GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 6, 2023

Jesus Guardado
2167 Innwood Drive Southeast
Kentwood, MI 49508

RE: License #: AF410400507
Investigation #: 2023A0583039
J.G. Home

Dear Mr. Guardado:

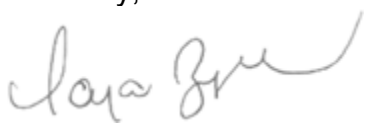
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF410400507
Investigation #:	2023A0583039
Complaint Receipt Date:	08/16/2023
Investigation Initiation Date:	08/17/2023
Report Due Date:	09/15/2023
Licensee Name:	Jesus Guardado
Licensee Address:	2167 Innwood Drive Southeast Kentwood, MI 49508
Licensee Telephone #:	(661) 675-9777
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	J.G. Home
Facility Address:	2167 Innwood Drive Kentwood, MI 49508
Facility Telephone #:	(616) 200-4051
Original Issuance Date:	11/19/2019
License Status:	REGULAR
Effective Date:	05/19/2022
Expiration Date:	05/18/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A tested positive for a medication that is not prescribed for him.	Yes

III. METHODOLOGY

08/16/2023	Special Investigation Intake 2023A0583039
08/17/2023	Special Investigation Initiated - Telephone Relative 1
08/17/2023	APS Referral
08/17/2023	Inspection Completed On-site
08/21/2023	Contact – Telephone Licensee Jesus Guardado
08/28/2023	Contact – Email Corewell Health Medical Records
08/30/2023	Contact – Email Corewell Health Medical Records
09/05/2023	Exit Conference Licensee Jesus Guardado

ALLEGATION: Resident A tested positive for a medication that is not prescribed for him.

INVESTIGATION: On 08/17/2023 I received complaint allegations from the BCAL online reporting system. The complaint stated that, "(Resident A) has a cognitive impairment and resides at JG Home". The complaint alleged that, "(Resident A) is in the hospital and his drug screening shows that he has been given a medication that was not prescribed to him" and that "this also happened back in March 2023."

On 08/17/2023 I interviewed Relative 1 via telephone. Relative 1 stated she is Resident A's sister and legal guardian. Relative 1 stated that on 03/16/2023 Resident A was at the facility and observed by licensee Jesus Guardado to be "lethargic and unresponsive" on the facility's couch. Relative 1 explained that Resident A was transported to the Emergency Room of Corewell Health Butterworth

and admitted. Relative 1 stated Resident A completed laboratory testing on 03/17/2023 which revealed that Resident A tested positive for Clozapine via a blood draw. Relative 1 stated Resident A is not prescribed Clozapine. Relative 1 stated hospital physicians suspected Resident A's episode may have been caused by neuroleptic malignant syndrome (NMS) which is a life-threatening idiosyncratic reaction to antipsychotic drugs characterized by fever, altered mental status, muscle rigidity, and autonomic dysfunction. Relative 1 stated hospital physicians reported that Clozapine can be a cause of neuroleptic malignant syndrome. Relative 1 stated she spoke with Mr. Guardado regarding Resident A's positive screen for Clozapine and Mr. Guardado stated one resident at the facility is prescribed Clozapine but Mr. Guardado had "no idea" how Resident A could have ingested Clozapine. Relative 1 stated Resident A recovered after the 03/16/2023 episode and was discharged from the hospital back to the facility. Relative 1 stated no further action was taken regarding the 03/16/2023 episode. Relative 1 stated that on 08/11/2023 Resident A was again observed by Mr. Guardado as lethargic and Resident A was transported to the Corewell Health Butterworth hospital where Resident A was admitted to the Intensive Care Unit. Relative 1 stated Resident A tested positive for Clozapine via blood draw on 08/12/2023 and his treating physicians are currently inclined to believe that Resident A was suffering neuroleptic malignant syndrome. Relative 1 stated Resident A's cognitive baseline limits his cognition and memory therefore Relative 1 could not determine the origin of Clozapine in his urinalysis.

On 08/17/2023 I emailed the complaint allegation to Adult Protective Services Centralized Intake.

