GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 30, 2023

Kaitlyn Shaffer
Centered Care LLC
15945 Wood Rd
Lansing, MI 48820

RE: License #: AM190408916
Investigation #: 2023A0783009
Centered Care LLC

Dear Ms. Shaffer:

Attached is the Special Investigation Report for the above referenced facility. Violations were established; however, a corrective action plan was received on 05/10/2023. Corrective Action Plan Compliance was received, specifically employee termination letter, medication administration policy/procedure change and staff training on policy/procedure changes were provided to the department.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM190408916
Investigation #:	2023A0783009
Complaint Receipt Date:	12/05/2022
Investigation Initiation Date:	12/05/2022
Report Due Date:	02/03/2023
Licensee Name:	Centered Care LLC
Licensee Address:	15945 Wood Rd Lansing, MI 48820
Licensee Telephone #:	(517) 394-1234
Administrator/Licensee Designee:	Kaitlyn Shaffer
Name of Facility:	Centered Care LLC
Facility Address:	12511 Old Us 27 Dewitt, MI 48820
Facility Telephone #:	(517) 394-1234
Original Issuance Date:	06/23/2021
License Status:	REGULAR
Effective Date:	12/23/2021
Expiration Date:	12/22/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was tipped upside down and left in wheelchair while using a discontinued headrest causing Resident A to have a stroke.	No
Resident A was not administered his Protonix as prescribed.	Yes

III. METHODOLOGY

12/05/2022	Special Investigation Intake 2023A0783009
12/05/2022	Special Investigation Initiated – Telephone call with facility registered nurse Teresa Hiatt
12/06/2022	Inspection Completed On-site- Interviews and documentation received.
05/10/2023	Inspection Completed On-site- Interviews and documentation.
05/10/2023	Inspection Completed-BCAL Sub. Compliance
05/10/2023	Exit Conference with licensee designee Kaitlyn Shaffer.
05/10/2023	Corrective Action Plan Requested and Due on 05/25/2023
05/10/2023	Corrective Action Plan Received
05/10/2023	Corrective Action Plan Approved

ALLEGATION: Resident A was tipped upside down and left in wheelchair while using a discontinued headrest causing Resident A to have a stroke.

INVESTIGATION:

On December 05, 2022, a complaint was received reporting Resident A's guardian was given a discontinued head rest for Resident A's wheelchair which was placed on the wheelchair. Resident A was then allegedly tipped upside down and left in this position according to the complaint.

On December 06, 2022, Adult Foster Care Licensing Consultant Leslie Herrguth conducted an unannounced onsite investigation but was unable to observe Resident A due to Resident A being hospitalized. Ms. Herrguth was provided progress notes from

Resident A's Primary Care Physician (PCP) with Harmony Cares Medical Group, Dr. Franklin Prashanti. Resident A was diagnosed with the following: quadriplegic with a traumatic brain injury, acute respiratory failure, GI Bleed, gastritis, Peg tube, colostomy, decrease in breathing. Resident A used a wheelchair to assist with mobility due to being frail and elderly according to the progress note.

On December 06, 2022 Ms. Herrguth interviewed Teresa Hiatt, Chief Operating Officer (COO) with Centered Care, who reported that on November 29, 2022 Guardian A1 contacted Ms. Hiatt because Guardian A1 was upset by direct care staff member treatment and because Resident A's headrest was not on his wheelchair. Ms. Hiatt reported Guardian A1 stated she put the headrest on Resident A's wheelchair and reclined Resident A's wheelchair. Ms. Hiatt reported Guardian A1 voiced concern about Resident A's right hand prior to leaving. Ms. Hiatt reported she went to the facility immediately to evaluate Resident A and found Resident A in his bed having rapid eye movement and called for an ambulance immediately. Ms. Hiatt reported Resident A was transferred to the emergency department around 4:00pm but no medical treatment was completed until November 30, 2022 when a CT Scan was completed with results of Resident A having a stroke.

During my onsite investigation on May 10, 2023 per the *Resident Register*, Resident A was admitted into the facility on April 22, 2022 with a *Health Care Appraisal* completed on April 22, 2022. The *Health Care Appraisal* documented Resident A used a wheelchair for ambulation and mobility. I reviewed Resident A's *Plan of Treatment* which documented Resident A needs a daily nursing assessment, full set of vitals, requires total care with turning, feeding, bathing, and dressing, has an electric wheelchair and a manual wheelchair, skin checks when bathing, dependent of staff with all Activities of Daily Living and medications are given through J-Tube. I reviewed all physician orders, instructions, and staff progress notes but did not find any documentation regarding the use and/or discontinuation of the wheelchair headrest noted in Resident A's resident record.

