GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 12, 2024

Nidhal Ghraib
Quality Care of Howell LLC
2820 N. Burkhard Road
Howell, MI 48855

RE: License #: AL470397950
Investigation #: 2024A0466036
Quality Care Of Howell 2 (South Wing)

Dear Mr. Ghraib:

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 #:	AL470397950
Investigation #:	2024A0466036
Complaint Receipt Date:	04/17/2024
Investigation Initiation Date:	04/18/2024
Report Due Date:	06/16/2024
Licensee Name:	Quality Care of Howell LLC
Licensee Address:	2820 N. Burkhard Road Howell, MI 48855
Licensee Telephone #:	(517) 579-2019
Administrator:	Nidhal Ghraib
Licensee Designee:	Nidhal Ghraib
Name of Facility:	Quality Care Of Howell 2 (South Wing)
Facility Address:	2820 N Burkhart Rd. Howell, MI 48855
Facility Telephone #:	(517) 579-2019
Original Issuance Date:	02/07/2020
License Status:	REGULAR
Effective Date:	08/07/2022
Expiration Date:	08/06/2024
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION:

	Violation Established?
Second and third shift direct care staff members who administer medications document medication that is prescribed to one resident as administered when they are really administering that same medication to a different resident for whom the medication is not prescribed.	No
Resident medication is not being documented as administered at the time the medication was administered.	Yes
Direct care worker (DCW) Jan Gibbs called Resident F “fat” and “a waste of space.”	No
Additional Findings	Yes

III. METHODOLOGY

04/17/2024	Special Investigation Intake 2024A0466036.
04/18/2024	Inspection Completed On-site.
04/18/2024	Special Investigation Initiated - On Site.
05/28/2024	Contact- telephone call made to DCW Allison Bona interviewed.
05/28/2024	Contact- telephone call made to DCW Madilynn Faulkner, message left.
05/28/2024	Contact- document sent to/from LD Nidhal Ghraib requesting phone numbers and documents.
05/29/2024	Contact- document sent to/from LD Nidhal Ghraib requesting phone numbers and documents.
05/30/2024	Contact- telephone received from DCW Allison Bona interviewed second time.
05/30/2024	Contact- telephone call made to DCW Brandi Spilling, message left.
05/30/2024	Contact- telephone call made to DCW Janet Clark, message left.
05/30/2024	Contact- telephone call made to DCW Madilynn Faulkner, second message left.

05/30/2024	Contact- telephone call made to DCW Kimberly Lowler, message left.
06/03/2024	Contact-Face to face on site.
06/03/2024	Contact- telephone received from DCW Kimberly Lowler, interview second time.
06/04/2024	Contact- telephone received from DCW Jan Griggs, interviewed.
06/12/2024	APS referral- not required no suspected abuse/neglect.
06/12/2024	Exit conference with licensee designee Nidhal Ghraib.

ALLEGATION:

- **Second and third shift direct care staff members who administer medications document medication that is prescribed to one resident as administered when they are really administering that same medication to a different resident for whom the medication is not prescribed**.
- **Resident medication is not being documented as administered at the time the medication was administered.**

INVESTIGATION:

On 04/16/2024, anonymous Complainant reported that second and third shift direct care staff members who administer resident medication have been documenting medication as administered that is prescribed for one resident but administering to a different resident. Complainant reported direct care staff will chart a medication pass and then wait several hours before administering the medication. Complainant reported that multiple complaints have been reported to the administrative team about these practices but the complaints are disregarded due to the administration team being friends with the shift lead direct care staff member. Complainant was anonymous, so no additional information or details regarding the allegation could be gathered.

On 04/18/2024, I conducted an unannounced investigation and I reviewed the facilities written incident reports (IR) from 03/01/2024-04/18/2024 and I did not find any incident reports documenting any medication errors including medication being administered to one resident that is prescribed to a different resident.

