GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 11, 2021

Janet Johnson
Bush Creek Manor Inc
1023 Alice Street
Whitehall, MI 49461

RE: License #: AS610073721
Investigation #: 2021A0583037
Bush Creek Manor

Dear Ms. Johnson:

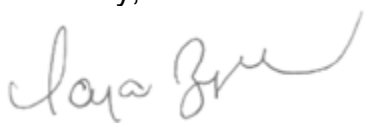
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. 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,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610073721
Investigation #:	2021A0583037
Complaint Receipt Date:	06/30/2021
Investigation Initiation Date:	06/30/2021
Report Due Date:	07/30/2021
Licensee Name:	Bush Creek Manor Inc
Licensee Address:	1023 Alice Street Whitehall, MI 49461
Licensee Telephone #:	(231) 893-0322
Administrator:	Janet Johnson
Licensee Designee:	Janet Johnson
Name of Facility:	Bush Creek Manor
Facility Address:	1023 Alice Street Whitehall, MI 49461
Facility Telephone #:	(231) 893-0322
Original Issuance Date:	11/01/1996
License Status:	REGULAR
Effective Date:	09/28/2019
Expiration Date:	09/27/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's prescribed medications were observed unsecured in the facility refrigerator.	Yes
Resident A's prescribed medications were not dispensed and administered by facility staff.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/30/2021	Special Investigation Intake 2021A0583037
06/30/2021	Special Investigation Initiated - Telephone Harbor Hospice Compliance Officer Jennifer Chupailo
07/01/2021	Inspection Completed On-site Licensee Designee Janet Johnson, Staff Elizabeth Casebolt
07/08/2021	Contact – Email Licensee Designee Janet Johnson
07/26/2021	Contact - Telephone call made Harbor Hospice Nurse Amie Lockhart
07/28/2021	Contact - Telephone call made Relative 1
07/29/2021	Contact - Telephone call made Relative 1
08/06/2021	Exit Conference Licensee Designee Janet Johnson

ALLEGATION: Resident A's prescribed medications were observed unsecured in the facility refrigerator.

INVESTIGATION: On 06/30/2021 I received complaint allegations from the BCAL online reporting system alleging Resident A's prescribed Morphine and Ativan were observed on 06/29/2021 unsecured in the facility refrigerator by Harbor Hospice nurse Amie Lockhart.

On 06/30/2021 I interviewed Harbor Hospice Compliance Officer Jennifer Chupailo via telephone. Ms. Chupailo stated on 06/29/2021 Harbor Hospice nurse Amie

Lockhart observed Resident A's liquid Morphine and liquid Ativan (Lorazepam) stored in the facility refrigerator unlocked. Ms. Chupailo emailed to me photographs of Resident A's liquid Morphine bottle/packaging and liquid Ativan bottle/packaging.

I observed Resident A's liquid Ativan bottle packaging stated Dr. R. Anderson prescribed Resident A Lorazepam .25 ML every four hours as needed. I observed Resident A's Lorazepam prescription number is #135225 and was filled 06/04/2021. I observed Resident A's liquid Morphine bottle indicates Resident A was prescribed to receive the medication every six hours as needed.

On 07/01/2021 I completed an unannounced onsite inspection at the facility and interviewed Licensee Designee Janet Johnson and Staff Elizabeth Casebolt. Ms. Johnson and Ms. Casebolt both confirmed Resident A was initially prescribed Ativan (Lorazepam) in a tablet form, however the medication was changed on a recent unknown date by an unknown physician to Ativan in a liquid form. Ms. Johnson and Ms. Casebolt both confirmed Resident A's prescribed liquid Morphine and liquid Ativan were stored by facility staff unlocked in the facility refrigerator. Ms. Johnson and Ms. Casebolt both confirmed the facility lacks a medication lock box that fits inside the facility refrigerator and lacks a locking refrigerator. Ms. Johnson and Ms. Casebolt both confirmed Resident A passed away this day at approximately 9:50 a.m. and the medications are no longer located at the facility due to Resident A's family members removing them. Ms. Johnson and Ms. Casebolt both confirmed Resident B and Resident C's Latanoprost eye drops were stored unsecured in the facility refrigerator.

While at the facility I observed Resident A's Medication Administration Record confirmed Resident A was prescribed Morphine Sulfate 100 mg per 5 ML every four hours PRN and Lorazepam Tab (Ativan) .5 PRN take one tablet by mouth as needed every four hours. The Medication Administration Record was not updated to reflect Resident A's prescription for liquid Lorazepam (Ativan) .25 ML every four hours as needed. I observed Resident B's prescribed medication, Latanoprost eye drops, and Resident C's prescribed medication, Latanoprost eye drops, unsecured in the facility refrigerator.

