GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 7, 2022

Mark Walker
Premier Operating Goodrich MC, LLC
8119 S State Road
Goodrich, MI 48438

RE: License #:	AL250382983
Investigation #:	2022A0123010
	The Pines of Goodrich Memory

Dear Mr. Walker:

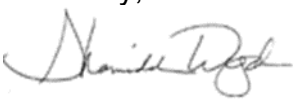
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (906) 226-4171.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250382983
Investigation #:	2022A0123010
Complaint Receipt Date:	11/18/2021
Investigation Initiation Date:	11/19/2021
Report Due Date:	01/17/2022
Licensee Name:	Premier Operating Goodrich MC, LLC
Licensee Address:	299 Park Ave - 6 Fl New York, NY 10171
Licensee Telephone #:	(419) 429-9984
Administrator:	Mark Walker
Licensee Designee:	Mark Walker
Name of Facility:	The Pines of Goodrich Memory
Facility Address:	8119 S State Road Goodrich, MI 48438
Facility Telephone #:	(810) 244-0694
Original Issuance Date:	02/09/2017
License Status:	REGULAR
Effective Date:	08/09/2021
Expiration Date:	08/08/2023
Capacity:	20
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A has only been receiving medication from other residents that have passed away, that Resident A was prescribed.	No
Additional Findings	Yes

III. METHODOLOGY

11/18/2021	Special Investigation Intake 2022A0123010
11/18/2021	APS Referral Information received regarding APS referral.
11/19/2021	Special Investigation Initiated - Telephone I spoke with Ruby Mogensen via phone.
11/24/2021	Contact - Telephone call made I conducted a Facetime call with the facility. I interviewed staff and Resident A.
11/24/2021	Contact - Document Received Requested documentation was received via email.
12/15/2021	Contact - Telephone call made I interviewed staff Nicole Brooks via phone.
12/20/2021	Contact - Telephone call made I made a call to Resident A's public guardian's office. I left a message requesting a return call.
12/21/2021	Contact - Telephone call received I spoke with Individual 1 from Resident A's public guardian's office.
12/21/2021	Contact - Document Sent I sent Ms. Mogensen an email requesting additional documentation.
12/21/2021	Contact - Document Received I received requested documentation via email.
12/21/2021	Contact- Document Sent

	I sent an email to adult protective services worker Michael Grant.
12/21/2021	Contact- Document Received I received an email response from adult protective services worker Michael Grant.
01/07/2021	Contact- Telephone call made I left a voicemail requesting a return call from licensee designee Mark Walker regarding an exit conference.
01/07/2021	Exit Conference I spoke with licensee designee Mark Walker via phone.

ALLEGATION: Resident A has only been receiving medication from other residents that have passed away, that Resident A was prescribed.

INVESTIGATION:
This investigation was conducted virtually due to the COVID-19 Pandemic.

On 11/19/2021 I made a call to administrator Ruby Mogensen. She stated that nothing is going on with Resident A. He just had a guardian appointed and his family lives out of state and won't answer calls. She stated that a lawyer had to be obtained to get him a guardian, and that he had issues with his health insurance, and trouble with his medication. She stated that Resident A goes through the Veterans Affairs (VA) hospital for medications. She stated that a friend of Resident A was assisting him, but also stopped answering their calls. She stated that she had to contact adult protective services because the VA Hospital would not speak with her regarding Resident A. She stated that they could not get a doctor to see Resident A so they sent him to the hospital, and things moved along when APS got involved. She stated that there have been no issues in the last month, and that Resident A did not go without his own medications. She stated that a hospital wrote scripts for Resident A and discharged him.

On 11/24/2021, I conducted the following interviews via Facetime:

I interviewed staff Jennifer O'Neal, the lead supervisor. Staff O'Neal stated that Resident A has a court appointed guardian as of a few months ago. He had not gone without his medications for a period. She stated that Resident A's medications were going to a family friend's home who would then bring the medication to the facility. She stated that they had to call APS because Resident A's family was not assisting and because Resident A needed assistance getting his medications straight. She stated that they could not get ahold of Resident A's family. She stated that Resident A's scripts did not lapse, and the medications stayed the same until things were straightened out. She denied that Resident A received any other person's medications. She stated that after a resident dies, their medications are disposed of with kitty litter or coffee grounds. She stated that two people dispose of

the medication, and if a resident is on hospice, hospice witnesses the disposal, and they are disposed immediately.

I made a face to face with Resident A. Resident A could not be interviewed due to his dementia. He could not answer questions. He appeared clean and appropriately dressed.

Resident A's medications were observed during this Facetime call. Resident A had 13 medication bubble packs. Each bubble pack was prescribed in his name.

I interviewed staff Kailey Williams. Staff Williams stated that Resident A has his own medications. She stated that Ms. Mogensen disposes the medications after residents pass away. She stated that she has no idea why someone would make these allegations and that there has not been a period where Resident A went without his medication.

On 11/24/2021, I obtained requested documentation. Resident A's Assessment Plan for AFC Residents indicates that he needs staff assistance with taking medication. His health care appraisal dated 10/28/2020 indicates that he is diagnose with dementia and confusion.