I interviewed direct care worker (DCW) and trained medication passer Kimberly Lowler who reported that she has worked at the facility for about year and throughout that time she has worked all shifts. DCW Lowler reported midnight shift direct care staff members document Resident A's pro re nata (PRN) Lorazepam as being administered to Resident A in Resident A's medication administration record

(MAR) then staff administer the Lorazepam to Resident B who is not prescribed Lorazepam. DCW Lowler reported that Resident B can be upset and anxious at night and that is why she was given Lorazepam. DCW Lowler reported that the medication count is always accurate making it difficult to prove. DCW Lowler stated DCWs have been directed to do this by shift manager Jan Grigg. DCW Lowler reported that multiple reports about this occurring have been reported to licensee designee and administrator Nidhal Ghraib however this concern has been disregarded due to him being friends with DCW Griggs. DCW Lowler was unsure why Resident B has not been prescribed her own prescription for an anxiety reducing medication. DCW Lowler denied that she has ever administered Resident B's Lorazepam as she does not work at night but reported multiple DCWs talk about this practice as no one is comfortable with this arrangement, but everyone is afraid of losing their job for not doing what shift manager Giggs tells them to do. DCW Lowler did not provide the names of any direct care staff members who administered Resident B's medication to Resident A.

DCW Lowler reported that Resident C is prescribed a ABH gel (a behavioral gel) that was prescribed every eight hours and to be administered topically to the inner wrist at midnight. DCW Lowler reported that the medication passer on midnights did not want to wake Resident C up, so they log the medication as passed at midnight although it was not actually administered until 4 am which does not keep the dosage spread out as prescribed.

DCW Lowler reported that there was a medication error that occurred with Resident D being administered Resident E's medications and an IR was written but she could not recall the date it occurred.

I interviewed DCW Katrina Seely who reported that she is a trained medication passer who has worked at the facility for five years as a contingent staff but only works first shift and she does not administer medications even though she is trained to do so. DCW Seely reported that she heard that medication passers were not administering Resident C's prescribed a ABH gel ointment at midnight but she was not sure why. DCW Seely reported the midnight dose has since been discontinued by hospice. DCW Seely reported that she had no knowledge of Resident A being administered Resident B's Lorazepam and she had no knowledge of a medication error with Resident D. DCW Katrina Seely reported that there was a medication error that occurred with Resident F.

I interviewed DCW Sara Duke who reported that she has worked at the facility for a year and she has only worked first shift. DCW Duke reported that she has heard that the midnight shift documents Resident A's Lorazepam as being administered to Resident A in Resident A's MAR then administers Lorazepam to Resident B who is not prescribed Lorazepam but has never observed this practice. DCW Duke reported the week of April 8, 2024, there was a sticky note in the medication cart regarding Resident C and an IR completed about holding Resident C's Abh gel until 8am. DCW Duke reported that DCW Griggs told her to hold the cream but to chart it

in the system therefore the medication was charted as passed when it was not. DCW Duke reported that she was relieving DCW Griggs which was why she provided this information. DCW Duke reported that she talked to licensee designee Ghraib about this and she completed an IR since the medication was not administered as prescribed. DCW Duke denied any knowledge of a medication error that occurred with Resident D being administered Resident E's medications.

I interviewed Nurse Shelly Conrad, RN with All American Hospice who reported that Resident C was prescribed ABH cream three times a day however it was recently changed to twice a day because DCW Griggs reported to Nurse Conrad the midnight dose was not being given due to Resident A sleeping. Nurse Conrad reported that medication can be held if it makes Resident C sleepy but reported those were verbal orders and not in writing. Nurse Conrad reported that this medication is for anxiety and that is why it was prescribed three times a day initially.

I interviewed licensee designee Ghraib who reported that there was a medication error that occurred with Resident D being administered Resident E's medications by DCW Paris Walker who is no longer employed at the facility. Licensee designee Ghraib denied that there were any other medications errors. Licensee designee Ghraib denied that DCWs document medication as administered for one resident and give it to another resident. Licensee designee Ghraib denied that DCWs chart medications as administered and then pass that medication at a later time.

I reviewed Resident A's March 2024 and April 2024 MAR which documented that she was prescribed "Lorazepam .5mg tablet, take 1 by mouth every six hours as needed (anxiety)." The March 2024 *MAR* documented that this medication was administered on the following dates, for the following reasons by the listed DCW:

- "3/08 at 7:17pm, anxiety, not effective by JG.
- 3/09 at 5:30am, anxiety, sleeping KL and 10:54pm, anxiety OK by BS.
- 3/11 at 4:22pm, anxiety, anxiety JC.
- 3/12 at 6:34pm, anxious, less anxious JC.
- 3/16 at 6:24pm, anxiety, better JC.
- 3/17 at 5:50pm, trying to find her parents, OK, KL.
- 3/26 at 5:30 am, anxiety, OK JG.
- 3/27 at 6:51 pm, anxiety, OK JG.
- 3/28 at 7:32 pm, anxiety, OK JG.
- 3/30 at 5:55 am, anxiety, helped JG."

