GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 30, 2023

Paul Barber
Directors Hall
600 Golden Drive
Kalamazoo, MI 49001

RE: License #: AH390236775
Investigation #: 2023A1028010
Directors Hall

Dear Mr. Barber:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH390236775
Investigation #:	2023A1028010
Complaint Receipt Date:	11/28/2022
Investigation Initiation Date:	11/28/2022
Report Due Date:	01/28/2023
Licensee Name:	Heritage Community of Kalamazoo
Licensee Address:	2400 Portage St. Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-5345
Administrator:	Amy Beach
Authorized Representative:	Paul Barber
Name of Facility:	Directors Hall
Facility Address:	600 Golden Drive Kalamazoo, MI 49001
Facility Telephone #:	(269) 349-8694
Original Issuance Date:	03/01/1974
License **Status:**	REGULAR
Effective Date:	08/14/2022
Expiration Date:	08/13/2023
Capacity:	89
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was given the wrong medication contributing to [their] death.	Yes
Resident A's death was not reported appropriately to the department by the facility.	Yes
Additional Findings	No

III. METHODOLOGY

11/28/2022	Special Investigation Intake 2023A1028010
11/28/2022	Special Investigation Initiated - Letter No letter initiated due to resident being deceased.
11/28/2022	APS Referral No APS referral due to resident being deceased.
12/05/2022	Contact - Face to Face Interviewed Employee A at the facility.
12/05/2022	Contact - Face to Face Interviewed Employee B at the facility.
12/05/2022	Contact - Face to Face Interviewed Employee C at the facility.
12/05/2022	Contact - Document Received Received Resident A's chart, record notes, med lists, MAR, investigation with records notes, and hospital/physician notes from Employee B.

ALLEGATION:

Resident A was given the wrong medication contributing to [their] death.

INVESTIGATION:

On 11/28/2022, this investigation was opened per the West Michigan Death review group request.

On 12/5/2022, I interviewed Employee A at the facility who reported Resident A was [their] own person and was only at the facility for about three weeks prior to [their] death. Employee A reported Resident A's family was supportive of Resident A being at the facility due to Resident A's declining health and prior home environment. Employee A reported Resident A could be resistive to care intermittently and to medication administration because Resident A "still wanted some control and a say in [their] life. [Resident A] was single and taking care of [themselves their] entire life, so the change was difficult at first". Employee A reported Resident A was in liver and kidney failure upon admission to the facility on 10/3/2022. Employee A reported Resident A demonstrated decline on 10/12/2022 and was seen by the physician. Resident A was seen again by the physician on 10/14/2022 due to demonstrating unresponsiveness resulting in chest compressions to arouse Resident A with emergency services being called as well. Resident A was sent to the hospital. Employee A reported despite decline, Resident A checked [themselves] out of the hospital on 10/16/2022 against physician orders and family wishes and returned to the facility. On 10/17/2022, Resident A was administered the wrong blood pressure medication by staff with the staff immediately recognizing the error and reporting it to the supervisor, Resident A's family, and the physician, who was on-site at the facility during the medication administration error. Resident A was given 5mg of Amlodipine with the physician ordering Resident A to receive neuro checks hourly and blood pressure checks hourly for 12 hours and to continue to monitor for any symptoms. Employee A reported staff followed physician orders and documented the blood pressure checks. Resident A was later found deceased in [their] room on 10/18/52022 at 6:00am with the physician and family being notified. Employee A also reported due to the medication error, the staff member involved was provided re-education and training and was pulled from the medication cart pending investigation. Employee A reported the police also investigated and Resident A's chart was sent to the coroner's office as well for pending investigation. Employee A provided me a copy of Resident A's incident report, chart, record notes, medication lists, MAR, and hospital/physician notes.

On 12/5/2022, I interviewed Employee B at the facility who reported Resident A was in kidney and liver failure upon admittance to the facility on 10/3/2022. Employee B reported Resident A was [their] own person and the family was very supportive of Resident A being at the facility due to continuing heath decline. Employee B confirmed Resident A was sent to the hospital on 10/14/2022 due to demonstrating unresponsiveness but checked [themselves] out of the hospital on 10/16/2022 against physician orders and family wishes and returned to the facility. Employee B confirmed a medication error did occur on 10/17/2022 with the physician attending to Resident A immediately due to being on-site at the time of the incident. Employee B reported staff were ordered to complete hourly neuro checks and hourly blood pressure checks for 12 hours and to continue to monitor Resident A for any further

symptoms or decline. Employee B reported to their knowledge staff followed physician orders and documented the blood pressure checks appropriately. Employee B also reported the staff member involved with the medication error was provided re-education and training and was pulled from the medication cart pending investigation. Employee B reported Resident A was found deceased in [their] room by staff on the morning of 10/18/2022.

On 12/5/2022, I interviewed Employee C at the facility whose statements are consistent with Employee A's statements and Employee B's statements.

On 12/6/2022, I reviewed the incident report which revealed the following:

- On 10/17/2022 at 12:15pm, Resident A was given 5 mg of Amlodipine by staff.
- The medication error was recognized immediately and Resident A's physician by phone.
- The physician ordered staff to completed hourly neuro checks on Resident A, hourly blood pressure checks for 12 hours, and to monitor any symptoms.
- Resident A did not demonstrate any known injuries at the time of the medication error, but staff were to watch for symptoms, signs, and abnormal reactions.
- The staff member involved was provided re-education on the *3 checks, 5 rights, and education in Relias.*

I reviewed Resident A's medication list and medication administration record which revealed Resident A was not prescribed Amlodipine.

