GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 28, 2023

Roseline Rowan
Medhealth Suppliers & Providers, Inc.
706 Britten Ave
Lansing, MI 48910

RE: License #: AS230294121
Investigation #: 2023A0466023
Evergreen Place II

Dear Ms. Rowan:

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) 284-9727.

Sincerely,

Julie Elkins, 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 #:	AS230294121
Investigation #:	2023A0466023
Complaint Receipt Date:	02/03/2023
Investigation Initiation Date:	02/03/2023
Report Due Date:	04/04/2023
Licensee Name:	Medhealth Suppliers & Providers, Inc.
Licensee Address:	706 Britten Ave Lansing, MI 48910
Licensee Telephone #:	(517) 712-8585
Administrator:	Roseline Rowan
Licensee Designee:	Roseline Rowan
Name of Facility:	Evergreen Place II
Facility Address:	4048 Windward Dr. Lansing, MI 48911
Facility Telephone #:	(517) 580-4990
Original Issuance Date:	04/28/2008
License Status:	REGULAR
Effective Date:	10/13/2021
Expiration Date:	10/12/2023
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED

ALLEGATION:

	Violation Established?
Resident D's prescription medication was sent with Resident E when she moved to another facility.	Yes
Additional Findings	Yes

****To maintain the coding consistency of residents across several investigations, the residents in this special investigation are not identified in sequential order.*

II. METHODOLOGY

02/03/2023	Special Investigation Intake 2023A0466023.
02/03/2023	Special Investigation Initiated - Telephone assigned licensing consultant Jana Lipps interviewed.
02/06/2023	Inspection Completed On-site.
02/06/2023	Contact - Document Sent email sent to Guardian E1.
02/06/2023	Contact- Telephone call to Missy Berlin, interievewed.
03/16/2023	APS Referral.
03/24/2023	Exit Conference with Roseline Rowan.

ALLEGATION: Resident D's prescription medication was sent with Resident E when she moved to another facility.

INVESTIGATION:
On 02/03/2023, Complainant reported Resident E was discharged from Evergreen 2 AFC on 02/01/2023. Complainant reported Resident E's medications were packed by licensee designee Roseline Rowan in a bag and licensee designee Rowan handed the medications to Guardian E1. Complainant reported that on 02/03/2023 she received an email from Resident D's case manager Dawn Eccles who reported that medications for Resident D were mixed in with Resident E's medications.

On 02/06/2023, I conducted an unannounced investigation and I interviewed licensee designee Rowan who reported Resident E moved out of the facility on 02/01/2023. Licensee designee Rowan reported she was the only direct care worker at the facility when Resident E left and she was responsible for giving Guardian E1, Resident E's medications. Licensee designee Rowan denied that she gave Guardian E1 Resident D's medications. Licensee designee Rowan reported she put an old bottle of Resident D's prescribed Chlorhexidine Gluconate oral rinse on the kitchen counter as she was planning to throw it away. Licensee designee Rowan reported she did not give Guardian E1, Resident D's oral rinse. Licensee designee Rowan reported Guardian E1 must have picked up the medication in error thinking it was Resident E's. Licensee designee Rowan reported both Resident D and Resident E are prescribed the same oral rinse.

I reviewed all the medication at the facility and found that there were 11 sealed bottles of Chlorhexidine Gluconate Oral Rinse .12% in the medication closet and a tube of Nystatin Ointment USP (100,000 USP Nystain Units) all prescribed to Resident E.

I interviewed licensee Rowan for a second time and she reported that the pharmacy continues to send two to three bottles of Chlorhexidine Gluconate Oral Rinse .12% monthly even when they do not need it. Licensee designee Rowan reported Resident E has a tube of the Nystatin Ointment USP (100,000 USP Nystain Units) that she packed before she discharged and reported that must be old tube. Licensee designee Rowan reported she did not have any written inventory of what prescribed medications were provided to Guardian E1 on 02/01/2023.

I interviewed Guardian E1 who reported that on 02/01/2023, she did not pick up any medications from the kitchen counter. Guardian E1 reported licensee designee Rowan placed all the medications in a bag and handed it directly to her. Guardian E1 reported licensee designee Rowan also handed her a plastic tub and said to add the bag to the tub which she did.

I contacted Missy Berlin, direct care worker/second shift manager, at another licensed facility where Resident E was admitted on 02/01/2023. DCW Berlin reported Resident E did come with one bottle of Chlorhexidine Gluconate Oral Rinse, .12% that was prescribed to someone other than Resident E. DCW Berlin reported that was the only medication provided that was not prescribed to Resident E. DCW Berlin reported licensee designee Rowan had not contacted her about any medication that may have been sent over to the facility in error. DCW Berlin reported that Resident E's case manager was notified.

