GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 3, 2023

Jennifer Zandstra
Rehoboth AFC, Inc.
9505 Homerich Ave. SW
Byron Center, MI 49315

RE: License #: AM030365385
Investigation #: 2023A0578020
Rehoboth Oaks

Dear Mrs. Zandstra:

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,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030365385
Investigation #:	2023A0578020
Complaint Receipt Date:	02/09/2023
Investigation Initiation Date:	02/09/2023
Report Due Date:	04/10/2023
Licensee Name:	Rehoboth AFC, Inc.
Licensee Address:	9505 Homerich Ave. SW Byron Center, MI 49315
Licensee Telephone #:	(616) 610-4097
Administrator:	Jennifer Zandstra
Licensee Designee:	Jennifer Zandstra
Name of Facility:	Rehoboth Oaks
Facility Address:	2990 138th Avenue Dorr, MI 49323
Facility Telephone #:	(616) 610-4097
Original Issuance Date:	04/16/2015
License Status:	REGULAR
Effective Date:	10/18/2021
Expiration Date:	10/17/2023
Capacity:	12
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's blood sugar levels have not been checked at night in over a week.	Yes
Resident A has not received her evening insulin in over a week.	No

III. METHODOLOGY

02/09/2023	Special Investigation Intake 2023A0578020
02/09/2023	Special Investigation Initiated - Telephone With Complainant.
02/09/2023	APS Referral Completed.
02/10/2023	Contact-Documentation Reviewed. -Social Work Contacts provide by APS Michael McClellan.
02/13/2023	Special Investigation Completed On-site -Interview with licensee designee Jennifer Zandstra. Interview with Resident A.
03/02/2023	Contact-Documentation Reviewed. -*Daily Sugar Testing Log* for Resident A.
03/29/2023	Contact-Telephone -Interview with Staff Person 1.
03/29/2023	Contact-Telephone -Interview with direct care staff Jessie Cain.
03/30/2023	Exit Conference -With licensee designee Jennifer Zandstra.

ALLEGATION:

- **Resident A's blood sugar levels have not been checked at night in over a week.**

- **Resident A has not received her evening insulin in over a week.**

INVESTIGATION:

On 02/09/2023, I received this complaint through the BCHS On-line Complaint System. Complainant reported that Resident A is diagnosed with diabetes. Complainant added Resident A does not have a Legal Guardian or Power of Attorney. Complainant reported Resident A is provided in-home health care services at this facility twice a week. Complainant alleged direct care staff at this facility oversee Resident A's medication but are not ensuring Resident A receives her insulin as prescribed. Complainant alleged direct care staff members have not checked Resident A's nighttime blood sugar levels in over week and therefore Resident A's nighttime insulin has not been administered appropriately in over a week. Complainant reported Resident A's fasting blood sugar levels will sometimes be over 600 in the morning, Complainant reported Resident A's blood sugar levels come down during the day as Resident A receives the correct doses of insulin in the mornings.

On 02/09/2023, I reviewed the details of the allegations with adult protective services worker Michael McClellan. Mr. McClellan reported he received allegations that Resident A's blood sugar was recorded on a "sticky note" on February 5th, February 6th, and February 7th, 2023 and was missing from the *Daily Sugar Testing Log* for Resident A. Mr. McClellan reported when he completed an unannounced investigation on-site at this facility, there were no missing entries in Resident A's *Daily Sugar Testing Log*. Mr. McClellan reported Complainant informed him if this *Daily Sugar Testing Log* was completed, it was because the documentation on this *Daily Sugar Testing Log* was falsified. Mr. McClellan reported he was informed by licensee designee, Ms. Jennifer Zandstra, that Resident A's blood sugar was initially recorded on a "sticky note" and then written in the *Daily Sugar Testing Log* for Resident A.

On 02/10/2023, I reviewed the *Social Work Contacts* provided by adult protective services worker Michael McClellan. Mr. McClellan's *Social Work Contacts* documented that he interviewed Spectrum Nurse Brianna Beilfuss regarding the allegations. Mr. McClellan's *Social Work Contacts* documented that Ms. Beilfuss was concerned about Resident A's high blood sugar and confirmed with night staff "Alice" while she was at the facility that Resident A was not receiving her prescribed insulin at night. Mr. McClellan's *Social Work Contacts* documented that Ms. Beilfuss observed blank spaces on Resident A's *Daily Sugar Testing Log* at night. Mr. McClellan's *Social Work Contacts* documented Ms. Beilfuss was informed by Resident A that she did not receive her insulin at night. Mr. McClellan's *Social Work*

Contacts documented Ms. Beilfuss also reported Resident A was experiencing vomiting, and this may be related to Resident A's blood sugar being too high.

