GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 27, 2024

Catherine Reese
New Friends Dementia Community, LLC
3700 W Michigan Ave
Kalamazoo, MI 49006

RE: License #: AL390299685
Investigation #: 2024A0581016
Vibrant Life Senior Living Kalamazoo Lodge 1

Dear Catherine Reese:

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390299685
Investigation #:	2024A0581016
Complaint Receipt Date:	01/04/2024
Investigation Initiation Date:	01/05/2024
Report Due Date:	03/04/2024
Licensee Name:	New Friends Dementia Community, LLC
Licensee Address:	3700 W Michigan Ave Kalamazoo, MI 49006
Licensee Telephone #:	(269) 372-6100
Administrator:	Laurel Space
Licensee Designee:	Catherine Reese
Name of Facility:	Vibrant Life Senior Living Kalamazoo Lodge 1
Facility Address:	3700 W. Michigan Ave. Kalamazoo, MI 49006
Facility Telephone #:	(269) 372-6100
Original Issuance Date:	06/21/2011
License Status:	REGULAR
Effective Date:	12/21/2023
Expiration Date:	12/20/2025
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATIONS

	Violation Established?
Resident A was given all his PRN medications.	No
Direct care staff, Cheryl [Unknown], doesn't know how to give medications.	No
Additional Findings	Yes

III. METHODOLOGY

01/04/2024	Special Investigation Intake 2024A0581016
01/05/2024	Special Investigation Initiated - Letter APS referral
01/05/2024	APS Referral Made via email
01/09/2024	Inspection Completed On-site Interviewed Administrator.
01/10/2024	Contact - Document Received Received email from Ms. Space, Administrator.
02/08/2024	Contact - Document Sent Left message with direct care staff, Cheryl Harrison.
02/08/2024	Contact - Telephone call made Interview with direct care staff, Sarah Dunning.
02/08/2024	Contact - Telephone call made Interview with Relative A1.
02/08/2024	Contact - Telephone call made Interview with Centrica personnel
02/08/2024	Contact - Telephone call made Interview with Ms. Space
02/09/2024	Contact - Document Received Email from Ms. Space.
02/20/2024	Inspection Completed-BCAL Sub. Compliance

02/20/2024	Contact – Document sent Email to Ms. Space.
02/21/2024	Contact – Telephone call made Interview with direct care staff, Rachel Ignasiban.
02/21/2024	Contact – Telephone call made Left message with direct care staff, Cheryl Harrison.
02/21/2024	Contact – Telephone call made Left message with Relative A2.
02/22/2024	Contact – Telephone call made Interview with Ms. Harrison.
02/22/2024	Contact – Telephone call made Attempted to contact direct care staff, Alicia Wilson. Unable to leave a message.
02/22/2024	Exit conference with Administrator, Laurel Space, via telephone.

ALLEGATION:

Resident A was given all his PRN medications.

INVESTIGATION: On 01/04/2024, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged “A resident was passing away and the 3rd shift gave him all of their PR and the resident passed away 2-3 days later”. The complaint identified direct care staff, Cheryl [Unknown], as the third shift staff working at the time. No additional information was provided.

On 01/09/2024, I conducted an unannounced inspection at the facility. I interviewed the facility’s Administrator, Laurel Space. Ms. Space identified Resident A as a resident who recently passed away during the time frame alleged in the complaint. She stated Resident A only resided in the facility approximately one month prior to passing away the end of December 2023. She stated towards the end of December, Resident A was in the hospital, where he was placed on hospice prior to returning to the facility. She stated Resident A had only returned to the facility for one day before he was sent back to the Emergency Room (ER) and was subsequently sent to a hospice facility where he passed away. Ms. Space did not know what “PR” meant, but stated if it meant PRN, or as needed medication, then she did not have any

knowledge of Resident A receiving all his PRN medications at once. She also stated she did not have any concerns with Resident A's medications, in general.

On 01/10/2024, I received and reviewed Resident A's November 2023 and December 2023 electronic Medication Administration Records (eMARs). According to my review of Resident A's November eMAR, the only PRN medications he was prescribed were the following:

- Albuterol HFA 90 MCG Inhale, with the instruction of "INHALE 1 PUFF INTO THE LUNGS EVERY 6 HOURS AS NEEDED (WHEEZING).

