GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 2, 2021

Kerry & Charles Grayson
6240 Pinecrest Dr.
Zeeland, MI 49464

RE: License #:	AF700263375
Investigation #:	2021A0356040
	The Graysons

Dear Kerry & Charles:

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,

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

License #:	AF700263375
Investigation #:	2021A0356040
Complaint Receipt Date:	09/03/2021
Investigation Initiation Date:	09/03/2021
Report Due Date:	11/02/2021
Licensee Name:	Grayson, Charles and Grayson, Kerry
Licensee Address:	6240 Pinecrest Dr. Zeeland, MI 49464
Licensee Telephone #:	(616) 875-8219
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	The Graysons
Facility Address:	6240 Pinecrest Dr. Zeeland, MI 49464
Facility Telephone #:	(616) 875-8219
Original Issuance Date:	03/11/2004
License Status:	REGULAR
Effective Date:	02/24/2021
Expiration Date:	02/23/2023
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's medications are not administered as prescribed.	Yes
Resident A's personal care needs are not being met .	No

III. METHODOLOGY

09/03/2021	Special Investigation Intake 2021A0356040
09/03/2021	Special Investigation Initiated - Telephone Amber Drooger, Life Circles Social Worker.
09/03/2021	APS Referral-denied for investigation.
09/07/2021	Contact - Telephone call received Amber Drooger.
09/17/2021	Contact - Face to Face Kerry Grayson, Licensee.
09/17/2021	Inspection Completed On-site Facility documents gathered.
09/20/2021	Contact - Telephone call received Amber Drooger.
09/21/2021	Contact-(Additional) BCAL Online Complaint received.
09/21/2021	Contact - Telephone call made Pharmacist, Lisa Mulder, Life Circles.
09/21/2021	Contact - Telephone call made Donna Elston, legal guardian.
09/22/2021	Contact - Telephone call received Molly Heger, Pharmacist.
09/22/2021	Contact-Document Received Molly Heger, documentation of pharmacy deliveries.
10/04/2021	Contact - Face to Face Kerry Grayson, Licensee, MARs documentation.

11/01/2021	Exit Conference-Kerry Grayson, Licensee.

ALLEGATION: Resident A's medications are not administered as prescribed.

INVESTIGATION: On 09/03/2021, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported from February 02, 2021, to the end of June 2021, 114 tablets of the medication Ativan were prescribed while documentation provided by Licensee, Kerry Grayson accounted for only 75 of the Ativan tablets. The complainant reported documentation of the medication through Medication Administration Records (MARs) and behavior logs was requested on different dates and, Ms. Grayson refused to provide the documentation.

On 09/03/2021, I interviewed Amber Drooger, Reliance Social Worker via telephone. Ms. Drooger stated in August 2021, Ms. Grayson requested a refill of the Ativan medication initially the first week of August, and when the pharmacy requested documentation of the administration of the pills, Ms. Grayson retracted the request stating she had enough. During a care coordination meeting on 08/19/2021, Ms. Grayson reported that Resident A was doing well and did not need Ativan as often. On 08/31/2021, Ms. Drooger stated Ms. Grayson called and requested more Ativan tablets for Resident A stating that Resident A exhibited more episodes of agitation over the weekend. Ms. Drooger stated behavior logs and the MARs (medication administration records) for Resident A were requested at that time (on 08/31/2021) but not received. Ms. Drooger stated on 09/01/2021 and again on 09/02/2021, the Reliance pharmacist requested the behavior logs and MARs again from Ms. Grayson. Ms. Grayson called and stated the request for those documents was odd and she did not provide the documentation at that time. Ms. Drooger stated Ativan was prescribed for Resident A in February 2021 due to agitation which resulted in Resident A ripping clothes and pushing furniture however, during day center attendance at Lifecircles no signs or periods of agitation have been noted. Ms. Drooger stated Resident A's Ativan medication is a PRN (as needed) medication and should be administered when he is seen ripping clothes out of the closets, stomping his feet, and pushing furniture. Ms. Drooger stated the main concern is the documentation of the medication Ativan and the fact that Ms. Grayson is hesitant on providing that documentation to Lifecircles PACE.

