GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 17, 2023

Kory Feetham
Reed City Fields Assisted Living II
22109 Professional Dr.
Reed City, MI 49677

RE: License #: AL670384778
Investigation #: 2023A0360032
Reed City Fields Assisted Living II

Dear Mr. Feetham:

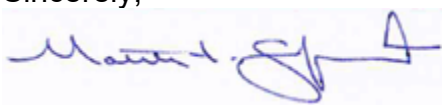
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (866) 865-0006.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL670384778
Investigation #:	2023A0360032
Complaint Receipt Date:	09/25/2023
Investigation Initiation Date:	09/25/2023
Report Due Date:	11/24/2023
Licensee Name:	Reed City Fields Assisted Living II
Licensee Address:	22109 Professional Dr., Reed City, MI 49677
Licensee Telephone #:	(231) 465-4371
Administrator:	Kory Feetham
Licensee Designee:	Kory Feetham
Name of Facility:	Reed City Fields Assisted Living II
Facility Address:	22109 Professional Dr., Reed City, MI 49677
Facility Telephone #:	(231) 465-4371
Original Issuance Date:	10/13/2017
License Status:	REGULAR
Effective Date:	04/13/2022
Expiration Date:	04/12/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident B was given the wrong medication.	Yes
Direct care staff Walther Harrington stole resident medication.	Yes

III. METHODOLOGY

09/25/2023	Special Investigation Intake 2023A0360032
09/25/2023	Special Investigation Initiated - Telephone Administrator Kristina Holmes
09/26/2023	Inspection Completed On-site Administrator Kristina Holmes, Supervisor Latasha Eltan, DCS Kami Wyman, Resident B, AG Special Agent Mark Lewandowsky
10/09/2023	Contact - Document Received Jeff Lenneman Attorney General's Office Health Care Fraud Division
11/13/2023	Contact - Telephone call made Jeff Lenneman
11/16/2023	Contact - Telephone call made DCS Danielle Gillman
11/16/2023	Contact - Telephone call made DCS Kaleb Brooks
11/16/2023	APS Referral online
11/17/2023	Exit Conference With licensee designee Kory Feetham

ALLEGATION: Resident B was given the wrong medication.

INVESTIGATION: On 9/25/2023 I was assigned a complaint from the LARA online complaint system.

On 9/25/2023 I received a phone call from the home supervisor Kristina Holmes. Ms. Holmes stated on 9/22/2023 direct care staff Walter Herrington attempted to steal a

deceased resident's medication. She stated that after they discovered the attempted theft, they did a medication review of all the residents at the facility and found that Mr. Herrington had administered the wrong medication to Resident B. I told Ms. Holmes that I would conduct an onsite inspection at the facility tomorrow.

On 9/26/2023 I conducted an onsite inspection at the facility. Ms. Holmes stated that the Michigan Attorney's Generals Office Health Care Fraud Division had arrived at the facility this morning investigating a complaint. Special agent Mark Lewandowsky stated they had received a complaint a year and a half ago about conditions in the facility, residents not being bathed and not getting proper food. I informed Mr. Lewandowsky that I had conducted several investigations over the past year and half with similar allegations and did not find any concerns. I informed Mr. Lewandowsky about the current complaint, and he sat in on the interview with Ms. Holmes. Ms. Holmes stated once she was contacted by staff about the alleged theft of medications by Mr. Herrington, they did a medication review of all the residents and discovered that on 9/22/2023 he administered the medication Humalog instead of Tresiba which was prescribed for Resident B. Ms. Holmes provided me with a written corrective action plan documenting that Mr. Herrington was suspended due to administering the wrong medication. She also provided Resident B's medication administration record which documented Resident B was prescribed Tresiba 100 unit injection which was not available in the facility and that Mr. Herrington administered Humalog in place of the Tresiba and documented that the Tresiba was administered.

On 9/26/2023 I interviewed the medication supervisor Kami Wyma. Ms. Wyma stated that on 9/23/2023 Mr. Herrington reported for work at 7 a.m. and at 9 a.m. she interviewed him regarding the medication error. She stated Mr. Herrington admitted to administering Humalog in place of Tresiba for Resident B. Ms. Wyma stated there were not adverse side effects from the wrong medication being administered. She stated the facility was able to fill the prescription for Tresiba on 9/24/2023 and Resident B has received her recommended doses.

While at the facility on 9/26/2023 I attempted an interview with Resident B. Resident B was not oriented to time, date, or place.

On 10/09/2023 I was contacted by Jeff Lenneman, special agent with the Attorney General's Health Care Fraud Division. Mr. Lenneman stated he would be opening a full criminal investigation into the alleged medication theft by Mr. Herrington and requested that I not contact Mr. Herrington prior to his interview with him.

On 11/13/2023 I contacted Mr. Lenneman who stated he had not yet interviewed Mr. Herrington and had an in-person interview scheduled for 11/21/2023.

APPLICABLE RULE	
R 400.15312	**Resident medications.**

	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The complaint alleged Resident B was given the wrong medication. The home supervisor Kristina Holmes and medication supervisor Kami Wyma both stated Resident B was administered prescription medication Humalog instead of Tresiba by direct care staff Walter Herrington on 9/22/2023 which she was prescribed. Ms. Wyma stated Mr. Herrington admitted to giving the wrong medication. Mr. Herrington was suspended on 9/23/2023. There is a preponderance of evidence that Resident B was not given the correct prescription medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff Walter Herrington stole resident medication.