- Alprazolam 0.5 MG Tablet, with the instruction of "TAKE 1 TABLET BY MOUTH 3 TIMES A DAY AS NEEDED (ANXIETY).

- Melatonin 5 MG SL, with the instruction of "TAKE 1 TABLET BY MOUTH AT BEDTIME AS NEEDED FOR INSOMNIA".

In addition to these PRN medications, Resident A was also prescribed additional PRNs on 12/29/2024 by hospice, which were the following:

- Lorazepam 0.5 MG Tablet, with the instruction of "TAKE 1 TABLET BY MOUTH EVERY 4 HOURS AS NEEDED (SOB/ANXIETY)".

- Morphine Sulf 100 MG/5 ML C, with the instruction of "GIVE 2 SYRINGES = 0.5ML (10MG) BY MOUTH EVERY 2 HOURS AS NEEDED (SOB/PAIN).

Upon my review of these PRNs on the November eMARs, there was no indication they were given unnecessarily or not as prescribed.

According to the December eMAR, Resident A did not receive his PRN Lorazepam 0.5 MG tablet on 12/29/2023 and was only administered medication on 12/30/2023 at 11:47 am and 3:58 pm. Resident A did not appear to receive his morphine on 12/29/2023. The eMAR documented this medication was only administered to Resident A on 12/30/2023 at 11:10 am, 2:03 pm, 3:58 pm, 5:20 pm and 7:32 pm. Additionally, Resident A did not receive his Alprazolam 0.5 MG tablet medication on 12/29/2024 and was only administered this medication on 12/30/2023 at 5:20 pm.

On 02/08/2024, I interviewed direct care staff, Sarah Dunning, via telephone. Ms. Dunning stated Resident A took "a lot of scheduled medications." She stated she could not recall his PRN medications. Ms. Dunning stated she did not recall any issues or concerns with Resident A's medications like staff giving all his medications, including PRNs, at once or not correctly. She stated staff would administrator medications according to the eMAR.

On 02/08/2024, I interviewed Relative A1, via telephone. Relative A1 stated she had concerns Resident A was not given his PRN hospice prescribed medication the night

he returned to the facility after he was placed on hospice. Relative A1 stated Resident A was prescribed morphine by hospice, but staff did not administer this medication to him during the overnight shift on 12/29/2024.

On 02/08/2024, I interviewed Centrica hospice nurse, Hannah Roach, via telephone. Ms. Roach confirmed Resident A was placed on hospice on 12/29/2023 while in the hospital and then returned to the facility. She stated upon her review of Centrica's nurse notes, Resident A was prescribed a "comfort pack" upon his release from the hospital, which included the medication morphine. She stated Resident A was administered morphine by a hospice nurse at 4 pm at the facility on 12/29/2024. She stated according to hospice notes, a facility staff member, Rachel [Unknown], contacted hospice at approximately 8:21 pm reporting Resident A was restless and she was afraid he was going to fall out of bed. Ms. Roach stated the morphine may not have been on the facility's eMAR system yet and staff may have been utilizing a paper MAR to document the morphine. Ms. Roach stated staff hospice staff contacted staff, Rachel [Unknown], at approximately 8:48 pm and she reported to the nurse she had administered a dose of morphine to Resident A since contacting hospice at 8:21 pm.

On 02/09/2024, Ms. Space provided me via email a copy of Resident A's paper MARs for hospice's morphine prescription. According to this paper MAR, the instructions for administering Resident A's morphine were "Take 0.25 (5 mg) by mouth or under tongue every 3 hours." Hospice nurse Genevieve Ladd administered Resident A .5 ML of morphine at 4 pm and then direct care staff, Rachel Ignasiban, administered 0.25 ML of morphine to Resident A at 7 pm and 11 pm. The paper MAR documented Ms. Ignasiban administered another 0.25 ML dose of morphine to Resident A after the 11 pm time; however, she did not date or document the time in which this dose was administered. Resident A's eMAR documented Resident A received his next morphine dose at 11:10 am on 12/30/2024.