On 09/07/2021, Ms. Drooger contacted me and reported that the pharmacist, Molly Heger received Resident A's MARs and behavior logs from Ms. Grayson and has concerns about the documentation of Ativan on the MARs. Ms. Drooger stated the pharmacist noted several refusals of the medication by Resident A documented on the MAR for the month of August, she had requested MARs for April, May and June 2021 and received May and June but not April, requested July and August and received both of those MARs. Ms. Drooger stated the pharmacist said the documentation of the administration of this medication was very confusing which supports their concern about how the medication is being administered to Resident A.

On 09/17/2021, I conducted an unannounced inspection at the facility and interviewed Ms. Grayson. Ms. Grayson stated she gets 15 Ativan tablets as she needs it for Resident A and only got 75 tablets between February and June 2021, not 114 as reported. Ms. Grayson stated she requests the medication as she uses it up, documents on a behavior log what Resident A was doing when she administered the medication and then documents it on the MAR. Ms. Grayson stated she used to document on the MAR with her initial K when she attempted to give Resident A the medication whether he took the medication or if he refused and then documented on the back of the MAR whether or not Resident A took the medication or refused it. Ms. Grayson stated on 05/21/2021, she changed the way she was documenting the PRN medication if Resident A refused it after a Beacon LRE (Lakeshore Regional Entity) audit. Ms. Grayson stated she was instructed to write an R for Refused on the MAR rather than her initial and continued to document on the back of the MAR whether or not Resident A took the medication or refused it. Ms. Grayson stated when Resident A becomes agitated, she tries to give Resident A the Ativan, pops the medication out of the container, puts it in a cup and if Resident A refuses to take the medication, she will put the medication in the cupboard in the cup and does not throw the medication away. Ms. Grayson stated on 09/01/2021 and 09/02/2021 she was hesitant to send documentation to the caller requesting Resident A's documents because she did not know the person calling and did not want to hand sensitive information to just anyone. Ms. Grayson stated on 08/31/2021, Ms. Drooger had requested Resident A's MARs and behavior logs, but she (Ms. Grayson) was out of ink and not able to get to the store to get more ink in order to copy the requested documents. Ms. Grayson stated she always communicates with Ms. Drooger and when it was not her requesting the documents on the following dates, it caused concern and she was hesitant to release the documents to someone she did not know. Ms. Grayson stated once assured the caller was a pharmacist with the Lifecircles program, she provided the requested documents. In addition, Ms. Grayson stated she is not used to requirements for as much documentation as required for Resident A and acknowledged it is challenging to keep the documentation clear as to when she administered Resident A's Ativan and when he refused it along with Resident A's behaviors. Ms. Grayson stated she administers the medication to Resident A as a PRN as prescribed.

On 09/17/2021, an interview was not conducted with Resident A as he is nonverbal and not able to provide pertinent information to this investigation.

On 09/21/202, I interviewed Donna Elston, Resident A's legal guardian via telephone. Ms. Elston stated Resident A does refuse the Ativan medication and Ms. Grayson attempts to give Resident A the Ativan PRN medication as prescribed when he becomes agitated by putting the medication in a cup for Resident A to take. Ms. Elston stated Ms. Grayson attempts 3 times to administer the medication and then if Resident A refuses to take the medication, she is not sure what Ms. Grayson does with the medication. Ms. Elston stated Ms. Grayson is not used to dealing with this level of documentation required by Lifecircles and this may be why the documentation is confusing.

On 09/21/2021, I interviewed Lisa Mulder, Lifecircles pharmacist via telephone. Ms. Mulder stated 129 Ativan tablets were prescribed to Resident A beginning 02/08/2021 through 07/2021. Ms. Mulder stated Resident A's MARs and behavior logs were received from Ms. Grayson for review, but it is difficult to tell when Ativan was administered in comparison to the amount of Ativan provided. Ms. Mulder suggested I interview Ms. Heger for more information.

On 09/21/2021, I interviewed Ms. Heger via telephone. Ms. Heger stated 9 Ativan tablets were prescribed for February 2021 and then 15 Ativan tablets were prescribed each month thereafter with the exception of August 2021 when no Ativan tablets were prescribed or delivered. Ms. Heger stated a total of 129 Ativan tablets from February 2021 through July 2021 were prescribed and delivered. Ms. Heger stated upon reviewing and comparing the behavior log vs. MARs it was difficult to track the administration of the medication. Ms. Heger stated Ms. Grayson's request for the refill of the medication was sooner at first and then the requests waned off, on February 8, 2021, 9 tablets were dispensed and then on February 15, 2021, 15 tabs were dispensed and then thereafter 15 were dispensed monthly until July 2021.

