GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 30, 2022

Simbarashe Chiduma
Open Arms Link
Suite 130
8161 Executive Court
Lansing, MI 48917

RE: License #: AM190409578
Investigation #: 2022A0790019
Open Arms Stoll

Dear Mr. Chiduma:

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:

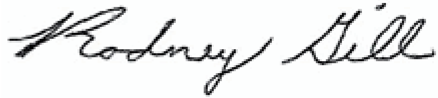
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance 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.

611 W. OTTAWA • P.O. BOX 30664 • LANSING, MICHIGAN 48909
www.michigan.gov/lara • 517-335-1980

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,



Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM190409578
Investigation #:	2022A0790019
Complaint Receipt Date:	06/01/2022
Investigation Initiation Date:	06/01/2022
Report Due Date:	07/31/2022
Licensee Name:	Open Arms Link
Licensee Address:	Suite 130 8161 Executive Court Lansing, MI 48917
Licensee Telephone #:	(517) 483-2489
Administrator:	Mascline Chiduma
Licensee Designee:	Simbarashe Chiduma
Name of Facility:	Open Arms Stoll
Facility Address:	Ste 130 3285 W Stoll Rd Lansing, MI 48906
Facility Telephone #:	(517) 455-8300
Original Issuance Date:	08/25/2021
License **Status:**	REGULAR
Effective Date:	02/25/2022
Expiration Date:	02/24/2024

Capacity:	9
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is out of his Clozapine medication and direct care staff member and home manager Jada Moore has not taken Resident A to get his blood drawn nor helped him receive new medication.	Yes

III. METHODOLOGY

06/01/2022	Special Investigation Intake 2022A0790019
06/01/2022	Special Investigation Initiated - On Site - Interviewed direct care staff member whose role is assistant home manager Misael Saldivan and Resident A.
06/08/2022	Inspection Completed-BCAL Sub Compliance
06/02/2022	Contact - Telephone call made to licensee designee Simbarashe Chiduma.
06/08/2022	Exit Conference with licensee designee Simbarashe Chiduma.

ALLEGATION:

Resident A is out of his Clozapine medication and direct care staff member and home manager Jada Moore has not taken Resident A to get his blood drawn nor helped him receive new medication.

INVESTIGATION:

I conducted an unannounced onsite investigation on 06-01-2022 and reviewed Resident A's *Resident Records.* I reviewed Resident A's *medication administration record* (MAR) and found Resident A had not received his Clozapine 50 mg tablet he is prescribed to take once per day since 05/16/2022. There was no indication that the missed medication had been discontinued based on information found on the MAR. I observed

that there were lines or circles entered each day from 05/16/2022 through 06/01/2022 indicating that Resident A did not receive the medication.

I reviewed Resident A's Community Mental Health (CMH) Treatment Plan Annual / Initial, *Health Care Appraisal,* and *Assessment Plan for AFC Residents*. Resident A's *Assessment Plan for AFC Residents* indicated Resident A requires assistance with taking his medication and indicated that Clozapine was prescribed by Dr. Alisa Schlacht. The *Health Appraisal* documented Resident A suffers from hypertension, chronic obstructive pulmonary disease, gastroesophageal reflux disease, dementia, headaches, mild intellectual disability, and his treatment plan from CMH indicated he suffers from medical and mental health conditions that impact his abilities.

I interviewed direct care staff member whose role is assistant home manager Misael Saldivan. Mr. Saldivan admitted that Resident A has not received his Clozapine 50 mg tablet since 05/16/2022. Mr. Saldivan stated direct care staff member, whose role is home manager, Jada Moore is responsible for ensuring residents at Open Arms Stoll are receiving all their prescribed medication. Mr. Saldivan said he and other direct care staff members have left numerous messages and notes for Ms. Moore informing her Resident A was out of his Clozapine 50 mg tablets. Mr. Saldivan stated Ms. Moore did not take Resident A to get bloodwork as needed so he can receive refills of his medication. Mr. Saldivan said he and other direct care staff members have also left numerous messages and notes for the new operations manager Brett Perhase informing him that Resident A was out of his Clozapine 50 mg tablets. He said nothing has been done to ensure Resident A is receiving all his prescribed medications.

