GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 21, 2023

Laura Kelling
American House Wyoming
5812 Village Dr SW
Wyoming, MI 48519

RE: License #: AH410402896
Investigation #: 2023A1028054
American House Wyoming

Dear Laura Kelling:

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

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

I. IDENTIFYING INFORMATION

License #:	AH410402896
Investigation #:	2023A1028054
Complaint Receipt Date:	05/25/2023
Investigation Initiation Date:	05/30/2023
Report Due Date:	07/24/2023
Licensee Name:	AH Wyoming Subtenant LLC
Licensee Address:	STE 1600 One Towne Square Southfield, MI 48076
Licensee Telephone #:	(248) 827-1700
Authorized Representative/Administrator:	Laura Kelling
Name of Facility:	American House Wyoming
Facility Address:	5812 Village Dr SW Wyoming, MI 48519
Facility Telephone #:	(616) 622-2420
Original Issuance Date:	11/05/2020
License Status:	REGULAR
Effective Date:	05/05/2023
Expiration Date:	05/04/2024
Capacity:	166
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive medications in accordance with physician orders.	Yes
The facility did not keep Resident A's room free of insects.	No
Additional Findings	Yes

III. METHODOLOGY

05/25/2023	Special Investigation Intake 2023A1028054
05/30/2023	Special Investigation Initiated - Letter
05/30/2023	APS Referral APS referral made to HFA through Centralized Intake.
05/31/2023	Contact - Face to Face Interviewed Employee A at the facility.
05/31/2023	Contact - Face to Face Interviewed Employee B at the facility.
05/31/2023	Contact - Face to Face Interviewed Employee C at the facility.
05/31/2023	Contact - Face to Face Interviewed Employee D at the facility.
05/31/2023	Contact - Document Received Received Resident A's MAR from Employee B.
06/05/2023	Contact - Telephone call made Interviewed facility AR/Admin/Laura Kelling by telephone.
06/05/2023	Contact - Document Received Received requested documents from AR/Admin/Laura Kelling.
06/07/2023	Contact - Document Received Received additional requested documents from AR/Admin/Laura Kelling.

ALLEGATION:

Resident A did not receive medications in accordance with physician orders.

INVESTIGATION:

On 5/26/2023, the Bureau received the allegations from Adult Protective Services (APS) who made the referral to Homes for the Ages (HFA) through Centralized Intake.

On 5/31/2023, I interviewed Employee A at the facility who reported no knowledge of Resident A not being administered medication as prescribed. Employee A reported Resident A has a history of refusing medications, but it is documented in the medication administration record (MAR) if Resident A refused or missed any medication for any reason. Employee A reported all resident medications are audited routinely by the health and wellness director to ensure accuracy of medication administration and wellbeing and health of the residents.

On 5/31/2023, I interviewed Employee B at the facility who reported no knowledge of Resident A not receiving medications in accordance with the physician orders. Employee B reported sometimes Resident A will refuse medications, even after staff have made three attempts to administer. Employee B reported the resident has the right to refuse medications and when a resident does, it is documented in the MAR and the resident's authorized representative and physician are notified of the refusal. Employee B reported per facility protocols, the medication is then destroyed with the supervisor present once a medication refusal occurs three times. Employee B reported knowledge that Resident A has a history of refusing medications and care at times and that Resident A's authorized representative and family were notified of the history of refusing medications and assistance. Employee B also reported medication audits are completed for all residents routinely to ensure medication administration accuracy. I received Resident A's MAR from March 2023 to May 2023 for my review.

On 6/5/2023, I interviewed the facility authorized representative and administrator by telephone who reported knowledge of Resident A having a history of refusing medications, but not missing any medication administration. Ms. Kelling reported any medication administration that is missed is documented in the resident's MAR and a reason is documented as well. Ms. Kelling reported the health and wellness director completes medication audits routinely to ensure medication administration accuracy. Ms. Kelling confirmed staff are to attempt medication administration three times. If a resident refuses three times, the resident's authorized representative and physician are notified; and the medication is destroyed with the supervisor present. Ms. Kelling

provided me Resident A's service plan and MAR for March 2023 to May 2023 for my review.