On 09/22/2021, I received and reviewed a copy of the pharmacy deliveries to the facility and between February 2021 and July 2021, 129 Ativan tablets were delivered to the facility.

On 09/17/2021 and 10/04/2021, I received and reviewed Resident A's MARs for the months of February, March, April, May, June, July, and August 2021. August 2021 was not counted in the number of medications given to the facility as there were no Ativan delivered during the month of August. The MAR documents Resident A was prescribed, on 02/15/2021, '*Lorazepam (*Ativan*) 0.5 MG tablet, take one tablet every 8 hours only as needed for severe agitation, use log to document behaviors (as needed controlled behavior*).' The MARs reflect the Ativan medication was administered or attempted to be administered and refused by Resident A on every MAR. During the months of February, March, April and most of May 2021, Ms. Grayson initialed the MAR with a K when Resident A took the medication and when he refused. Ms. Grayson would then document on the behavior log when Resident A took the medication and when Resident A refused the medication. The documentation is confusing and in order to see if Resident A took the medication or not, a comparison between the MAR and the behavior log would have to done. After May 21, 2021, Ms. Grayson began to initial a K when Ativan was administered and an R when Resident A refused the medication. The following information is what I deciphered from the documents reviewed.

- February 2021-on the MAR, it appeared as though 9 Ativan medications were administered and 5 were attempted and refused.
  The behavior log documented 18 Ativan medications were administered.
- March 2021-on this MAR, it was very difficult to tell the difference between the initial K for the administration of the Ativan medication vs. an R which stands for refusal to take the Ativan medication. It appears as though there are 22

dates marked with a K and 7 marked with an R. On the behavior log there are 25 documented Ativan administered to Resident A throughout the month and 4 documented as refused.

- April 2021-on this MAR, Ms. Grayson put her initial and the time the medication was taken and wrote 'refused' and the time with no initial on the MAR which is difficult to decipher if Resident A took the Ativan and when it was refused because there is a lot of documentation on the MAR. It appears as though Resident A took Ativan 18 times and refused 5 times. The behavior log documented 18 Ativan medications were administered and 4 were refused.
- May 2021-the MAR reflects 15 times Ativan was administered and 7 times it was attempted and refused.
- June 2021-the MAR reflects 10 Ativan administered and 7 refusals. Documented on the back of the MAR it shows 9 dates that Resident A refused Ativan.
- July 2021-the MAR reflects 14 Ativan administered and 4 refused.
- August 2021-the MAR reflects 6 Ativan administered and 4 refused, the back of the MAR corresponds and reflects 6 Ativan administered and 4 refused. These medications are not counted in the 129 delivered medications because the pharmacy reported they did not deliver any Ativan to the facility in August.

In sum, Resident A's MARs document 88 administered Ativan medications between February 2021 and July 2021. The Mars document 35 refused attempts to administer Ativan between February 2021 and July 2021. Total tablets 123. Resident A's behavior logs document 100 tablets administered between February 2021 and July 2021 and 35 refused between February 2021 and July 2021. Total 135 tablets. According to what I can decipher, the totals do not fully account for the pharmacy's 129 tablets dispersed from February 2021 through July 2021.

On 11/01/2021, I conducted and Exit Conference with Licensee, Kerry Grayson via telephone. Ms. Grayson acknowledged that the medication Ativan was removed from the pharmacy labeled container and not destroyed if Resident A refused to take it but kept for later administration. Ms. Grayson acknowledged that while she tried to keep the documentation clear, it is difficult to follow. Ms. Grayson stated Resident A's Ativan medication was used only for Resident A and she will submit an acceptable plan of correction for this rule violation.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(1) Prescription medication, including tranquilizers, sedatives, dietary supplements, or individual special medical procedures, shall be given, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy container which shall be labeled for the specific resident in accordance with the