On 12/15/2021, I interviewed staff Nicole Brooks. Staff Brooks stated that there are no issues that she is aware of where Resident A did not have his medication. She stated that she does not think the facility would hold old medications, and that they are discarded. She stated that she has never seen medication belonging to a resident in the facility after they pass away. She stated that she is not sure who disposes the medication, but that it's probably management that does so. She denied that Resident A received old medication prescribed to previous residents.

On 12/21/2021, I spoke with Individual 1 from Resident A's public guardian's office. Individual 1 stated that their office was appointment as Resident A's emergency guardian. The facility was struggling getting medications from the VA Hospital. The VA Hospital had refused to give more medications unless they saw Resident A. The pharmacy was contacted and allowed for Resident A to private pay, and he was assisted with getting Medicare Part D. APS was involved and APS pushed to get the guardian's office involved. Individual 1 denied hearing anything about Resident A receiving anyone else's medication. The VA Hospital did provide scripts a few times in the beginning of his stay at the facility. The medication issue has been straightened out. Individual 1 denied knowing whether Resident A ever went without his medications. Individual 1 stated that Resident A was going to be set up with transportation to the VA hospital in Saginaw, MI to be seen then it was discovered that it was cheaper to pay out of pocket. Individual 1 stated that their office got involved at the end of October 2021. Individual 1 denied having any concerns regarding Resident A's care.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Staff O'Neal, Staff Williams, and Staff Brooks were interviewed and denied the allegations that Resident A was administered medications belonging to previous residents. Individual 1 from Resident A's public guardian's office denied hearing anything regarding Resident A receiving anyone else's medications. Resident A's medication bubble packs were observed via Facetime on 11/24/2021. Each bubble pack was prescribed in his name. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	Staff O'Neal, Staff Williams, and Staff Brooks were interviewed and denied the allegations. They stated that medications that are prescribed to individuals in the facility that pass away are disposed of. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 12/21/2021, I sent an email to adult protective services worker Michael Grant inquiring whether there was a period that Resident A went without his medications. Mr. Grant responded via email and stated the following that he still has an active case with Resident A, as the current public guardian is

temporary pending permanency. He stated that there have been periods and several instances where Resident A went without medications as the VA Hospital would not refill the prescription. He stated that Resident A's family did not respond to requests to assist in the matter, therefore an emergency petition had to be filed to get Resident A's medications and health needs met. He stated that he cannot "*breakdown to a period of time of him going without the meds but it has been an issue for the majority of the time I have kept an open case with him."*

On 12/21/2021, I received copies of Resident A's August 2021 through November 2021 medication administration records (MARS).

Resident A's August 2021 MARS was reviewed and observed to have multiple pages (pages three through eight) of medication doses listed as not administered due to "awaiting med arrival from pharmacy." There are also a significant number coded as "out of facility" as well. The medications are Atorvastatin Tab 40 MG, Carbidopa/Levodopa 25/100 MG, Clopidogrel Tab 75 MG, Divalproex Tab 500 MG DR and Divalproex Tab 250 MG DR, Metoprolol Tar Tab 25 MG, Quetiapine Tab 100 MG, and Quetiapine Tab 50 MG.

Resident A's September 2021 MARS was reviewed and observed to have multiple pages (page two through six) of medication doses listed as not administered due to "awaiting med arrival from pharmacy." The medications are Atorvastatin Tab 40 MG, Carbidopa/Levodopa 25/100 MG, Clopidogrel Tab 75 MG, Divalproex Tab 500 MG DR and Divalproex Tab 250 MG DR, Metoprolol Tar Tab 25 MG, Quetiapine Tab 100 MG, and Quetiapine Tab 50 MG. All the missed doses were coded as "awaiting med arrival from pharmacy."

Resident A's October 2021 MARS was reviewed and observed to have multiple pages (pages two through seven) of medication doses listed as not administered due to "awaiting med to arrive from pharmacy" between 10/01/2021 and 10/30/2021. The medications are Divalproex Tab 500 MG DR and Divalproex Tab 250 MG DR, Quetiapine Tab 50 MG, Carbidopa/Levodopa 25/100 MG, Ensure Chocolate- B4150, Clopidogrel Tab 75 MG, and Atorvastatin Tab 40 MG.

Resident A's November 2021 MARS were reviewed and observed to have no medications noted as not being passed by staff during the entire month. No issues were noted.

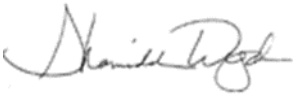
APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Medication Administration Record (MARS) documentation was reviewed for Resident A for the months of August through November 2021. I observed in the documentation that there

	were multiple missed doses of several medications due to "awaiting med arrival from pharmacy." Adult protective services worker Michael Grant confirmed that Resident A not receiving his prescribed medication had been an ongoing issue. There were no issues noted in the MARS documentation for the month of November 2021. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/07/2022, I conducted an exit conference with licensee designee Mark Walker via phone. I informed him of the findings and conclusions.

IV. RECOMMENDATION

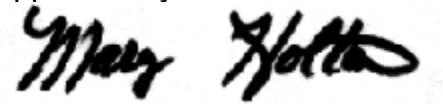
Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of this AFC large group home license (capacity 20).



01/07/2022

Shamidah Wyden — Date
Licensing Consultant

Approved By:



01/07/2022

Mary E Holton — Date
Area Manager