GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 21, 2024

Anngenette Turner
The Neighborhoods of White Lake
10770 Elizabeth Lake Rd
White Lake, MI 48386

RE: License #: AH630397715
Investigation #: 2024A1027083
The Neighborhoods of White Lake

Dear Licensee:

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 authorized representative 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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630397715
Investigation #:	2024A1027083
Complaint Receipt Date:	07/19/2024
Investigation Initiation Date:	07/22/2024
Report Due Date:	09/18/2024
Licensee Name:	The Neighborhoods of White Lake
Licensee Address:	10770 Elizabeth Lake Rd White Lake, MI 48386
Licensee Telephone #:	(810) 989-7492
Authorized Representative/ Administrator:	Anngenette Turner
Name of Facility:	The Neighborhoods of White Lake
Facility Address:	10770 Elizabeth Lake Rd White Lake, MI 48386
Facility Telephone #:	(248) 618-4150
Original Issuance Date:	07/01/2019
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	48
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Medication was administered improperly.	Yes
There was improper testing. Property was stolen.	No
There was a HIPPA violation.	Yes
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

07/19/2024	Special Investigation Intake 2024A1027083
07/22/2024	Special Investigation Initiated - Letter Email sent to administrator Ms. Turner to request additional information
08/14/2024	Contact – Telephone call made Interview with the APS complainant
08/14/2024	Inspection Completed On-site
08/20/2024	Contact - Document Sent Email sent to Ms. Turner requesting additional documentation
08/20/2024	Contact - Telephone call made Telephone call conducted with hospice agency staff
08/21/2024	Contact - Document Received Email received from Ms. Turner with requested documentation
08/21/2024	Inspection Completed-BCAL Sub. Compliance
08/21/2024	Exit Conference Conducted by email with Anngenette Turner

ALLEGATION:

Medication was administered improperly.

INVESTIGATION:

On 7/22/2024, the Department received allegations forwarded from Adult Protective Services (APS) which read medication was administered improperly. APS did not initiate an investigation.

On 8/14/2024, a telephone interview was conducted with the APS complainant, who reported that Resident A moved into the home on 5/10/2024 and discharged on 7/13/2024. The complainant alleged that Resident A's Fentanyl patches were not administered according to the prescription and that the facility ran out of patches, resulting in a 24-hour period without a patch. The complainant stated hospice staff could confirm his allegations. Additionally, the complainant stated there were issues with facility ordering medications through their pharmacy before utilizing Resident A's home medications.

On 8/14/2024, an on-site inspection was conducted, and administrator Anngenette Turner was interviewed.

Ms. Turner explained that initially, Relative A1 wanted to manage the medications but later allowed the facility to handle them. Ms. Turner noted that while the facility sent current medications to the pharmacy for filling, Relative A1 requested some medications be discontinued and he was billed for all medications. Ms. Turner stated the facility is reimbursing Relative A1 for the discontinued medications.

Ms. Turner also stated that medication administration was documented in the medication administration records (MAR), with any exceptions noted.

Review of Resident A's physician progress note dated 5/15/2024 revealed that the nurse practitioner reviewed Resident A's medications with Relative A1. The note indicated that Relative A1 requested changes to the medication regimen, suggesting some medications were no longer needed.

Review of the MARs for May, June, and July 2024 revealed the following for:

May 2024 MAR:

Fentanyl 12 mcg/hr, apply two patches every 72 hours (remove old patch before applying new patch) for 2 doses from 5/11/2024 and stopped on 5/16/2024.

Fentanyl 12 mcg/hr, apply every 72 hours (remove old patch before applying new patch) for 3 doses, then discontinue from 5/17/2024 and stopped on 5/18/2024.

Fentanyl 12 mcg/hr, apply 1 patch topically every 72 hours for 3 doses, then discontinue from 5/18/2024 and stopped on 5/23/2024.

Fentanyl 12 mcg/hr, apply 1 patch topically every 72 hours (remove old patch before applying new patch) from 5/27/2024 and stopped on 7/16/2024.

The MARs indicated that Fentanyl patches were applied on 5/17/2024, then 5/22/2024, 5/27/2024, and 5/30/2024.

June and July 2024 MARs:

Fentanyl patches were documented as administered every 72 hours.

Chart notes for Resident A included:

May 11, 2024: A transdermal patch was applied after a shower.

May 18, 2024: A Fentanyl patch was applied, but the system did not allow documentation.