I reviewed Resident A's April 2024 MAR which documented that she was prescribed "Lorazepam .5mg tablet, take 1 by mouth every six hours as needed (anxiety)." The April 1, 2024-April 17, 2024 MAR documented that this medication was administered on "4/08/2024 at 12:34 am, anxiety, anxiety gone BS."

I reviewed Resident B's March 2024 and April 2024 *MAR* through 04/17/2024 which documented that she is prescribed Citalopram HBR 10 mg tablet take 1 by mouth every day for mood. There was no prescription for Resident B to take Lorazepam

.5mg tablet nor was there any documentation that supported that she had been administered Lorazepam .5mg tablet.

I reviewed an *Adult Foster Care (AFC) Licensing Division Incident/Accident Report* (IR) that was dated 2/28/2024 and signed by licensee designee Ghraib. In the "explain what happened" section of the report it stated, "I prepare medications and passed them to [Resident D] and [Resident E]." In the "action taken by staff" section of the report it stated, "Shortly after passing medications out Jilian came into the medication room with a cup of medication and the other cup empty. She stated that Resident D noticed before she took her medications the name on the cup wasn't her name and it had Resident E's name on it. Resident E took Resident D's medications. In the "corrective measures taken to remedy and or prevent reoccurrence" stated, "To prevent reoccurrence I'm going to make sure next time I'm paying the most attention to the names before I pass the medication and most definitely double check afterwards." The IR documented Relative D1 and Relative E1 were contacted but the section of the report that documented "physician or RN" was contacted was left blank.

On 05/28/2024, I interviewed DCW Allison Bona who reported that although she is a trained medication passer that works first shift, she had no knowledge about Resident B being administered Resident A's Lorazepam. DCW Bona denied any knowledge of Resident C's ABH gel not being administered as prescribed and denied knowledge of any medication error with Resident E. DCW Bona reported that she typically works in another licensed facility on the same property and not in this building.

On 05/29/2024, licensee designee Ghraib reported that there was a medication error involving Resident E and supplied the requested Incident Report (IR) for medication and all supporting documents pertaining to that incident. Licensee designee Ghraib reported the DCW who made the medication error notified management immediately after the error was realized. Licensee designee Ghraib reported that Resident E's family representative and hospice nurse were also notified. Licensee designee Ghraib reported that Resident E's vitals were monitored hourly for the next twelve hours. Licensee designee Ghraib reported the incident was written up as a written warning, the DCW was re-trained in medication passing and re-took a medication passing test. Licensee designee Ghraib reported that the DCW Bona wrote a plan of action to remedy and/or prevent reoccurrence and was also removed from Resident E's medication per family representative's request for the next month following the incident.

On 05/30/2024, DCW Bona called and reported that she was the medication passer that had the medication error with Resident E. DCW Bona reported that she has since been medication re-trained and moved to a day shift at another licensed building on the property. DCW Bona reported that the medication error occurred as she was moving too fast and felt like she was behind. DCW Bona also reported that she had difficulty concentrating with the others on her shift as they were loud and

always talking. DCW Bona reported that she has no knowledge if Resident E's health care professional was contacted when the medication error occurred.

On 06/03/2024, I interviewed DCW Lowler for a second time and she reported that she has never administered Resident B, Resident A's prescribed Lorazepam. DCW Lowler reported that any MAR that she signed was when she administered the Lorazepam to Resident A as prescribed. DCW Lowler reported Resident B now has Lorazepam prescribed to her by her physician.

On 06/04/2024, I conducted a second unannounced investigation and I interviewed licensee designee Ghraib about the confusing IR written on 01/02/2024 which documents several different residents involved in the medication error. Licensee designee Ghraib reported that he included the written write up for the employee that was disciplined in the email as the names of the residents noted in that document were the correct residents involved in the medication error. Licensee designee Ghraib reported that Resident I's medications were passed to Resident H on second shift on 01/02/2024. Licensee designee Ghraib reported that when a medication error occurs that that he is in verbal contact with the residents family and physician about the resident. Licensee designee Ghraib reported that the house physician sees each resident every 4-6 weeks and that his interaction with the physician is typically verbal and contact is documented on the IR.

