GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 29, 2023

Jennifer Hescott
Provision Living at Canton
49825 Ford Road
Canton, MI 48187

RE: License #: AH820412296
Investigation #: 2023A0784095
Provision Living at Canton

Dear Jennifer Hescott:

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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820412296
Investigation #:	2023A0784095
Complaint Receipt Date:	09/21/2023
Investigation Initiation Date:	09/25/2023
Report Due Date:	11/20/2023
Licensee Name:	AEG Canton Opco LLC
Licensee Address:	9450 Manchester Rd. Ste 207 St. Louis, MO 63119
Licensee Telephone #:	(314) 272-4980
Administrator:	Jami McDaniel
Authorized Representative:	Jennifer Hescott
Name of Facility:	Provision Living at Canton
Facility Address:	49825 Ford Road Canton, MI 48187
Facility Telephone #:	(734) 589-0380
Original Issuance Date:	07/17/2023
License Status:	TEMPORARY
Effective Date:	07/17/2023
Expiration Date:	01/16/2024
Capacity:	95
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Misadministration of Resident A's medication and lack of adequate action taken to protect Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/21/2023	Special Investigation Intake 2023A0784095
09/25/2023	Special Investigation Initiated - Telephone Interview with Complainant
09/25/2023	Contact - Telephone call made Interview with administrator Jami McDaniel
09/25/2023	Contact - Document Sent Special Investigation Document/Info Request sent via email to Ms McDaniel
10/03/2023	Contact - Document Received Documents received from Complainant via email
11/29/2023	Exit - Email Report sent

ALLEGATION:

Misadministration of Resident A's medication and lack of adequate action taken to protect Resident A.

INVESTIGATION:

On 9/21/2023, the department received this complaint.

According to the complaint, on 6/17/2023, Resident A was administered a double dose of Propafenone, one at 6am and the second at 8:30am after which Resident A spent the day in the emergency room (ER) under observation. On 6/19/2023, a meeting was held with the facilities administrative management staff (AMS), which included Associate 1, Associate 2 and regional clinical director (RCD) Katie Johnson, with Relative A1 an A2, to discuss the medication errors (med errors).

Relatives A1 and A2 notified AMS on 6/22/2023, via email, of additional med errors noticed in review of Resident A's medication administration record (MAR) which included the following; April, 2023, Resident A received Metoprolol 13 times when it should have been held; May, 2023, Resident A received Metoprolol 17 times when it should have been held: 6/01/2023 through 6/19/2023, Resident A received Metoprolol 7 times when it should have been held. After the meeting on 6/22/2023 the med errors continued including the following: 6/22/2023 through 6/26/2023, Resident A received Metoprolol 3 times when it should have been held; 7/26/2023 through 8/07/2023, Resident A received Metoprolol 4 times when it should have been held. Regarding the med error on 7/26/2023, Resident A was administered Metoprolol at 8pm and should not have received it as her heart rate was at 48 beats per minute (BPM). Resident A fell within an hour of this med error and looked like she had passed out and "face planted on the floor" and was taken to the hospital experiencing AFIB [Atrial Fibrillation – An irregular and often very rapid heart rhythm] where she spent four days and subsequently spent 28 days a skilled nursing home.

On 9/25/2023, I interviewed Complainant by telephone. Complainant stated Resident A is no longer at the facility as she passed away on 9/09/2023. Complainant stated that after Resident A's fall on 7/26/2023, believed to be related to misadministration of Metoprolol, Resident A never fully recovered continued to decline in her health and passed away. Complainant stated that the double dose of Propafenone on 6/17/2023 was the result of staff not administering the medication timely in the first place leading to a change in the administration timing and miscommunication about regarding the time change scheduled for the med-administration. Complainant explained that Resident A's Propafenone medication was ordered to be taken three times a day at 6am, 2pm and 10pm. Complainant stated staff could never seem to get Resident A her 6 am dose on time and would often administer it at between 10am and 11am, too close to the time of the second administration at 2pm. Complainant stated that after pointing out the misadministration on several occasions and having to constantly address the issue with the facility, the order for the 6am dose was changed to 8am. Complainant stated that after investigating the error of the double dose of medication on 6/17/2023, it was discovered that the original order, for the 6am administration, was never taken out of the system so staff administered the 6am dose and another dose at 8:30am. Complainant stated the multiple issues with Resident A's Metoprolol medication were due to staff not following appropriate protocol for the administration of this medication. Complainant stated that staff were supposed to take Resident A's vitals before administration of the Metoprolol and that if her systolic blood pressure was under 100 and/or her heart rate was under 60, the medication was not supposed to be given. Complainant stated that on each occasion noted in the complaint, Resident A's vitals were outside of the appropriate range for administration.

