stated that once she signed for medications, she put them directly into the medication office. She is sure the door was locked. She stated that herself, Katie Schef, and Rob McDaniel are the only staff who have a key to the medication office the medication office. She did not believe Katie was present when the medications were delivered. Ms. Fulton stated that she has no idea what happened to Resident A's Norco. She stated that Robert McDaniel is very diligent, and it is possible that she signed for something that was not delivered.

On 06/07/2021, I interviewed Staff, Katie Schef. She stated that she was previously the Resident Care Coordinator, however, asked to step down to be a caregiver. She stated that she was in her new position at the time of the incident, however, still had a key as she had items in the office. Ms. Schef stated that she was off work on 05/06/2021 when the medications were delivered. Ms. Schef stated that she never remembers seeing the pills in the office. She has no idea what happened to Resident A's Norco and has not heard anything. Ms. Schef did hear that Norco came up missing at the facility before sometime this year. She was not sure when, however, believed it was within the last six months. She was not sure what had occurred.

On 06/07/2021, I interviewed Jamie Sauri, Director of Health and Wellness and Denise Kunkelman Regional Director of Operations. Ms. Sauri and Ms. Kunkelman were at facility completing their own investigation. Ms. Sauri confirmed that there was a previous investigation involving Norco at the facility. She stated that in March 2021 they received a call from the visiting physician who does routine drug screens for the residents that are prescribed narcotics. Residents had negative tests that should have been positive. Ms. Sauri stated that all the medication was accounted for, however, they found systems issues such as verbal orders being taken to change medication from routine to PRN. The Nurse Practitioner, Alex, has denied giving verbal orders. They put corrections in place that included not changing prescriptions without a physical order. They also do not want overflow medications to be stored separately because then they are not counted. The corrections were not implemented. They have a new Director of Nursing that started two weeks ago, who is able to provide additional oversight. The system shows that Licensee Designee, Robert McDaniel, who is an RN changed Resident A's Norco to a PRN without the written order.

On 06/07/2021, I interviewed Resident A. She stated that she is having a problem with leg spasms. She puts a rub on her leg twice a day. Her leg does hurt at times. She stated that she takes a lot of pills, but she does not know what they are. She believes she takes a medication for her heart. She described a topical medication/rub she uses for pain in her leg and aspirin. Resident A did not know if she is taking Norco.

On 06/07/2021, I received written statements from Robert McDaniel, Vicki Fulton and Darlene Mason, RN. Part of Mr. McDaniel's written statement says, "I do not remember

seeing or placing the medication in question out to the medication techs to be administered. Also, no medication was dispensed to the resident during that time to confirm that the medications were present". Ms. Fulton's written statement included a statement saying, "At no time do I ever look to see what medications are delivered, I leave that to a qualified employee". Ms. Fulton's statement includes the following, "I, Darlene Mason, RN was present during a Video/Telehealth appointment with Alex from Visiting Physicians Association (VPA) and Emily Burns, the Med Tech here at Lakeshore Woods. The appointment was held on the afternoon of 06/02/2021. During the scheduled appointment for (Resident A), Emily and I requested to obtain a prescription be sent to the pharmacy for the prescribed Hydrocodone/APAP 5-325 mg by mouth twice daily, as Lakeshore Woods has yet to received prescribed order from Wadham's Hometown Pharmacy". She also states, "Per Alex, he called the medication into the Pharmacy on 05/04/2021. The Hydrocodone/APAP 5-325 mg was said to be delivered to Lakeshore Woods on 05/06/2021 but was never entered into the MAR at Lakeshore Woods by pharmacy until 05/11/2021." On 06/08/2021, I received a copy of Katie Schef's written statement dated 06/07/2021 by email. Ms. Schef stated that she still had keys due to still having personal belongings in the office, however, was not aware of medication issue at that time.

On 06/08/2021, I interviewed Alex Joji, Nurse Practitioner from Visiting Physicians. Mr. Joji stated that he had some concerns he could not figure out with pharmacy, so he contacted Lakeshore Woods. He stated that Resident A is scheduled to take Norco two times per day. He stated that he does not do verbal orders and does not agree with Mr. McDaniel who is saying he switched Norco to PRN with verbal order. He stated that there is no verbal orders in his practice. He could do an electronic prescription and generate written orders to fax. Mr. Jogi stated that there was another issue with Norco at the facility. He stated that residents who take Norco are given drug screens every 90 days to confirm they are taking the prescription. He stated that two residents, Resident B and Resident C, were negative and should have been positive. He believes this occurred in January or February 2021. He stated that he met with Jamie Sauri and Scott Peters and an internal investigation was completed.

Lakeshore Woods did not notify licensing when medications were missing prior and an incident report was not received.

On 06/08/2021, I made a referral to Adult Protective Services (APS). APS Worker, Marnie DeBell, was assigned the investigation. On 07/14/2021, Ms. Debell stated that she would be substantiating for neglect due to the missing medications.

