GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 28, 2022

Karen Gardner
4522 Old Lansing Road
Lansing, MI 48917

RE: License #: AM330015780
Investigation #: 2022A0783039
Gardner's Adult Foster Care

Dear Ms. Gardner:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care related violations established in this report, the quality of care related violations established in special investigation number 2022A0783029 and the fact you were placed on a 1st provisional license on February 1, 2022, for the violations established in the renewal licensing study report dated February 1, 2022, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 (517) 284-9730.

Sincerely,

Leslie Herrguth

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM330015780
Investigation #:	2022A0783039
Complaint Receipt Date:	04/15/2022
Investigation Initiation Date:	04/18/2022
Report Due Date:	06/14/2022
Licensee Name:	Karen Gardner
Licensee Address:	4522 Old Lansing Road Lansing, MI 48917
Licensee Telephone #:	(517) 322-4050
Administrator:	Karen Gardner
Name of Facility:	Gardner's Adult Foster Care
Facility Address:	2924 W Willow Road Lansing, MI 48917
Facility Telephone #:	(517) 886-1114
Original Issuance Date:	01/09/1995
License Status:	1ST PROVISIONAL
Effective Date:	02/01/2022
Expiration Date:	07/31/2022
Capacity:	12
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff members Dorothea “Dottie” Jarrett and Jan Chambers told Resident C she could not have her prescribed pain medication.	No
Resident C did not get her medication as prescribed by her physician.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/15/2022	Special Investigation Intake – 2022A0783039
04/18/2022	Special Investigation Initiated – Telephone call with Complainant
04/20/2022	Contact - Face to Face interviews with facility manager Natalie Gardner and Resident C
04/20/2022	Inspection Completed On-site
04/20/2022	Contact - Telephone call made to direct care staff member Deborah Redman
04/20/2022	Contact - Document Received – Resident C's resident record
04/22/2022	Contact - Telephone call made to Resident B
04/22/2022	Contact - Telephone call made to Natalie Gardner
04/22/2022	Contact - Telephone call made to direct care staff member Dorothea "Dottie" Jarrett
04/22/2022	Contact - Telephone call made to direct care staff member Jan Chambers
04/25/2022	Exit Conference – left message for Karen Gardner

ALLEGATION:

Staff members Dorothea "Dottie" Jarrett and Jan Chambers told Resident C she could not have her prescribed pain medication.

INVESTIGATION:

On April 15, 2022, I received a complaint via centralized intake that stated Resident C told an Adult Protective Services (APS) investigator that staff members Dorothea "Dottie" Jarrett and Jan Chambers told her she could not have the medication she needed.

On April 18, 2022, I spoke to Complainant who confirmed the allegation as reported to him by Resident C and had nothing further to add.

On April 20, 2022, I interviewed Resident C who said at 7:00 am on an unknown date direct care staff member Dorothea "Dottie" Jarrett told Resident C "no" when Resident C requested her prescribed Norco medication. Resident C said Ms. Jarrett called her a "druggie," and a "pill head," and told her she did not need the medication. Resident C said Resident B heard Ms. Jarrett call her a "druggie," and a "pill head." Resident C stated after approximately 10 minutes Ms. Jarrett returned with Resident C's medication, apologized, and gave her the medication. Resident C stated this was the only time Ms. Jarrett told her she could not have her medication. Resident C denied that staff member Jan Chambers ever told her she could not have her medication.

On April 22, 2022, I spoke to Resident B who stated she is familiar with direct care staff member Dorothea "Dottie" Jarrett and denied that she ever heard Ms. Jarrett refer to Resident C as a "druggie," nor a "pill head."

On April 20, 2022, and April 22, 2022, I interviewed facility manager Natalie Gardner who said there was one occasion brought to her attention by Resident C where direct care staff member Dorothea "Dottie" Jarrett asked Resident C "to wait for two minutes" to get her prescribed Norco and Resident C found that unacceptable. Ms. Gardner stated at that time Resident C's prescribed Norco was to be taken as – needed (PRN) and her physician has since changed the order for Resident C's prescribed Norco to be administered on a scheduled basis rather than as – needed. Ms. Gardner stated she has consistently asked Resident C since that occasion if Ms. Jarrett has been administering her medication correctly and Resident C has reported that she has been receiving her medication as prescribed. Ms. Gardner denied Resident C ever reported that Ms. Jarrett nor Ms. Chambers have ever refused to administer Resident C's Norco as prescribed nor that Ms. Jarrett ever called Resident C a "druggie," or a "pill head."