May 23, 2024: Fentanyl was not due until Friday.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	The review found that while a Fentanyl patch was applied on May 11, 2024, there were discrepancies between the MARs and chart notes. Notably, the patches were not applied every 72 hours as ordered in May 2024. Therefore, the allegation of improper administration of Fentanyl patches was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There was improper testing. Property was stolen.

INVESTIGATION:

On 7/22/2024, the Department received allegations forwarded from APS which read there was improper testing and property was stolen. APS did not initiate an investigation.

On 8/14/2024, a telephone interview was conducted with APS' complainant. a telephone interview was conducted with the APS complainant. The complainant reported that Resident A had experienced burning during urination for approximately 35 days without any intervention from the facility. The complainant noted that Resident A was prescribed Ciprofloxacin for a urinary tract infection, but the facility did not complete the ordered urinalysis, which was requested on 6/24/2024.

Additionally, the complainant claimed that someone attempted to open a credit card in Resident A's name while he was on vacation and mentioned that other residents' families had reported stolen belongings.

On 8/14/2024, an on-site inspection was conducted, and administrator Anngenette Turner was interviewed.

> Ms. Turner confirmed that the urinalysis results should be included in Resident A's medical records. She addressed the claim about identity theft, stating that while Relative A1 alleged someone attempted to steal his identity, no evidence linked the theft to anyone at the facility, and no specific names were provided. Ms. Turner also stated that if an item was reported stolen, staff would attempt to locate it, and if it could not be found and was valued over $10, it would be reported to the police. She noted that no recent reports of stolen belongings had been received from residents' families.

The review of Resident A's resident agreement dated 5/7/2024 included a notice that the facility does not ensure residents' personal property against damage or loss and advised residents to obtain their own insurance if desired. read in part:

A review of Resident A's physician progress notes revealed:

> Note dated 6/26/2024: Resident A complained of pain during urination and symptoms for the past two days. The note indicated that a urinalysis with culture and sensitivity was ordered, with antibiotics to be prescribed if staff were unable to collect a urine sample due to Resident A's incontinence.
>
> Note dated 7/10/2024: Resident A reported urinary frequency, prompting the nurse practitioner to order another urinalysis with culture and sensitivity. Staff were instructed to have Resident A urinate into a hat for collection.

Review of Resident A's service plan dated 5/10/2024 read in part he was incontinent.

Review of Resident A's June and July 2024 MARs read Ciprofloxacin was ordered and staff initialed it as administered from 6/28/2024, to 7/3/2024.

Review of Resident A's records revealed lab results dated 7/10/2024 which in part the urinalysis was abnormal, and the urine culture was gram negative bacilli.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Resident A's physician's note indicated he reported pain during urination starting two days prior to the visit on 6/26/2024. However, the facility records did not document any urinary symptoms before this date; therefore, it could not be established the timeframe for Resident A's symptoms. The medication administration records showed an antibiotic was ordered on 6/28/2024. Resident A's physician progress notes revealed follow up was conducted on 7/10/2024 for his urinary concern. Additionally, interview with Ms. Turner revealed an organized program for allegations of stolen resident belongings. The facility demonstrated an organized program for medical follow-up and handling allegations of stolen belongings; therefore, these allegations could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There was a HIPPA violation.

INVESTIGATION:

On 7/22/2024, the Department received allegations forwarded from APS which there were HIPPA violations. APS did not initiate an investigation.

On 8/14/2024, a telephone interview with the APS complainant revealed that the complainant had requested Resident A's records but instead received records for

another resident with an infectious disease. The complainant noted that hospice staff could corroborate his allegations.

On 8/14/2024, an on-site inspection was conducted, and reviewed Resident A's records showed no documentation pertaining to any other residents.

On 8/20/2024, a telephone interview with staff from the hospice agency confirmed that records provided for the evaluation of Resident A included documentation for another resident. The staff person stated she had instructed Relative A1 to notify the facility about the incorrect records.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(c) A patient or resident is entitled to confidential treatment of personal and medical records, and may refuse their release to a person outside the health facility or agency except as required because of a transfer to another health care facility, as required by law or third party payment contract, or as permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.**
ANALYSIS:	An attestation from an external evaluating agency confirmed that the facility had included records for a different resident in Resident A's documentation. Therefore, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

08/21/2024

Jessica Rogers Date
Licensing Staff

Approved By:

08/21/2024

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section