GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 9, 2024

Katie Edwards
Symphony of Brighton Health Care Center LLC
Suite 167
30150 Telegraph Road
Bingham Farms, MI 48025

RE: License #: AL470378851
Investigation #: 2024A0466031
Van Gogh House Inn

Dear Ms. Edwards:

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,

Julie Elkins

Julie Elkins, 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 #:	AL470378851
Investigation #:	2024A0466031
Complaint Receipt Date:	03/19/2024
Investigation Initiation Date:	03/20/2024
Report Due Date:	05/18/2024
Licensee Name:	Symphony of Brighton Health Care Center LLC
Licensee Address:	Suite 167 30150 Telegraph Road Bingham Farms, MI 48025
Licensee Telephone #:	(810) 299-1320
Administrator:	Katie Edwards
Licensee Designee:	Katie Edwards
Name of Facility:	Van Gogh House Inn
Facility Address:	1014 E. Grand River Ave. Brighton, MI 48116
Facility Telephone #:	(810) 220-5222
Original Issuance Date:	01/24/2017
License Status:	REGULAR
Effective Date:	07/24/2023
Expiration Date:	07/23/2025
Capacity:	20

Program Type:	AGED

ALLEGATIONS:

	Violation Established?
Resident A was administered her medications and also administered medications prescribed to Resident B which subsequently required hospitalization for Resident A.	Yes
On 3/8/24 multiple medications were left in Resident A's room in a cup until 7:30pm.	No

II. METHODOLOGY

03/19/2024	Special Investigation Intake 2024A0466031.
03/20/2024	Special Investigation Initiated – On Site.
03/21/2024	Contact- document received.
04/24/2024	APS referral made.
05/06/2024	Contact telephone call made to DCW Lynsey Johnson, interviewed.
05/07/2024	Contact telephone call made to DCW Dede Dovine, message left.
05/07/2024	Exit Conference with licensee designee Katie Edwards.

ALLEGATION: Resident A was administered her medications and also administered medications prescribed to Resident B which subsequently required hospitalization for Resident A.

INVESTIGATION:
On 03/19/2024, Complainant reported that Resident A was given her medications and the medications of another resident which required hospitalization. Complainant was anonymous, so no additional information or details regarding the allegation could be gathered.

On 03/20/2024, I conducted an unannounced investigation and I reviewed an *Adult Foster Care (AFC) Licensing Division-Incident/Accident Report* dated 3/15/2024 and signed by assistant director of assisted living (ADAL) Amanda Hawley and licensee designee/administrator Katie Edwards. In the "explain what happened" section of the report it stated:

"Guest observed with low blood pressure after being given another guests medications. Guest was given Cardizem 120 mg, Folic Acid 1 mg, MVI Spironolactone 50mg, Flomax .04 mgs, Vitamin B-1, 100 mg, Lactulose 20 mg. Symptoms involving cognitive functioning and awareness, A.Fib, HLD, HTN, Psteparthritis of knee, abnormalities of gait and mobility."

In the "action taken by staff" section of the report it stated:
"V/S obtained (70/48, N51, 97.2, 14, 93%). POA notified. Physician notified. EMS notified. Guest on 1:1 monitoring until EMS arrived."

In the "corrective measures taken to remedy and /or prevent recurrence" it stated:
"Guest transferred to Trinity Health Ann Arbor for further evaluation and treatment. Will update plan of care upon return."

I reviewed Resident A's *MTS Discharge* from Trinity Health St. Joseph Mercy Hospital which documented an admission date of 3/15/2024 and a discharge date of 03/16/2024. In the "brief hospital course" it documented:

"Resident A is 86 years and was accidently administered Cardizem 120 mg, folic acid, Aldactone, Flomax, vitamin B1, lactulose. Patient was hypotensive during initial presentation and poison control recommended observation. Overnight blood pressures improved and patient reports resolution of symptoms. Poison control was contacted once more for clearance to discharge. Patient was discharged in stable condition."

I reviewed a *Progress Note* Date: 3/15/2024 at 15:47:38 which stated:

"Med tech stated that guest had received the wrong medications. NP stated to check BP q 2 hours and push fluids. Blood pressure obtained: initial BP 189/75.

Then 104/63 @ 1:18pm and 67/45 @ 2:51pm. Following the 2:51pm BP, NP advised guest to be sent to ER for: continuous monitoring and IV fluids. Physician and family notified."

I interviewed ADAL Hawley who reported that Resident A was hospitalized on 3/15/2024 because direct care worker (DCW) Lynsey Johnson left medication for Resident B in a medication cup unsecured in Resident A's room. ADAL Hawley reported that Resident A self-reported to the DCWs on duty that she took the medications left in her room believing that they were for her. ADAL Hawley reported that Resident A was transported to the hospital for observation because her blood pressure dropped while observing her during 15 minute checks. ADAL Hawley reported that DCW Johnson has not been back to work since the medication error occurred. ADAL reported that licensee designee Edwards has a one-on-one medication training scheduled with DCW Johnson on 3/21/2024.