Mr. Saldivan said he does not know for sure why Resident A ran out of his Clozapine. He believed it was because due to Resident A not having required bloodwork completed in order to refill the medication. Mr. Saldivan stated Resident A is scheduled to have lab work completed on 06/04/2022 at 9:30 a.m. Mr. Saldivan said Ms. Moore is supposed to check each residents' *MAR* the begin of every week to ensure they have all their medications, and each medication is being administered correctly. Mr. Saldivan stated he has attempted to call the pharmacy on behalf of Resident A but there was nothing he could do until Resident A had his blood drawn and bloodwork completed.

Mr. Saldivan said he has not noticed any change in Resident A's behavior or physical health since he has not been receiving his Clozapine 50 mg. He said Resident A has not complained of any mental nor physical health conditions.

I attempted to interview Resident A but due to his dementia and mental illness, he was difficult to interview. He did say he was feeling well and did not disclose any concerns regarding his mental nor physical health.

I contacted licensee designee Simbarashe Chiduma via phone and informed him Resident A had not been getting his prescribed Clozapine 50 mg tablet since 05/16/2022. I asked that he address the concern immediately.

Mr. Chiduma called me on 06-02-2022 and stated he contacted the new operations manager Brett Perhase and Mr. Perhase admitted Resident A had not been getting his Clozapine 50 mg tablet at 8:00 p.m. each day since 05-16-2022. Mr. Chiduma said Mr. Perhase said Resident A had his bloodwork completed on 06-01-2022. Mr. Chiduma sent me a Lab Report showing Resident A's bloodwork had been completed by 05/17/2022. Mr. Chiduma later informed me he misunderstood Mr. Perhase and that Resident A's last blood draw was on 05-16-2022 not 06-01-2022.

Mr. Chiduma said that Resident A was taking his Clozapine 50 mg tablet as of today 06-02-2022. Mr. Chiduma stated he asked Mr. Perhase for an explanation as to why Resident A had not been taking the medication and was awaiting a response. Mr. Chiduma stated at this time he is unaware why Resident A was not getting his Clozapine 50 mg tablet but will ensure that he receives it going forward. He asked administrator Mascline Chiduma and she was unaware as well.

Mr. Chiduma said home manager/direct care staff member Jada Moore had begun a process of reviewing all the residents' *MAR* every Monday and immediately ordering a refill for any medication with a 10-day supply or less.

I conducted an exit conference with Simbarashe Chiduma on 06-08-2022. Mr. Chiduma said he has no explanation for why Resident A did not receive his Clozapine 50 tablet from 05-16-2022 through 06-01-2022. He said it was an oversite on the part of direct care staff member including home manager Jada Moore and will not happen again. Mr. Chiduma emailed me Resident A's *MAR* for the month of June 2022. It indicated that Resident A has been receiving his Clozapine 50 mg tablet each day at 8:00 p.m. since 06-02-2022. Mr. Chiduma stated they have implemented the plan previously discussed and added additional safeguards to ensure residents at Open Arms Stoll and all Open Arms Link homes are properly and consistently receiving their prescribed medications.

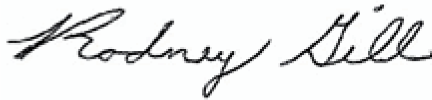
I informed Mr. Chiduma a Corrective Action Plan (CAP) will be required due to the evidence found and violation established during this investigation involving Resident A not receiving a prescribed medication. Mr. Chiduma indicated he would promptly provide a CAP upon receipt of the Special Investigation Report and ensure that the residents at all Open Arms Link homes are receiving their prescribed medications properly and consistently.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Resident A did not receive his prescribed medication Clozapine 50 mg tablet from 05-16-2022 through 06-01-2022. No explanation was given for Resident A missing this daily medication for this length of time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

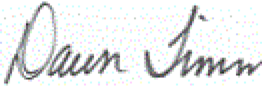
Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.



06/14/2022

Rodney Gill — Date
Licensing Consultant

Approved By:



06/30/2022

Dawn N. Timm — Date
Area Manager