GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 15, 2021

Timothy Rantz
Ferny AFC Home, LLC
5914 Longhorn Trail
Stevensville, MI 49127

RE: License #: AL110388345
Investigation #: 2021A0579042
Golden Shore

Dear Mr. Rantz:

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,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW, 7th Floor-Unit 13
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL110388345
Investigation #:	2021A0579042
Complaint Receipt Date:	09/23/2021
Investigation Initiation Date:	09/24/2021
Report Due Date:	10/23/2021
Licensee Name:	Ferny AFC Home, LLC
Licensee Address:	5914 Longhorn Trail Stevensville, MI 49127
Licensee Telephone #:	(269) 449-5400
Administrator:	Timothy Rantz
Licensee Designee:	Timothy Rantz
Name of Facility:	Golden Shore
Facility Address:	1564 N. M 63 Benton Harbor, MI 49022
Facility Telephone #:	(269) 210-5293
Original Issuance Date:	11/07/2017
License Status:	REGULAR
Effective Date:	12/02/2020
Expiration Date:	12/01/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has been offered the wrong medication on multiple occasions and had not been receiving her medication for restless leg syndrome.	No
Staff are not sufficiently trained in the passing of medication.	No
Additional Finding	Yes

III. METHODOLOGY

09/23/2021	Special Investigation Intake 2021A0579042
09/23/2021	Contact- Document Sent Email to Complainant
09/24/2021	Special Investigation Initiated - Face to Face Resident A, Amanda Kiser (Direct Care Worker), Claudette Johnson (Direct Care Worker), Veronica Clemons (Direct Care Worker), and Timothy Rantz (Licensee Designee).
09/24/2021	Contact- Document Received Timothy Rantz, Licensee Designee
10/13/2021	Contact- Telephone call made Sandie Pullins, Direct Care Worker
10/13/2021	Contact- Telephone call made Shane Woods, Direct Care Worker
10/14/2021	Exit Conference Timothy Rantz, Licensee Designee

ALLEGATION: Resident A has been offered the wrong medication on multiple occasions and had not been receiving her medication for restless leg syndrome.

INVESTIGATION: On 09/23/2021, I received this referral through the Bureau of Community Health Systems on-line complaint system. The referral alleged Resident A reported to the complainant that she has been offered, but not taken, the wrong medication on multiple occasions. Resident A has restless legs syndrome and reports she was not receiving her medication for that as well.

On 09/23/2021, I exchanged emails with the complainant who confirmed the allegations as reported.

On 09/24/2021, I completed an unannounced on-site investigation at the home. Interviews were completed with Resident A, Amanda Kiser (Direct Care Worker), Claudette Johnson (Direct Care Worker), Veronica Clemons (Direct Care Worker), and Timothy Rantz (Licensee Designee). Interviews were completed privately, except for that Resident A requested her friend remain in her room during the interview.

Resident A stated she has been offered the wrong medication on multiple occasions. She stated she knows what her medications look like, so she corrects staff before taking the medications. She stated one night she was tired, so she did not check her medications, when she woke up the empty medication cup next to her bed had a man's name on it, so she believes she took the wrong medication. She stated staff have also offered her the wrong insulin pen before. She stated she was not getting her medication for restless leg syndrome when she first moved in, but she receives it now. She denied knowing what the medication was called but stated it is a yellow pill and a narcotic. She stated Direct Care Worker Claudette has offered her the wrong medication multiple times, Direct Care Worker Shane has brought her the wrong insulin, and Direct Care Worker Sandie gave her the medication cup with the man's name on it.

Ms. Kiser stated Resident A has not lived at the facility very long but shortly after Resident A moved in, she started having paranoid delusions and targeting staff based on their skin color. She stated Resident A consistently accuses certain staff, especially Claudette, of giving her incorrect medication. She stated Resident A has told Claudette, "I will have your job." She stated she has shown Resident A all her medications and her Medication Administration Record to confirm that Resident A is getting all her medication as prescribed. She stated Resident A continues to insist she is not getting her Gabapentin, even though it is a controlled substance, so it is counted and documented by staff at every shift and no errors have ever been found. She stated Resident A was confused regarding her insulin because she was changed from Admelog to Novolog which are two different looking insulin pens. She stated staff consistently need to remind her that she does not take Admelog anymore and that is why her pen looks different. She stated due to Resident A's allegations that she was receiving the wrong medication; they have moved Resident A's medication to its own drawer so there is no possible way her medications would be mixed with another resident. She stated she observed the cup that Resident A claimed had a man's name on it and it was a clear cup with no name on it. She stated she has not witnessed or made any errors with Resident A's medications. She stated there is no truth to the allegations.

Ms. Claudette Johnson stated Resident A is confused and sometimes angry as a result of her dementia. She stated she has never brought Resident A the wrong medication even though Resident A claims that she has multiple times. She stated

she has not heard Resident A threaten her but if Resident A did threaten her, she would not “fall into it” because she knows that is just a behavior from Resident A’s dementia. She stated Resident A’s narcotics are counted and documented every shift and there has never been an error. She stated she has not witnessed or made any errors with Resident A’s medications. She stated the allegations Resident A makes are not true.

