GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 20, 2024

Achal Patel
DeWitt MI Opco, L.L.C.
3520 Davenport Ave.
Saginaw, MI 48602

RE: License #: AL190404601
Investigation #: 2024A1033019
Serene Gardens of DeWitt 3

Dear Mr. Patel:

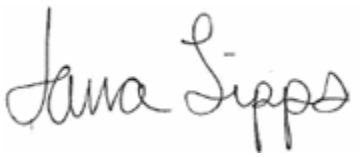
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL190404601
Investigation #:	2024A1033019
Complaint Receipt Date:	12/26/2023
Investigation Initiation Date:	01/02/2024
Report Due Date:	02/24/2024
Licensee Name:	DeWitt MI Opco, L.L.C.
Licensee Address:	3520 Davenport Ave. Saginaw, MI 48602
Licensee Telephone #:	(517) 484-6980
Administrator:	Achal Patel
Licensee Designee:	Achal Patel
Name of Facility:	Serene Gardens of DeWitt 3
Facility Address:	1177 W. Solon Rd, Ste 3 DeWitt, MI 48820
Facility Telephone #:	(517) 484-6980
Original Issuance Date:	11/02/2020
License Status:	REGULAR
Effective Date:	05/02/2023
Expiration Date:	05/01/2025
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's opioid medication was missing and unaccounted for from the facility, therefore direct care staff could not administer the medication as prescribed.	Yes

III. METHODOLOGY

12/26/2023	Special Investigation Intake 2024A1033019
01/02/2024	Special Investigation Initiated - On Site Interview with Vivek Thakore, Kerri Wheeler, Kortney Hamill, direct care staff, Cheyanne Rodriguez, review of Resident A & Resident B's Medication Administration Records. Review of narcotics count for Resident A & Resident B.
01/31/2024	Contact - Telephone call made Interview with PACE, Nursing Supervisor Clinical Coordinator, Sophia Guzman, via telephone.
01/31/2024	APS Referral- Referral made.
02/20/24	Exit Conference Conducted via telephone voicemail message and email with licensee designee, Achal Patel.

ALLEGATION: Resident A's opioid medication was missing and unaccounted for from the facility, therefore direct care staff could not administer the medication as prescribed.

INVESTIGATION:

On 12/26/23 I received an online complaint regarding Serene Gardens of DeWitt 3 adult foster care facility (the facility). The complaint alleged that Resident A's opioid medication was missing from the facility and unaccounted for and may have potentially been stolen. On 1/2/24 I completed an unannounced, on-site investigation at the facility. I interviewed direct care staff/Director of Nursing, Kortney Hamill. Ms. Hamill reported the facility recently changed ownership/management on 12/22/23. She reported that this was the closing date for the sale of the facility. Ms. Hamill

reported that she had been in the facility on 12/21/23 and observed direct care staff/Resident Care Manager, Aimee Nelson (who worked under the previous ownership) in her daily activities as she was learning the resident care needs and the daily operations of the facility. She reported that the campus houses three 20 bed adult foster care facilities. Ms. Hamill reported that she was job shadowing Ms. Nelson as she walked between the three buildings to have direct care staff sign off on the narcotics count report for each facility. Ms. Hamill reported that the narcotics count for each facility was on a piece of paper that the direct care staff would initial. She reported Ms. Nelson had direct care staff sign these sheets, but she did not observe direct care staff had completed the narcotics counts themselves. Ms. Hamill reported that on 12/21/23 direct care staff, Cheyanne Rodriguez, reported to Ms. Hamill that Resident A's Norco medication was missing. Ms. Hamill reported that she had instructed Ms. Rodriguez to report the missing Norco to Ms. Nelson, as she was just an observer on 12/21/23. Ms. Hamill reported that when she arrived at the facility on 12/22/23, Ms. Rodriguez, again, reminded her that Resident A's Norco was missing from the medication cart. Ms. Hamill reported that she then checked the medication cart for Resident A and the Norco medication was not in the cart. Ms. Hamill reported that on 12/22/23 Ms. Nelson was no longer employed at the facility, due to the change in ownership/management and was not available to discuss the missing Norco medication. Ms. Hamill reported that the PACE (Program of All-Inclusive Care for the Elderly) staff were notified of Resident A's missing Norco because they prescribe the medication for Resident A. Ms. Hamill reported that the nurse practitioner through PACE ordered Resident A a small script of Norco to get her through the rest of the month. Ms. Hamill reported she looked through the facility files for the narcotics count sheets that Ms. Nelson had been completing on 12/21/23 and she could not locate where these sheets were placed. She reported that it appeared the narcotics count sheets had been removed from the facility, but she had no evidence of where they were or who may have taken them. Ms. Hamill reported that going forward the facility has instituted use of the electronic tracking record for narcotics medications. She reported that now narcotics counts are done via computer and there is no paper copy to lose. She reported that each shift must sign with two direct care staff verifying the correct count to proceed in the computerized system. Ms. Hamill reported that if an incorrect number is entered for the narcotics count then the system will provide an error message and will not allow the employees to move forward without resolving the issue.

