GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 5, 2021

Sibonginkosi Osei
Eden Haven LLC
1339 Kingston Ave.2021A0578048
Kalamazoo, MI 49001

RE: License #: AS390272314
Investigation #: 2021A0578048
Darby Lane

Dear Mrs. Osei:

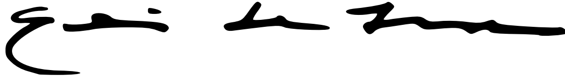
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9727.

Sincerely,



Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390272314
Investigation #:	2021A0578048
Complaint Receipt Date:	08/12/2021
Investigation Initiation Date:	08/13/2021
Report Due Date:	10/11/2021
Licensee Name:	Eden Haven LLC
Licensee Address:	1339 Kingston Ave. Kalamazoo, MI 49001
Licensee Telephone #:	(269) 806-5459
Administrator:	Alicia Siegfried
Licensee Designee:	Sibonginkosi Osei
Name of Facility:	Darby Lane
Facility Address:	600 Darby Lane, Kalamazoo, MI 49006
Facility Telephone #:	(269) 383-5926
Original Issuance Date:	02/04/2005
License Status:	REGULAR
Effective Date:	02/28/2021
Expiration Date:	02/27/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A ran out of diabetic testing strips and her blood sugar had not been checked for several days beginning 08/02/2021.	Yes

III. METHODOLOGY

08/12/2021	Special Investigation Intake 2021A0578048
08/12/2021	Special Investigation Initiated – Telephone call with ORR Michele Schiebel
08/13/2021	*Integrated Services of Kalamazoo Incident Report* regarding this incident dated 08/09/2021.
08/18/2021	Contact-Telephone Interview- Interview with Integrated Services of Kalamazoo recipient rights officer Michelle Schiebel and I direct care worker Erica Osei.
08/18/2021	Contact-Telephone Interview- Interview with Integrated Services of Kalamazoo recipient rights officer Michelle Schiebel and Resident A.
08/18/2021	Contact-Telephone Interview- Integrated Services of Kalamazoo recipient rights officer Michelle Schiebel and I interviewed the licensee, Ms. Sibonginkosi Osei.
08/19/2021	Contact-Document Reviewed- *Integrated Services of Kalamazoo Incident Report* dated 08/09/2021.
08/19/2021	Contact-Document Reviewed- *Medication Administration Records* for Resident A.
08/19/2021	Contact-Document Received- *Exception Reports* for Resident A.
09/29/2021	Special Investigation Completed On-site.- Interview with Resident A.
09/29/2021	Exit Conference with licensee designee Ms. Sibonginkosi Osei.

ALLEGATION:

Resident A ran out of diabetic testing strips and her blood sugar had not been checked for several days beginning 08/02/2021.

INVESTIGATION:

On 08/12/2021, I received this complaint through the BCHS on-line complaint system. Complainant alleged that on 8/9/21, Resident A reported she was out of diabetic testing strips and her blood sugar had not been checked since 8/2/21. Complainant reported it was unclear if staff at this facility had ordered Resident A's diabetic testing strips when they ran out on 8/2/21 but there was a note from 8/6/21 for direct care staff Erica Osei to call the pharmacy to order the strips. Complainant reported that upon reviewing the details of this incident, direct care staff Gelma Ahoi confirmed by reading the Medication Administration Records for Resident A that Resident A's blood sugar had not been documented as being completed by staff since 08/02/2021. Complainant clarified the testing strips were delivered to this facility on 8/9/21 at 8:45 pm.

On 8/12/2021, AFC licensing consultant Ondrea Johnson conducted an interview with Integrated Services of Kalamazoo recipient right officer Michele Schiebel. Ms. Schiebel informed Ms. Johnson that direct care staff members are responsible to check Resident A's blood sugar levels daily as prescribed by a physician. Ms. Schiebel informed Ms. Johnson that Resident A ran out of strips and direct care staff never reordered new strips therefore, Resident A's blook sugar levels have not been checked for weeks. Ms. Schiebel informed Ms. Johnson she would be conducting interviews in the near future with staff members Erica Osei and Agnus Osei, who were the staff members involved that were supposed to call to reorder strips. Ms. Schiebel informed Ms. Johnson that Alicia Siegfried is the administrator of this facility.

On 08/13/2021, I reviewed the *Integrated Services of Kalamazoo Incident Report* regarding this incident dated 08/09/2021. The *Integrated Services of Kalamazoo Report* documented that during a telehealth video meeting, Resident A indicated that she was out of diabetic test strips and her blood sugar levels had not been checked since 08/02/2021. The *Integrated Services of Kalamazoo Incident Report* documented the facility would contact the pharmacy for more information.

