GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 27, 2022

Paul Meisel
AUGUST HAUS ASSISTED LIVING LLC
1201 Village Parkway
Gaylord, MI 49735

RE: License #: AL690392652
Investigation #: 2022A0009013
AUGUST HAUS ASSISTED LIVING LLC

Dear Mr. Meisel:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the 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 (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL690392652
Investigation #:	2022A0009013
Complaint Receipt Date:	01/05/2022
Investigation Initiation Date:	01/06/2022
Report Due Date:	02/04/2022
Licensee Name:	AUGUST HAUS ASSISTED LIVING LLC
Licensee Address:	1201 Village Parkway Gaylord, MI 49735
Licensee Telephone #:	(989) 732-6374
Licensee Designee/Admin:	Paul Meisel
Name of Facility:	AUGUST HAUS ASSISTED LIVING LLC
Facility Address:	1201 Village Parkway Gaylord, MI 49735
Facility Telephone #:	(989) 448-7094
Original Issuance Date:	10/23/2018
License Status:	REGULAR
Effective Date:	04/23/2021
Expiration Date:	04/22/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was at the hospital twice for a fractured left arm. During the second visit, medical personnel believed that staff at August Haus had not elevated Resident A's arm as ordered in the initial discharge instructions. The facility did not fill Resident A's pain medication prescription between visits and Resident A complained of pain.	Yes

III. METHODOLOGY

01/05/2022	Special Investigation Intake 2022A0009013
01/05/2022	APS Referral
01/06/2022	Special Investigation Initiated – Telephone made to adult protective services worker Ms. Penny Kelly
01/07/2022	Contact – Telephone call made to emergency room director Ms. Katie Drewiecki, Otsego Memorial Hospital
01/10/2022	Inspection Completed On-site Interviews with home manager Ms. Sara Gagnon and medication supervisor Ms. Margaret Warren
01/13/2022	Contact – Documents received via email from home manager Ms. Sara Gagnon
1/26/2022	Contact – Telephone call made to Resident A's Power of Attorney
1/26/2022	Exit conference with licensee designee/administrator Mr. Paul Meisel

ALLEGATION: Resident A was at the hospital twice for a fractured left arm. During the second visit, medical personnel believed that staff at August Haus had not elevated Resident A's arm as ordered in the initial discharge instructions. The facility did not fill Resident A's pain medication prescription between visits and Resident A complained of pain.

INVESTIGATION: I spoke with adult protective services worker Penny Kelly by phone on January 6, 2022. Adult Protective Services did not have a current investigation regarding the most recent matter. They did have previous reports of

Resident A falling at home, not eating and self-neglect. Ms. Kelly indicated that Resident A was placed at the August Haus Assisted Living adult foster care (AFC) home due to her needing licensed care.

I spoke with emergency room director Katie Drzewiecki by phone on January 7, 2022. Resident A was seen at the emergency room on December 23, 2021 and also on December 30, 2021. She was relaying what the doctor had reported during Resident A's second emergency room visit on December 30, 2021. The doctor believed that Resident A's arm had not been kept raised as directed in the discharge instructions. This conclusion was reached as a result of the swelling and discoloration of her arm. Her arm should have been raised to heart-level or higher. They also noted that Resident A's pain medication had not been filled between the visits as directed and she complained of pain during the second visit.

I conducted an unannounced site inspection at the August Haus Assisted Living AFC home on January 10, 2022. I wore personal protection equipment to protect myself and others. I spoke with home manager Sara Gagnon at the time of my visit. She said that they did try to keep Resident A's arm elevated but Resident A was "fighting" them on it. Her arm was in a sling and she kept removing her arm from the sling. They reportedly had her arm propped up on a stack of pillows but she would take her arm off the stack of pillows. Ms. Gagnon reported that her staff told her repeatedly that Resident A was taking her arm off the pillow stack. She said that she did contact Resident A's Power of Attorney to ask if anything else could be done for Resident A. Resident A's Power of Attorney told her that the only suggestion he had was to take her back to the emergency room. Resident A's arm was swollen and purple by that point. I asked Ms. Gagnon what else they did to address the issue of Resident A not keeping her arm propped. She replied that she asked staff to "chart it" but she was not sure if they did. I also asked Ms. Gagnon about the report that Resident A's prescription for pain medication was not filled between the two emergency room visits. She stated that during the time between hospital visits, they could not figure out where her prescription had been sent. It was not sent to the pharmacy that the facility uses. Ms. Gagnon stated that she repeatedly contacted the hospital, but they would not release any information to her. Unbeknownst to Ms. Gagnon, the prescription was sent to Wal-Mart where Resident A previously had her prescriptions filled. Ms. Gagnon stated that she had no way to know that because the information was contained in the discharge instructions which they did not have. I asked her why they did not have the discharge instructions. The staff who accompanied Resident A during her initial emergency room visit stated that they were not given any discharge instructions. She said that she asked staff to look for the discharge instructions, but they were not found until a couple of days later in Resident A's room. Ms. Gagnon stated that both she and the medication supervisor, Margaret Warren, dealt with Resident A's medication issue.