During the on-site investigation on 1/2/24 I interviewed new owner, Vivek Thakore. Mr. Thakore reported that Ms. Nelson is no longer employed at the facility. He reported that the change in ownership occurred and was effective on 12/22/23. Mr. Thakore reported that on 12/22/23 he and the direct care staff were made aware of Resident A's missing Norco prescription from the medication cart. He reported that on 12/22/23 Ms. Rodriguez reported to Ms. Hamill that the Norco medicaiton for Resident A was gone and not in the medication cart where it should be kept. Mr. Thakore reported that the PACE program staff were called to discuss the issue. Mr. Thakore reported that PACE representative, Sophia Guzman, made a visit to the facility. He reported that she asked about the missing narcotics and noted she was

going to call Ms. Nelson and the police to report the narcotics as potentially stolen. Mr. Thakore reported that he has not heard back from Ms. Guzman.

During on-site investigation on 1/2/24 I interviewed Ms. Rodriguez. Ms. Rodriguez reported that Resident A received a shipment of 84 Norco tablets around 11/28/23 (she could not recall the exact date), as she counted the medication into the system herself. She reported that she noticed on 12/19/23 that the Norco tablets for Resident A were not in the medication cart and appeared to be missing. Ms. Rodriguez stated she reported the missing Norco to Ms. Nelson (date unknown) and Ms. Nelson advised her to contact the PACE program and report the issue. Ms. Rodriguez reported that she did call PACE, but she could not recall who she spoke with regarding the issue. Ms. Rodriguez reported that Ms. Guzman with the PACE program made a visit to the facility and she spoke with her about the missing Norco. Ms. Rodriguez reported that there were at least two "cards" of Norco missing. The Norco was delivered in prepackaged cards. She reported that the missing cards could not be located, and neither could the narcotics sign off sheets for Resident A. Ms. Rodriguez reported that prior to 12/22/23 the process for counting narcotics happened between direct care staff members upon shift change. She reported that there were narcotics sheets (kept on paper copies) that the direct care staff would sign off on that they counted the resident narcotics prior to their shift. She reported that there were times when the narcotics count did not match what was listed on the narcotics sign off sheet and Ms. Nelson would have direct care staff members sign off that they administered a medication to make the narcotics count look correct. Ms. Rodriguez reported that with the new management the direct care staff must use the computerized *Medication Administration Record* (MAR) for each resident and this requires that the direct care staff members must enter the correct narcotics numbers for each resident into the computer upon starting their shift. She reported that the incoming staff will work with the exiting staff to count the narcotics and enter the correct number into the system and if the count is off then the computerized system triggers and error and will not allow the direct care staff to administer medications until the error is resolved. Ms. Rodriguez reported that this system appears to be working better and more accountable than the previous system.