On 06/04/2024, I interviewed DCW Jan Griggs, shift manager who denied that there were any medications errors. DCW Griggs denied that DCWs document medication being administered for one resident but give it to another resident. DCW Griggs reported that every narcotic needs to be witnessed to chart it in the electronic medication administration system (EMAR) system and on midnights there is just one DCW on shift. DCW Griggs reported that when day shift comes in they have to witness the narcotics that were administered while they were not on shift so that the system will not lock up. Consequently, narcotic medications that were administered timely and as prescribed may not be able to be charted as administered until hours later when a witness is available. DCW Griggs stated this may explain why DCWs may be assuming that medications are being held or not administered as prescribed on second and third shift.

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.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Although anonymous Complainant reported that second and third shift DCWs document medication that is prescribed to one resident as administered when DCWs are really administering that same medication to a different resident for who the medication is not prescribed. I could find no evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	DCW Griggs reported that every narcotic needs to be witnessed to chart it in the electronic medication administration system (EMAR) system and on midnights there is just one DCW on shift. DCW Griggs reported that when day shift comes in they have to witness the narcotics that were administered while they were not on shift so that the system will not lock up. Consequently, narcotic medications that were administered timely and as prescribed may not be able to be charted as administered until hours later when a witness is available therefore a violation has been established as the medication log was not documented at the time that the medication was administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care worker (DCW) Jan Gibbs called Resident F "fat" and "a waste of space.

INVESTIGATION:

On 4/18/2024 Complainant reported that DCW Jan Gibbs called Resident F "fat" and

tells her that “she is waste of space.”

On 4/18/2024 DCW Katrina Seely reported that DCW Jan Gibbs called Resident F “fat” and tells her that “she is waste of space.”

On 05/28/2024, DCW Bona reported she has heard a DCW call Resident F “fat and a waste of space” but could not recall the name of the DCW she heard say this to Resident F. DCW Bona stated she reported the incident to shift manager Jan Griggs and licensee designee/administrator Nidhal Ghraib. DCW Bona reported that licensee designee Ghraib reported that he would handle the situation and DCW Bona reported that she has not heard anyone talk to Resident F like that since.

On 05/30/2024, DCW Bona reported that DCW Griggs “yells” at the residents when she is upset with them, if they talk back or don’t a shower when asked. DCW Bona reported that this is DCW Griggs personality and she gets frustrated with a lot of the residents, not just Resident F when they do not follow instructions such as to take a shower. DCW Bona reported that she reported this to licensee designee Ghraib and switched shifts so that she no longer had to work with DCW Griggs.

On 06/03/2024, DCW Lowler reported that she has heard DCW Griggs call Resident F “fat” and other names such has “beached whale.” DCW Lowler reported that Resident F’s family was called into a meeting with licensee designee Ghraib telling Resident F that she is not allowed to complain anymore about the DCWs at the facility. DCW Lowler reported that Resident F is not as ambulatory anymore so DCW Griggs is not calling her names as much. DCW Lowler reported DCW Griggs usually used these phrases when discussing Resident F with other DCWs.

On 06/04/2024, I conducted a second unannounced investigation and I interviewed Deborah Wagner the point person when licensee designee Ghraib is not available. Ms. Wagner reported that Resident F is diagnosed with dementia, depression and hypothyroidism and that she does have a “difficult personality.” Ms. Wagner reported that Resident F has difficulty waiting her turn and “wants what she wants now.” Ms. Wagner reported that Resident F has little patience to wait and can be stubborn and difficult when upset. Ms. Wagner denied that Resident F or any other DCW has reported to her that anyone calls Resident F names nor has she observed any DCW being disrespectful.

I interviewed Resident F who reported that the caregivers are mean, if she asks for anything they say “no” and that one of the DCWs calls her a “stupid ass.” Resident F could not provide any other examples and she could not recall the names of DCWs who are disrespectful to her.

I interviewed licensee designee Ghraib who denied that any DCW has ever reported to him that DCW Griggs has called any resident any name including “fat or beached whale.” Licensee designee Ghraib reported that he has never observed DCW Griggs talking or acting inappropriately or disrespectful to any resident. Licensee

designee Ghraib reported that Resident F has never reported any of these complaints to him.