On 08/17/2023 I completed an unannounced onsite investigation at the facility and privately interviewed licensee Jesus Guardado, Resident B, and Resident C.

Licensee Jesus Guardado stated that 03/16/2023 Resident A was observed as lethargic and therefore Mr. Guardado obtained medical treatment for Resident A which resulted in his hospitalization. Mr. Guardado stated that after the 03/16/2023 hospitalization Relative 1 informed Mr. Guardado that Resident A had tested positive for Clozapine via a hospital laboratory blood draw. Mr. Guardo confirmed that Resident A is not prescribed Clozapine. Mr. Guardado stated no residents at the facility are prescribed Clozapine therefore he does not know how or where Resident A ingested that medication. Mr. Guardado stated that on 08/12/2023 Resident A was again observed as lethargic and therefore Mr. Guardado obtained medical treatment for Resident A which resulted in a second hospitalization. Mr. Guardado stated that Resident A is currently a patient at Corewell Health in the Intensive Care Unit. Mr. Guardado stated he was not aware that Resident A tested positive for Clozapine while currently hospitalized. Mr. Guardado stated no resident of the facility is currently prescribed Clozapine. Mr. Guardado stated he has never administered Clozapine to Resident A. Mr. Guardado stated that staff Sylvia Florez and staff Norma Guardado typically administer medications to residents however Ms. Florez and Ms. Guardado did not administer resident medications during the months of March 2023 or August 2023.

A review of the facility's Medication Administration Records indicates that Resident B is prescribed Clozapine TAB 200 mg every night at bedtime and Clozapine TAB 50 mg every night at bedtime. The Medication Administration Record indicates that Resident A is not prescribed Clozapine.

Resident B stated he is prescribed Clozapine which is administered by Mr. Guardado. Resident B was asked if he had given his Clozapine to other residents and Resident B vacillated between stating "yes" and "no" multiple times.

Resident C stated he receives his medications as prescribed from Mr. Guardado. Resident C stated he visually inspects his medications before ingesting them to verify that he is being administered the correct medications. Resident C stated he has never been provided incorrect medications to his knowledge.

On 08/21/2023 I interviewed Licensee Jesus Guardado via telephone. Mr. Guardado stated from February to March 2023 and July to August 2023 he was the only person to administer Resident A's medications. Mr. Guardado stated "sometimes residents drop pills" but to his knowledge, Mr. Guardado has always immediately found the dropped medication and administered the medication as prescribed. Mr. Guardado stated Resident A does sit next to Resident B at the dining table which is where residents are seated during the medication administration process. Mr. Guardado stated that during the medication administration process he places each resident's medications into a small paper cup, hands each resident their cup of medications, and watches each resident ingest their medications. Mr. Guardado stated all resident medications are locked in a medication cabinet located in the facility's living room and that he does not "pre-set" resident medications before they are given.

On 08/28/2023 I received an encrypted email from Corewell Health Medical Records Department which contained Resident A's Medical Records. I observed that on 08/12/2023 Dr. Wahaaj Khan ordered a venous blood draw in which Resident A tested positive for Clozapine. I observed that on 03/16/2023 Dr. Farjana Alam ordered a venous blood draw in which Resident A tested positive for Clozapine. I observed that on 03/17/2023 Dr. Brandon Vieder ordered a venous blood draw which found that Resident A's Clozapine level was 147 ng/mL which is below the expected therapeutic range >350 ng/mL.

On 08/30/2023 I received an encrypted email from Corewell Health Medical Records Department which contained Resident A's Medical Records specific to an 08/21/2023 Corewell Health Hospital Discharge Summary and a 03/22/2023 Corewell Heath Hospital Discharge Summary.