On 06/24/2021, I received a copy of the St. Clair County Sherriff's Office report from Rob McDaniel. The report was taken on 06/08/2021. Rob McDaniel was interviewed, and the case has been closed.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Licensee Designee, Robert McDaniel, stated that he received a verbal order from Nurse Practitioner, Alex Joji to change Resident A's Norco to a PRN. Mr. Joji denied giving verbal orders and stated that the medication is supposed to be given two times per day. In addition, according to Nurse Practitioner, Alex Joji, there was a previous issue with Norco at the facility. He stated that residents who take Norco are given drug screens every 90 days to confirm they are taking the prescription. Two residents, Resident B and Resident C, were negative and should have been positive. He believed this occurred in January or February 2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Resident A's Norco (Hydrocodone/APAP 5-325 mg) was reportedly delivered to Lakeshore Woods on 05/06/2021 by the pharmacy and went missing. A receipt was provided by the pharmacy showing that Staff, Vicki Fulton, in fact signed for the medication when it was delivered. Regional Director, Jamie Saueri, reported the medication was missing on 06/03/2021 when it was discovered they could not get a refill because the medication was already delivered. Three staff at Lakeshore Woods, Robert McDaniel, Vicki Fulton and Katie Schef, had access to the medication office where medications were allegedly locked up. Ms. Schef reportedly was not at Lakeshore Woods when the medications were delivered.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/08/2021, I received copies of Resident A's medication logs for April, May and June 2021. The April and May 2021 logs list Hydrocodone/APAP 5-325 mg (Norco), take one tablet by mouth two times a day, as a PRN. There are no initials to indicate the mediation was given as a PRN during those months. Resident A's June 2021 medication log lists list Hydrocodone/APAP 5-325 mg, take one tablet by mouth two times a day at 8:00 am and 8:00 pm. The medication logs indicates that on 06/01/2021 and 06/02/2021 the medication was unavailable. On 06/03/2021, the log indicates that at 8:00 am the medication was unavailable and at 8:00 pm the resident refused.

On 06/08/2021, I reviewed Resident B's medication logs for January, February and March 2021. The January 2021 medication logs indicates that her Hydrocodone/APAP 5-325 mg was not available on 01/13/2021 and 01/14/2021. The medication was again unavailable from 01/25/2021-02/01/2021 and then from 02/18/2021-02/28/2021. The March 2021 medication indicates that the medication was not available on 03/01/2021-03/04/2021, however, on 03/05/2021-03/06/2021 there are notes that the medication was refused. On 03/07/2021 at 1:52 am, the medication is marked as refused and on the same day at 8:49 pm the medication is unavailable. On 03/13/2021, the medication is also marked as both refused and not available. The medication is also marked unavailable from 03/23/2021 to 03/31/2021. Staff initials are missing on the medication log for Hydrocodone/APAP 5-325 mg for 2:00 am dose on 02/07, 02/15, and 02/20 and 2:00 pm dose on 03/16 and 03/19.

I reviewed Resident C's medication log. Resident C's January, February and March 2021 medication log shows she is prescribed Hydrocodone/APAP 5-325 mg every 8 hours as a PRN. No Hydrocodone/APAP 5-325 was given and/or initiated on the medication logs.

I completed an exit conference by email on 08/03/2021. I left messages for Licensee Designee, Robert McDaniel and Regional Director, Jamie Saueri. I informed Mr. McDaniel of the violations found and that a provisional license would be recommended. I also informed him that a corrective action would be requested, and a copy of the special investigation report would be mailed once approved.

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: (a) Be trained in the proper handling and administration of medication. (b) Complete an individual medication log that contains all of the following information: (i) The medication. (ii) The dosage. (iii) Label instructions for use. (iv) Time to be administered. (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. (vi) A resident's refusal to accept prescribed medication or procedures. (c) Record the reason for each administration of medication that is prescribed on an as needed basis.
ANALYSIS:	Resident A and Resident B's medication logs give inconsistent reasons for medications not being given. Resident A's June 2021 medication log lists list Hydrocodone/APAP 5-325 mg, take one tablet by mouth two times a day at 8:00 am and 8:00 pm. The medication logs indicates that on 06/01/2021 and 06/02/2021, the medication was unavailable. On 06/03/2021, the log indicates that at 8:00 am the medication was unavailable and at 8:00 pm the resident refused. Resident B's March 2021 medication log indicates that her Hydrocodone/APAP 5-325 mg was not available on 03/01/2021-03/04/2021, however, on 03/05/2021-03/06/2021 there are notes the medication was refused. On 03/07/2021, at 1:52 am the medication is marked as refused and on the same day at 8:49 pm the medication is unavailable. On 03/13/2021, the medication is also marked as both refused and not available. In addition, staff initials are missing on the medication log for Hydrocodone/APAP 5-325 mg for 2:00 am dose on 02/07, 02/15, and 02/20 and 2:00 pm dose on 03/16 and 03/19.
CONCLUSION:	**VIOLATION ESTABLISHED**

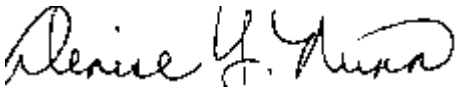
IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend modification of the license to provisional.

08/03/2021

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



08/04/2021

Denise Y. Nunn — Date
Area Manager