	requirements of Act No. 368 of the Public Acts of 1978, as amended, being (33.1101 et. seq. of the Michigan Compiled Laws.
ANALYSIS:	The complainant reported that between February 2021 thru June 2021, 114 tablets of the medication Ativan were prescribed while documentation provided by Licensee, Kerry Grayson accounted for only 75 of the Ativan tablets. Ms. Grayson stated she attempts to administer Resident A's Ativan as a PRN medication as prescribed by placing the medication in a cup for administration, but if Resident A refuses to take the medication, she places the cup in a cupboard for future use. Ms. Heger, Ms. Drooger and Ms. Mulder reported that it does not appear as though Resident A's Ativan is being administered as prescribed. Ms. Elston stated Ms. Grayson removes the Ativan from the pharmacy labeled container, places it in a cup and attempts to administer it to Resident A when he is agitated. If Resident A does not take the medication, she is unaware of what Ms. Grayson does with the medication. Based on investigative findings, Resident A's Ativan medication is removed from the pharmacy labeled container, it may or may not be administered to Resident A and if Resident A refuses to take the medication, the medication is placed in a cupboard for future use. In addition, based on a review of Resident A's MARs and behavior logs, the number of medications dispersed by the pharmacy does not add up to the number of medications documented and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's personal care needs are not being met.

INVESTIGATION: On 09/03/2021, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported dried feces on Resident A's bottom directly after arriving to the center from the AFC home.

On 09/03/2021, I interviewed Ms. Drooger via telephone. Ms. Drooger stated the only information she has regarding Resident A with feces on him is that a family member went to the facility and found Resident A in the bathroom at the facility with

feces on him. Ms. Drooger reported that Ms. Grayson was not available to the family member nor was she assisting Resident A as needed with toileting.

On 09/17/2021, I conducted an unannounced inspection at the facility and interviewed Ms. Grayson. Ms. Grayson stated she is always at the home and available to provide care for her residents. Ms. Grayson stated Resident A usually gets off the bus, comes into the home and goes straight to the bathroom. Ms. Grayson does not know the incident the complainant is reporting because Resident A does have accidents, he is always assisted with wiping BM's (bowel movements) at the home and there are times she is not right by the door waiting and may be assisting other residents when Resident A gets off the bus. Ms. Grayson stated when agitated Resident A does refuse at times to allow her to wipe him after a BM. Ms. Grayson stated she will back off a little and then Resident A will allow her to wipe him. Ms. Grayson stated it is not unheard of that Resident A has a BM on the bus for his day program. Ms. Grayson stated she does not recall an incident when a relative came into the home and could not find her. Ms. Grayson stated she provides Resident A with the personal care needs he requires at all times.

On 09/17/2021, an interview was not conducted with Resident A as he is nonverbal and not able to provide pertinent information to this investigation.

On 09/21/202, I interviewed Ms. Elston via telephone. Ms. Elston stated she is not aware of this incident regarding Resident A having BM on him upon arriving at his day program. Ms. Elston stated Resident A has a history of accidents on the bus, Lifecircles toilets Resident A before he leaves the program in an attempt to prevent an accident from happening on the bus. Ms. Elston stated Resident A wears briefs at all times, and they are changed as needed. Ms. Elston stated as far as Ms. Grayson not being available when a relative stopped in, that relative was not her (Ms. Elston) and Ms. Grayson was probably in another area of the home and not readily available, but Ms. Elston stated that is not a consistent problem that she is aware of.

On 09/17/2021, I received and reviewed Resident A's Assessment Plan for AFC Residents signed on 02/28/2021 by Ms. Grayson and Ms. Elston. The assessment plan documents Resident A's need for assistance with toileting and documents, '*wipe after BM*.'

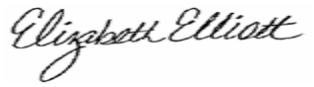
On 09/17/2021, I reviewed Resident A's Health Care Appraisal dated 08/07/2021, signed by Shauna Wishka, PAC (physician's assistant). The HCA documents Resident A as '*incontinent of bowel-intermittent.*'

On 11/01/2021, I conducted and Exit Conference with Licensee, Kerry Grayson via telephone. Ms. Grayson agrees with the findings of this applicable rule.

APPLICABLE RULE	
R 400.1408	**Resident care; licensee responsibilities.**
	(1) A licensee shall provide basic self-care and habilitation training in accordance with the resident's written assessment plan.
ANALYSIS:	Based on investigative findings, there is not a preponderance of evidence to show that Resident A's personal care needs are not being attended to at the facility. A violation of this rule is not established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

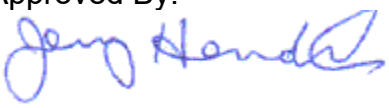
Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.



10/29/2021

Elizabeth Elliott Date
Licensing Consultant

Approved By:



11/02/2021

Jerry Hendrick Date
Area Manager