I then spoke with the medication supervisor, Margaret Warren. She said that Resident A did not originally get her medication because the prescription for the medication went to Wal-Mart. They were not aware that the prescription went there

because they use another pharmacy to fill the residents' prescriptions. They were not aware that Resident A used Wal-Mart before coming to their facility. The staff who had taken Resident A to the emergency room stated that they did not receive any discharge instructions from the hospital. Ms. Warren stated that she kept calling the hospital to try to find out where Resident A's medication prescription went but the hospital would not give her any information. She said that she contacted Resident A's Power of Attorney who was the one who reported that the prescription might have gone to Wal-Mart. He said that he would check on it and get back to her. Resident A's Power of Attorney forgot about doing that, though. As a result, Resident A did not receive any of the newly prescribed pain medication during the week between the two emergency room visits. They did give Resident A Tylenol that she had previously been prescribed to her. I asked Ms. Warren about Resident A's arm being swollen and discolored. She replied that she didn't work with Resident A directly during that week so she didn't know much about it. She did say that when they noticed that Resident A's arm was a darker color than normal, they took Resident A right to the emergency room.

At the time of my visit, I requested that Ms. Gagnon send me documentation regarding the hospital's discharge instructions, the medication log and any staff notes during the time between the hospital visits. Ms. Gagnon provided the requested documentation by email on January 13, 2022. I received Resident A's Patient Visit Information from Otsego Memorial Hospital dated December 23, 2021. This indicated that Resident A was prescribed Hydrocodone/Acetaminophen (1 tab oral three times per day PRN for 5 days). It indicated that the prescription was sent to the Wal-Mart pharmacy. I also reviewed the Charting Notes I was provided for the dates between December 23 and December 30, 2021. On December 23, 2021 staff recorded that Resident A fell and hurt her wrist and that she went to the hospital. On December 24, 2021, it was documented that Resident A was in a lot of pain and asking for pain medication. She was having the pain "from her arm". On December 26, 2021, staff wrote, "No meds to give they were all out". On December 27, 2021, staff wrote that Resident A was "in a very pleasant mood considering she is in a lot of pain". I also received a Narcotic Count form for Resident A that seemed to indicate that Resident A received her Hydrocodone/Acetaminophen prescription on December 30, 2021. The form begins with December 30, 2021 as the first recorded line. On that date it indicates "Added +15".

I spoke with Resident A's Power of Attorney by phone on January 26, 2022. He reported that it was a real "cluster-mess" what had happened with Resident A's medication. He said that the medication prescription had erroneously gone to Resident A's previous pharmacy as opposed to the pharmacy the facility uses. When the pharmacy called to say the prescription was filled, they called Resident A's telephone and she no longer answers her own phone. Resident A's Power of Attorney stated that he didn't fault the facility for the mix-up. He said that they were calling him trying to get it resolved. He did understand my concern that she went a full week without a needed medication. Resident A's Power of Attorney mentioned that he visited Resident A at least a couple of times during the time frame I was

looking at. He denied that Resident A complained of pain. She said that it was just a “dull ache”. I asked him if she had her arm propped up at heart-level or above during his visits. He said that he just observed that she was on the couch with her arm on the arm rest of the couch. Resident A’s Power of Attorney stated that the arm rests are about at heart-level so felt that her arm was properly raised during his visits with her.

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. (b) Special diets. (c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate. (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:	There was a concern that the facility did not prop Resident A’s arm up as instructed during the initial hospital visit. It was reported that Resident A did remove her arm from the sling and sometimes would drop her arm. The facility staff did reportedly attempt to prop her arm up as instructed but reported that she was not always compliant. Resident A’s Power of Attorney reported that during his visits, he did observe her arm somewhat propped up by resting on the couch arm rest. She did have to return to the hospital because of swelling and discoloration to her wrist and arm. It was confirmed through this investigation that the licensee did not follow the instructions or recommendation of a health care professional when Resident A was not provided with needed pain medication. Resident A’s pain medication prescription provided by the hospital was not filled for a week. Resident A complained of pain to the staff at August Haus during that week. She also complained to the emergency room staff during her second visit that she was in pain.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee designee/administrator Mr. Paul Meisel by phone on January 26, 2022. I told him of the findings of my investigation and gave him the opportunity to ask questions.

IV. RECOMMENDATION

I recommend no change in the license status.

01/27/2022

Adam Robarge Date
Licensing Consultant

Approved By:

01/27/2022

Jerry Hendrick Date
Area Manager