I reviewed the physician notes from 10/14/2022 which revealed the following:

- Resident A was assisted to the bathroom and then back to bed on 10/14/2022 when Resident A became unresponsive.
- The physician was called to Resident A's bedside for assistance with Resident A demonstrating diaphoresis, unresponsiveness, pale, and shallow breaths.
- A weak thready pulse was palpitated, but Resident A became apneic and the pulse became weaker.
- Compressions were started and Resident A began to arouse. Compressions were completed for 45 seconds.
- Blood glucose was 70 prior to this event and Resident A was given glucose gel becoming more alert and responsive.
- Emergency services were called, and Resident A was transported to the hospital.
- *Caregiver was counseled regarding diagnosis, regarding treatment, medications, diet, activity, prognosis, and end of life issues. Verbalized understanding.*

I reviewed the physician notes from 10/18/2022 which revealed the following:

- Resident A was sent to emergency department on 10/14/2022 due to requiring CPR for 45 seconds. At emergency room, Resident A was found to be hypothermic at 93 degrees with elevated levels of lactic acid, anemia, and hypoglycemia. Resident A was stabilized*. The attendings had not completed their testing to determine the cause of AMS and arrest when [Resident A] left [the hospital].*
- On 10/17/2022, an incorrect medication administration occurred, and staff were ordered to obtain vitals hourly x 12 hours with neuro checks. Vitals were reported stable.
- On 10/18/2022 at 0600, staff found Resident A on the floor, motionless, and without a pulse. Emergency services were called, and CPR was initiated. Emergency services reported performing for 40 minutes and an IV was inserted and Resident A was intubated. Resident A was not revived. Physician was notified. Family was notified and declined autopsy request from medical examiner.
- *Do not suspect the medication error that occurred the day prior attributed to death, [Resident A] was observed on Friday pulseless, however, unsure of cause related to leaving the hospital.*

I reviewed the blood pressure check log for 10/17/2022 to 10/18/2022 and compared it with the physician orders and the time the medication error occurred. The review and comparison of documentation revealed the following:

- Resident A incurred a medication error on 12:15pm on 10/17/2022.
- Resident A's physician ordered hourly blood pressure checks with neuro checks on 10/17/2022 beginning at 12:30pm.
- Documented blood pressure checks occurred at 1:30pm, 2:57pm, 5:23pm, 7:33pm, 7:34pm, 10:06pm.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**

ANALYSIS:	It was alleged the medication administration error that occurred on 10/17/2022 contributed to Resident A's expiration on 10/18/2022. Interviews, on-site inspection, and review of documentation reveal that while a medication administration error occurred on 10/17/2022, it was addressed immediately by the facility and physician orders were implemented immediately. Further review of physician documentation revealed the physician [did] *not suspect the medication error that occurred the day prior attributed to [Resident A's] death* on 10/18/2022. However, further review of the documentation also revealed that due to the medication administration error on 10/17/2022, Resident A's physician ordered hourly blood pressure checks with neuro checks beginning at 12:30pm. Documentation only notates the following blood pressure checks were performed by staff at 1:30pm, 2:57pm, 5:23pm, 7:33pm, 7:34pm, 10:06pm. Per physician orders, the blood pressure and neuro checks were to be completed by staff until 12:30am on 10/18/2022. The last documented blood pressure and neuro check was completed by staff at 10:06pm on 10/17/2022. Staff did not provide Resident A the supervised care and assistance as ordered by the physician. Staff did not follow physician orders of completing hourly blood pressure and neuro checks for 12 hours after the medication administration error occurred, therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility did not complete an appropriate incident report in a timely manner concerning Resident A's expiration.

INVESTIGATION:

On 10/19/2022, Resident A's death was reported via email to the department by facility administrator, Amy Beach. The email read:

Julie, we had a death yesterday am, it is currently being investigated by Kalamazoo Public Safety.

[Resident A] Directors Hall License # AH39036775

Do you need anything else from me?

Amy Beach MSCL, FLE, LPN

On 10/19/2022, I responded to the email requesting an incident report be completed for Resident A's death. The response email read:

Hi Amy,

The death information just needs to be reported in an incident report and submitted.

Kind Regards,

Julie Viviano - MSOTR/L, Health Care Surveyor

On 12/5/2022, I completed an on-site visit at the facility and requested the death incident report, as I had not received it yet. I was provided an *"In the Event of Death"* report by Employee A dated 10/18/2022. This report was not sent to the department on or after 10/18/2022.

On 12/9/2022, Employee A emailed me an incident report for Resident A dated 10/18/2022 in which Resident A was found on the floor of [their] room. The incident report notates emergency services were called and that Resident A was *a "Full Code – EMTs working on [them]*; and that Resident A's physician and family were notified as well. This report was also not sent to the department on or after 10/18/2022.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.

ANALYSIS:	Resident A's death was reported on 10/19/2022 by facility administrator, Amy Beach, via email. An incident report containing the death information was subsequently requested by the department for compliance. However, the department was not provided Resident A's death incident report as requested. The department was also not provided the incident report from 10/19/2022 in a timely manner in which Resident A was found unresponsive on the floor of [their] room. The facility did not comply with reporting guidelines of submitting incident reports within 48 hours of the occurrence.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an approved corrective action plan, I recommend the status of this license remains unchanged.

Julie Viviano

12/15/2022

Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

01/27/2023

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