



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

March 31, 2021

Vickie Runyon  
Jerry's Dreams Adult Homes  
PO Box 1086  
Grand Rapids, MI 49501

RE: License #:	AS410269763
Investigation #:	2021A0356017
	Jerry's Dream #2

Dear Ms. Runyon:

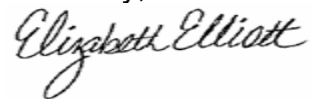
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in cursive script that reads "Elizabeth Elliott".

Elizabeth Elliott, Licensing Consultant  
Bureau of Community and Health Systems  
Unit 13, 7th Floor  
350 Ottawa, N.W.  
Grand Rapids, MI 49503  
(616) 901-0585

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS410269763
<b>Investigation #:</b>	2021A0356017
<b>Complaint Receipt Date:</b>	02/02/2021
<b>Investigation Initiation Date:</b>	02/03/2021
<b>Report Due Date:</b>	04/03/2021
<b>Licensee Name:</b>	Jerry's Dreams Adult Homes
<b>Licensee Address:</b>	PO Box 1086 Grand Rapids, MI 49501
<b>Licensee Telephone #:</b>	(616) 293-7198
<b>Administrator:</b>	Paris Manuel
<b>Licensee Designee:</b>	Vickie Runyon
<b>Name of Facility:</b>	Jerry's Dream #2
<b>Facility Address:</b>	1124 W Leonard Court NW Walker, MI 49534-6835
<b>Facility Telephone #:</b>	(616) 318-0082
<b>Original Issuance Date:</b>	10/15/2004
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	04/28/2020
<b>Expiration Date:</b>	04/27/2022
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A did not receive medications as prescribed.	Yes

## III. METHODOLOGY

02/02/2021	Special Investigation Intake 2021A0356017
02/03/2021	Special Investigation Initiated - Telephone Valerie Burke-Network 180 case manager.
03/18/2021	Inspection Completed On-site
03/18/2021	Contact - Face to Face Resident A and staff, Josh Runyon.
03/22/2021	Contact - Document Received Facility documents received.
03/23/2021	Contact - Telephone call made. Denise Koeper, legal guardian.
03/23/2021	Contact - Telephone call made. LD, Vickie Runyon.
03/29/2021	Contact-Telephone call made. Mercy Health LTC Pharmacy-Pharmacist, Shari Keillor.
03/31/2021	Exit Conference-Licensee Vickie Runyon.

### **ALLEGATION: Resident A did not receive medications as prescribed.**

**INVESTIGATION:** On 02/02/2021, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported that Resident A was not given his medication for four days. The complainant reported upon further investigation into this complaint, the complainant reported that Resident A's medications were not available at the facility for Resident A to take on Saturday, January 23, 2021, Sunday, January 24, 2021 and Monday, January 25, 2021. The complainant stated according to the Licensee, Vickie Runyon, Resident A's medications were not available for administration only on Sunday, January 24, 2021 as they had not been delivered yet the pharmacy reported all medications were delivered.

On 02/03/2021, I interviewed Valerie Burke, Network 180 (Community Mental Health) case manager for Resident A. Ms. Burke stated Resident A initially stated he missed his medications for 4 days during the month of January 2021, but it turned out that Resident A missed 1 dose of 1 of his medications, Olanzapine. Ms. Burk stated she then spoke to Resident A's legal guardian, Denise Koeper who told her Resident A got the Olanzapine medication, but it was Depakote that he missed on 01/23, 01/24 & 01/25/2021. Ms. Burke stated she was not informed, and neither was Ms. Koeper that Resident A had missed any of his medications in January.

On 03/18/2021, I conducted an unannounced inspection at the facility and interviewed Resident A. Resident A stated he did miss his medication Olanzapine for three days in January. Resident A stated he does not have any other issues regarding his medications.

On 03/18/2021, I conducted an unannounced inspection and interviewed staff Josh Runyon at the facility. Mr. Runyon stated the bubble packing machine at the pharmacy was not working so they could not pack the residents' medications and if any medications were missed for Resident A it was due to the pharmacy not being able to send the medications because of the machine being down. Mr. Runyon stated Resident A did not miss any medications that he has knowledge of.