During on-site investigation on 1/2/24 I reviewed the following document with the following observations:

- Resident A's MAR for the month of December 2023. Resident A is prescribed Hydroco/APAP (Norco) Tab 5-325MG, take one tablet by mouth three times daily. This medication was marked administered by direct care staff 12/1/23 through 12/19/23 at 2pm, and 12/23/23 through 12/31/23. The medication is marked as not administered from 12/19/23 at 8pm through 12/22/23 at 8pm. It was also marked as not administered on 12/1/23 at 2pm, 12/12/23 at 2pm, and 12/26/23 at 2pm. The reasons noted on the MAR for the Norco medication not being administered as prescribed are as follows:
    - 12/1/23 2pm: "out of facility"
    - 12/12/23 2pm: "out of facility"
    - 12/19/23 – 12/20/23: "awaiting med arrival from pharmacy"

- 12/21/23 8am: “withheld per DR/RN orders”
- 12/21/23 2pm – 12/22/23 2pm: “awaiting med arrival from pharmacy”
- 12/22/23 8pm: “Med not available”
- 12/26/23 2pm: “withheld per DR/RN orders”

Also, during on-site investigation, I reviewed the electronic MAR system and observed how the direct care staff count narcotics each shift for residents who are prescribed narcotics. I also counted the narcotics on hand for Resident A and Resident B to ensure the count matched the system. The narcotics counts for Resident A and Resident B matched the electronic system.

On 1/31/24 I interviewed PACE program, Nursing Supervisor Clinical Coordinator, Sophia Guzman. Ms. Guzman reported that the direct care staff at the facility had reported to her that Resident A had multiple Norco tablets missing and there had been statements that it was believed to be stolen. Ms. Guzman reported that there were no individuals identified as the alleged perpetrator. Ms. Guzman reported that on this occasion there were about 40 – 50 Norco tablets prescribed to Resident A that had come up as “missing”. Ms. Guzman reported that this is not the first instance her staff have come across medications that have come up as “missing” at the facility. Ms. Guzman reported that she attempted to speak with the previous management of the facility, Kelly McCann & Ms. Nelson, and neither would talk with her about the investigation into the missing Norco or provide any documentation to assist with the investigation. Ms. Guzman reported that Ms. Nelson stated that the facility had filed its own internal investigation into the missing Norco and Ms. Guzman did not need to be involved. Ms. Guzman reported that the direct care staff working with the new management/ownership of the facility have been working with her on this investigation and noted that when they assumed control of the facility the documentation for narcotics counts was missing and so were the Norco tablets for Resident A. Ms. Guzman reported she expressed to the new management that a referral to law enforcement should be made. Ms. Guzman reported that she did not make a referral to law enforcement as the new management team has addressed the issue with medication mismanagement and they have not experienced any further issues regarding missing medications.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based upon interviews with Mr. Thakore, Ms. Hamill, Ms. Rodriguez, & Ms. Guzman, as well as review of Resident A's MAR for the month of December 2023, it can be determined that Resident A was not administered her Norco mediation as prescribed by her provider on the dates 12/19/23 through 12/22/23. Each individual interviewed confirmed that Resident A's medication was missing from the medication cart and the whereabouts of the medication was not able to be explained. The direct care staff were not able to administer the medication due to the medication not being available to administer.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based upon interviews with Mr. Thakore, Ms. Hamill, Ms. Rodriguez, & Ms. Guzman, as well as review of Resident A's MAR for the month of December 2023, it can be determined that there is not adequate evidence to suggest that a direct care staff member had taken/stolen the missing Norco medication from the medication cart. The medication was identified as being "missing" but there were no witnesses to report who would have stolen the medication. The prior management at the facility was maintaining paper copies of narcotics counts for each resident and these paper copies were not available for review at the time of the on-site investigation. Although it cannot be determined what happened to the Norco medication, it is clear the licensee did not assure there was a system in place to secure the medication, so others did not have access to use or take this medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

02/06/24

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Jana Lipps Date
Licensing Consultant

Approved By:

02/20/2024

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Dawn N. Timm Date
Area Manager