On 9/25/2023, I interviewed administrator Jami McDaniel by telephone. Ms. McDaniel stated she was familiar with Resident A and the concerns raised regarding her medication errors. Ms. McDaniel stated she was not working in the facility until

sometime in August 2023 and was not directly involved with those circumstances. Ms. McDaniel stated Associate 1 and Associate 2 no longer work with the facility. I discussed required information/documentation needed for the investigation and Ms. McDaniel agreed to provide what was requested for review.

I reviewed Resident A's *Physician Order Report*, provided by Ms. McDaniel. According to the report, Resident A was prescribed "metoprolol tartrate tablet; 25 mg; Oral", with "Special Instructions" which read "TAKE ONE TABLET BY MOUTH TWICE DAILY, HOLD IF SYSTOLIC PRESSURE IS LESS THAN 100 AND IF PULSE IS LESS THAN 60 Twice a day; 8:00 AM, 8:00 PM". The report also indicated Resident A was prescribed "propafenone tablet; 150 mg; oral", with "special instructions" to "TAKE ONE TABLET BY MOUTH EVERY EIGHT HOURS; 6:00am, 2:00pm, 10:00pm".

I reviewed medication administration records (MARs) for Resident A for April, May, June and July 2023, provided by Complainant. The records read consistently with the complaint allegations and additional statements provided by Complainant regarding misadministration of Resident A's medications. Ms. McDaniel also provided a copy of Resident A's MARs for the same date periods which read consistently with the MARs provided by Complainant.

I reviewed a copy of an email dated 6/22/2023 addressed to Associates 1, 2 and 3, provided by Complainant. The context of the email indicated the Complainant was following up regarding an in-person meeting had with Associates 1, 2 and 3 on 6/22/2023 and provided a summary of the discussion which included a breakdown of medication errors in April, May, and June 2023.

On 9/28/2023, Ms. McDaniel provided a typed statement with Associate 3's name indicated as the statement provider. The statement read:

"Summary of Corrective Measures regarding Medication Errors: Resident A Medication Errors:

Corrective Measures were taken at the time the errors occurred regarding education about proper medication administration-the 6 rights of medication administration. This education was provided by the previous DON, but this written documentation cannot be located at this time.

There will be ongoing education regarding proper medication administration which involves education from our pharmacy nurse who provides medication technician certification classes as well as clinical management in the community providing continued education and oversight regarding proper medication administration and medication safety."

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
R 325.1932	**Resident's 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 complaint alleged that on multiple dates between April and July of 2023, staff did not appropriately follow instructions for Resident A's Metoprolol, on multiple dates, and her Propafenone medication, on at least two dates. Review of Resident A's MARs for the referenced date periods confirmed staff continually administered Resident A's medications outside of the clear instructions provided within the physician's orders. Additionally, while Associate 3 provided a statement that corrective measures were taken at the time of the errors in order to address the issue, given that the mis-administrations continued, even after an in-person meeting identifying the extent of the issue, it is clear the actions taken were not sufficient for correction leaving Resident A vulnerable to potential harm. Resident A ultimately had a fall, on 7/26/2023, after a misadministration of medication and subsequently declined in her health and was placed on hospice on 8/06/2023. Based on the findings, the facility is not in compliance with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

Review of Resident A's MARs revealed several dates, 4/23/2023, 4/26/2023, 4/30/2023 and 5/06/2023, which did not include staff initials for the 8pm does of Resident A's Metoprolol, to indicate if Resident A's medication had been administered or not.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.** **professional if a resident repeatedly refuses prescribed medication or treatment. The home shall follow and record the instructions given.**
ANALYSIS:	Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

10/27/2023

Aaron Clum — Date
Licensing Staff

Approved By:

11/29/2023

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