GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 9, 2022

Brandy Shumaker
Oliver Woods Retirement Village LLC
Suite 200
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL780314126
Investigation #: 2022A0584024
Oliver Woods #4

Dear Ms. Shumaker:

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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Candace Coburn, Licensing Consultant
Bureau of Community and Health Systems
Coburnc3@michigan.gov
517-243-7590

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL780314126
Investigation #:	2022A0584024
Complaint Receipt Date:	06/09/2022
Investigation Initiation Date:	06/10/2022
Report Due Date:	08/08/2022
Licensee Name:	Oliver Woods Retirement Village LLC
Licensee Address:	Suite 200 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(810) 334-8809
Administrator:	Daniel Marchione
Licensee Designee:	Brandy Shumaker
Name of Facility:	Oliver Woods #4
Facility Address:	1310 W. Oliver Street Owosso, MI 48867
Facility Telephone #:	(989) 729-6060
Original Issuance Date:	04/02/2012
License Status:	REGULAR
Effective Date:	10/02/2020
Expiration Date:	10/01/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive his 12:00 pm dose of the medication Morphine on 05/08/2022	No
Additional Findings	Yes

III. METHODOLOGY

06/09/2022	Special Investigation Intake 2022A0584024
06/10/2022	Special Investigation Initiated – Telephone interview with Amanda Jones, Director of Clinical Services Corso Care
07/19/2022	Inspection Completed On-site visual walkthrough only. In person interview with Dan Marchione, Administrator.
08/01/2022	Contact - Telephone call made to Brenda Willing, direct care worker Contact – Telephone call made to Brittany Griesbach, Corso Care nurse.
08/08/2022	Contact – Telephone interview with Relative A
08/08/2022	Exit Conference – email to Rochelle Lyons, Licensee Designee
08/09/2022	Contact – Documents received from Litha Hatmaker – Adams Assessment plans for all facility residents and Medication Incident Forms for 2020, 2021, 2022.
08/29/2022	Contact – In person interview with Litha Hatmaker - Adams, Director of Resident Care.

ALLEGATION:

Resident A did not receive his 12:00 pm dose of the medication Morphine on 05/08/2022

INVESTIGATION:

On 6/09/2022, Adult Protective Services dismissed the above allegation for investigation and forwarded the complaint to the Bureau of Community and Health Systems (BCHS) via the BCHS online complaint system.

On 6/10/2022, I conducted a telephone interview with Amanda Jones, Director of Clinical Services at the hospice agency Corso Care, who provided services for Resident A in the facility from April 2022 until his passing on 05/12/2022. Ms. Jones stated their agency received a complaint from Relative A 1 alleging the facility did not administer Resident A his 12:00 pm dose of prescribed morphine on 05/08/2022. Ms. Jones stated that Relative A 1's written complaint to them, documented he was in Resident A's bedroom all morning, did not leave Resident A's side, and noticed no one came in to administer the 12:00 pm dose. Ms. Jones stated she was also contacted by the facility's administrator Dan Marchione who informed her he was conducting an internal investigation regarding the allegation. Ms. Jones stated their agency has no concerns regarding the quality of care received in the facility for any residents they provided services to. Ms. Jones stated Corso Care nurse Brittany Griesbach went to the facility around 3:00 pm on 05/05 to draw the prescribed syringes of morphine for Resident A and documented the amount of filled syringes on the *Living Leisure Management of Controlled Substance Proof-of-use* form. According to Ms. Jones, she stated law enforcement was also notified of the allegation.

On 7/19/2022, I conducted an unannounced investigation onsite and observed five residents in the facility's common area. All five residents appeared well groomed and well cared for. Resident A was no longer at the facility since he had passed away prior to receipt of the referral complaint.

Mr. Marchione, who was present at the time of my onsite investigation, provided me with documentation from his internal investigation. I reviewed a written statement by direct care worker Brenda Willing which indicated she passed the 12:00 pm medication on 05/08/2022, a written statement from the Ms. Griesbach addressing the complaint allegations, a *BCAL-4607 Incident and Accident report* (IR) dated 05/12/2022, Resident A's medication administration record (MAR) for the month of May 2022, and a facility internal document called *Leisure Living Management Controlled Substance Proof-of-use* record dated 05/05/2022.

The written statement from Ms. Willing read;

“On Sunday May 8 I was preparing to give [Resident A] his dose of morphine. The time that I signed to medication out of the Narcotic book was approximately 11:40 am [sic]. I went into his room and found him resting peacefully in his bed. I did not see anyone else in the room at that time. [Resident A] did not seem to be in any distress at that time. I greeted him and administered his morphine”.