I interviewed DCW Griggs who denied calling Resident F “fat” and other names such has “beached whale” or a “waste of space.” DCW Griggs reported that she has never been disrespectful to Resident F nor has she observed any other DCW being disrespectful to her either.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Although Complainant reported that DCW Jan Gibbs called Resident F “fat” and tells her that “she is waste of space” after interviewing several DCWs, license designee Ghraib and Resident F there was not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:
On 04/18/2024, I reviewed Resident D and Resident E’s MARs from February 1, 2024 through April 18, 2024 which documented that medications were refused by the resident for several months without documentation that a medical professional had been contacted about each resident refusal of medication. Resident D refused the following:

- Ammonium Lactate 12% cream apply twice daily” refused twice daily on 02/01/2024-02/04/2024, refused once on 02/05/2024, refused twice daily on 02/06/2024-02/09/2024, refused once on 02/10/2024, 02/13/2024 and 02/14/2024, refused twice on 02/15/2024, once 02/16/2024, 02/17/2024, twice on 02/18/2024-02/21/2024, once 02/22/2024, 02/24/2024, twice on 02/25/2024,

02/27/2024-03/01/2024, once 03/02/2024, 03/05/2024, 03/06/2024, twice on 03/11/2024, once on 03/12/2024, 03/14/2024, 03/15/2024, twice on 03/16/2024, once on 03/17/2024, twice on 03/18/2024, once on 03/21/2024, 03/22/2024, 03/23/2024, 03/25/2024, 03/26/2024, 03/27/2024, 03/28/2024, twice on 03/29/2024, once on 03/31/2024, 04/01/2024, 04/04/2024, twice on 04/05/2024, 04/06/2024, once on 04/08/2024, twice on 04/09/2024, once 04/10/2024, 04/11/2024, 04/12/2024, twice on 04/13/2024, once on 04/14/2024, 04/15/2024, 04/16/2024, twice on 04/17/2024 and once on 04/18/2024."

- "Diclofenac Sodium 1% gel apply 4 GM to affected area 2 times a day." Refused once on 02/18/2024, 02/19/2024, 02/20/2024, 02/25/2024, 02/27/2024, refused twice on 02/28/2024,02/29/2024, 03/01/2024, once 03/11/2024, 03/12/2024, 03/14/2024, 03/15/2024, twice on 03/16/2024,once on 03/17/2024, twice on 03/18/2024, once on 03/21/2024, 03/22/2024, 03/23/2024, twice on 03/26/2024,03/27/2024, twice on 03/29/2024, once on 03/31/2024, 04/01/2024, 04/02/2024, 04/04/2024, 04/05/2024, twice on 04/06/2024,refused once on 04/08/2024, 04/09/2024, 04/10/2024, 04/11/2024, 04/12/2024, 04/13/2024, 04/14/2024, 04/15/2024, 04/16/2024, twice on 04/17/2024, once on 04/18/2024.

On 06/03/2024, DCW Lowler reported that she has no knowledge if any DCW contacts a resident's health care professional when a resident refuses a prescribed medication as she reported that she has never done that nor has she reviewed any documentation about that. DCW Lowler reported that she reports medication refusal to licensee designee Ghraib.

On 06/03/2024, I went to the facility unannounced and interviewed licensee designee Ghraib who reported that when a resident refuses medication that he is in verbal contact with the residents family and physician about the resident. Licensee designee Ghraib reported that the house physician sees each resident every 4-6 weeks and that his interaction with the physician is typically verbal with no written physician instructions documented in the resident record. There are some physician contact records documenting physician medication changes but there is no documentation available for review for every medication refusal. Licensee designee Ghraib reported sometimes this discussion occurs through text messages. Licensee designee Ghraib reported that when a resident is continually refusing medications typically a medication change is made by the prescribing physician.

On 06/04/2024, I interviewed DCW Griggs who reported that she and other DCWs who administer medications report medication refusals to licensee designee Ghraib. DCW Griggs has no knowledge of what happens from there.

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: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	MARs for March 2024 through April 17, 2024 were reviewed for Resident D and Resident E and although there were resident medication refusals, there was not documentation that a resident's health care professional was contacted to report each refusal. Therefore, there was not medical guidance provided by the health care professional to ensure the medical needs of the residents were met.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an approved corrective action plan I recommend no change in license status.

Julie Elkins

06/12/2024

_____

Julie Elkins Date
Licensing Consultant

Approved By:

Dawn Timm

06/12/2024

_____

Dawn N. Timm Date

Area Manager