



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 28, 2024

Jodie Nowak
Tranquility AFC Home LLC
11590 Lakeshore Drive
Lakeview, MI 48850

RE: License #: AM590407641
Investigation #: 2024A0622009
Tranquility AFC Home LLC

Dear Ms. Nowak:

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) 284-9727.

Sincerely,

A handwritten signature in black ink, appearing to read 'Amanda Blasius', written in a cursive style.

Amanda Blasius, 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 #:	AM590407641
Investigation #:	2024A0622009
Complaint Receipt Date:	02/09/2024
Investigation Initiation Date:	02/09/2024
Report Due Date:	04/09/2024
Licensee Name:	Tranquility AFC Home LLC
Licensee Address:	11590 Lakeshore Drive Lakeview, MI 48850
Licensee Telephone #:	(989) 304-4041
Administrator:	Jodie Nowak
Licensee Designee:	Jodie Nowak
Name of Facility:	Tranquility AFC Home LLC
Facility Address:	1380 East Main Street Edmore, MI 48829
Facility Telephone #:	(989) 560-9733
Original Issuance Date:	04/12/2023
License Status:	REGULAR
Effective Date:	10/12/2023
Expiration Date:	10/11/2025
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was missing nine days of medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/09/2024	Special Investigation Intake 2024A0622009
02/09/2024	Special Investigation Initiated – Telephone call made to licensee, Jody Nowak.
02/09/2024	Contact - Document Received- documentation received regarding resident and medication.
02/09/2024	APS Referral made.
02/12/2024	Contact - Telephone call to recipient rights officer, Milessa Leach.
02/14/2024	Inspection Completed-BCAL Sub. Compliance. Interview with licensee, Jody Nowak and Resident A. Phone call to pharmacist, Joan Schrader.
02/14/2024	Phone call with former employee Michelle Barber.
02/26/2024	Exit conference with licensee, Jody Nowak.

ALLEGATION: Resident A was missing nine days of medication.

INVESTIGATION:

On 02/09/2024, an email was received that Resident A was missing nine days of medication.

On 02/09/2024, I interviewed licensee designee Jody Nowak via phone regarding the allegation. Ms. Nowak stated that she was administering medication at 8pm on 02/08/24 and noticed Resident A only had three additional days left of her bedtime medication while Resident A's morning and daytime medications had more than three days left. Ms. Nowak stated that they recently rearranged the medication room, and she had looked through all the other residents' medications and did not find any additional medications belonging to Resident A. She stated she ordered more medication for Resident A and she has not missed any medication administrations. Ms. Nowak stated that she was concerned that a staff member had taken the

medication. Ms. Nowak reported the following medication to be missing: Cyclobenzaprine, 10mg, Montelukast, 10mg, Trazadone, 100mg, Aripiprazole, 15mg, Melatonin 15mg, Gabapentin, 300mg and Acetaminophen, 500mg. Ms. Nowak reported that currently all the bedtime medications arrive in one pack all together, which is called a multi dose pack. For the future orders of medications, they will be bubble packs with single medications per pack.

On 02/09/2024, I reviewed documentation sent from licensee designee Jody Nowak. The following documents were received: an incident report, recipient rights report, medication chart for Resident A, an employee termination form for DCW Michelle Barber, a *Michigan workforce background check* for Michelle Barber and her completed trainings.

On 02/12/2024, I interviewed recipient rights officer, Milessa Leach via phone. She reported that Resident A is not receiving services from Montcalm Care Network, but she was at the facility on 1/29/2024 regarding missing medications. Ms. Leach visited the facility and was able to help Ms. Nowak locate the missing medication. She stated that she has given Tranquility AFC many recommendations to improve their medication documentation. Ms. Leach stated that DCW Michelle Barber had put in a complaint that the facility was not completing medication counts.

On 02/14/2024, I completed an unannounced onsite investigation at Tranquility AFC with recipient rights officer, Milessa Leach. An in-person interview with licensee designee Jody Nowak was conducted. Ms. Nowak reported that she re-counted Resident A's medication, called the pharmacy, and determined that only two days of medication were missing. Ms. Nowak stated that she also remembered that when she was administering nighttime medication to Resident A, the resident dropped her medications on the floor two separate nights, which required new medications to be administered. Ms. Nowak stated that Resident A puts all her medications in one hand and then takes them at once. Ms. Nowak stated that these two medication errors were not documented on her medication chart. Ms. Nowak reported that seven days of bedtime medications were accounted for, leaving two days of bedtimes medications to be unaccounted.

On 02/14/2024, Jody Nowak called the pharmacy, Downtown Drugs and spoke with pharmacist, Joan Schrader via speaker phone. Ms. Schrader confirmed that the facility will no longer be receiving multi pack medications and single cassette packs will be delivered as of 2/14/24.

On 02/14/2024, Milessa Leach and I interviewed Resident A in person at Tranquility AFC. Resident A reported that she enjoyed living in the facility as she was able to have her cats and it was quiet. Resident A confirmed that she goes into the medication room to take her medications. She stated that she prefers to put all her medications in one hand and hold onto her water cup with the other hand. Resident A reported that on occasion, medication has fallen on her shirt and the floor.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	As of 02/14/2024, two multi packs of bedtime medications were missing for Resident A. After interviewing licensee, Ms. Nowak, and viewing the medication room, it was found that reasonable precautions are not in place to prevent prescription medication from being lost or used by a person other than the resident for whom the medication was prescribed for. During the onsite investigation it was found that medication errors were not being documented to assure medication was not being used by others.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION:

On 02/09/2024, I interviewed licensee designee Jody Nowak via phone. She stated bedtime medications were missing for Resident A, and she identified a previous employee who she was concerned about misplacing the medications or taking them. Ms. Nowak emailed over documents for DCW Michelle Barber, which contained her termination notice, *Michigan Workforce Background Check* and her training. After reviewing her training documents, it was confirmed that DCW Michelle Barber had not completed medication administration training prior to administering medication to residents at Tranquility AFC.

On 02/14/2024, I interviewed DCW Michelle Barber via phone. DCW Barber stated that she worked at Tranquility AFC for two months. DCW Barber reported that she worked 7am-7pm and administered medication to residents. DCW Barber stated that she did not complete medication administration training and was not trained by other staff. DCW Barber reported that Resident A did not drop any medication while she was administering her medication. She reported that she did not dispose or take any medication while working at Tranquility AFC.

APPLICABLE RULE	
R 400.14312	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:	DCW Barber reported that she was administering medication to residents while working at Tranquility AFC but had not completed training regarding medication administration. Based on training documents reviewed, Michelle Barber did not complete medication administration training prior to administering medication to residents at Tranquility AFC.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains the same.

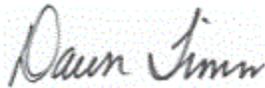


02/26/2024

Amanda Blasius
Licensing Consultant

Date

Approved By:



02/28/2024

Dawn N. Timm
Area Manager

Date