The written statement from Ms. Griesbach read;

“Writer received call from DRC Litha whom reports [Relative A 1] is concerned morphine 5mg scheduled @ 12pm was not given despite being documented as given [sic]. EMAR documentation of 12:54 by Brenda Willing [sic]. Written count documentation states 11:40am. [Relative A 1] reports he has not left patients side since arrival at 10:15 am and a family friend has been present since 1100 until 1300. Family had been in contact with administrator Dave. Family contacted police and filed a report. Med count was accurate. Instructed caregiver Mikayla whom currently on meds she may bring a second care giver with her when administering meds if she felt uncomfortable [sic]. Incident report filed. Litha updated on police report”.

I reviewed documentation on the 05/12/2022 IR, that was received as a notice of Resident A passing away on that date.

I reviewed documentation on Resident A’s MAR for the month of May 2022, which indicated that on 05/08/2022, Resident A was administered his noon dose of morphine, as evidenced by Ms. Willings initials.

I reviewed documentation on the *Leisure Living Management Controlled Substance Proof-of-Use* record, which confirmed that at 11:40 am on 05/08/2022, Ms. Willing administered Resident A his noon morphine. According to documentation on this form, the morphine count descended accurately after the initial amount was supplied, without any syringes missing.

On 8/1/2022 I attempted to conduct telephone interviews with Ms. Willings and Ms. Griesbach. I left voice messages requesting they return my telephone call. As of the date of this report, I have not received a return telephone call from either individual.

On 8/8/2022 I interviewed Relative A 1 via telephone. Relative A 1’s statements regarding the allegation were consistent with the statements he provided to Corso Care. Relative A 1 stated that while he was at the facility on 05/08/2022, he notified the facility’s nurse that no one had administered Resident A his noon dose of morphine. Relative A 1 stated he talked with Ms. Willing, who was assigned to administer the medication and she told him she did administer it. Relative A 1 stated Ms. Willing acted very defensive when he confronted her about it. Relative A 1 stated he contacted Corso Care, Oliver Woods administration, and law enforcement about his concern. According to Relative A 1, Corso Care, who investigated the allegation, informed him that facility documentation indicated the medication was administered and there was no evidence that it was not given as prescribed.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon my investigation, which consisted of interviews with facility staff members, hospice care givers, Relative A 1, and a review of facility documents relevant to this investigation, there is not enough evidence to substantiate the allegation Resident A did not receive his 12:00 pm dose of the medication Morphine on 05/08/2022.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

On 8/9/2022, I received an internal facility form titled *Medication Incident Form* for the years 2020, 2021, and 2022 via email from director of resident care Litha Hatmaker-Adams. Documentation on the forms from 2022 read;

"Describe the Incident:
MAR states 2.5. Bottle less than 2

Describe Your Actions Following the Incident (including any notifications):
George Majied has been having multiple med errors since starting to med pass. The count has been correct daily until after George worked 5/11/22. George has been removed from the med cart. Bottle 1.75 ml 5/12 at 6:30A. signed J. Kinsey, staff member and L. Hatmaker-Adams, DRC [sic]"

On 8/29/2022 I conducted an in-person interview with Ms. Hatmaker-Adams. Ms. Hatmaker-Adams confirmed that on 05/12/2022, it was discovered Resident B was missing .75 ml of morphine. Ms. Hatmaker-Adams stated the error was documented on the facility's internal form and direct care worker George Majied was removed from passing medications. Ms. Hatmaker-Adams stated the facility's policy is to retrain any direct care staff that make serious medication errors and Mr. Majied no longer works at the facility. Ms. Hatmaker-Adams did not indicate any additional actions taken to attempt to locate the missing medication and/or determine how/why the medication was missing.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based upon my investigation, which consisted of interviews with a facility staff member and a review of facility documents relevant to this investigation, it has been established that on 05/12/2022, Resident B was missing .75 ml of her medication morphine. According to Director of Resident Care Litha Hatmaker-Adams, due to the missing medication, direct care worker George Majied was removed from administering medications. However, no addition action was taken to attempt to locate the missing medication and/or determine how/why the medication was missing, as to prevent the incident from occurring again. Subsequently, it has been established the facility did not take reasonable precautions to insure prescription medication was not used by a person other than the resident for whom the medication was prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/8/2022, I conducted an exit conference with licensee designee Rochelle Lyon via an email and shared with her the findings of this investigation.

On 9/8/2022, I emailed the newly appointed Licensee Designee, Brandy Shumaker, and shared with her the findings of this investigation.

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan, I recommend no change in the status of the license.

9/8/2022

Candace Coburn — Date
Licensing Consultant

Approved By:

9/09/2022

Michele Streeter — Date
Section Manager