On 08/18/2021, through virtual audio and video conferencing, Integrated Services of Kalamazoo recipient rights officer Michelle Schiebel and I interviewed direct care staff Erica Osei regarding the allegations. Ms. Osei could not recall if she was informed on 08/03/2021 or 08/06/2021 that True Metrix Glucose Strips for Resident A were out and needed to be ordered. Ms. Osei reported that she wrote a note that Resident A's True Metrix Glucose Strips needed to be reordered. Ms. Osei reported that she also attempted to reorder medications through the electronic Medication Administration Records but acknowledged that she may not have done so correctly.

Ms. Osei clarified that when the True Metrix Glucose Strips were not delivered, she anticipated the True Metrix Glucose Strips would be delivered eventually as other medications are usually delivered on time when ordered. Ms. Osei reported she was not familiar with the new ordering system and it is not her ordinary job but will order medications when they need to be refilled. Ms. Osei denied that Resident A's True Metrix Glucose Strips had run out before and denied having medications delivered from the pharmacy.

Ms. Osei clarified the direct staff that ordinarily orders medication was out sick during this incident, and that she and direct care staff Agnes Osei were covering her responsibilities.

Ms. Osei denied that Resident A reported or complained of any ill side effects. Ms. Osei reported that Resident A's blood sugar is usually 65 in the morning and at night.

On 08/18/2021, through virtual audio and video conferencing, Integrated Services of Kalamazoo recipient rights officer Michelle Schiebel and I interviewed Resident A regarding the allegations. Resident A acknowledged that staff were unable to document her blood sugar levels due to her True Metrix Glucose Strips not being present in the facility. Resident A reported her True Metrix Glucose Strips were unavailable for five days. Resident A acknowledged that her True Metrix Glucose Strips were delivered on 08/09/2021 and that staff resumed testing her blood sugar that same night. Resident A denied having any adverse side effects due to not having her blood sugar measured.

On 08/18/2021, through virtual audio and video conferencing, Integrated Services of Kalamazoo recipient rights officer Michelle Schiebel and I interviewed the licensee, Ms. Sibonginkosi Osei regarding the allegations. Ms. Osei acknowledged that True Metrix Glucose Strips for Resident A were not present in the facility from 08/02/2021 until 08/09/2021. Ms. Osei clarified that a reorder button for refilling medications was present on the electronic Medication Administration Records for Resident A and this button needed to be pushed in order to refill the True Metrix Glucose Strips for Resident A. Ms. Osei acknowledged this was a new system for ordering medications and initially thought the message "out of facility" indicated on the electronic Medication Administration Record for Resident A indicated the pharmacy was out of True Metrix Glucose Strips. Ms. Osei acknowledged the pharmacy should have been directly notified.

Ms. Osei denied that Resident A's blood sugar levels were associated with any other instructions or medications, stating that Resident A's primary physician had ordered the blood sugar testing for Resident A to monitor for potential Diabetes.

On 08/19/2021, I reviewed the *Medication Administration Records* for Resident A. The August 2021 *Medication Administration Records* for Resident A documented that Resident A is prescribed True Metrix Glucose Strips and is to "Use as directed

to test blood sugars twice daily”. The *Medication Administration Records* for Resident A documented the True Metrix Glucose Strips were not administered on 08/03/2021 until 08/09/2021. I observed no other medications prescribed to Resident A that were contingent on Resident A’s blood sugar levels.

On 08/19/2021, I reviewed the *Exception Reports* associated with the *Medication Administration Records* for Resident A. The August 2021 *Exception Reports* associated with the *Medication Administration Records* for Resident A documented that from 08/03/2021 until 08/09/2021, Resident A’s True Metrix Glucose Strips were “out of the facility”.

On 09/29/2021, I completed an unannounced investigation on-site at this facility and reviewed the *Health Care Appraisal* for Resident A. The *Health Care Appraisal* for Resident A identified her diagnosis as Dementia, Hypertension, Hypothyroid, Cognitive Impairment, Gastroesophageal Reflux Disease and Legal Blindness.

While at the facility I interviewed Resident A, who reported doing well and denied having any additional concerns.

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:	During an interview, Resident A confirmed not being able to monitor her blood sugar as prescribed by her physician from 08/03/2021until 08/09/2021 due to the facility not having her True Metrix Glucose Strips. During an interview, direct care staff Erica Osei acknowledged that True Metrix Glucose Strips were not present in the facility and confirmed attempting to reorder the True Metrix Glucose Strips on or around 08/06/2021 but not receiving the True Metrix Glucose Strips until 08/09/2021. I reviewed electronic *Medication Administration Record*s and *Exemption Reports* associated with these electronic *Medication Administration Records* that confirmed True Metrix Glucose Strips were not present in the facility from 08/03/2021 until 08/09/2021. As such, the licensee did not follow physician instructions and recommendations for the health care needs of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

10/01/2021

Eli DeLeon — Date
Licensing Consultant

Approved By:

10/05/2021

Dawn N. Timm — Date
Area Manager