GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 20, 2023

Robert Abramson
The Young Home For The Elderly
3900 E. 9 Mile Rd.
Warren, MI 48091

RE: License #: AL500094345
Investigation #: 2023A0617033
The Young Home

Dear Mr. Abramson:

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 (248) 975-5053.

Sincerely,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500094345
Investigation #:	2023A0617033
Complaint Receipt Date:	08/16/2023
Investigation Initiation Date:	08/17/2023
Report Due Date:	10/15/2023
Licensee Name:	The Young Home For The Elderly
Licensee Address:	3900 E. 9 Mile Rd. Warren, MI 48091
Licensee Telephone #:	(585) 756-5307
Administrator:	Robert Abramson
Licensee Designee:	Robert Abramson
Name of Facility:	The Young Home
Facility Address:	3900 E. 9 Mile Rd Warren, MI 48091
Facility Telephone #:	(586) 756-5307
Original Issuance Date:	07/16/2001
License Status:	REGULAR
Effective Date:	01/23/2022
Expiration Date:	01/22/2024
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff are not trained on how to use Resident A's feeding tube.	**Yes**
Staff adjusted Resident A's Xanax medication without proper authorization	**Yes**

III. METHODOLOGY

08/16/2023	Special Investigation Intake 2023A0617033
08/16/2023	APS Referral Adult Protective Services (APS) referral received - denied
08/17/2023	Special Investigation Initiated - Face to Face Unannounced investigation conducted.
08/17/2023	Inspection Completed On-site I completed an unannounced onsite investigation at the Rosewood facility. I interviewed staff Samantha Miller, Shayla Ware, Licensee designee Robert Abramson and facility nurse Lisa via phone. I also observed Resident A sleeping in her bed.
09/04/2023	Contact - Document Received Email Received from Mr. Abramson
10/12/2023	Contact - Telephone call made I interviewed Nurse Melanie Abner of Personalize Home Care Services.
10/12/2023	Contact - Telephone call made TC to Accension Hospital Social Worker Dept
10/18/2023	Contact - Document Received Email sent to LD Mr. Abramson
10/19/2023	Exit Conference I contacted licensee designee Robert Abramson for the exit conference to inform him of the findings of the investigation.

ALLEGATION:

- **Staff not trained on how to use Resident A's feeding tube.**
- **Staff adjusted Resident A's Xanax medication without proper authorization.**

INVESTIGATION:

On 08/16/23, I received a complaint for The Young Home For The Elderly facility. The complaint indicated that Resident A has dementia, a feeding tube, and resides in The Young Home (an AFC home). Jessica is the manager at the AFC Home. Three weeks ago, Jessica discontinued Resident A's Xanax medications without consulting with her doctor. This is not the first time that Jessica has changed or altered Resident A's medications without consulting with the doctor. A week ago, Resident A was admitted to the hospital due to not eating and back pain. Jessica has been attempting to get Resident A released from the hospital sooner, so she can get Resident A's per diem money to the AFC home. The hospital has recommended two weeks, but they will be discharging her back tomorrow due to Jessica informing them that her staff can manage the feeding tube and other care needs for Resident A. The staff are not trained or qualified to deal with feeding tubes and Jessica is making them due a quick course to learn.

On 08/17/23, I completed an unannounced onsite investigation at The Young Home For The Elderly. I interviewed staff Samantha Miller, Shayla Ware, Licensee designee Robert Abramson and facility nurse Lisa via phone. I also observed Resident A sleeping in her bed. During the onsite investigation, I observed residents sitting in the living room watching TV. I interviewed the residents and they all reported that they enjoy residing in the facility. Residents did not have any concerns to report. Residents appeared to be clean and did not have a noticeable odor.

During the onsite investigation, staff Samantha Miller and Shayla Ware stated that they have not been trained on how to administer medications via a feeding tube. Ms. Miller stated that a nurse is scheduled to come to the facility later that day at 5pm to provide training on how to properly use a feeding tube. Ms. Miller also stated that staff were trained years ago on the use of feeding tubes, but she cannot recall when that training took place. According to Ms. Miller, she was unaware of the medications that Resident A is prescribed due to Resident A being recently discharged from the hospital a few hours prior to the onsite investigation. Ms. Miller was unaware if Resident A had medications due to be passed and stated that I would need to speak with the Licensee Designee Mr. Abramson.

During the onsite investigation, I interviewed Licensee Designee Robert Abramson. According to Mr. Abramson, Resident A went to the hospital on 08/05/23. Mr. Abramson stated that on 08/14/23 or 08/15/23, he and staff Jessica went to the hospital to visit Resident A. Mr. Abramson inquired about Resident A's release from the hospital and he

was told that Resident A requires at least two more weeks in the hospital. Mr. Abramson denied requesting that the hospital release Resident A early to the facility's care.

Mr. Abramson stated that he and Jessica told the hospital that the facility misses Resident A but never informed them they could care for her needs at the time. Mr. Abramson stated that he was very surprised that Resident A just "showed up" at the facility today. However, Mr. Abramson stated that he was informed by the hospital two days prior that Resident A would be discharged and sent back to the facility. Mr. Abramson stated that he is unsure what medications Resident A is now prescribed since being discharged from the hospital.