APPLICABLE RULE	
R 400.14312	**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:	Licensee designee Rowan reported that she was at the facility when Resident E left so she was responsible for giving Guardian E1, Resident E's medications. Guardian E1 and Missy Berlin reported Resident E came to another licensed facility with prescription Chlorhexidine Gluconate Oral Rinse, .12% which was prescribed to Resident D. A violation has been established as reasonable precautions were not taken by licensee Rowan to ensure that medication was not used by someone other than for whom the medication was prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:
On 02/06/2023, I reviewed the January 2023 and February 2023 MARs for Resident C. Licensee designee Roseline Rowan was signing for MARs for five for medications as if they were being administered when the medications were not available. Those medications are:

- Aspirin 81 mg, take 1 tablet in the morning for prophylaxis.
- Decara 125mg, take 1 capsule in the morning every 7 days.
- Omeprazole 20 mg, take 1 capsule in the morning for gastro esophageal reflux.
- Sulfacetamide Sodium Ophthalmic Solution 10%, instill five drops in right eye twice daily.
- Terazosin HCL 2mg oral capsule. Take 2 tablets by mouth at bedtime for hypertension.

On 02/06/2023, I interviewed licensee designee Rowan who reviewed Resident C's medications on the MAR and compared them to the pharmacy labeled medications that were at the facility. Licensee designee Rowan acknowledged that Aspirin, Decara, Omeprazole and Sulfacetamide Sodium Ophthalmic Solution were listed in Resident C's MAR and initialed as administered by licensee designee Rowan when these medications were all not available in the facility to be administered to Resident C. Licensee designee Rowan contacted Nancy (last name unknown) at Geona Pharmacy through speaker phone. Nancy reported that according to the pharmacy's records, Aspirin 81 mg, Omeprazole 20 mg and Sulfacetamide Sodium Ophthalmic Solution had been previously discontinued by Resident C's physician. Nancy confirmed that Resident C's Sulfacetamide Sodium Ophthalmic Solution had been discontinued in July 2022. Nancy could not locate the discontinued dates for

Resident C's prescribed Aspirin 81 mg, Omeprazole 20 mg. Nancy reported that Decara 125mg and Terazosin HCL 2mg were still active orders for Resident C by Resident C's physician and should be administered to Resident C. Nancy reported that these medications would be refilled and sent out the facility on 02/08/2023. Nancy reported the current label instructions for Decara 125mg were take 1 capsule in the morning every 7 days and for Terazosin HCL 2mg were take 2 tablets by mouth at bedtime for hypertension. These medications could not be refilled any sooner because they were not eligible for refill based on when both medications were filled last month.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Geona Pharmacy confirmed Resident C was prescribed Decara 125mg, 1 capsule in the morning every 7 days and Terazosin HCL 2mg, take 2 tablets by mouth at bedtime for hypertension however these medications were not at the facility and available to be administered to Resident C. Additionally, Geona pharmacy confirmed that these medications were not available for refill until 02/08/2023 based on the dates these medications were previously filled. A violation has been established as Resident C was prescribed these two medications and was not being administered these two medications as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 02/06/2023, I found 11 sealed bottles of Chlorhexidine Gluconate Oral Rinse, .12% in the medication closet and a tube of Nystatin Ointment USP (100,000 USP Nystain Units) all prescribed to Resident E even though Resident E was discharged from the facility and her medications were dispersed to Guardian E1 at the time of discharge.

On 03/27/2023, I interievewed Guardian E1 who reported that she was not notified by licensee designee Rowan in writing about any personal belongings of Resident E being left behind.

On 03/27/2023, licensee designee Rowan did not provide any written documentation that supported that Guardian E1 was notified in writing about Resident E's personal belongings that remain at the facility.

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**

	(16) Personal property and belongings that are left at the home after discharge shall be inventoried and stored by the licensee. The resident and designated representative shall be notified by the licensee, by registered mail, of the existence of property and belongings. Personal property and belongings that remain unclaimed, or for which arrangements have not been made, may be disposed of by the licensee after 30 days from the date that written notification is sent to the resident and the designated representative.
ANALYSIS:	On 02/06/2023, licensee designee Rowan was aware that Resident E had belongings that were left behind when she discharged. Licensee designee Rowan did not put in writing, nor did she contact Guardian E1 about these items which belong to Resident E.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Contingent upon the receipt of an acceptable plan of correction, I recommend no change in the current license status.

03/27/2023

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Julie Elkins Date
Licensing Consultant

Approved By:

03/28/2023

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Dawn N. Timm Date
Area Manager