INVESTIGATION: On 9/26/20023 I conducted an onsite inspection at the facility. Special agent Mark Lewandowsky sat in on the interview with Ms. Holmes. Ms. Holmes stated they have video surveillance of Mr. Herrington dropping Resident A's prescription Lorazepam in the hallway just before the end of his shift on 9/22/2023. She stated Resident A died on 9/8/2023 and Mr. Herrington had documented that he destroyed Resident A's medications on 9/8/2023. She stated another direct care staff Kaleb Brooks and Danielle Gillman picked up the medication from the hallway and contacted the supervisor, Kami Wyma. She stated she requested all three staff to take a drug test and Mr. Herrington tested positive for several drugs. She stated Mr. Herrington has been suspended. Ms. Holmes then showed me video surveillance of 9/22/2023 at 8:45 p.m. In the video the direct care staff identified by Ms. Holmes as Walter Herrington goes into the medication room and when he comes out at 8:48 p.m. a small packet falls out of his pocket when he reaches for his cell phone. At 8:50 p.m. another direct care staff identified by Ms. Holmes as Kaleb Brooks picks up the medication. Ms. Holmes stated on 9/23/2023 Mr. Herrington refused to answer any questions about the medication he dropped in the hallway. Ms. Holmes stated he refused to sign the written suspension and walked out of the facility. She stated she then contacted the police and made contact with Osceola County Sheriff Deputy Andrew Salinas. Ms. Holmes provided me a copy of Mr. Herrington's positive drug test and a picture of Resident A's prescription Lorazepam which was a packet of three pills each individually wrapped, and one was missing. Ms. Holmes also provided me with a written incident report. The incident report was written by direct care staff Kaleb Brooks. It was dated 9/22/2023 at 9 p.m. and stated, "I was walking near the water fountains in the front rooms when I seen a small ziplock bag with a

med label. Upon inspection I realized it was a controlled med from a deceased resident (Resident A) for Lorazepam." Under actions taken it stated, "This was brought to my supervisor's attention who then got med coordinator/upper management involved." Ms. Holmes also provided me with a copy of the written corrective action for Mr. Herrington dated 9/22/2023 which stated, "At 9 p.m. on 9/22/2023 a pack of hospice Lorazepam was found on the facility floor, after review the medication appears to have fallen out of your scrub pockets."

While at the facility on 9/26/2023 I interviewed the medication supervisor Kami Wyma. Ms. Wyma stated she was notified on 9/22/2023 that Resident A's prescription Lorazepam was found in the hallway by direct care staff Kaleb Brooks. Ms. Wyma stated on 9/23/2023 she interviewed Mr. Herrington and he refused to answer any questions regarding the Lorazepam. She stated Mr. Brooks reported to her that he found the Lorazepam packet on the floor in the hallway which she observed on the surveillance cameras.

On 10/09/2023 I was contacted by Jeff Lenneman, special agent with the Attorney General's Health Care Fraud Division. Mr. Lenneman stated he would be opening a full criminal investigation into the alleged medication theft by Mr. Herrington and requested that I not contact Mr. Herrington prior to his interview with him.

On 11/13/2023 I contacted Mr. Lenneman who stated he had not yet interviewed Mr. Herrington and had an in-person interview scheduled for 11/21/2023. He stated it would be fine to contact Mr. Brooks and Ms. Gillman but he asked that I hold off on contacting Mr. Herrington until he interviewed him. He stated regardless of the interview with Mr. Herrington he would be pursuing criminal charges against him based on the evidence gathered so far.

On 11/16/2023 I contacted direct care staff Danielle Gillman. Ms. Gillman stated at about 9 p.m. on 9/22/2023 her co-worker Kaleb Brooks told her that he had found a packet of Lorazepam from deceased Resident A in the hallway, and they suspected that Walter Herrington had dropped it. She stated Mr. Herrington was getting off shift a few minutes later and they waited for him to leave and then contacted their supervisor who handled the matter.

On 11/16/2023 I contacted Kaleb Brooks and left a message for him.

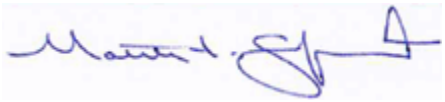
APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	The complaint alleged direct care staff Walter Herrington stole resident medications.

	The home supervisor Kristina Holmes provided surveillance video showing Mr. Herrington dropping Resident A's prescription medication in the hallway of the facility out of his pocket just before the end of his shift. She also provided a positive drug screen and a written corrective action for Mr. Herrington suspending him for stealing medication. She also provided a written incident report written by direct care staff Kaleb Brooks who found the medication. Michigan Attorney General special agent Jeff Lenneman stated he would be pursing criminal charges against Mr. Herrington. There is a preponderance of evidence that prescription medication was used by a person other than the resident for the medication was prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/17/2023 I conducted an exit conference with licensee designee Kory Feetham. Mr. Feetham concurred with the findings of the investigation and stated he would submit a corrective action plan for approval.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in status of the license.



11/17/2023

Matthew Soderquist — Date
Licensing Consultant

Approved By:

11/17/2023

Jerry Hendrick — Date
Area Manager