GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 20 , 2022

Cynthia Duzenbury
Altam Inc
6300 Douglas Road
Riverdale, MI 48877

RE: License #: AM590091656
Investigation #: 2022A0577010
Pine Point

Dear Ms. Duzenbury:

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 (231) 922-5309.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM590091656
Investigation #:	2022A0577010
Complaint Receipt Date:	11/23/2021
Investigation Initiation Date:	11/24/2021
Report Due Date:	01/22/2022
Licensee Name:	Altam Inc
Licensee Address:	6300 Douglas Road Riverdale, MI 48877
Licensee Telephone #:	(989) 560-0292
Administrator/Licensee Designee:	Cynthia Duzenbury
Name of Facility:	Pine Point
Facility Address:	6300 Douglas Road Riverdale, MI 48877
Facility Telephone #:	(989) 833-5274
Original Issuance Date:	03/01/2000
License **Status:**	REGULAR
Effective Date:	02/05/2020
Expiration Date:	02/04/2022
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents are being hospitalized and incident reports are not being submitted to the appropriate parties.	Yes
The facility is administering Nyquil and Vitamin C to residents without a doctor's order.	Yes

III. METHODOLOGY

11/23/2021	Special Investigation Intake 2022A0577010
11/24/2021	Special Investigation Initiated – Letter- Email to Complainant requesting additional information and paperwork.
11/24/2021	Referral - Recipient Rights to Angela Loiselle, ORR-MCN.
12/10/2021	Inspection Completed On-site- Interviews with staff and residents. Review medications cart and MARs.
12/10/2021	Contact - Document Sent- Faith Simison, Mid-Michigan Guardianship.
12/21/2021	Exit Conference with Cynthia Duzenbury, Licensee.
12/21/2021	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Residents are being hospitalized and incident reports are not being submitted to the appropriate parties.

INVESTIGATION:

The complaint received on November 23, 2021, alleged the facility is not completing incident reports to notify guardians or case managers when residents are going to hospital.

On November 24, 2021, I interviewed Complainant who reported not receiving *AFC Licensing Division-Incident/Accident Reports* (IR) when residents are taken to the emergency room or are hospitalized as required. The Complainant reported Resident A was hospitalized on November 14, 2021 and an IR was not provided.

On December 08, 2021, I interviewed Relative A1 who reported Resident A was taken to the emergency room at Carson City Hospital for a bladder infection, was

tested for COVID-19 and tested positive. Relative A1 reported Resident A was taken to the emergency room by ambulance and then Relative A1 was notified. Relative A1 reported it was a couple of weeks ago when Resident A went to the hospital, but Relative A1 could not remember the exact date. Relative A1 reported about a month ago (beginning of November 2021) Resident A was taken to the emergency room and then transferred to Sparrow Hospital. Relative A1 reported they have not received any paperwork from the facility for when Resident A has been hospitalized or taken to the emergency room.

On December 10, 2021, I interviewed Elizabeth Yeager, Manager with Mid-Michigan Guardianship, who reported the agency had not received any Incident/Accident Reports from the facility regarding their wards being hospitalized. Ms. Yeager reported none of their wards have been hospitalized recently, or at least none of whom she was aware.

On December 10, 2021, I interviewed Faith Simison Mid-Michigan Guardianship Services who reported none of her residents she represents have been hospitalized recently so there was no need for an IR to be submitted to her agency.

On December 10, 2021, during the unannounced onsite investigation I interviewed direct care staff (DCS) Michelle Barber-Button who reported Resident F is currently in the hospital due to COVID-19 and Resident A had been hospitalized within the last 30 days. Ms. Barber-Button reported she was not aware of IRs being completed as this was not her responsibility.

On December 10, 2021, I interviewed DCS Rebecca Race who reported she completes IRs when residents are hospitalized or taken to the emergency room, puts the IRs in a folder for licensee designee (LD) Cynthia Duzenbury to sign and send to the appropriate parties. Ms. Race showed me a folder where the completed IRs are kept and I reviewed and received a copy of an IR completed for Resident A being hospitalized on November 14, 2021. Ms. Race reported the IR completed for Resident A has not been sent to the appropriate parties. Ms. Race reported an IR has not been completed regarding Resident F who was currently in the hospital and had been in the hospital since November 15, 2021.

On December 21, 2021, I interviewed LD Cynthia Duzenbury who reported IRs are completed by direct care staff, put in a folder for her signature and then she sends the IRs to responsible agency. Ms. Duzenbury reported she is not aware of an IR being completed for Resident F.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	Based on the information gathered during the investigation it has been found *AFC Licensing Division-Incident/Accident Reports (IR)* were not completed after Resident A was hospitalized on November 14, 2021 or after Resident F was hospitalized on November 15, 2021 notifying the resident's responsible agency or the adult foster care licensing consultant within 48-hours of the hospitalization. During the onsite investigation on December 10, 2021 an incomplete IR was observed for Resident A from November 14, 2021 but was not signed by the administrator nor was a copy provided to the appropriate parties. Ms. Race and Ms. Duzenbury both reported no IR was completed regarding Resident F currently being in the hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility is administering Nyquil and Vitamin C to residents without a doctor's order.

