GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 3, 2023

Robert Norcross
Medilodge of Grand Rapids
2000 Leonard Street
Grand Rapids, MI 49505

RE: License #: AH410413805
Investigation #: 2023A1010089
Medilodge of Grand Rapids

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 (616) 356-0183.

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 #:	AH410413805
Investigation #:	2023A1010089
Complaint Receipt Date:	09/21/2023
Investigation Initiation Date:	09/22/2023
Report Due Date:	11/21/2023
Licensee Name:	Grand Rapids Opco, LLC
Licensee Address:	2000 Leonard St. NE Grand Rapids, MI 49505
Licensee Telephone #:	(618) 458-1133
Administrator:	Samantha Rorie
Authorized Representative:	Robert Norcross
Name of Facility:	Medilodge of Grand Rapids
Facility Address:	2000 Leonard Street Grand Rapids, MI 49505
Facility Telephone #:	(616) 458-1133
Original Issuance Date:	09/01/2022
License Status:	REGULAR
Effective Date:	02/28/2023
Expiration Date:	02/28/2024
Capacity:	103
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents have not been getting their prescribed medications.	No
Residents are served meals that are cold and late.	Yes

III. METHODOLOGY

09/21/2023	Special Investigation Intake 2023A1010089
09/22/2023	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
09/22/2023	APS Referral APS referral emailed to Centralized Intake
09/27/2023	Contact - Telephone call made Interviewed the complainant by telephone
09/27/2023	Inspection Completed On-site
09/27/2023	Contact - Document Received Menu, staff schedule, and resident MAR received
01/03/2024	Exit Conference

ALLEGATION:

Residents have not been getting their prescribed medications.

INVESTIGATION:

On 9/21/23, the Bureau received the allegations from the online complaint system. The complaint read, “Residents have not been getting medication.”

On 9/22/23, I emailed an Adult Protective Services (APS) complaint to Centralized Intake.

On 9/27/23, I interviewed the complainant by telephone. The complainant reported approximately three or four weeks ago, Resident A did not receive her prescribed medications. The complainant was unable to provide the names of any other

residents who did not receive their prescribed medications. The complainant reported she worked at the facility for approximately one year and “quit.”

On 9/27/23, I interviewed the facility’s clinical care coordinator Jessica Andrews at the facility. Ms. Andrews stated she received an email notification from Relative A1 on 9/5/23, regarding Resident A’s medications being administered late. Ms. Andrews explained the reason Resident A’s medications were administered late on 9/5/23, was because the medication technician (med tech) who was scheduled on Resident A's hall did not call in or show up for her shift. Ms. Andrews reported med tech coverage for the shift was found, however some resident medications were administered later than their usual time as a result.

Ms. Andrews said Resident A’s medications were administered as prescribed. Ms. Andrews provided me with a copy of Resident A’s September medication administration record (MAR) for my review. The MAR read Resident A’s medications were administered as prescribed. I observed some of Resident A’s medications were prescribed to be administered “at bedtime,” however no specific time for administration was outlined.

Ms. Andrews provided me with a copy of the September staff schedule for my review. I observed there were three med techs scheduled in the facility on first shift on 9/5/23.

On 9/27/23, I interviewed Staff Person 1 (SP1) at the facility. SP1 reported Resident A’s medications were administered as prescribed. SP1’s statements regarding incidents of resident medications being administered “later than usual” to accommodate a staff “no call, no show” were consistent with Ms. Andrews. SP1 stated resident medications are never intentionally not administered. SP1 said resident medications are administered as prescribed.

On 9/27/23, I interviewed SP2 at the facility. SP2’s statements were consistent with SP1. SP2 said there are also incidents when Resident A “wants her medications when she wants them.” SP2 clarified there are times when Resident A won’t take her medications when staff initially attempt to administer them. SP2 said as a result, staff have to return and re-approach Resident A.

On 9/27/23, I interviewed Relative A1 at the facility. Relative A1 reported there was not a med tech in the facility on 9/5/23. Relative A1 stated a staff person did eventually arrive to administer resident medications. Relative A1 stated Resident A’s medications were administered “late” on 9/5/23, however she did receive them.

On 9/27/23, I attempted to interview Resident A at the facility. I was unable to engage Resident A in meaningful conversation due to her hearing loss.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	The interviews with Ms. Andrews, SP1, SP2, Relative A1, along with review of Resident A's September MAR and staff schedule revealed there were med techs in the facility during first shift on 9/5/23. Resident A's September MAR read her medications were administered as prescribed. There is insufficient evidence to suggest the facility was out of compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are served meals that are cold and late.

INVESTIGATION:

On 9/21/23, the complaint read, "Residents been getting late and cold food."

On 9/27/23, the complainant reported breakfast at the facility was often not served until 9:30 am or 10:00 am each day. The complainant stated the food that was delivered to residents in their rooms was often left sitting for long periods of time and was cold by the time the residents got it.

On 9/27/23, I interviewed the facility's dietary director Sherry Cremona at the facility. Ms. Cremona reported there are several residents in the facility who receive meals delivered to their room, rather than eating in the facility's dining room. Ms. Cremona reported the meals are covered; however, they are transported in an open cart. Ms. Cremona said the facility does not have heated carts to transport the meals to resident rooms.

Ms. Cremona reported there have been issues getting resident meals to their rooms while their food is still hot. Ms. Cremona stated she has observed the carts holding resident meals in the resident hallways for long periods of time. Ms. Cremona reported she observed a cart with resident meals sitting in a resident hallway for 20 minutes. Ms. Cremona said she has also received complaints from residents regarding their meals being cold.

Ms. Cremona stated resident hot meals are plated at the required temperature of 140 degrees or more Fahrenheit, however they lose temperature after being

transported and sitting in resident hallways because the hot meals are not transported in a heated cart. Ms. Cremona said residents eating in the dining room are served first to ensure their hot meals are served timely and still hot.

I observed kitchen staff preparing resident meals that were being delivered to resident rooms. I observed the hamburger patties were 178.4 degrees Fahrenheit and the mashed potatoes were at 159 degrees Fahrenheit when plated. I observed the plates were covered and placed on an open cart for delivery to resident rooms. I observed covered meals sitting on an open cart for several minutes while the remaining meals were being loaded.

On 9/27/23, SP2's statements were consistent with Ms. Cremona. SP2 stated there have been some instances when lunch was not delivered to resident rooms until 2:00 pm. SP2 reported there are microwaves on each resident unit in the facility, however residents have complained that the food is no longer good after it sat cold for a long period of time.

On 9/27/23, I interviewed SP3 at the facility. SP3's statements were consistent with SP1 and SP2.

On 9/27/23, Relative A1 reported she was present several times when Resident A received a meal that was cold by the time it arrived. Relative A1 stated Resident A has informed her this occurs often. Relative A1 said she often brings meals in for Resident A as a result. I observed Relative A1 brought a meal in that Resident A was eating for lunch.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(5) A home shall prepare and serve meals in an appetizing manner.
ANALYSIS:	The interviews with Ms. Cremona, SP2, SP3, Relative A1, along with my observations during the lunch meal on 9/27/23 revealed meals are delivered to resident room on unheated, open carts. Staff reported there have been numerous incidents in which the open carts sat in the resident hallways for long periods of time causing the meals to lose temperature. Staff reported receiving multiple complaint from residents regarding the cold meals. The meals were not served in an appetizing manner; therefore the facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Robert Norcross by telephone on 1/3/24.

IV. RECOMMENDATION

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

10/24/2023

Lauren Wohlfert — Date
Licensing Staff

Approved By:

01/03/2024

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