I interviewed Resident A who reported she recalled the day that she recevied medications that were prescribed to another resident by accident. Resident A reported the assigned medication passer does not typically leave medication in her room rather the direct care worker assigned to pass medications for the day hands her the medication in a medication cup directly and watches her take them. However, on the date of this incident Resident A stated she recalled finding medications in a medication cup on her nightstand and since it was in her room, she assumed it was for her and she took the medications. Resident A reported she was hospitalized overnight for observation but that she was fine. Resident A reported this was only time medication has ever been left in her room.

On 03/21/2024, licensee designee Edawards emailed me verification that all direct care staff members trained to administer resident medication were re-trained in medication administration on 03/15/2024.

On 05/06/2024, I interievewed DCW Johnson who reported that she was responsible for Resident A's medication error on 03/15/2024. DCW Johnson reported that it was a busy day and Resident B had been adamant about wanting his medication. DCW Johnson stated she was behind in administering medication because the residents had been at an activity and it was getting close to lunchtime. DCW Johnson reported that even though they are trained to prepare one resident medication at a time, she prepped both Resident A and Resident B's medications at the same time. DCW Johnson reported that she went into Resident A's room first because her call light was on. DCW Johnson reported that she took both Resident A and Resident B's medications into Resident A's room. DCW Johnson reported that she set Resident Bs' medication on Resident A's nightstand while she administered Resident A her prescribed medications. DCW Johnson reported that while with Resident A, Resident A was complaining about her knees and hemorrhoids hurting, so she left Resident A's room to get Resident A's knee and hemorrhoid ointment and ultimately left Resident B's medications on the nightstand. DCW Johnson reported that as soon as she realized that Resident A took Resident B's medications, she immediately told management and checked her vitals. DCW Johnson reported that Resident A was later hospitalized for low blood pressure. DCW Johnson reported she called Resident A's designated representative to let him know what had occurred. DCW Johnson confirmed that all direct care staff members assigned to administer resident medication were re-trained on medication administration on 03/21/2024 and that she was counseled and trained in a one-on-one session with licensee designee Edwards. DCW Johnson knows that she was not supposed to bring two residents medication out together and she reported that she learned her lesson and that even when she is busy she will not do that again.

On 05/06/2024, licensee designee Edwards reported that DCW Johnson is still currently employed and she did receive a 1:1 counseling and then a 1:1 medication training.

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:	Complainant, ADAL Hawley, Resident A and DCW Johnson all reported that on 3/15/2024, Resident A ingested Resident B's prescribed medications because DCW Johnson left them in Resident A's room unsupervised. Resident A was hospitalized on 3/15/2024 through 3/16/2024 due to low blood pressure. A violation has been established as DCW Johnson did not take reasonable precautions to ensure Resident B's medications were not used by a person other than for whom the medication was prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 3/8/24 multiple medications that were prescribed to be administered around noon to Resident A were left in Resident A's room in a cup until 7:30pm.

INVESTIGATION:
On 03/19/2024, anonymous Complainant reported on 3/8/24 multiple noontime medications were left in Resident A's room in a cup until 7:30pm. Complainant reported that family notified staff and the medications were removed. Complainant was anonymous, so no additional information or details regarding the allegation could be gathered.

On 03/20/2024, I reviewed the *Staff Schedule* which documented that on 03/08/2024, DCW Dede Dovine worked 7am-7pm and DCW Jamyll Adams worked from 9am-7pm. DCW Adams was DCW assigned to administer resident medication on the date of the allegation.

I interviewed Resident A who reported the DCW assigned to administer resident medication does not leave medication in her room, the direct care worker assigned to pass medications for the day hands her medication in a medication cup directly and watches her take them. Resident A did recall a time when medication for another resident was left in her room and she took those medications. Resident A reported that was an isolated incident and that medication has not been left in her room prior or after that incident. Resident A did not recall a time when multiple noontime medications were left in Resident A's room in a cup until 7:30pm.

I interviewed DCW Adams who reported that on 03/08/2024 he was the direct care worker that was assigned to pass medication. DCW Adams reported that he administered Resident A's noontime medications to her and watched her ingest

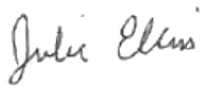
them. DCW Adams reported that he watched her put the pills in her mouth, made sure the medication cup was empty, gave her some water and then asked her to open her mouth so that he could check for medications in her mouth. DCW Adams reported that he never leaves medications in any resident room and he denied leaving medications in Resident A's room on 03/08/2024 or any other date. DCW Adams did report that he does administer medications around mealtimes. DCW Adams reported that he could not recall if any of Resident A had any visitors on 03/08/2024 but he did report that Resident A's family is typically vocal with DCWs if there is a problem.

On 05/07/2024, I left a message for DCW Dovine requesting a return phone call. As of the writing of this report that telephone call has not been retuned and therefore DCW Dovine has not been able to be interviewed.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Complainant reported on 3/8/24 multiple noon medications were left in Resident A's room in a cup until 7:30pm however Resident A and DCW Adams both denied this allegation. DCW Adams was assigned the task of medication administration on 3/08/2024 and he reported that he administered Resident A's noontime medications to her and watched her ingest them. DCW Adams reported that he never leaves medications in any resident room and he denied leaving medications in Resident A's room on 03/08/2024. There is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

III. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in license status.



05/09/2024

Julie Elkins Date
Licensing Consultant

Approved By:

05/09/2024

Dawn N. Timm Date
Area Manager