GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

Julie Norman
Farmington Hills Inn
30350 W. Twelve Mile Road
Farmington Hills, MI 48334

December 29, 2022

RE: License #: AH630236784
Investigation #: 2022A1022016
Farmington Hills Inn

Dear Julie Norman:

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 authorized representative and a date.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630236784
Investigation #:	2022A1022016
Complaint Receipt Date:	08/03/2022
Investigation Initiation Date:	08/03/2022
Report Due Date:	10/02/2022
Licensee Name:	Alycekay Co.
Licensee Address:	30350 W 12 Mile Rd. Farmington Hills, MI 48334
Licensee Telephone #:	(248) 851-9640
Administrator/ Authorized Representative	Julie Norman
Name of Facility:	Farmington Hills Inn
Facility Address:	30350 W. Twelve Mile Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 851-9640
Original Issuance Date:	12/29/2000
License Status:	REGULAR
Effective Date:	10/10/2021
Expiration Date:	10/09/2022
Capacity:	137
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Medication was improperly administered to the Resident of Concern (ROC) resulting in dangerously elevated blood pressure.	Yes
Inadequate staffing has resulted in employee carelessness in administering medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/03/2022	Special Investigation Intake 2022A1022016
08/03/2022	Special Investigation Initiated - Telephone Spoke with complainant by phone.
08/11/2022	Inspection Completed On-site
08/11/2022	APS Referral
09/20/2022	Contact - Telephone call made Request made for the multiple medication error reports.
12/29/2022	Exit Conference

ALLEGATION:

Medication was improperly administered to the Resident of Concern (ROC) resulting in dangerously elevated blood pressure.

INVESTIGATION:

On 7/27/2022, the Bureau of Community and Health Systems received a complaint that read “On 07/01/2022, I (complainant) received a call from the medical assistant [staff member name]. She told me that I needed to take my dad to the hospital because his blood pressure was very high. She was instructed by [Wellness Director name] to give him a drink of water and tell him to lay down. When I arrived, my dad was in bed and could not hold his head up and he told me that he felt like he wasn't going to make it. I proceeded to get him dressed and I took him to Henry Ford Hospital emergency in Detroit. We arrived at the hospital, and he was seen by the ER doctors, and they asked what medication was he on? I gave them a copy of the medication list given to me by Farmington Hills Inn staff. The doctor's asked me if they were taking his blood pressure before giving him the medication midodrine. I informed them that they are supposed to take his blood pressure before giving the medication. If his blood pressure is greater than 150, they are not supposed to give the midodrine. The ER doctor told me that he was being over medicated with midodrine and that was contributing to the high blood pressure and the swelling in his legs and feet… I (complainant) discovered that he was actually being over medicated by the staff. He was given midodrine when his blood pressure was over 150. There were times when his blood pressure was 230 and the staff still gave the medicine. My dad suffers from orthostatic blood pressure, his blood pressure runs low and the midodrine is given to raise the blood pressure…They are going to cause my dad to have a stroke.”

On 8/3/2022, I interviewed the complainant by phone. The complainant reiterated the details of the situation as she had put into her original complaint and stated that in her opinion, a lack of care staff training especially in the ROC’s medical condition contributed to multiple instances of medication errors.

On 8/11/2022, a referral was made to Adult Protective Services.

On 8/11/2022, during the onsite visit, I interviewed the administrative assistant and the wellness director, as the facility administrator was not available (on leave). The wellness director acknowledged that the ROC had been administered the medication midodrine at times according to the physician’s order, when the medication should have been held.

According to the website, WebMD.com, midodrine “is used for certain patients who have symptoms of low blood pressure when standing… This medication can cause blood pressure to increase, especially when lying down.”

According to the physician’s order, the ROC was to receive the medication “midodrine 10 mg by mouth three times daily (8 am, 12 pm, 4 pm), hold for systolic blood pressure greater than 150.”

Review of the medication administration record 5/27/2022 through 6/30/2022, revealed that the ROC received midodrine on the following occasions despite having a systolic blood pressure reading greater than 150 mmHg (millimeters of mercury).

- 5/28, 12 pm dose, when the systolic blood pressure reading was 183 mmHg
- 5/28, 4 pm dose, when the systolic blood pressure reading was 218 mmHg
- 6/3, 4 pm dose, when the systolic blood pressure reading was 171mmHg
- 6/4, 8 am dose, when the systolic blood pressure reading was 159 mmHg
- 6/4, 12 pm dose, when the systolic blood pressure reading was 162 mmHg
- 6/6, 4 pm dose, when the systolic blood pressure reading was 210 mmHg
- 6/10, 8 am dose, when the systolic blood pressure reading was 157mmHg
- 6/11, 8 am dose, when the systolic blood pressure reading was 158 mmHg
- 6/11, 4 pm dose, when the systolic blood pressure reading was162 mmHg
- 6/12, 8 am dose, when the systolic blood pressure reading was 198 mmHg
- 6/12, 12 pm dose, when the systolic blood pressure reading was 179 mmHg
- 6/12, 4 pm dose, when the systolic blood pressure reading was 230 mmHg
- 6/16, 12 pm dose, when the systolic blood pressure reading was 157 mmHg
- 6/16, 4 pm dose, when the systolic blood pressure reading was 154 mmHg
- 6/17, 12 pm dose, when the systolic blood pressure reading was 154 mmHg
- 6/18, 4 pm dose, when the systolic blood pressure reading was 172 mmHg
- 6/19, 8 am dose, when the systolic blood pressure reading was 176 mmHg
- 6/20, 4 pm dose, when the systolic blood pressure reading was 199 mmHg
- 6/21, 4 pm dose, when the systolic blood pressure reading was174 mmHg
- 6/22, 4 pm dose, when the systolic blood pressure reading was 159 mmHg
- 6/22, 4 pm dose, when the systolic blood pressure reading was 159 mmHg
- 6/23, 8 am dose, when the systolic blood pressure reading was 228 mmHg
- 6/25, 8 am dose, when the systolic blood pressure reading was 151 mmHg
- 6/26, 12 pm dose, when the systolic blood pressure reading was 153 mmHg
- 6/26, 4 pm dose, when the systolic blood pressure reading was 180 mmHg
- 6/28, 12 pm dose, when the systolic blood pressure reading was 180 mmHg
- 6/28, 4 pm dose, when the systolic blood pressure reading was 223 mmHg
- 6/29, 12 pm dose, when the systolic blood pressure reading was 154 mmHg
- 6/30, 12 pm dose, when the systolic blood pressure reading was 189 mmHg
- 6/30, 4 pm dose, when the systolic blood pressure reading was 183 mmHg