On 02/10/2023, I reviewed the *Social Work Contacts* provided by adult protective services worker Michael McClellan. Mr. McClellan's *Social Work Contacts* documented he interviewed Spectrum at Home nurse "Mel", last name not documented, regarding the allegations. Mr. McClellan's *Social Work Contacts* documented Nurse Mel had concerns regarding Resident A's high blood sugar and was asking staff about the situation when licensee designee Jennifer Zandstra immediately denied Resident A's insulin was provided incorrectly by staff and removed Nurse Mel from the facility and informed her not to return. Mr. McClellan's *Social Work Contacts* documented Nurse Mel reported Resident A's insulin had been changed to a sliding scale. Mr. McClellan's *Social Work Contacts* documented Nurse Mel reported that when Resident A's sugar is controlled it stays within a 100-160 range. Mr. McClellan's *Social Work Contacts* documented Nurse Mel reported staff were giving Resident A "what she feels" before this sliding scale. Mr. McClellan's *Social Work Contacts* documented that before this sliding scale, Resident A was to receive 20 units of insulin at mealtime. Mr. McClellan's *Social Work Contacts* documented Nurse Mel reported staff are not medical providers and needed to provide medication appropriately.

On 02/10/2023, I reviewed the *Social Work Contacts* provided by adult protective services worker Michael McClellan. Mr. McClellan's *Social Work Contacts* documented he interviewed Resident A while on-site at this facility. Mr. McClellan's *Social Work Contacts* documented Resident A acknowledged receiving her insulin at night, but added feeling frustrated in the morning with no understanding why.

On 02/10/2023, I reviewed the *Social Work Contacts* provided by adult protective services worker Michael McClellan. Mr. McClellan's *Social Work Contacts* documented he interviewed staff member "Allison", last name not documented, while on-site at this facility. Mr. McClellan's *Social Work Contacts* documented direct care staff member Allison was asked about Resident A's Blood Sugar log and missing documentation and Allison reported that sometimes she records Resident A's blood sugar on a "sticky note" before recording in the Blood Sugar log. Mr. McClellan's *Social Work Contacts* documented that when asked about Resident A's insulin, Allison reported Resident A's physician had just ordered a new sliding scale for the administration of Resident A's insulin.

On 02/13/2023, I completed an unannounced investigation on-site at this facility and interviewed the licensee designee, Ms. Jennifer Zandstra, regarding the allegations. Ms. Zandstra reported that she already knew what the allegations were about and explained that an In-home nurse had been rude to her staff, and she asked that this nurse not return to the facility. Ms. Zandstra added direct care staff member Patti Paul had explained to her this in-home nurse was rude and demanding and was belittling staff. Ms. Zandstra denied that Resident A had ever missed her prescribed insulin or insulin on a sliding scale based on Resident A's blood sugar for any

reason. Ms. Zandstra clarified that one of her staff had recorded Resident A's blood sugar on sticky note instead of the *Daily Sugar Testing Log,* but this information was transcribed later. Ms. Zandstra reported this direct care staff member was corrected and Resident A's blood sugar is now directly recorded on Resident A's *Daily Sugar Testing Log*. While at the facility, I reviewed the electronic medication administration records for Resident A for November 2022, December 2022, January 2023 and February 2023 and found them to be complete with no missing administration times. Ms. Zandstra reported Resident A is prescribed Humalog Insulin on a sliding scale based on Resident A's blood sugar three times a day and 28 units of Toujeo Insulin at night. While at the facility, I reviewed the *Daily Sugar Testing Log* for Resident A for November 2022, December 2022, January 2023 and February 2023 and found it to be complete with no omissions with documented testing occurring four times a day including the units of insulin provided to Resident A. I reviewed the high blood sugar results for Resident A with Ms. Zandstra. Ms. Zandstra reported Resident A is seen by a visiting physician every two weeks and reviews the *Daily Sugar Testing Log.* Ms. Zandstra acknowledged the physician's office is notified when Resident A's blood sugar is over 350 and provided physician notes which identified concerns for the physician as well as instructions provided by the physician. Ms. Zandstra denied that direct care staff ever provided Resident A her insulin based on what she requests or how she feels. Ms. Zandstra reported direct care staff will communicate with Resident A and on occasion Resident A requested that she only wanted a certain amount of insulin, but direct care staff provided Resident A with her insulin as prescribed. Ms. Zandstra reported the nurse had accused direct care staff of administering Resident A's insulin based on her request and she denied this to the nurse as well. When asked if Resident A had experienced vomiting, Ms. Zandstra reported Resident A has had a Hiatal Hernia which makes her nauseous. Ms. Zandstra reported Resident A is prescribed Metoclopram for nausea every six hours as needed. Ms. Zandstra reported that when Resident A is nauseous, she will usually present with chills and sweat and excessive spit.

