GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 6, 2023

Paul Barber
Directors Hall
600 Golden Drive
Kalamazoo, MI 49001

RE: License #: AH390236775
Investigation #: 2023A1028084
Directors Hall

Dear Paul Barber:

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 #:	AH390236775
Investigation #:	2023A1028084
Complaint Receipt Date:	08/08/2023
Investigation Initiation Date:	09/18/2023
Report Due Date:	11/07/2023
Licensee Name:	Heritage Community of Kalamazoo
Licensee Address:	2400 Portage St. Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-5345
Administrator:	Amy Beach
Authorized Representative:	Paul Barber
Name of Facility:	Directors Hall
Facility Address:	600 Golden Drive Kalamazoo, MI 49001
Facility Telephone #:	(269) 349-8694
Original Issuance Date:	03/01/1974
License Status:	REGULAR
Effective Date:	08/14/2023
Expiration Date:	08/13/2024
Capacity:	89
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff did not provide Resident A care in a timely manner.	No
Resident A did not receive medications in accordance with the service plan.	Yes
Additional Findings	No

III. METHODOLOGY

08/08/2023	Special Investigation Intake 2023A1028084
09/18/2023	Special Investigation Initiated - Letter
09/18/2023	APS Referral No APS referral. Resident is deceased.
09/27/2023	Contact - Face to Face Interviewed Admin/Amy Beach at the facility.
09/27/2023	Contact - Face to Face Interviewed Employee A at the facility.
09/27/2023	Contact - Face to Face Interviewed Employee B at the facility.
09/27/2023	Contact - Document Received Received Resident A's record from Admin/Amy Beach.

ALLEGATION:

Staff did not provide Resident A care in a timely manner.

INVESTIGATION:

On 9/18/2023, the Bureau received the allegations through the online complaint system.

On 9/27/2023, I interviewed the facility administrator, Amy Beach, at the facility who reported Resident A was admitted to the facility in March 2023. Resident A lived

independently in her own home in Maryland prior to being moved to the facility. Resident A made [their] own decisions as well. Ms. Beach reported to her knowledge there were no complaints from Resident A, Resident A's authorized representative or family about care or call lights not being answered in a timely manner. Resident A was capable of using the call light appropriately but did not always use it consistently. Ms. Beach reported all resident call light logs are reviewed weekly to ensure good call light response time. If call light response times are outside of facility parameters of 10 minutes, then re-education, training, and/or disciplinary action may occur. Ms. Beach reported Resident A passed away in May 2023 due to Covid-19 related symptoms. Ms. Beach provided me Resident A's call light log and record for my review.

On 9/27/2023, I interviewed Employee A at the facility who reported Resident A moved to the facility from [their] own home in Maryland in March 2023. Resident A made [their] own decisions and could use the call light appropriately but was not always consistent. Employee A reported to [their] knowledge there were no complaints from Resident A, Resident A's authorized representative or family concerning care or call lights not being answered in a timely manner. Employee A reported the facility answers call lights in a timely manner and call light logs for all residents are reviewed weekly to ensure staff are answering call lights in a timely manner, Employee A reported to [their] knowledge, Resident A did not have any exceptional call light wait times during their stay at the facility.

On 9/27/2023, I interviewed Employee B at the facility whose statements were consistent with Ms. Beach's statements and Employee A's statements.

On 9/27/2023, I reviewed Resident A's call light log which revealed no significant call light times for Resident A from March 2023 to May 2023.

On 9/27/2023, I reviewed Resident A's record which revealed no concerns.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	It was alleged facility staff did not provide Resident A care in a timely manner. Interviews, on-site investigation, and review of documentation revealed there is no evidence to support this allegation. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A did not receive medications in accordance with the service plan.

INVESTIGATION:

On 9/27/2023, Ms. Beach reported Resident A moved to the facility from her own home in Maryland in February 2023 and was admitted to the facility in March 2023. Resident A's physician orders and medical documentation were requested and when obtained, there were discrepancies between Resident A's physician orders and medication orders and what Resident A's family was reporting. Ms. Beach reported an assessment was completed at admittance by the facility physician and medication orders were prescribed and/or continued. Ms. Beach reported Resident A's authorized representative inquired about Resident A missing [their] daily Levothyroxine medication, with the facility checking physician orders and the pharmacy. The medication showed as still being on order, so the facility contacted the pharmacy directly again to inquire on the status. Ms. Beach reported there were physician orders for Levothyroxine and the facility was to provide the medication in accordance with the physician orders. Ms. Beach provided me Resident A's medication administration record (MAR) from March 2023 to May 2023 and physician orders with notes for my review.

On 9/27/2023, Employee A's statements and Employee B's statements are consistent with Ms. Beach's statements.

On 9/27/2023, I reviewed Resident A's MAR from March 2023 which revealed the following:

- Resident A was to receive Levothyroxine 75 mcg tablet by mouth once daily for hypothyroidism.
- On 3/29/2023, 3/30/2023, and 3/31/2023, Resident A did not receive Levothyroxine 75 mcg tablet by mouth once daily due to waiting on the pharmacy order.
- Only 3/30/2023 is marked in the MAR as waiting in the pharmacy order. The record is blank for 3/29/2023 and 3/31/2023. There are no notes in the MAR demonstrating staff contacted the pharmacy to check on the medication status.

I reviewed Resident A's MAR from April 2023 which revealed the following:

- Resident A was to continue to receive Levothyroxine 75 mcg tablet by mouth once daily for hypothyroidism.
- From 4/1/2023 to 4/10/2023, Resident A did not receive Levothyroxine 75 mcg tablet by mouth once daily due to waiting on the pharmacy order.
- However, the record is blank for 4/1/2023 and 4/8/2023.
- Beginning 4/11/2023, the medication is received at the facility from the pharmacy, but the record is blank on 4/15/2023, 4/22/2023, 4/25/2023, and

4/26/2023. There are no notes in the MAR of Resident A refusing medication. It cannot be determined if Resident A received the medication or not.

I reviewed Resident A's MAR from May 2023 which revealed no concerns about medication administration for Levothyroxine.

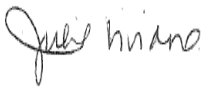
I also reviewed the medication record notes which revealed the following:

- Resident A's admission date was 3/28/2023.
- On 4/5/2023, a blood lab draw was completed.
- On 4/10/2023, there is a physician note of *"No Levothyroxine for almost 2 weeks. Redraw in one month."*
- On 4/26/2023, a blood lab draw was completed.

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 in accordance with the service plan. Interviews, on-site investigation, and review of documentation revealed the facility did not provide appropriate medication administration for the medication Levothyroxine. Resident A was to receive Levothyroxine 75 mcg tablet by mouth once daily. Documentation reveals while the facility documented they were waiting on the pharmacy to fulfill the order, there was no continued follow-up on the status of the medication. There are blank entries on the record for March 2023 and April 2023 as well, and it cannot be determined if Resident A received the medication or not. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



10/18/2023

Julie Viviano Date
Licensing Staff

Approved By:

10/30/2023

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