The wellness director stated that the medication passers were in the habit of only looking at the electronic medication administration computer screen and not comparing that to the prescribing information that appears on the medication blister packaging. According to the wellness director, the blood pressure parameter was listed on the medication blister packaging, but not entered into the list that appeared on the computer screen of the electronic medication administration record. The wellness director acknowledged that even she herself had administered midodrine to the ROC when his systolic blood pressure was greater than 150 mmHg.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	The wellness director acknowledged the medication errors that were clearly documented in the medication administration record.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Inadequate staffing has resulted in employee carelessness in administering medications.

INVESTIGATION:

According to the complainant, she had a hard time locating staff members when she visited in the evening, usually around 8:30 pm. The complainant wondered if a shortage of staff caused the employees who were responsible for administering medications to hurry through the medication pass, resulting in medication errors.

According to the administrative assistant and the wellness director, the facility was not achieving optimal staffing. They both acknowledged that on both the day and the afternoon shifts, there should be 7 total caregivers. However, the facility was only able to manage scheduling 6 caregivers on the morning shift, 6 on the afternoon shift and 4 on the midnight shift.

A review of staffing sheets for the week of 6/26/2022 through 7/2/2022 revealed the following:

- Sunday, 6/26, staffing was 5 caregivers plus the administrator on the morning shift; 5 caregivers on the afternoon shift; and 3 caregivers on the midnight shift
- Monday, 6/27, staffing was 7 caregivers on the morning shift; 5 caregivers on the afternoon shift; and 1 or 2 caregivers on the midnight shift (notation not clear)
- Tuesday, 6/28, staffing was 3 caregivers plus the administrator, the wellness director, and the administrative assistant on the morning shift; 6 caregivers on the afternoon shift; and 3 caregivers on the midnight shift
- Wednesday, 6/29, staffing was 5 caregivers plus the director of wellness on the morning shift; 6 caregivers on the afternoon shift; and 3 caregivers on the midnight shift

- Thursday, 6/30, staffing was 5 caregivers plus the director of wellness on the morning shift; 7 caregivers on the afternoon shift; and 4 caregivers on the midnight shift
- Friday, 7/1, staffing was 6 caregivers plus the director of wellness on the morning shift; 5.5 caregivers on the afternoon shift; and 4 caregivers on the midnight shift
- Saturday, 7/2, staffing was 6 caregivers on the morning shift; 6 caregivers on the afternoon shift; and 3 caregivers on the midnight shift

When the wellness director was asked if the less-than-optimal staffing levels negatively affected the ability of the medication passers to administer medication without errors, the wellness director said she did not think that was the case. In the general assisted living unit, where the ROC resided, all caregivers assigned pass their own medications and in the memory care unit, the caregivers and the 1 assigned medication passer work together to get all care completed.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	The investigation was not able to establish the complainant's allegation that having too few caregivers was the cause of the medication errors; however, the facility was unable to maintain the number of care staff that they had self-identified as optimal. While there were several shifts during the sampled timeframe when there were 7 caregivers during either the morning or the afternoon shifts, there were others like the morning shift of Tuesday, 6/27/2022 when only 3 caregivers came to work, requiring that the administrator, the administrative assistant, and the director of wellness give care to residents. Most of the midnight shifts during the sampled timeframe had only 3 caregivers in the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

According to the complainant, after the ROC had been examined in the ER of the local hospital, he returned the complainant's home and did not return to the facility until 7/3/2022. At that time, the complainant pointed out the medication errors to the facility administrator. On 9/20/2022, via email, the administrator, the administrative assistant, and the wellness director were asked to supply the medication error reports that should have been made to report the multiple medication errors in the administration of the ROC's midodrine. The facility could find only one report for an error occurring on 7/4/2022 when the ROC had a systolic blood pressure reading of 225 mmHg and was given midodrine. According to the administrative assistant, there were no other medication error reports "because we (facility) were not aware of the medication errors until this incident."

APPLICABLE RULE	
R 325.1932	**Resident medications**
	(3)(g) Upon discovery, contact the resident's licensed health care professional if a medication error occurs. A medication error occurs when a medication has not been given as prescribed.
ANALYSIS:	The facility was first notified of the medication errors at the beginning of July 2022 by the complainant and they reported an error made on 7/4/2022. It is not clear as to why no additional reports were made.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 12/29/2022. When asked if there were any comments or concerns with the investigation, the AR stated there were none.

IV. RECOMMENDATION

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

12/29/2022

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

12/06/2022

_____

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section