On 03/22/2021, I received and reviewed the January 2021 MAR (medication administration record) for Resident A. The MAR reflects that Resident A takes Aspirin EC, one tablet, once daily, Centrum Silver, one tablet, once daily, Divalproex SOD 250 mg tab once daily and twice at bedtime, Lisinopril 40mg tab by mouth once daily, Vitamin D 10 mcg, Metformin 1000 mg tab, take one tablet by mouth twice daily with meals, Olanzapine ODT 20 mg tab, one tablet by mouth at bedtime and Simvastatin 10 mg tab, one tablet by mouth at bedtime. The medications for the entire month are signed as administered by Licensee, Vickie Runyon except for Olanzapine ODT 20 mg tablet by mouth at bedtime for January 2, 3, & 4, 2021, those dates are not signed showing the medication was administered.

On 03/23/2021, I interviewed Denise Koeper, Resident A's legal guardian via telephone. Ms. Koeper stated Resident A did not get all of his medications for a few days during the month of January 2021. Ms. Koeper stated she called the pharmacy, and they said their packing machine was down at some point in January, but they still delivered all of Resident A's medications as they always do but they packed them in bottles rather than bubble packs. Ms. Koeper stated she discussed this with Ms. Runyon who told her they did not get Resident A's medications in bottles. Ms. Koeper stated Resident A is a reliable, compliant individual as well as an accurate reporter and she believes Resident A missed medication during the month of January 2021.

On 03/23/2021, I interviewed Ms. Runyon via telephone. Ms. Runyon stated there were three days in the month of January 2021 that Resident A was without Olanzapine. Ms. Runyon stated she contacted the pharmacy and was given the "run

around” that the bubble packing machine not working, and that Medicaid would not cover this medication, but she was finally able to get a 7-day supply before the new 30-day cycle began. Ms. Runyon explained Olanzapine comes separately from Resident A’s other medications because it is packaged different, it does not come in the bubble pack or in a bottle, it is sealed in aluminum, this medication dissolves under the tongue and therefore, it comes separate from all other medications. Ms. Runyon stated during the month of January 2021, Resident A missed three days of the medication because they did not have the medication at the facility. Ms. Runyon stated she does not know why they were out of the medication.

On 03/29/2021, I interviewed Shari Keillor, Mercy Health LTC Pharmacist. Ms. Keillor stated they send all Resident A’s medications every 30 days with no lapse during that time, including January 2021. Ms. Keillor stated Resident A’s medications are on a “health minder auto fill” so the medications go out automatically each month at the same time. Ms. Keillor stated there was an issue with the bubble pack machine however, they send medications out no matter how they package them, they would just pack them a different way and Resident A should have had all his medications in January 2021. Ms. Keillor stated a 30-day supply of Olanzapine medications went out to the home on October 7, 2020, November 6, 2020, December 4, 2020, January 5, 2021, and February 1, 2021. Ms. Keillor stated Resident A should have had enough to cover all through the month.

On 03/31/2021, I conducted an Exit Conference with Ms. Runyon via telephone. Ms. Runyon stated she will submit an acceptable corrective action plan.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
<b>ANALYSIS:</b>	Resident A reportedly missed his medication Olanzapine ODT, 20 mg tablet once daily on three dates in January 2021. According to the pharmacy, a 30-day supply was delivered to the facility on Dec. 4, 2020 and then again on Jan. 5, 2021, and there should have been enough Olanzapine to cover the month including 01/02, 01/03 & 01/04/21. Resident A’s Olanzapine medication was not administered on those three dates per Ms.

	Runyon nor was it documented as administered on the MAR. Based on investigative findings, there is a preponderance of evidence to establish a violation of this applicable rule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Upon receipt of an acceptable corrective action plan, I recommend the current status of the license remain unchanged.
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03/30/2021

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Elizabeth Elliott  
Licensing Consultant

Date

Approved By:



03/31/2021

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Jerry Hendrick  
Area Manager

Date