On 6/5/2023, I reviewed Resident A's MAR from March 2023 to May 2023 and noted discrepancies in medication administration and missing record notes. I requested additional information from Ms. Kelling pertaining to the discrepancies and record notes.

On 6/7/2023, I received the correct medication record with notes pertaining to the review of Resident A's MAR from March 2023 to May 2023 from Ms. Kelling. I completed a review of Resident A's MAR which revealed the following:

- On 3/3/2023, Resident A was to receive 1 tablet by mouth, twice daily of Eliquis 5mg tablet. The record for 8:00pm is blank and no reason is documented as to why Resident A did not receive this medication.
- On 3/3/2023, Resident A was to receive 1 tablet by mouth at bedtime of Melatonin 5mg Oral tablet. The record for 8:00pm is blank and no reason is documented as to why Resident A did not receive this medication.
- On 3/3/2023, Resident A was to receive 1 tablet by mouth, twice daily of Metoprolol SUCC ER 50mg. The record for 8:00pm is blank and no reason is documented as to why Resident A did not receive this medication.
- On 3/3/2023 and 3/4/2023, Resident A was to receive 1 tablet by mouth every 6 hours of Hydroxyzine HCL 25mg tab. The record is blank for 12:00am on both days and no reason is documented as to why Resident A did not receive this medication.
- On 3/5/2023, Resident A was to receive 1 tablet by mouth every 6 hours of Hydroxyzine HCL 25mg tab. The record is blank for 6:00am and no reason is documented as to why Resident A did not receive this medication.
- On 3/8/2023, Resident A was to receive 1 tablet by mouth of Furosemide tab 20mg one time per day in the AM, every day at 8:00am. The record for 8:00am is blank and no reason is documented as to why Resident A did not receive this medication.
- April 2023 MAR demonstrates no missed or refused medication administration from Resident A.
- May 2023 MAR demonstrates no missed or refused medication administration from Resident A.

On 6/7/2023, I reviewed Resident A's service plan which revealed the following:

- Resident A was independent with dressing, bathing, transferring, ambulation and is continent of bladder and bowel.
- The facility manages Resident A's housekeeping, laundry, and medication.
- Resident A requires reminders to wear call pendant at all times for safety.
- Resident A does not demonstrate any neurocognitive or memory impairment.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	It was alleged Resident A did not receive medications as prescribed by the physician in the service plan. Interviews, on-site investigation, and review of documentation reveal multiple missed medications with no documentation as to why Resident A did not receive those medications. Despite facility staff reporting Resident A had a history of refusing medications, it cannot be determined if the medications on 3/3/2023, 3/4/2023, 3/5/2023, and 3/8/2023 were refused or missed, as there is no documentation noted in the MAR. There is also no documentation to support that Resident A has a history of refusing medications either. The facility failed to appropriately administer Resident A's medications and failed to appropriately document any potentially missed or refused medications, therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility did not keep Resident A's room free of insects.

INVESTIGATION:

On 5/31/2023, Employee A reported Resident A's room recently had a case of bed bugs from April 2023 to May 2023 with the facility treating the room and all of Resident A's belongings several times to eradicate the bed bugs. Employee A reported [they] are unsure of where the bed bugs came from and do not know how Resident A's room became infested with the bed bugs. Employee A reported no knowledge of any staff member making homemade pillows and distributing those or selling those to residents. Employee A reported to her knowledge, Resident A's room no longer has bed bugs, and the bed bugs did not spread to any other room in the facility. Employee A reported Resident A's authorized representative and physician were notified of the bed bugs; and Resident A receives daily skin checks to ensure skin integrity and health.

On 5/31/2023, Employee B reported knowledge of Resident A's room being infested with bed bugs. Employee B reported bed bug sniffing dogs were brought into the facility to determine origin; and pest control services treated Resident A's room several times due to the infestation from April 2023 to May 2023. Resident A's chairs and couch were disposed of because of the bed bugs as well. Employee B reported the bed bugs did not spread to any other room in the facility and to [their] knowledge Resident A's room no longer has bed bugs. Employee B reported no knowledge of any staff member making homemade pillows and distributing those or selling those to residents. Employee B reported no knowledge of where the bed bugs originated from, but it was discussed with Resident A's family due to Resident A rarely leaving the room or the facility. Employee B reported Resident A's authorized representative and physician were notified of the bed bugs; and Resident A receives daily skin checks to ensure skin integrity and health. Employee B reported housekeeping also increased visits to clean Resident A's apartment to ensure the bed bugs were gone. Employee B reported staff are trained in the facility to spot insects and vermin and to report it immediately to management.