On 02/21/2024, I interviewed direct care staff, Rachel Ignasiban, via telephone. Ms. Ignasiban stated she could not recall how many times she administered morphine to Resident A on 12/29/2023, but recalled the medication was in the facility on 12/29/2023. She stated she documented when she administered this medication on a paper MAR since the eMAR hadn't been updated to reflect the morphine. Ms. Ignasiban denied any issues with Resident A's PRN or scheduled medications. She denied giving all Resident A's PRN medications at once or being aware of any other staff giving his PRN medications at once.

On 02/22/2024, I interviewed direct care staff, Cheryl Harrison, via telephone. Ms. Harrison stated she only administered Resident A's PRN and scheduled medications, as prescribed. She stated she hadn't worked in the facility when Resident A was prescribed additional PRN medications by hospice. She stated she did not administer these medications to him.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation, which included a review of Resident A's November 2023 and December 2023 electronic Medication Administration Records (eMARs) and paper MARs and my interviews with the facility's Administrator, Laurel Space, direct care staff, Sarah Dunning, Cheryl Harrison, and Rachel Ignasiban, Relative A1 and Centrica hospice nurse, Hannah Roach, there is no supporting evidence Resident A was administered all his PRN, or as needed, medications on 12/29/2023 and 12/30/2023 prior to him going back to the Emergency Room where he passed away shortly after being placed in a hospice facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Direct care staff, Cheryl [Unknown], doesn't know how to give medications.

INVESTIGATION: The complaint alleged Cheryl [Unknown] was on 3rd shift when she contacted "someone" saying that she was neither sure what medications to give a resident nor was she sure how to give the medications to the resident. The complaint alleged Cheryl [Unknown] did not know what she was doing on the medications cart, but she continued to be administering medications.

The facility's Administrator, Laurel Space, identified Cheryl [Unknown] as direct care staff, Cheryl Harrison. She stated she had no concern with Ms. Harrison administering medications and confirmed Ms. Harrison was trained on how to administer medications. Ms. Space stated she would send me Ms. Harrison's verification of training.

On 01/10/2024, Ms. Space forwarded me via email medication training verification for direct care staff, Cheryl Harrison. The training certificate, dated 07/12/2022, verified Ms. Harrison successfully completed training for "Resident Medication Requirements in Adult Foster Care Group Homes", which was presented by the Department's AFC Policy, Enforcement, and Training Section Manager, Michelle Streeter.

Neither direct care staff, Sarah Dunning nor Rachel Ignasiban, identified any concerns with Ms. Harrison administering medications to residents. They both stated

Ms. Harrison was trained on how to administer medications and followed all instructions on the facility's eMAR system when administering medications to residents.

Direct care staff, Cheryl Harrison, stated she'd been working in the facility off and on for approximately eight years. She stated she was the only "Cheryl" working in the facility. Ms. Harrison confirmed she was trained on how to administer medications and stated she had no issues or concerns with how to administer them. She stated she felt "confident" when administering medications.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Based on my investigation, there is no supporting evidence direct care staff, Cheryl Harrison, is not trained on how to administer medications to residents, as alleged.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

Resident A was placed on hospice on 12/29/2024. Upon being discharged from the hospital and placed back in the facility, he was prescribed by hospice a comfort pack, which included the medication Morphine Sulf 100 MG/5 ML C. Upon my review of the paper MAR, dated 12/29/2023, this medication was administered to Resident A on 12/29/2023 at 4 pm by Centrica hospice nurse, Genevieve Ladd. Direct care staff, Rachel Ignasiban, then administered 0.25 ML of morphine to Resident A at 7 pm (amount left = 14.50 ML) and 11 pm (amount left = 14.25 ML). The paper MAR documented Ms. Ignasiban administered another 0.25 ML dose of morphine to Resident A after the 11 pm time (amount left = 14.00 ML); however, she did not date or document the time in which this dose was administered.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Upon review of Resident A's paper MAR, dated 12/29/2023, for Resident A's Morphine Sulf 100 MG/5 ML C medication, direct care staff, Rachel Ignasiban, did not document the time and date when she administered a dose of Morphine to Resident A despite initialing the medication was administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/22/2024, I conducted the exit conference with the facility's Administrator, Laurel Space, via telephone. Ms. Space acknowledged the findings.

IV. RECOMMENDATION

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

02/26/2024

Cathy Cushman — Date
Licensing Consultant

Approved By:

02/27/2024

Dawn N. Timm — Date
Area Manager