On April 22, 2022, I spoke to direct care staff member Dorothea “Dottie” Jarrett who stated she never told Resident C she could not have her prescribed Norco. Ms. Jarrett stated she never referred to Resident C as a “druggie,” nor a “pill head.” Ms. Jarrett said Resident C has mentioned that all the staff members at the facility think she is a druggie or a pill head but said she never said that, nor does she think that. Ms. Jarrett said she has always administered Resident C’s medication as prescribed at 12:00 am and 6:00 am and the only medication she administers to Resident C is Norco. Ms. Jarrett said on one occasion Resident C became agitated because she asked for her medication and Ms. Jarrett asked her to wait until she was done administering medication to another resident. Ms. Jarrett said Resident C’s medication was administered within 10 minutes and as soon as she administered the other resident’s medication.

On April 22, 2022, I spoke to direct care staff member Jan Chambers who denied that she ever told Resident C she could not have her prescribed Norco. Ms. Chambers said when the medication was prescribed every 6 hours as – needed (PRN) Resident C at times requested more Norco before 6 hours passed and it could not be administered. Ms. Chambers said once the medication was prescribed to be administered on a schedule, Resident C has been satisfied with medication administration at the facility. Ms. Chambers denied that anyone ever reported nor that she ever heard Ms. Jarrett refer to Resident C as a “druggie,” nor a “pill head.”

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(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: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	Based on Resident C’s statement along with statements from Ms. Gardner, Ms. Jarrett, Ms. Chambers, and Resident B there is lack of evidence to indicate that Ms. Jarrett or Ms. Chambers withheld medication from Resident C, told her she could not have it, nor that Ms. Jarrett referred to Resident C as a “druggie,” nor a “pill head.”
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident C did not get her medication as prescribed by her physician.

INVESTIGATION:

On April 15, 2022, I received a complaint via centralized intake that stated adult protective services (APS) received a complaint on April 14, 2022, that alleged Resident C is not getting her medication for congestive heart failure (CHF) and pain as prescribed, which has resulted in more frequent doctor visits to treat her CHF and an unnecessary increase in the amount of pain Resident C suffers. The complaint stated Resident C said the failure to dispense her medication as prescribed has been occurring since her arrival at the AFC home in January 2022. The complaint stated the assigned APS investigator subsequently spoke with facility manager Natalie Gardner, who advised she had been working on getting the correct medication in the prescribed dosages for Resident C that day and noted that Resident C's physician increased the Norco dosage, but the pharmacy did not provide the correct amount of medication. The complaint stated the APS investigator took pictures of the letter from Resident C's physician and the medication logs. The complaint stated Resident C reported that a staff member tried to give Resident C medication that was discontinued.

On April 18, 2022, I spoke to Complainant who reported that there was a "mix – up" between Resident C's physician, the pharmacy where Resident C's prescriptions are filled, and staff members at the facility. Complainant said Resident C's physician changed the written order for Resident C's Norco, allowing her to take one or two pills every six hours but did not prescribe additional medication to account for the increase in the number of prescribed pills. Complainant said Resident C went to the hospital on April 6, 2022, and the physician discontinued one of Resident C's medications which was not communicated to staff members at the facility and Resident C received one dose of the discontinued medication. Complainant said he reviewed Resident C's medication administration records and a letter from Resident C's physician. Complainant said there would be no medical neglect substantiated against anyone at the facility.

On April 20, 2022, I interviewed Resident C who said after she was discharged from Sparrow Hospital on April 6, 2022, her medications were changed by the physician who treated her and staff members at the facility "couldn't get it right." Resident C said staff members attempted to give her Metoprolol, which was discontinued, but she did not take the medication. Resident C said the pill was already in the bubble pack with the rest of her prescribed medication and staff members "had a hard time taking the [Metoprolol] out of the bubble pack." Resident C stated her physician increased her prescribed Norco from one pill every six hours as – needed (PRN) to up to two pills scheduled every six hours and staff members claimed she did not

have enough pills and she missed at least one dose of her prescribed Norco during the first week of April 2022.