Ms. Veronica Clemons stated she has not heard Resident A make allegations that she was getting the wrong medication from any staff. She stated Resident A receives narcotics that are counted and documented at every shift and have never been off. She stated she has not witnessed or made any errors with Resident A’s medications.

Mr. Rantz stated Ms. Kiser is most involved with medications and their administration. He stated Resident A has brought him complaints that she was not receiving her Gabapentin which is a controlled substance that is accounted for with both staff at the end of each shift. He stated Resident A accused staff of bringing her the wrong insulin but that was after there was a change to her medication. He stated she also told him that an empty medication cup was left in her room, and it had a man’s name on it, but it was found that did not occur.

While on-site I observed Resident A’s pill bottles and Medication Administration Record. I did not see any documented errors on Resident A’s Medication Administration Record. Resident A’s narcotic count for her Gabapentin for Restless Leg Syndrome showed her Gabapentin was accounted for without error. Resident A’s medication supply appeared consistent with the documented distribution of medication. Resident A’s medications were kept in their own space in the bottom drawer of the locked medication cabinet and her Gabapentin was kept in a locked controlled substance box.

On 10/13/2021, I completed a telephone interview with Ms. Sandie Pullins. She stated she has spoken to Resident A about her accusations that she was not receiving or received the wrong medication on multiple occasions. She stated one incident she was made aware of was when Resident A claimed she was given another resident’s medication at nighttime. She stated she spoke to Claudette who was working at that time and Claudette confirmed there was a cup with Resident A’s name on it and an extra cup with water in it. She stated Claudette showed her both the empty cup with Resident A’s name on it and the cup with water. She stated since the cup did not have her name on it, Resident A assumed the cup was another resident’s. She stated there was another incident where Resident A said Ms. Kaiser gave her another resident’s pills because Ms. Kaiser walked into the room with the other resident’s empty, disposable cup in her hand. She stated there was a recent change with making Gabapentin a controlled substance and Resident A was the first resident to receive Gabapentin separately from her other medications. She stated there was one time that staff initially did not put the controlled substance in Resident A’s medication cup, because for the other residents it comes with their medication in

their bubble pack, so staff initially missed it. She stated Resident A received the medication appropriately but after her other medications, when staff noticed the Gabapentin was now a controlled substance and was not distributed with the other medications because it was kept now in a locked box. She said since that error was made, Resident A is fixated that she continues not to receive her Gabapentin. Ms. Pullins stated she immediately put a note in Resident A's drawer, reminding staff that Resident A's Gabapentin is kept as a controlled substance to ensure they pass it in the same cup with her medications. She denied that Resident A ever did not receive her Gabapentin. She stated overall Resident A is not happy at the facility, is bothered by other residents, and has struggled to adjust to no longer living independently. She stated Resident A has been upset with her because she told Resident A that she cannot keep medications, even over the counter medications, in her room and took the medications Resident A bought and put them in the medication cart. She stated Resident A accused her of taking the medications and giving them to other residents, but they are in the medication cart for Resident A. She stated she also has noticed that Resident A targets African American staff, especially Claudette. She stated there is "no truth, not at all" to allegations that Resident A was receiving incorrect medications or not receiving her medications.

On 10/13/2021, I completed a telephone interview with Ms. Shane Woods. She stated Resident A has accused her of giving her the wrong insulin before. She stated Resident A takes two different types of insulin and switched her type of morning insulin shortly after moving into the home. She stated Resident A also did not use two different types of insulin on herself at home, even though she was prescribed two types of insulin. She stated there was one incident when after dealing with an assaultive resident, she went and grabbed Resident A's insulin pen before bedtime. She stated as she walked into the room, she realized the insulin pen in her hand was Resident A's morning insulin and not her evening insulin. She stated she never uncapped the medication and she told Resident A she would be right back with her bedtime insulin. She stated since then, Resident A has fixated on the belief that she gave Resident A the wrong insulin. She stated there was another incident with Resident A's insulin, that did not involve her, when she accused another staff person of giving her the wrong insulin because they had to use two of the same insulin pens because the first pen did not have a sufficient dose. She stated Resident A also targets Claudette. She stated since her first night in the home, Resident A has fixated on the idea that Claudette gave her the wrong medication cup because the disposable cup did not any name on it. She stated since then, staff put resident names on the medication cups. She stated Resident A fixates on making allegations against everything Claudette does including cooking and cleaning. She stated Resident A's accusations and targeting staff continue to get worse. She stated although Resident A does not require the assistance of two staff, no staff person will be alone near Resident A out of fear of false allegations being made against them. She stated all staff now want a witness when engaging with Resident A due to her behaviors. She stated there is "absolutely no truth" to the allegation that Resident A was given the wrong medication or not given medication as prescribed. She stated she believes Resident A would have reactions or side effects if she did not receive

her medication as prescribed or if she received another resident's medication, especially if it was something that happened regularly like Resident A claims.

