GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 26, 2023

Michelle Aylor-Robbins
Burcham Hills Retirement Center II
2700 Burcham Drive
East Lansing, MI 48823

RE: License #: AH330236746
Investigation #: 2023A1010072
Burcham Hills Retirement Center II

Dear Licensee:

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 authorized representative 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) 241-1970.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH330236746
Investigation #:	2023A1010072
Complaint Receipt Date:	07/06/2023
Investigation Initiation Date:	07/10/2023
Report Due Date:	09/05/2023
Licensee Name:	Burcham Hills Retirement Center II
Licensee Address:	2700 Burcham Drive East Lansing, MI 48823
Licensee Telephone #:	(517) 351-8377
Authorized Representative/Administrator:	Michelle Aylor-Robbins
Name of Facility:	Burcham Hills Retirement Center II
Facility Address:	2700 Burcham Drive East Lansing, MI 48823
Facility Telephone #:	(517) 351-8377
Original Issuance Date:	07/01/1999
License Status:	REGULAR
Effective Date:	01/31/2023
Expiration Date:	01/30/2024
Capacity:	266
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident E went approximately 15 hours without her prescribed pain medication.	Yes

III. METHODOLOGY

07/06/2023	Special Investigation Intake 2023A1010072
07/10/2023	Special Investigation Initiated - On Site
07/10/2023	APS Referral APS referral emailed to Centralized Intak
07/10/2023	Inspection Completed On-site
07/10/2023	Contact - Document Received received resident service plan and MAR
08/04/2023	Contact – Document Received Received resident June MAR
10/26/2023	Exit Conference

ALLEGATION:

Resident E went approximately 15 hours without her prescribed pain medication.

INVESTIGATION:

On 7/6/23, the Bureau received the allegations from the online complaint system. The complaint read, [Resident E] has bone cancer that is progressing. She requires pain medication and is doctor ordered that she can have it as requested. Last night her prescription for her pain medication ran out, for the third time. Staff knew it was running out and did nothing or said nothing about it. [Resident E] is now in hour 15 without pain meds and is in pain. Staff tell is [sic] they don't know when they will be able to refill the order."

On 7/10/23, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 7/10/23, I interviewed clinical director Jessica Gullett at the facility. Ms. Gullet stated Resident E called Relative E1 upset and crying on 6/21/23 because she was informed by staff that her prescribed as needed Norco pain medication ran out. Ms. Gullet reported Resident E told Relative E1 she was in plain. Ms. Gullet said she was informed by Relative E1 on 6/22/23 by telephone that Resident E went approximately 21 hours without her prescribed as needed Norco pain medication. Ms. Gullet reported after she was informed of this information, she met with Relative E1 and Resident E at the facility on 6/22/23 to address the issue.

Ms. Gullet stated Resident E is prescribed Norco three times a day and as needed for pain management. Ms. Gullet reported resident E always takes her as needed Norco pill every night at 9:00 pm. Ms. Gullet explained she found the pharmacy was filling a 90-day supply of Resident E's prescribed Norco at a time. Ms. Gullet said when Resident E ran out of her prescribed as needed Norco, staff followed the facility's protocol to refill a resident's prescription.

Ms. Gullet explained when a resident utilizes one of the facility's contracted physicians, the medication technician (med tech) who observes the resident's prescribed medication to be low or about to run out, must notify the "care coordinator" on shift. Ms. Gullet reported the "care coordinator" then writes a notification to the resident's physician regarding the refill and places it in the physician's "communication box" in the facility. Ms. Gullet said the facility's contracted physicians are onsite weekly at the facility and take and review the contents in their "communication boxes" regularly. Ms. Gullet stated care coordinators mark prescription refill notifications as "urgent" as needed.

Ms. Gullet reported on 6/19/23, Staff Person 1 (SP1) placed a refill notification for Resident E's as needed Norco in Resident E's physician's "communication box" in the facility. Ms. Gullet stated Resident E's physician or someone with Resident E's physician's office is in the facility weekly and takes the contents in their "communication box." However, Ms. Gullet said Resident E's physician was out of office when SP1 placed Resident E's Norco refill request in the "communication box." Ms. Gullet explained the notification was not marked as "urgent" therefore it was missed and not properly followed up on. Ms. Gullet said on 6/19/23, Resident E had eleven total Norco pills left.

Ms. Gullet provided me with a copy of Resident E's *Progress Notes* for my review. A note written by SP1 dated 6/19/23 read, "Situation: Norco Background: Resident needs new script for Norco Recommendations: Please assess and write necessary orders Thanks." A note dated 6/22/23 written by SP2 read, "This morning CD and WN were made aware of an out-of-stock medication that resident has scheduled and PRN. WN spoke with One Care about delivery and prescription. PCP was asked to write correct script for refill. Pharmacy confirmed med would be sent out tonight. WN pulled from Stat Safe for today's doses. CC and MT reported [Relative E1] was verbally aggressive and rude to staff. WN placed Stat Safe doses in cart for

administration today. MT reported [Relative E1] brought in full tab Norco to administer to resident, med dose unknown."

Ms. Gullet provided me with a copy of Resident E's service plan for my review. The *Behavior/Mood* section of the plan read, "Resident is a Level 2 and is alert and oriented to person, place and time. She has chronic pain due to her cancer diagnosis; please ensure she is not in pain upon every visit to her apartment. If she has breakthrough pain please notify the Care Coordinator so Dr. Haque can be aware and make any changes necessary."

On 7/10/23, I interviewed Resident E at the facility. Resident E reported there was a recent incident in which her 9:00 pm pain medication ran out and staff were unable to administer it as a result. Resident E was unable to recall how long she went without the medication. Resident E was only able to recall the one recent incident in which this occurred. Resident E reported she was in pain today but did receive her scheduled pain medication.

On 8/7/23, I reviewed Resident E's June 2023 MAR. The MAR read Resident E was prescribed "Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 0.5 tablet by mouth every 6 hours as needed for [sic] Give ½ Tablet for pain." The MAR read this medication was not administered on 7/1/23, 7/4/23, 7/5/23, 7/7/23, 7/10/23, 7/11/23, and 7/21/23.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(o) A patient or resident is entitled to adequate and appropriate pain and symptom management as a basic and essential element of his or her medical treatment.**
ANALYSIS:	The interviews with Ms. Gullet and Resident E, along with review of Resident E's MAR revealed she did not receive her prescribed as needed Norco pain medication on 6/21/23. Resident E is diagnosed with cancer and complained of being in pain, however the facility was out of her prescribed Norco medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	The interview with Ms. Gullet and review of Resident E's MAR revealed the facility was out of Resident E's prescribed as needed Norco medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Michelle Aylor-Robbins on 10/26/2023.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

08/07/2023

Lauren Wohlfert Date
Licensing Staff

Approved By:

10/25/2023

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