GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 17, 2023

Sheryl Klein
Grace Senior Living
985 N Lapeer Rd
Orion, MI 48362

RE: License #: AH630400653
Investigation #: 2024A1019008

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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) 284-9730.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630400653
Investigation #:	2024A1019008
Complaint Receipt Date:	10/25/2023
Investigation Initiation Date:	10/26/2023
Report Due Date:	12/24/2023
Licensee Name:	Conscious Senior Living Properties II LLC
Licensee Address:	985 N Lapeer Rd Lake Orion, MI 48362
Licensee Telephone #:	(248) 670-9823
Administrator:	Cynthia Tanner
Authorized Representative:	Sheryl Klein
Name of Facility:	Grace Senior Living
Facility Address:	985 N Lapeer Rd Orion, MI 48362
Facility Telephone #:	(248) 977-6200
Original Issuance Date:	09/10/2020
License Status:	REGULAR
Effective Date:	03/10/2023
Expiration Date:	03/09/2024
Capacity:	71
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Improper medication administration to Resident A.	Yes
Additional Findings	No

III. METHODOLOGY

10/25/2023	Special Investigation Intake 2024A1019008
10/26/2023	Special Investigation Initiated - Letter Notified APS of the allegations via email referral template.
10/26/2023	APS Referral
11/09/2023	Inspection Completed On-site
11/09/2023	Inspection Completed BCAL Sub. Compliance
11/09/2023	Contact - Document Sent Emailed APS worker for additional information and status update.
11/09/2023	Contact - Document Sent Emailed hospice nurse for additional information, documentation requested.
11/09/2023	Contact - Telephone call received Call received from APS worker, interviewed conducted.

The complainant identified some concerns that were not related to licensing rules and/or statutes regulating a home for the aged. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation.

ALLEGATION:

Improper medication administration to Resident A.

INVESTIGATION:

On 10/25/23, the department received a complaint alleging that facility staff failed to administer prescribed medication to Resident A. The complaint alleged that on 10/23/23, Resident A was vomiting, and staff did not administer her nausea medication to her. The complaint also alleged that Resident A has chronic breathing issues, but staff do not administer her nebulizer to her (no dates provided).

On 11/9/23, I conducted an onsite inspection. I interviewed administrator Cynthia Tanner onsite. Ms. Tanner reported that Resident A has a physician's order for scheduled and PRN "as needed" nausea medication as well as a scheduled order for albuterol (nebulizer). Regarding the 10/23/23 allegation, Ms. Tanner confirmed that the medication was available and, in the building, but that it was not administered. Ms. Tanner reported that this was the result of a clerical issue, and that Employee 1 inadvertently discontinued the medication in Resident A's electronic medication administration record (eMAR).

Ms. Tanner reported that facility staff administered Resident A's albuterol as ordered by hospice. Ms. Tanner reported that Relative A had an issue with the hospice order and wanted it changed. Ms. Tanner could not recall the exact nature of Relative A's concern; however Ms. Tanner was adamant that staff adhered to the orders that they were given, and Relative A took up her issue with hospice.

Hospice orders were obtained for Resident A's ondansetron. The order read "give one tablet PO every 6 hours as needed for nausea and vomiting". I reviewed Resident A's MAR for ondansetron in October 2023. Staff did not initial that the medication was given to Resident A at all during the month.

Hospice orders were obtained for Resident A's albuterol. I observed an order dated 10/17/23 that read "every 4 hours As Needed for Congestion". A second order dated 10/23/23 read "inhale one ampule via nebulizer every 4 hours around the clock for 7 days".

I reviewed Resident A's MAR for albuterol in October 2023. I observed two albuterol orders, one scheduled every four hours with a start date of 10/28/23 and a PRN order with a start date of 10/18/23. The MAR was void of the seven-day order dated

10/23/23 and facility staff could not demonstrate that the medication was given as instructed for that order.

Facility staff did document that they administered scheduled albuterol to Resident A from 10/28/23-10/31/23, but MAR instruction for that order was not followed (the MAR read to be administered every four hours). For example, three doses were administered to Resident A instead of six on 10/29/23, four doses were administered instead of six on 10/30/23 and five doses were administered instead of six on 10/31/23. Staff did not provide documentation to justify the missed doses.

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:	Physician's orders were not followed for albuterol during October 2023. Additionally, Resident A experienced severe nausea and vomiting and staff failed to administer her PRN ondansetron. Staff reportedly discontinued the medication without orders to do so.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

11/15/2023

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

11/17/2023

Andrea Moore Date
Area Manager