On May 10, 2023, I interviewed administrator Kaitlyn Shaffer who reported Resident A's wheelchair had a removable headrest that could be used as needed. Ms. Schaffer reported there were no prescriptions written discontinuing the use of the headrest. Ms. Shaffer reported she was at the facility in the afternoon of November 29, 2022 conducting a fire drill and observed Resident A sitting in his wheelchair visiting with Guardian A1.

On May 10, 2023, I interviewed Tammy Eakins, Clinical Therapy Supervisor with Residential Home Care, who reported Resident A had a wheelchair with a removable headrest with no specific instructions pertaining to the use of the headrest. Ms. Eakins reported there was no documentation in the physical, occupational, or speech therapy orders discontinuing the use of the head rest for Resident A's wheelchair. Ms. Eakins reported due to no specific instructions pertaining to the headrest then then headrest can be used or removed as necessary. Ms. Eakins reported the wheelchair Resident A was prescribed could recline but could not be positioned in an upside-down position.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	There was no evidence found that Resident A's wheelchair headrest was discontinued. Resident A has a removable headrest and was prescribed with no specific instructions for the use of the headrest. The wheelchair itself does recline but does not move into an upside-down position per interview statements. Consequently, Resident A has been provided supervision, protection, and personal care as defined in the act and specified in his written assessment plan.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was not administered his Protonix as prescribed.

INVESTIGATION:

The complaint received on December 05, 2022 reported resident A was not administered his Protonix medication for 40 days causing a GI Bleed and hospitalization on November 29, 2022.

During Ms. Herrguth AFC Licensing Consultant's onsite investigation on December 06, 2022, Ms. Herrguth received copies of Resident A's Medication Administration Record (MAR) for the months of September 2022 and October 2022 which documented Resident A was prescribed Protonix Pak 40mg, dissolve one packet, and to be given via J-Tube twice daily. Per the September and October 2022 MARs, Resident A was not administered his Pantoprazole (generic version of Protonix) at any time during this time due to the medication clogging the J-Tube per the MAR notes completed by direct care staff members. The MAR notes indicated direct care staff members were waiting on a prior authorization from physician to order a different medication. Ms. Herrguth received a copy of Resident A's *Summary* from Sparrow Health Systems documenting Resident A being admitted into the hospital on October 28, 2022 through November 14, 2022 for acute respiratory failure with hypoxia.

On May 10, 2023 I reviewed the *AFC Licensing Division-Incident/Accident Report* dated October 23, 2022, at 4:00pm Justin DeVille and Mohammed Ahmed, direct care staff noticed Resident A's colostomy bag had dark bowel movement was liquid, so an ambulance was called and Resident A was taken to the Sparrow Hospital for evaluation where he was admitted.

On May 10, 2023 I received a copy of a physician contact from Dr. Franklin Prashanti PCP with Harmony Cares Medical Group. The physician contact documented a home call was completed on October 06, 2022 due to nutrition evaluation needed and a request of prior authorization for Omeprazole 40mg to replace Protonix. Dr. Prashanti documented the Protonix was clogging Resident A's J-Tube so a new medication was needed. I received a copy of authorization approval from Humana for Omeprazole DR 40mg dated October 13, 2022. Upon review of Resident A's resident file there were no physicians contacts or orders discontinuing the Protonix until the Omeprazole was approved on October 13, 2022.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A was not given his Protonix per the label instructions of dissolve one packet and give via J-Tube twice daily. Per the Medication Administration Records for Resident A, Resident A did not receive his Protonix medication for the month of September 2022 and half of October 2022 when Resident A was prescribed Omeprazole to replace the Protonix.
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 10, 2023 I completed an exit conference with Kaitlyn Shaffer, Licensee Designee/Administrator acknowledged Resident A's Pantoprazole 40mg not being administered as prescribed due to the medication clogging the J-Tube and waiting for authorization from Humana for Omeprazole to replace Pantoprazole. Ms. Shaffer reported LaKeida Mustaffa, Director of Nursing, was terminated on December 01, 2022, Medication Administration for Centered Care was updated on December 12, 2022 documenting when a medication is prescribed and an insurance authorization is needed Centered Care will pay for the medication until the authorization has been approved or denied. Ms. Shaffer reported all staff were trained on December 12, 2022 at staff meeting of new medication policy. Ms. Shaffer reported Resident A's headrest for the wheelchair was removable and would often be removed, but there were no physician orders discontinuing the headrest or specific instructions pertaining to the use of the head rest.

IV. RECOMMENDATION

An acceptable corrective action plan (CAP) has been completed and verification of CAP compliance. It is recommended that the current status of the license remains unchanged.

05/11/2023

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

05/30/2023

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Dawn N. Timm Date
Area Manager