On April 20, 2022 and April 22, 2022, I interviewed facility manager Natalie Gardner who said on March 29, 2022, Resident C's physician wrote an order stating Resident C could take "one or two" Norco tablets every six hours, but the physician did not prescribe additional Norco tablets to account for the increase of allowing Resident C to take two Norco tablets every six hours instead of one tablet. Ms. Gardner said one of Resident C's 6:00 pm doses of Norco was "skipped" because Resident C did not have enough Norco tablets left. Ms. Gardner said a staff member located additional Norco tablets prescribed for Resident C and only one dose was "skipped" before Ms. Gardner worked with Resident C's physician and pharmacy to get additional Norco tablets for Resident C. Ms. Gardner said Resident C was hospitalized on April 5, 2022, and the physician who treated Resident C discontinued Resident C's prescription for Metoprolol. Ms. Gardner said the pill was already in the bubble pack created by the pharmacy and nobody from the facility reviewed Resident C's discharge paperwork containing new orders for Metoprolol until the following day so one dose of Metoprolol was administered to Resident C after it was discontinued. Ms. Gardner stated the "skipped dose" of Norco nor the administration of Metoprolol which was discontinued was the "fault" of anyone at the facility.

On April 20, 2022, I spoke to direct care staff member Deborah Redman who said even though Resident C's physician increased her prescribed dosage from one Norco tablet to two tablets every six hours and the pharmacy did not provide additional pills, the medication was administered as prescribed because a staff member at the facility found a small supply of Resident C's Norco that was used until the pharmacy sent more medication. Ms. Redman denied that she ever "skipped" administering any doses of Resident C's Norco. Ms. Redman said she never administered Metoprolol to Resident C because she removed it from the pharmacy bubble pack before she administered the medications to Resident C.

On April 22, 2022, I spoke to direct care staff member Jan Chambers who confirmed that Resident C's physician increased her prescribed Norco from one tablet every six hours as needed (PRN) to up to two tablets scheduled every six hours. Ms. Chambers said when the prescription was changed the pharmacy did not send additional Norco tablets but a staff member at the facility located extra Norco tablets that belonged to Resident C and those tablets were administered until the pharmacy supplied additional Norco tablets. Ms. Chambers denied that she ever "skipped" administering Resident C's prescribed Norco. Ms. Chambers said she never administered Metoprolol to Resident C after it was discontinued because Ms. Gardner told her which pill to remove from Resident C's pharmacy – supplied bubble pack and that she removed the medication at each pass and did not administer the medication to Resident C.

On April 22, 2022, I spoke to direct care staff member Dorothea "Dottie" Jarrett who said she always gave Resident C her prescribed Norco per the written physician's

order and denied that she ever “skipped” administering any of Resident C’s prescribed Norco. Ms. Jarett stated she only works the overnight shift and Norco is the only medication she administers to Resident C.

On April 20, 2022, I received Resident C’s written resident record and noted a written order from her physician that stated, “This is a note to confirm that [Resident C’] is currently taking Hydrocodone – Acetaminophen [Norco] 4 times a day. Her medication should be given at 6:00 AM, 12 PM, 6PM, and 12 AM daily.”

On April 20, 2022, I received and reviewed a written physician’s order for Resident C dated March 29, 2022, that stated Resident C’s “pain medication has been increased to 1 – 2 tablets every 6 hours as needed.”

On April 20, 2022, I received and reviewed a written physician’s order for Resident C dated April 12, 2022, that stated Metoprolol Tartrate was discontinued.

On April 20, 2022, I received and reviewed Resident C’s written medication administration record (MAR) for April 2022 which indicated direct care staff member Deborah Redman administered Metoprolol Tartrate on the morning of April 13, 2022 and direct care staff member Jan Chambers administered Metoprolol Tartrate at bedtime on April 13, 2022.