INVESTIGATION:

On November 23, 2021, a complaint was received alleging the residents in the facility tested positive for COVID-19 and the facility providing medications such as

Nyquil and Vitamin C without doctor's order. The information was confirmed with Visiting Physician and residents.

On November 24, 2021, I interviewed Complainant who reported speaking with Resident B, Resident C, and Resident D who all reported being given Nyquil and Vitamin C by direct care staff after residents tested positive for COVID-19. Complainant reported medical records for Resident B, Resident C, and Resident D, did not have a physician's order for Nyquil and Vitamin C.

Relative A1 reported on December 08, 2021, not being aware of Resident A being administered any non-prescribed over the counter medications when Resident A had COVID-19. Relative A1 reported being unsure what medications Resident A is prescribed.

On December 08, 2021I interviewed Tiffany Torres, Medical Assistance with Visiting Physicians Association (VPA), who reported VPA was last at the facility on November 05, 2021 with no COVID-19 being reported at that time. Ms. Torres reported not being notified by the facility of any residents being COVID-19 positive. Ms. Torres reported VPA currently provides physician services to Resident D, Resident E, Resident F, and Resident G. Ms. Torres reported Resident D is the only resident that has an active prescription for Vitamin C which was prescribed in October 2020. Ms. Torres reported there are no active prescriptions for any over the counter cold medication for the four residents VPA oversees medical care for at the facility.

On December 10, 2021, I interviewed Faith Simison Mid-Michigan Guardianship Services who reported she called Pine Point on November 16, 2021, to schedule a visit with Resident D and Resident E for November 18, 2021 and then received a call from Eden Stevens, Case Manager with Montcalm Care Network notifying Ms. Simison of residents being positive for COVID-19. Ms. Simison reported she did a visit by Zoom with Resident D and Resident E who both reported they were feeling fine. Ms. Simison reported neither Resident D nor Resident E reported anything to her about the facility giving them Vitamin C or any other over the counter cold medication.

On December 10, 2021, I completed an unannounced onsite investigation and interviewed DCS Michelle Barber-Button who reported she was not aware of residents receiving Nyquil, Vitamin C, or any other non-prescribed over the counter medications to assist with the symptoms of COVID-19. Ms. Barber-Button reported there are three bottles of Vitamin C in the medication cart with no labels or instructions so she was not sure to whom the Vitamin C belongs.

On December 10, 2021, DCS Rebecca Race reported she was not aware of residents receiving Nyquil or Vitamin C and stated, “residents can only be administered medications that are prescribed to them by a physician.” Ms. Race denied administering residents Vitamin C and cold medications.

On December 10, 2021, during my investigation I completed a medication audit and found three bottles of Vitamin C, 500mg in the medication cart with no labels documenting to whom they are prescribed. I reviewed the Medication Administration Record (MAR) and found no residents had Vitamin C on their MAR for November or December 2021, nor did I see any type of over-the-counter cold medication on the MARs for November and December 2021. Per VPA on December 08, 2021, Resident D has an ongoing prescription for Vitamin C but Resident D did not have Vitamin C on their MAR for November and December 2021, nor was there a prescription for Vitamin C for Resident D found at the facility. I interviewed Resident A, Resident B, Resident C, Resident D, and Resident E. Resident A reported she received cough syrup two times a day when she had COVID-19. Resident A reported she was not sure if the cough medication was prescribed by a physician. Resident B reported she does not believe she was given Vitamin C or cold medications. Resident C reported Cynthia Duzenbury and Rebecca Race gave her a red liquid-cold medication and Vitamin C gummies while she was recovering from COVID-19. Resident D reported she did not receive Vitamin C or cold medication. Resident D denied being prescribed Vitamin C. Resident E reported he was given Vitamin C and Nyquil for three days when he had COVID-19. Resident E reported he is not prescribed Nyquil or Vitamin C and was given both for a couple of days when everyone was sick.

On December 21, 2021, I interviewed licensee designee Cynthia Duzenbury who denied the allegation that Vitamin C and/or Nyquil was administered to the residents. Ms. Duzenbury reported some of the residents are prescribed Vitamin C, but Ms. Duzenbury reported she was not sure which residents are prescribed Vitamin C.

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:	On December 10, 2021 during the onsite investigation, three bottles of Vitamin C were found in the medication cart with no labels to whom the Vitamin C was prescribed. Upon review of the residents *Medication Administration Records* (MAR) for November and December 2021, Vitamin C was not listed on any of the residents MARs as a prescribed medication, including Resident D who VPA reported on December 08, 2021 as having an ongoing prescription for Vitamin C. I was not able to find the current and ongoing prescription of Vitamin C for Resident D while at the facility. Although Resident A, Resident C and Resident E reported they were provided Vitamin C and a liquid cold medication while recovering from COVID-19, there is not any documented evidence this occurred. However, there is enough evidence, Resident D should have been receiving Vitamin C but was not.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended the current status of the license remains unchanged.

Bridget Vermeesch 01/04/2022

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 01/20/2022

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Dawn N. Timm Date
Area Manager