Mr. Abramson provided me with a Resident A's discharge paperwork in a sealed unopened envelope. Mr. Abramson stated that he has not had time to review Resident A's discharge documentation. I reviewed Resident A's discharge paperwork and observed that Resident A is prescribed several medications that the facility did not have an onsite. Mr. Abramson stated that he was unaware of the medication changes and had not ordered the medications. Mr. Abramson stated that he did not coordinate with the hospital prior to the discharge of Resident A to ensure that the facility would be prepared and equipped to provide adequate care for Resident A upon her return. Mr. Abramson stated that a nurse is scheduled to come to the facility later today at 5pm to provide training on how to properly use the feeding tubes. Mr. Abramson was unable to provide any contact information for the nurse or the organization that the nurse is affiliated with. Mr. Abramson also stated that staff were trained years ago on the use of feeding tubes, but he cannot recall when that training took place.

During the onsite investigation, I completed a medication review for Resident A and observed the following errors:

- According to Resident A's discharge paperwork, she is prescribed the following medications, however the medications were not listed on the medication log and the facility did not have the medications onsite:
    - Acetaminophen 500MG - PEG tube every 4 hours as needed
    - Acetaminophen -hydrocodone - 10ML PEG Tube every 6 hours as needed
    - Docusate 100mg - Peg tube 2 times a day as needed
    - Famotidine 20mg PEG Tube - once a day – start 8/18/23 Morning
    - Fluphenazine 1mg PEG Tube - 2 times a day- start 08/17/23 Night
    - Magnesium Oxide 400mg PEG tube - once a day -start 8/18/23 Morning
    - Valproic Acid 500mg PEG tube- every 12 hours - start 08/17/23 Night
    - Atorvastatin 10mg PEG Tube- once a day at bedtime - start 08/17/23 Night
    - Donepezil 5mg PEG Tube- once a day at bedtime - start 08/17/23 Night
    - Levetiracetam 500mg PEG tube- every 12 hours - start 08/17/23 Night
    - Meclizine 12.5mg PEG Tube- 3 times a day - as needed
    - Melatonin 5mg PEG Tube - once a day at bedtime and as needed for Insomnia
    - Sumatriptan 100mg by mouth - as needed

- According to the Medication Log dated July 2023, Resident A was prescribed the medication Xanax 0.5mg and it was discontinued on 07/10/23. However, the facility does not have a written order to discontinue or adjust the medication. According to Mr. Abramson and Nurse Lisa, Resident A's doctor gave a verbal order to adjust the Xanax medication on an unknown date in July. Also, the facility was still in possession of Resident A's Xanax medication.

On 09/04/23, I received an email from Mr. Abramson stating that arrangements had been made with Resident A's probate support representative, Jen Edge, to be transferred to a facility (skilled nursing) that can provide the level of care she now needs.

On 10/12/23, I interviewed Nurse Melanie Abner of Personalize Home Care Services. Ms. Abner stated that on 08/17/23, she provided staff from the Young Home facility training on how to properly use Resident A's feeding tubes. Ms. Abner stated that staff was actively engaged in the training. According to Ms. Abner, during her onsite training, staff contacted the pharmacy regarding Resident A's medication. Resident A's medication had not been delivered but the medications were scheduled to be delivered that day 08/17/23.

On 10/19/23, I contacted licensee designee Robert Abramson for the exit conference to inform him of the findings of the investigation. Mr. Abramson stated that he would complete an appropriate corrective action plan.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my interviews, there is sufficient information to conclude that this licensing violation occurred when the facility accepted Resident A back into the facility without being properly trained on the use of her feeding tubes. Also, the facility was without Resident A's medications and had not ordered the medications at the time of the onsite inspection.
CONCLUSION:	**VIOLATION ESTABLISHED**

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.**
ANALYSIS:	During the onsite investigation, staff Samantha Miller, Shayla Ware and Licensee Designee Robert Abramson, stated that they have not been trained on how to administer medications via a feeding tube. They stated that a nurse is scheduled to come to the facility later that day at 5pm to provide training on how to properly use a feeding tube. Staff also stated that staff were trained years ago on the use of feeding tubes, but cannot recall when that training took place. I reviewed Resident A's discharge paperwork and observed that Resident A is prescribed several medications that the facility did not have onsite. Mr. Abramson was unaware of the medication changes and had not ordered the medications. Mr. Abramson stated that he did not coordinate with the hospital prior to the discharge of Resident A to ensure that the facility would be prepared and equipped to provide adequate care for Resident A upon her return. Resident A had several medications that were prescribed on a as needed basis for pain, however staff were not trained how to properly administer the medications, nor did they have the correct medications onsite.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(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.**

ANALYSIS:	During my onsite investigation on 08/17/23, I observed the Medication Log dated July 2023. Resident A was prescribed the medication Xanax 0.5mg and it was discontinued on 07/10/23. However, the facility does not have a written order to discontinue or adjust the medication. According to Mr. Abramson and Nurse Lisa, Resident A's doctor gave a verbal order to adjust the Xanax medication on an unknown date in July. Also, the facility was still in possession of Resident A's Xanax medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/19/2023

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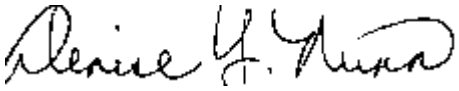
Eric Johnson Date
Licensing Consultant

Approved By:



10/20/2023

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Denise Y. Nunn Date
Area Manager