On 5/31/2023, I interviewed Employee C at the facility who confirmed Resident A's room had bed bugs and the room was treated multiple times throughout April 2023 and May 2023 to eradicate the infestation. Employee C reported to [their] knowledge the bed bugs did not spread to any other room in the facility. Employee C reported due to the bed bugs, housekeeping increased cleaning visits and Resident A's chairs and couches were disposed of as well. Employee C reported all staff are trained to spot insects and vermin and to report it to management immediately. Employee C reported to [their] knowledge, Resident A's room no longer has bed bugs.

On 5/31/2023, I interviewed Employee D at the facility who reported Resident A's room had a case of bed bugs from April 2023 to May 2023. The facility called pest control to treat several times to eradicate the bed bugs. Employee D reported Resident A's room and all belongings were treated at least three times to ensure the eradication of bed bugs. Employee D reported Resident A's chairs and couch were disposed of as well due to the infestation. Employee D reported "I don't know how Resident A's room had bed bugs to begin with because [Resident A] never leaves the room. I assume someone brought them in unknowingly". Employee D reported to their knowledge, the room was checked again today, and the room no longer has bed bugs.

On 5/31/2023, I interviewed Resident A at the facility who reported the room did have bed bugs and the room was still active with bed bugs. Resident A confirmed the room was treated several times and the chairs and couch were disposed of because of the infestation. Resident A also confirmed receiving skin checks and medication due to the bed bug infestation. However, Resident A reported [their] current chair [they] were observed sitting in still had bed bugs in it and [they] were moving from the facility in June 2023 and not taking the chair or couch with [them].

I briefly inspected the room and did not observe any bed bugs in the room, on Resident A's chair, or on Resident A.

On 6/5/2023, Ms. Kelling's statements were consistent with Employee A's statements, Employee B's statements, Employee C's statements, and Employee D's statements.

On 6/7/2023, Ms. Kelling provided me the requested pest control policy and pest control documents for my review.

APPLICABLE RULE	
R 325.1978	**Insect and vermin control.**
	(1) A home shall be kept free from insects and vermin.(2) Pest control procedures shall comply with MCL 324.8301 et seq.
ANALYSIS:	It was alleged Resident A's room was infested with bed bugs from April 2023 to May 2023. Interviews, on-site investigation, and review of documentation reveal Resident A's room did have a bed bug infestation, but the facility complied with the facility pest control policy. Resident A's room was treated multiple times by professional pest control services to eradicate the bed beg infestation. There is evidence the bed bugs were only contained to Resident A's room and did not spread. Also, there is evidence the facility routinely receives pest control services to keep the facility free from insects and vermin. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

Additional Findings:

On 6/9/2023, I received an email from Ms. Kelling stating she resigned the facility effective 6/9/2023.

On 6/12/2023, I received an email from regional operations director, Kristen Viscum, stating she was the point of contact until a "executive director" for the facility is hired. I sent the required appointment of administrator form with request to complete and return with resume by email that day. I also requested information from Ms. Viscum about the appointment of a new facility authorized representative, explaining Ms. Kelling held that position and it will need to be appointed as well. Ms. Viscum did not

return my request for information and did not return the appointment of administrator form with resume either.

On 6/15/2023, no communication has been sent regarding the appointment of administrator or authorized representative to me.

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: **(d) Appoint a competent administrator who is responsible for operating the home in accordance with the established policies of the home.**
ANALYSIS:	The facility's prior authorized representative and administrator, Laura Kelling, notified the department on 6/9/2023 that she resigned from the facility effective 6/9/2023. As of 6/15/2023, the facility has not appointed a new authorized representative and/or administrator for the facility despite being provided the information pertaining to this requirement. Therefore, the facility is non-compliant and in violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Viviano

6/13/2023

Julie Viviano Date
Licensing Staff

Approved By:

08/17/2023

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