On 07/26/2021 I interviewed Harbor Hospice nurse Amie Lockhart via telephone. Ms. Lockhart confirmed that on 06/29/2021 she visited the facility and observed Resident A's liquid Ativan (Lorazepam) located in the facility refrigerator unlocked.

On 08/06/2021 I completed an Exit Conference with Licensee Designee, Janet Johnson, and informed her of the investigative findings. Ms. Johnson stated she agreed with the findings and has recently secured a lock box to place in the facility refrigerator. Ms. Johnson stated she would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(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.
ANALYSIS:	I observed Resident A's liquid Ativan (Lorazepam) bottle packaging stated Dr. R. Anderson prescribed Resident A Lorazepam .25 ML every four hours PRN. I observed Resident A's Lorazepam prescription number is #135225 and was filled 06/04/2021. I observed Resident A's Medication Administration Record confirmed Resident A was prescribed Morphine Sulfate 100 mg per 5 ML every four hours PRN. Licensee Designee Janet Johnson and Licensee Designee Amie Casebolt both confirmed Resident A's prescribed liquid Morphine and liquid Ativan (Lorazepam) were stored by facility staff unlocked in the facility refrigerator. Ms. Johnson and Ms. Casebolt both confirmed the facility lacks a medication lock box that fits inside the facility refrigerator and lacks a locking refrigerator. Harbor Hospice nurse Amie Lockhart confirmed that on or about 06/29/2021 she visited the facility and observed Resident A's liquid Ativan (Lorazepam) located in the facility refrigerator unlocked. While at the facility, I observed Resident B's prescribed medication, Latanoprost eye drops, and Resident C's prescribed medication, Latanoprost eye drops, unsecured in the facility refrigerator. There is sufficient evidence to substantiate a violation of the applicable rule. Resident A's liquid Morphine and liquid Ativan (Lorazepam), Resident B's Latanoprost, and Resident C's

	Latanoprost were not properly secured in a locked cabinet or drawer.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's prescribed medications were not dispensed and administered by facility staff.

INVESTIGATION: On 06/30/2021 I received complaint allegations from the BCAL online reporting system indicating Resident A's prescribed Morphine and Ativan (Lorazepam) were dispensed and administered by Resident A's family.

On 06/30/2021 I interviewed Harbor Hospice Compliance Officer Jennifer Chupailo via telephone. Ms. Chupailo stated that as a result of facility staff not properly securing Resident A's liquid Morphine and liquid Ativan (Lorazepam), Harbor Hospice staff trained Resident A's family members to administer Resident A's medications starting on 06/29/2021 and continuing until her death on 07/01/2021. Ms. Chupailo stated a physician did not provide consent for Resident A's family to administer Resident A's medications from 06/29/2021 until 07/01/2021.

On 07/01/2021 I completed an unannounced onsite inspection at the facility and interviewed Licensee Designee Janet Johnson and staff Elizabeth Casebolt. Ms. Johnson and Ms. Casebolt both confirmed that from 06/29/2021 until Resident A's death on 07/01/2021; Resident A's family members dispensed and administered her prescribed medications of Morphine and Ativan (Lorazepam). Ms. Johnson and Ms. Casebolt both confirmed a physician did not provide permission to allow Resident A's family members to administer her medications from 06/29/2021 until 07/01/2021. Ms. Johnson and Ms. Casebolt identified Resident A's daughter, Relative 1, and Resident A's son, Relative 2, dispensed and administered Resident A's medications from 06/29/2021 until 07/01/2021. Ms. Johnson and Ms. Casebolt stated they did not have contact information for Relative 2 but were able to provide the telephone number for Relative 1.

While at the facility I observed Resident A's Medication Administration Record confirmed facility staff did not administer Resident A's prescribed liquid Morphine and liquid Ativan 06/29/2021 and 06/30/2021. I observed that 06/30/2021 was the last page in Resident A's Medication Administration Record.

On 07/26/2021 I interviewed Harbor Hospice nurse Amie Lockhart via telephone. Ms. Lockhart confirmed that on 06/29/2021 she provided medication administration training to Resident A's family members and allowed Resident A's family to administer Resident A's liquid Morphine and liquid Ativan from 06/29/2021 until her death on 07/01/2021. Ms. Lockhart stated a physician did not provide consent for Resident A's family members to administer Resident A's medications from 06/29/2021 until 07/01/2021. Ms. Lockhart stated she did not remember the names

of Resident A's family members who administered Resident A's medications from 06/29/2021 until 07/01/2021.

