GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 17, 2023

Steven Gerdeman
Serenity Homes - North, L.L.C.
3109 Lawton Dr. N.E.
Grand Rapids, MI 49525

RE: License #: AL700382076
Investigation #: 2023A0467015
Serenity Homes - North

Dear Mr. Gerdeman:

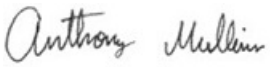
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (616) 356-0183.

Sincerely,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700382076
Investigation #:	2023A0467015
Complaint Receipt Date:	11/22/2022
Investigation Initiation Date:	11/23/2022
Report Due Date:	01/21/2023
Licensee Name:	Serenity Homes - North, L.L.C.
Licensee Address:	3109 Lawton Dr. N.E. Grand Rapids, MI 49525
Licensee Telephone #:	(419) 494-4008
Administrator:	Steven Gerdeman
Licensee Designee:	Steven Gerdeman
Name of Facility:	Serenity Homes - North
Facility Address:	830 Hayes Street Marne, MI 49435
Facility Telephone #:	(419) 494-4008
Original Issuance Date:	06/02/2016
License Status:	REGULAR
Effective Date:	09/26/2022
Expiration Date:	09/25/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has not received some of her seizure medications during her time at the AFC, resulting in her being hospitalized.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/22/2022	Special Investigation Intake 2023A0467015
11/22/2022	APS Referral Referral received from Ottawa County APS worker, Thomas Cannon.
11/23/2022	Special Investigation Initiated - On Site
01/17/2023	Exit conference completed with licensee designee, Steve Gerdeman

ALLEGATION: Resident A has not received some of her seizure medications during her time at the AFC, resulting in her being hospitalized.

INVESTIGATION: On 11/22/22, I received a BCAL online complaint stating that there is concern regarding neglect towards Resident A due to not receiving her medications. Resident A reportedly has seizures and she was admitted to Spectrum Health Blodgett Hospital ICU on 10/20/22 and an internal transfer was made on 10/25/22 to the Neuro ICU. Resident A has reportedly not been receiving some of her seizure medications for one and a half month.

On 11/22/22, Ottawa County Adult Protective Services (APS) worker, Thomas Cannon sent an email stating that he will be closing his investigation due to Resident A denying the allegations during an interview with her at the hospital.

On 11/22/22, I left a voicemail for Mr. Cannon with APS requesting a call back. As of the completion of this investigation, Mr. Cannon has not returned my call.

On 11/23/22, I made an unannounced onsite investigation to the facility. Upon arrival, I spoke to staff member Nancy Robinson. Ms. Robinson stated that Resident A has five seizure medications. When she became a resident of the facility, Resident A reportedly arrived without one of her seizure medications. Ms. Robinson stated that she called the hospital that Resident A came from, as well as her case manager, Stephanie Hood through Pine Rest. Ms. Robinson stated that she also

contacted Resident A's primary care doctor (PCP) and she was told that two of the seizure medications could be used as psych meds and therefore, she did not feel comfortable prescribing the medications.

Ms. Robinson stated that Resident A's case manager, Stephanie Hood investigated this yesterday and found out that she has a neurologist, Dr. David Burnett through Spectrum Health. Per Ms. Robinson, Dr. Burnett was sending Resident A's seizure medication prescriptions to her old pharmacy as he was not made aware that she moved into an AFC facility. Ms. Robinson stated that she received two of Resident A's seizure medications from Meijer pharmacy yesterday, which are Briviact 100MG and Lacosamide 200MG. Ms. Robinson confirmed that Resident A did not receive some of her medications during her time at the AFC facility due to not having them. These medications were restarted when Resident A was admitted to the hospital on 10/20/22.

Ms. Robinson stated that she is still waiting to receive two other medications for Resident A. Ms. Robinson stated that the medications that Resident A is currently out of are Valporic Acid 250MG and Omeprazol 20MG. Ms. Robinson was unable to recall Resident A's admission date but stated she has been at the home for a couple of months and the issues with medications started in October. Ms. Robinson stated that she believes Resident A came to the home after discharging directly from Pine Rest. Ms. Robinson again confirmed that Resident A was not receiving some of her medications for a few months. Ms. Robinson stated that Resident A's guardian was not helpful with gathering information and needed items.

After speaking to Ms. Robinson, I spoke to Resident A in her room. Resident A stated that she is "stressed" due to personality issues with residents at the facility. Resident A stated that the staff at Serenity Homes – North are "great, super friendly, and they treat us well." Resident A stated that she has been at the AFC facility for nearly three months. Regarding her medications, Resident A stated that her prescriptions were supposed to go to her neurologist, Dr. David Burnett through Spectrum Health. However, there was somehow a "mix up in communication" and the staff at the AFC home were not aware that the prescriptions were supposed to come from Dr. Burnett. Resident A stated that the AFC did not find out until recently about some of her seizure medications. Resident A stated that she has been out of her seizure medications for a couple of days, and she did end up in the hospital due to having seizures. Resident A was adamant that her guardian failed to communicate with the AFC staff about her medications.

