GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 28, 2022

Kimberly Gee
Wood Care X, Inc., d/b/a Caretel Inns of Linden
910 S. Washington Ave.
Royal Oak, MI 48067

RE: License #:	AL250331295
Investigation #:	2022A0872053
	Homer House Inn

Dear Mrs. Gee:

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 (517) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250331295
Investigation #:	2022A0872053
Complaint Receipt Date:	08/23/2022
Investigation Initiation Date:	08/23/2022
Report Due Date:	10/22/2022
Licensee Name:	Wood Care X, Inc., d/b/a Caretel Inns of Linden
Licensee Address:	910 S. Washington Ave. Royal Oak, MI 48067
Licensee Telephone #:	(810) 735-9400
Administrator:	Kimberly Gee
Licensee Designee:	Kimberly Gee
Name of Facility:	Homer House Inn
Facility Address:	202 S Bridge Street Linden, MI 48451
Facility Telephone #:	(810) 735-9400
Original Issuance Date:	05/01/2014
License Status:	REGULAR
Effective Date:	11/03/2020
Expiration Date:	11/02/2022
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is a diabetic and she went without insulin for several days.	Yes

III. METHODOLOGY

08/23/2022	Special Investigation Intake 2022A0872053
08/23/2022	Special Investigation Initiated - On Site Unannounced
09/12/2022	Contact - Document Sent I emailed Home House Inn management requesting information about this complaint
09/14/2022	Contact - Document Received I received AFC documentation regarding this complaint
09/22/2022	Inspection Completed On-site
09/26/2022	APS Referral I made an APS complaint via email
09/27/2022	Contact - Telephone call made I interviewed Relative A1
09/27/2022	Exit Conference I conducted an exit conference with the licensee designee, Kimberly Gee
09/27/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A is a diabetic and she went without insulin for several days.

INVESTIGATION: On 8/23/22, I conducted an unannounced onsite inspection of Homer House Inn. I interviewed the director of assisted living, (ALD) Amanda Walworth, the general manager, Ronda Pype, and the assistant to the director of assisted living,

Raelynn Fonger. Ms. Walworth has been the director of AL since April 2022 and Raelynn Fonger has been the assistant ALD since February 2022.

On 8/23/22, I reviewed the allegations, and Ms. Fonger said that there is one resident at this facility, Resident A who is diabetic. Ms. Fonger stated that when Resident A was admitted to this facility, she had a prescription from her doctor for injectable insulin. Since none of the staff are trained in insulin injections, Resident A did miss her insulin for a couple of days. Ms. Fonger worked with Resident A's doctor and the pharmacy to change the order from traditional injection to an injection-pen administration. Resident A has been receiving her insulin as prescribed since that time. Ms. Fonger said that Resident A did not have any ill effects from missing this medication. I inspected several resident bedrooms and observed several residents who all appeared to be clean and receiving adequate care and supervision. I did not observe or interview Resident A on this date.

On 9/14/22, I received Adult Foster Care documentation regarding Resident A. Resident A was admitted to Homer House Inn on 8/18/22. I reviewed her medication record dated 8/18/22 through 8/31/22. According to this record, Resident A was supposed to begin receiving the following medications on 8/19/22 at 9:00am but she missed them due to her being asleep: Amlodipine 10mg, Aspirin 81mg, Cholecalciferol 50mcg, Decubi-Vite, Januvia 50mg, Thiamine 100mg, Ferrex 150mg, Fluticasone 100mcg, and Pantoprazole 40mg.

Resident A missed medications on a couple other occasions due to one of the following reasons: drug refused, absent from home, other/see nurse's notes, or hold/see nurse's notes.

On 8/18/22, Resident A was prescribed Insulin Lispro injection solution 100 units which staff is to administer before each meal and at bedtime, based on her blood sugar levels. This order went into effect on 8/18/22 at 11:30am and was not discontinued until 8/20/22 at 6:06pm. According to the medication record, staff did not consistently check Resident A's blood sugar and did not administer the medication on 8/18/22, 8/19/22, or 8/20/22.

On 8/20/22 at 9:00pm, Resident A was prescribed Insulin Lispro 100 units subcutaneously via pen-injector which staff is to administer before each meal and at bedtime, based on her blood sugar levels. According to the medication record, staff began checking Resident A's blood sugar and administering the medication as prescribed beginning on 8/21/22 at 7:30am.

On 9/22/22, I conducted another onsite inspection of Homer House Inn. According to the assisted living director, Amanda Walworth, Resident A was unavailable. Ms. Walworth said that Resident A had fallen and broke her leg, and she is currently at rehab. The rehab facility has active Covid-19 cases, so I was unable to interview her. Ms. Walworth said that she does not yet have a return date for Resident A. Since I was conducting my renewal inspection on this date, I interviewed several residents and

inspected all resident rooms. The residents I interviewed reported no concerns and all residents I observed appeared to be clean and dressed appropriately.

On 9/27/22, I interviewed Relative A1 via telephone. Relative A1 confirmed that Resident A is at rehab due to a broken leg and her return date to Homer House Inn is unknown at this time. I reviewed the allegations with Relative A1 and she confirmed that Resident A is a diabetic but said that she was not aware that she had gone without insulin. I explained the results of my investigation and told her that I am substantiating a rule violation due to this issue.

On 9/27/22, I conducted an exit conference with the licensee designee, Kimberly Gee via telephone. I discussed the results of my investigation and explained which rule violation I am substantiating. Mrs. Gee agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A was admitted to this facility on 8/18/22. She was prescribed an insulin injection to be administered based on her blood sugar levels. I reviewed her medication log and confirmed that staff did not administer her insulin from 8/18/22-8/20/22. The assistant ADL, Raelynn Fonger confirmed that Resident A went without her insulin when she was first admitted to this facility because the facility did not have trained staff to administer traditional insulin and had to wait for the insulin injection pen. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

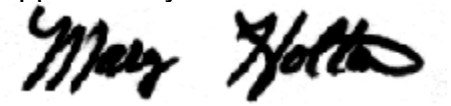
IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

September 27, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:



September 28, 2028

Mary E. Holton Area Manager	Date