This showed that Dr. Mubarak Dawaski MD authored an 08/21/2023 Discharge Summary which indicated Resident A was hospitalized at Corewell Health from 08/11/2023 until 08/21/203 due to the presenting problem of an, *'Altered mental status, Toxic metabolic encephalopathy, Encephalopathy acute, Encephalopathy*

acute, suspect metabolic + possibly toxic from Clozapine use, Moderate dementia, Lactic acidosis, Fever, Essential hypertension with intermittent hypotension Shock'. The Discharge Summary further indicated that Resident A, *'Presented with altered mental status. He arrived via EMS from his AFC home tachycardic and hypertensive with SBP>200. Patient had a GCS of 6. His last known well was between 2000 and 2200 on 08/12/2023. Patient was given Narcan 2 mg on his way to the emergency department. No seizure-like activity noted by EMS or in the ED. Patient placed on a non-rebreather and given additional dose of Narcan without significant improvement in GCS. Decision was made to intubate secondary to depressed mental status and inability to protect airway. Initial lab workup insignificant. No lactic acidosis, normal troponins, no significant acidosis/alkalosis. Imaging including CXR, CT Head, CT Thorax/Abd/Pelvis, CTA A/P insignificant for acute findings. Patient transferred to the ICU for further management of altered mentation requiring ventilator support. Of note, patient was admitted for encephalopathy of unclear etiology in March 2023. At that time he was found to be encephalopathic due to polypharmacy, taking clozapine inappropriately and an increased dose of tramadol. He improved with holding of all medications except Depakote. Comprehensive drug screen positive for clozapine, but no known rigidity, normal CK". The Discharge Summary further indicated that Resident A was discharged with the following diagnosis: Carotid artery stenosis, Thrombosis of left iliac vein, Encephalopathy acute, Bipolar disorder, Essential hypertension, Depression with anxiety.'*

The previously noted documentation indicated that Dr. Amarinder S Atal MD authored a 03/22/2023 Discharge Summary which indicated Resident A was hospitalized at Corewell Health from 3/16/2023 until 3/22/2023 due presenting with an, *'Altered mental status'* and was, '*Admitted for acute encephalopathy, likely secondary to polypharmacy as clozapine was noted in drug screen and tramadol dosing was recently increased'.* The Discharge Summary further stated that *'Clozapine is not among his listed home medications'*. The Discharge Summary stated Resident A was diagnosed with Hypertensive emergency, Neuroleptic malignant syndrome, Fever, and SIRS (systemic inflammatory response syndrome).

On 09/05/2023 I completed an Exit Conference via telephone with Licensee Jesus Guardado. Mr. Guardado stated he agreed with the Special Investigation Findings and would submit an acceptable Corrective Action Plan. Mr. Guardado stated he would accept the issuance of a Provisional License.

APPLICABLE RULE	
R 400.1418	**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:	Resident A's Medication Administration Record indicated Resident A is not prescribed Clozapine.

	Resident B's Medication Administration Record indicates Resident B is prescribed Clozapine TAB 200 mg every night at bedtime and Clozapine TAB 50 mg every night at bedtime. Resident A's Corewell Health Medical Records indicates that on 03/16/2023 and 08/11/2023 Resident A was admitted to Corewell Health Hospital for acute encephalopathy, likely secondary to polypharmacy as clozapine was noted in two drug screens. Furthermore, Resident A's Medical Records indicate that upon discharge on 03/22/2023 Resident A was diagnosed with Neuroleptic Malignant Syndrome. Licensee Jesus Guardado stated from February to March 2023 and July to August 2023 he was the only person to administer Resident A's medications. Mr. Guardado stated that sometimes residents drop pills but to his knowledge he has always immediately found the dropped medication and administered it as prescribed. Mr. Guardado stated Resident A does sit next to Resident B at the dining table which is where residents are seated during the medication administration process. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule. Resident A tested positive for a medication (Clozapine) he was not prescribed on two occasions which led to the need for hospitalization during both incidents.
CONCLUSION:	**VIOLATION ESTABLISHED**

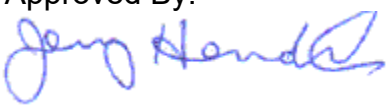
IV. RECOMMENDATION

I recommend the license be modified to Provisional Status as a result of the above cited quality of care violation.

09/05/2023

Toya Zylstra, Licensing Consultant Date

Approved By:



09/06/2023

Jerry Hendrick, Area Manager Date