Except for running out of medications for a few days, Resident A stated that she mostly received her medications on time from staff at Serenity Homes – North. Resident A did acknowledge that she received her medications late "by a day" sometime in October 2022 but she could not recall the specific day. Again, Resident A spoke highly of staff at the AFC facility and attributes not receiving her seizure medications due to a communication error with her neurologist, guardian, and AFC staff.

Prior to concluding my onsite investigation, I spoke to Ms. Robinson and requested copies of Resident A's MAR from the time of her admission through November 2022. Ms. Robinson emailed the requested MARs.

Resident A's August 2022 MAR indicated that she did not receive the following seizure medications on multiple days between 8/27- 8/31: Briviact 100MG, Gabapentin 300MG PO CAP, and Lacosamide 200MG PO Tab. Her other 2 seizure medications, Clobazam 10MG and Valproic Acid 250 MG were not listed on the MAR.

Resident A's September 2022 MAR indicated that she did not receive the following seizure medications. Briviact 100MG on 9/10/22 at 8:00 pm, Gabapentin 300MG between 9/6/22 – 9/8/22, and Lacosamide 200MG PO Tab on 9/10/22 at 8:00 pm. Her 2 other seizure medications, Clobazam 10MG and Valproic Acid 250MG were not listed on the MAR.

Resident A's October 2022 MAR indicated that she did not receive the following seizure medications: Briviact 100MG from 10/4/22 – 10/6/22, Gabapentin 300MG between 10/4/22 – 10/6/22, and Lacosamide 200MG PO Tab between 10/4/22 – 10/6/22. Her 2 other seizure medications, Clobazam 10MG and Valproic Acid 250MG were not listed on the MAR.

Resident A's November 2022 MAR indicated that she did not receive the same seizure medications listed above on different days throughout the month. It should be noted that the November 2022 MAR listed her two additional seizure medications, Clobazam 10MG and Valproic Acid 250MG. However, the MAR was not initialed for any day during this month, indicating that she did not receive her Clobazam and Valproic Acid seizure medication.

On 01/17/2023, I conducted an exit conference with licensee designee, Steve Gerdeman. He was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Ms. Robinson acknowledged that Resident A has not received some of her seizure medications since her admission. Ms. Robinson explained that Resident A's neurologist, Dr. David Burnett was mistakenly sending her medication prescriptions to her previous pharmacy.

	Resident A confirmed that she did not receive some of her seizure medication. Resident A's MARS from August 2022 through October revealed that Resident A missed several seizure medications for various reasons, including the facility not having the medications. Also, two of Resident A's seizure medications (Clobazam 10MG and Valproic Acid 250MG were not listed on her MAR until November 2022. Even then, the AFC staff did not have the medications at the facility and Resident A did not receive them. Based on the information provided, Resident A did not receive her Clobazam and Valproic Acid seizure medications since admission to the AFC. She also missed sporadic doses of her other seizure medications. Therefore, is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegation listed above, I reviewed Resident A's MARs from August 2022 through November 2022. While reviewing the MARS, I noticed that there were multiple days that MARs were not initialed for three medications. Even if Resident A received the medications, there is no documentation to support it. The medications include the following: Briviact 100MG, Gabapentin 300G, and Lacosamide 200MG, all of which are used to treat seizures.

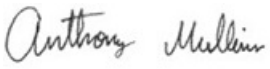
On 01/17/2023, I conducted an exit conference with licensee designee, Steve Gerdeman. He was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.**

	(ii) The dosage. **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.** **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.** **(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as needed basis. The review process shall include the resident's prescribing physician, the resident or his or her designated representative, and the responsible agency.** **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.** **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	Staff at the AFC home did not properly document Resident A receiving or refusing three of her seizure medications (Briviact, Gabapentin, and Lacosamide) on sporadic days between August 2022 and November 2022. There were also days that did not have staff initials on the listed medications, or an explanation as to why the medications were not received by Resident A. Even if the medications were not available, the MAR should reflect this. Therefore, there is a preponderance of evidence to support the allegations.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

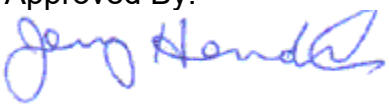
Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



01/17/2023

Anthony Mullins Date
Licensing Consultant

Approved By:



01/17/2023

Jerry Hendrick Date
Area Manager