On 03/30/2023, I reviewed a Humalog Kwik Injection 100/ML prescription for Resident A to be administered on a sliding scale. I reviewed a Toujeo Solo Injection 300IU/ML prescription for Resident A which indicated that 28 units would be administered every day at 10PM.

While at the facility, I interviewed Resident A regarding the allegations. Resident A denied ever missing her insulin in the morning or evening for any reason. Resident A acknowledged having her blood sugar tested four times a day. Resident A acknowledged that her blood sugar is not always obtained by staff. Resident A could not recall when her blood sugar was not obtained by staff but reported that her blood sugar is not missed by staff very often. Resident A reported her blood sugar has been obtained by staff consistently for the last two weeks. Resident A acknowledged experiencing recent vomiting and reported that she feels nauseous in the morning, but this feeling resides by lunch. Resident A acknowledged having a PRN medication for nausea that helps with this. Resident A reported the staff at this facility are always very helpful. Resident A denied having any additional concerns.

On 03/29/2023, I interviewed Staff Person 1 regarding the allegations. Staff Person 1 acknowledged working with Resident A and acknowledged that Resident A is Diabetic and ordered by a physician to have her blood sugar tested several times a day and have insulin administered on a sliding scale. Staff Person 1 denied ever missing a test of Resident A's blood sugar or the administration of Resident A's insulin according to a sliding scale. Staff Person 1 reported that one or two months ago, new direct care staff "Allison" and "Jessie" forgot to take Resident A's blood sugar, and this resulted in Resident A missing the appropriate dosage of insulin. Staff Person 1 denied observing any missed documentation in the medication administration records or *Daily Sugar Testing Log* for Resident A but clarified that "everyone" was aware this had occurred as a result of new staff and that Resident A is capable of recalling whether or not she has had her blood sugar taken and can recall whether or not she received her insulin.

On 03/29/2023, I interviewed direct care staff Jessie Cain regarding the allegations. Ms. Cain reported working at this facility for two or three months. Ms. Cain acknowledged working with Resident A and acknowledged that Resident A is Diabetic and ordered by a physician to have her blood sugar tested several times a day and have insulin administered on a sliding scale. Ms. Cain acknowledged that on one occasion, Resident A was not provided her insulin as prescribed as the lancets needed to test Resident A's blood sugar were unavailable. Ms. Cain added she may have forgotten to record Resident A's blood sugar on one or more occasion but clarified this did not mean Resident A's blood sugar was not tested.

On 03/29/2023, I reviewed the details of the investigation with adult protective services worker Michael McClellan. Mr. McClellan confirmed interviewing two separate health care providers that had expressed concerns regarding Resident A's blood sugar being taken or insulin being administered as prescribed. Mr. McClellan reported facility direct care staff members were doing a better job with Resident A's blood sugar and insulin administration and since he had recently been at the facility, Resident A's blood sugar has been too low. Mr. McClellan reported he was substantiating a violation of neglect for this facility.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled

	Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	During an interview, Resident A acknowledged that her blood sugar is not always consistently obtained by staff but could not recall specific dates or times. In an interview, direct care staff Jessie Cain acknowledged that on one occasion, Resident A was not provided her insulin as prescribed as the lancets needed to test Resident A's blood sugar were unavailable. Adult Protective Services worker Michael McClellan documented interviewing Spectrum Nurse Brianna Beilfuss who expressed concern for Resident A's high blood sugar and reported observing missing documentation in the *Daily Blood Sugar Log* for Resident A. Adult Protective Services worker Michael McClellan reported that since the allegations, Resident A's blood sugar has been more controlled, and reported Resident A having blood sugar results within the 100 to 160 range, which is consistent with Resident A's stable blood sugar levels provided to Mr. McClellan by Spectrum Nurse "Mel" during an interview. As such, there is enough evidence that Resident A's blood sugar has not always been consistently obtained to provide the appropriate sliding scale dose of insulin to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

03/31/2023

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Eli DeLeon Date
Licensing Consultant

Approved By:

04/03/2023

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Dawn N. Timm Date
Area Manager