APPLICABLE RULE	
R 400.15310	**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: **(a) Medications.**
ANALYSIS:	Resident A stated she was given a man's medication, the incorrect insulin, and the wrong medication on multiple occasions. She also reported she was not receiving her Gabapentin when she first moved into the home. Ms.Kiser, Ms. Johnson, Ms. Clemons, Ms. Pullins, Ms. Woods, and Mr. Rantz all reported Resident A has delusions and fixates on the belief she does not receive the correct medications or her own medications correctly. Each provided an explanation for the incidents Resident A claimed she did not receive medications correctly. Each reported there is no truth to the allegations Resident A had made. While on-site, I observed Resident A's Medication Administrator Record, medication supply, and her controlled substance count long. The records and medication did not show any error and were consistent with Resident A receiving her medication appropriately. Based on the interviews completed, documentation reviewed, and observation of Resident A's medication, there is insufficient evidence to support the allegation that the licensee, with Resident A's cooperation, did not follow the instructions and recommendations of a resident's physician with regard to medication.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff are not sufficiently trained in the passing of medication.

INVESTIGATION: On 09/23/2021, I reviewed the referral which alleged due to the medication errors that have occurred, the complainant is concerned staff are not sufficiently trained in the passing of medication.

Ms. Kiser stated she has many years of medical training, so she came to this facility with education and now is responsible for the medication in the home. She stated she does not specifically recall what her training was at this home. She stated she now trains workers by having them shadow her for two days, then staff do supervised medication passes on their own for three days. She stated she measures staff competency by observing their medication passes and having them sign off as they complete tasks. She stated she feels she and all other staff in this home are competent in passing medication.

Ms. Claudette Johnson stated she learned to pass medication by watching another worker for a few shifts and being supervised passing medication for a few shifts. She stated she signed paperwork noting she knew policies and procedures in the home. She stated she feels competent passing resident medication.

Ms. Veronica Clemons stated she learned to pass medication by shadowing Ms. Kiser for two days and then being supervised passing medication by Ms. Kiser for three days. She stated she signed-off on policies and procedures as she learned and practiced them. She stated she feels competent passing resident medication.

Mr. Rantz stated staff primarily learn how to pass medication by shadowing for a few days when they start and then completing supervised medication passes for a few days as well. He stated staff sign-off on their trainings to confirm they are competent. He agreed to provide documentation confirming staff are competent in medication handling and administration.

On 09/24/2021, I received medication training material from Mr. Rantz. Included was a seven-page document called, “Golden Shore and Ferny’s Home: Medication, Urine & BM Logging, and Resident Care Logging Procedures”. The document was initialed as reviewed by staff at the end of each page and signed as being understood on the last page. Mr. Rantz included the performance evaluation he completes on staff where he reviews staff performance relating to many topics including medication passing. He included a page called the “Narcotic Med Count Procedure” which is signed off by staff. He also included a four-page document called “Training Plan” where staff complete standard tasks around the home and confirm competency by initialing next to each task, including medication passing.

APPLICABLE RULE	
R 400.15312	**Resident medication.**
	(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.

ANALYSIS:	Ms. Kiser, Ms. Johnson, Ms. Clemons, and Mr. Rantz confirmed there is medication training for staff in place where staff shadow an experienced worker for two days, then are supervised passing medication for three days, and then sign documentation confirming their training and competence. Mr. Rantz provided records confirming staff were trained in various policies and procedures in the home, including medication passing. Their competence was confirmed by their initialing and signing off after reviewing and/or completing each task. Mr. Rantz also showed that he evaluates staff performance relating to many policies and procedures, including medication passing, at 30-days, 90-days, annually, and as needed, to ensure staff are competent. Based on the interviews completed, there is insufficient evidence to support the allegation that staff are not sufficiently trained in the handling and administration of medication.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

On 09/24/2021, while observing Resident A's medications and looking in the medication cabinet, I found other resident medications pre-set in medication cups.

On 09/24/2021, Ms. Kiser reported she pre-sets medication for staff to ensure it is passed correctly as that is the "easiest way."

On 09/24/2021, I spoke to Mr. Rantz and advised him that medications cannot be pre-set by staff. It was reported the medications can be put in bubble packs by the pharmacy but otherwise, they must be kept in their pharmacy supplied container until immediately before they are passed. It was also discussed that the person who prepares the medication should be the one to immediately distribute the medication, one resident at a time. The increased likelihood of medication being given to the wrong resident when medications are pre-set by staff was discussed. Mr. Rantz expressed understanding.

APPLICABLE RULE	
R 400.15312	**Resident medication.**
	(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 pre-set medications in the medication cabinet while on-site. Ms. Kiser acknowledged to pre-setting resident medication. Therefore, sufficient evidence was found that resident medications are not kept in their appropriately labeled pharmacy supplied container.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/14/2021, I completed an exit conference with Licensee Designee, Mr. Rantz reviewing our on-site discussion about pre-setting medication. Mr. Rantz did not dispute my findings or recommendations.

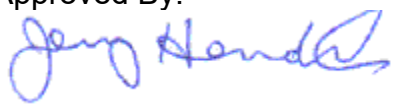
IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

10/15/2021

Cassandra Duursma Date
Licensing Consultant

Approved By:



10/15/2021

Jerry Hendrick Date
Area Manager