On April 20, 2022, I reviewed Resident C’s written medication administration records and noted that Hydrocodone – Acetaminophen [Norco] was not on the medication administration record with all the other scheduled medications but rather it was documented on a form entitled *Resident PRN Medication Record*. According to the written form the Hydrocodone – Acetaminophen was administered twice on March 9, 2022, once on March 12, 2022, once on March 15, 2022, once on March 16, 2022, twice on March 18, 2022, and once on March 21, 2022, March 22, 2022, March 27, 2022, and March 28, 2022. I also noted that the medication was not administered at the times specified on the written physician’s order. I noted that according to the written *Resident PRN Medication Record* for April 2022, the medication was not administered four times daily at 6:00 am, 12:00 pm, 6:00 pm, and 12:00 am as ordered from April 1, 2022 – April 10, 2022. The medication was not administered at all between April 1, 2022 and April 7, 2022. The medication was administered twice on April 8, 2022 and twice on April 10, 2022.

On April 20, 2022, I searched Resident C’s entire resident record and did not locate a discharge summary nor any other documentation that Resident C was hospitalized on or about April 5 – 6, 2022.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on statements from Complainant, Resident C and Ms. Gardner as well as written documentation in Resident C's resident record, I determined that Resident C's Norco was not administered as prescribed between March 1, 2022 and April 11, 2022, as according to the written MAR the medication was not administered four times daily at 6:00am, 12:00 pm, 6:00 pm, and 12:00 am as ordered by Resident C's physician . Ms. Gardner acknowledged, which was verified by Resident C that at least one dose of Resident C's prescribed Norco was "skipped" due to not receiving more tablets from the pharmacy when the dosage increased. Further, according to Complainant, Ms. Gardner, and Resident C as well as written documentation in Resident C's resident record, at least two 50 milligram Metoprolol tablets were administered to Resident C after the medication was discontinued by April 12, 2022 and based on interviews as early as April 6, 2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On April 20, 2022, I reviewed Resident C's entire resident record and did not locate an incident report for Resident C's hospitalization on or about April 5 – April 6, 2022.

On April 25, 2022, I searched the electronic facility record and did not locate a single incident report for Resident C nor any other resident.

On April 25, 2022, I spoke to direct care staff member Deborah Redman who said Resident C did go to the hospital on April 5th or 6th 2022 and that a written incident report was not completed because Resident C went to the hospital from her physician's office and not from the facility.

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: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	Based on my observations at the onsite inspection, my review of the electronic file as well as a statement from Ms. Redman I determined that no written report was submitted to Resident C's designated representative nor the adult foster care licensing division within 48 hours of Resident C's hospitalization on or about April 5, 2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On April 20, 2022, I completed an unannounced onsite investigation at the facility and heard Resident C, who was working with a physical therapist, state she found a loose pill on the dining room floor. I observed as Ms. Gardner picked up the pill, showed it to me and stated it was an aspirin that was mistakenly dropped on the floor.

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:	Based on my observations at the unannounced onsite inspection as well as a statement from Ms. Gardner it can determined that medication was left unlocked when it was located on the dining room floor.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [Reference LSR dated February 1, 2022 and written corrective action plan dated January 21, 2022.]**

INVESTIGATION:

On April 20, 2022, I received and reviewed Resident C's MARS from January 2022 – current and noted that the medication administration records stated only "AM" or "Bed." None of the medication administration records specified the time in which the medication was administered.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(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: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Based on a review of Resident C's written resident record I determined that the medication administration records do not include the time the medication was administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On April 20, 2022, I requested Resident C's written resident record and noted that there were no medication logs in the record from January 2022 – March 2022. When questioned, Ms. Gardner stated the medication logs were not in Resident C's resident record and were located elsewhere outside the facility.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.**
ANALYSIS:	Based on my finding at the unannounced onsite investigation and a statement from Ms. Gardner I determined that Resident C's medication logs from January – March 2022 were not maintained on-site in Resident C's resident record as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Due to the facility being on a 1st provisional license because of the violations established in the licensing study report dated February 1, 2022, the quality of care related violations established special investigation 2022A0783029, and the quality of care related violations established in this report, I continue my recommendation for revocation of the license.

04/25/2022

Leslie Herrguth Date
Licensing Consultant

Approved By:

04/26/2022

Dawn N. Timm Date
Area Manager