On 08/06/2021 I completed an Exit Conference with Licensee Designee, Janet Johnson, and informed her of the investigative findings. Ms. Johnson stated she agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	Licensee Designee Janet Johnson and staff Elizabeth Casebolt. confirmed that from 06/29/2021 until 07/01/2021 Resident A's family members dispensed and administered Resident A's prescribed medications of Morphine and Ativan (Lorazepam) despite a physician not providing consent to do so. Harbor Hospice nurse Amie Lockhart confirmed that on 06/29/2021 she provided medication administration training to Resident A's family members and allowed Resident A's family to dispense and administer Resident A's liquid Morphine and liquid Ativan from 06/29/2021 until her death on 07/01/2021. Ms. Lockhart stated a physician did not provide consent for Resident A's family members to administer Resident A's medications from 06/29/2021 until 07/01/2021. I observed Resident A's Medication Administration Record confirmed facility did not administer Resident A's prescribed liquid Morphine and liquid Ativan (Lorazepam) 06/29/2021 and 06/30/2021. I observed that 06/30/2021 is the last page in Resident A's Medication Administration Record. There is sufficient evidence to substantiate violation of the applicable rule. Facility staff allowed Resident A's family to administer Resident A's prescribed medications without a physician's written approval.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Licensee Designee Janet Johnson did not verify that household member Keith Johnson is in such physical or mental health so as not to negatively affect the heath of residents.

INVESTIGATION: On 06/30/2021 I interviewed Harbor Hospice Compliance Officer Jennifer Chupailo via telephone. Ms. Chupailo stated Licensee Designee Janet Johnson's adult son, Keith Johnson, resides at the facility.

On 07/01/2021 I completed an unannounced onsite inspection at the facility and interviewed Licensee Designee Janet Johnson and Staff Elizabeth Casebolt. Ms. Johnson and Ms. Casebolt both confirmed Ms. Johnson's adult son, Keith Johnson, resides at the facility.

On 07/08/2021 I received an email from Licensee Designee Janet Johnson. I reviewed the email stated, "Keith moved into the facility on June 3rd, 2021" and "We are still waiting on his doctor to sign the medical clearance form".

On 08/06/2021 I completed an Exit Conference with Licensee Designee, Janet Johnson, and informed her of the investigative findings. Ms. Johnson stated she agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(1) A licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household shall be in such physical and mental health so as not to negatively affect either the health of the resident or the quality of his or her care.
ANALYSIS:	Licensee Designee Janet Johnson and staff Elizabeth Casebolt both confirmed Ms. Johnson's adult son, Keith Johnson, resides at the facility. I received an email from Licensee Designee Janet Johnson which stated, "Keith moved into the facility on June 3rd, 2021" and "We are still waiting on his doctor to sign the medical clearance form". There is sufficient evidence to substantiate violation of the applicable rule. Licensee Designee Janet Johnson has not verified household member Keith Johnson's physical and mental health.

CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Licensee Designee Janet Johnson administered Resident A's prescribed medications without adequately documenting the dosage.

INVESTIGATION: On 07/01/2021 I completed an unannounced onsite inspection at the facility and interviewed Licensee Designee Janet Johnson. Ms. Johnson stated Resident A is prescribed liquid Morphine, liquid Ativan, and Atropine drops as needed. Ms. Johnson stated she has been administering Resident A's Morphine, Ativan, and Atropine as needed and recording the administration in a notebook.

Ms. Johnson provided a notebook for my review that Ms. Johnson reported she utilized to document Resident A's medication administration. I observed the notebook appeared to document Ms. Johnson's administering of Resident A's Morphine, Ativan, and Atropine from 06/04/2021 until 06/28/2021. I observed the notebook contained several dates of medication administration which lacked the required medication dosage administered.

On 08/06/2021 I completed an Exit Conference with Licensee Designee, Janet Johnson, and informed her of the investigative findings. Ms. Johnson stated she agreed with the findings and would submit an acceptable Corrective Action Plan.

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: **(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.**
ANALYSIS:	Licensee Designee Janet Johnson provided a notebook for my review that Ms. Johnson reported she utilized to document

	Resident A's medication administration. I observed the notebook appeared to document Ms. Johnson's administering of Resident A's Morphine, Ativan, and Atropine from 06/04/2021 until 06/28/2021. I observed the notebook contained several dates of medication administration which lacked the medication dosage administered. There is sufficient evidence to substantiate violation of the applicable rule. Licensee Designee Janet Johnson administered Resident A's prescribed medications without adequately documenting the dosage.
CONCLUSION:	**VIOLATION ESTABLISHED**

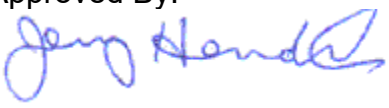
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

08/11/2021

Toya Zylstra — Date
Licensing Consultant

Approved By:



08/11/2021

Jerry Hendrick — Date
Area Manager