GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 14, 2024

Michelle Aylor-Robbins
Burcham Hills Retirement Center II
2700 Burcham Drive
East Lansing, MI 48823

RE: License #: AH330236746
Investigation #: 2024A1010084
Burcham Hills Retirement Center II

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 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) 241-1970.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH330236746
Investigation #:	2024A1010084
Complaint Receipt Date:	09/20/2024
Investigation Initiation Date:	09/25/2024
Report Due Date:	11/20/2024
Licensee Name:	Burcham Hills Retirement Center II
Licensee Address:	2700 Burcham Drive East Lansing, MI 48823
Licensee Telephone #:	(517) 351-8377
Authorized Representative/ Administrator:	Michelle Aylor-Robbins
Name of Facility:	Burcham Hills Retirement Center II
Facility Address:	2700 Burcham Drive East Lansing, MI 48823
Facility Telephone #:	(517) 351-8377
Original Issuance Date:	07/01/1999
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	266
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Due to confusion regarding Resident F's medications, some medications were not administered as prescribed.	Yes

III. METHODOLOGY

09/20/2024	Special Investigation Intake 2024A1010084
09/25/2024	Special Investigation Initiated - Telephone Message left for the APS complainant, a telephone back was requested
10/01/2024	Inspection Completed On-site
10/01/2024	Contact - Document Received Received resident admission contract forms, resident physician order to self-administer nasal spray, resident service plan, resident neurology documents, and physician progress notes
10/11/2024	Contact - Telephone call received Interviewed the APS complainant by telephone
11/14/2024	Exit Conference

Allegations regarding the pharmacy used by Resident F and the quantities of some medications delivered were not investigated as no licensing rule violations were alleged. I observed documents to verify Resident F was enrolled to use the facility's contracted pharmacy were completed and signed at the time of Resident F's admission.

ALLEGATION:

Due to confusion regarding Resident F's medications, some medications were not administered as prescribed.

INVESTIGATION:

On 9/20/24, the Bureau received the allegations from Adult Protective Services (APS). The complaint read, "On 9/16/24 [Resident F] was supposed to start taking 100 mg of Magnesium. [Relative F1] provided the facility with a bottle of 100mg

Magnesium pills. [Relative F1] provided the facility with specific instructions for the medication. On or around the 16th [Staff Person 1 (SP1)] made [Resident F] take a 400mg Magnesium pill that the facility had provided. The pill was supposed to be cut in half, but [SP1] did not cut it. [Resident F] also told [SP1] she was not supposed to take the pill in the morning, but [SP1] made [Resident F] take the pill anyway."

On 10/1/24, I interviewed the administrator at the facility. The administrator stated because Resident F enrolled to use the facility's contracted pharmacy, staff administered Resident F's medications as prescribed and provided by the contracted pharmacy. The administrator explained confusion began to occur because Relative F1 also began to bring in some of Resident F's medications from an outside pharmacy. The administrator stated Relative F1 also wrote out instructions for staff regarding Resident F's medications and how Relative F1 wanted staff to administer them.

The administrator reported she met with Relative F1 to explain the only medications that can be provided to Resident F must come from the facility's contracted pharmacy because Resident F elected to use it. The administrator stated Relative F1 was informed staff must follow the physician orders for Resident F's medication administration, not Relative F1's instructions. The administrator explained some of the medications Relative F1 brought into the facility from an outside pharmacy were over the counter medications that were not labeled.

The administrator denied knowledge regarding any issues regarding the administration of Resident F's prescribed magnesium. The administrator provided me with a copy of Resident F's September 2024 medication administration record (MAR) for my review. The MAR read Resident F's prescribed "Magnesium Oxide-Mg Supplement Oral Tablet 200 MG (Magnesium Oxide (Mg Supplement) Give 1 tablet by mouth one time a day" was administered as prescribed.

The administrator reported staff administer Resident F's medications, however she does have a physician's order to store and self-administer some of her own over the counter medications, such as her prescribed nasal spray. The administrator provided me with a copy of Resident F's physician order to store and self-administer her nasal spray that was dated 2/2/23 for my review. The order read, "OK to self-administer Ipratropium Bromide Solution 0.06% nasal spray. Please update PCC order. Please give nasal spray supply in cart to resident."

The administrator provided me with a copy of Resident F's service plan for my review. The *medications and Treatments* section of the plan read, "Medication Administration: Burcham Hills staff administers my medications and orders them from OneCare Pharmacy. Please offer a FULL applesauce with all med administration. Prefers to have her Iron Pill and Tylenol in the morning both crushed. Per Physician order, I am able to self administer the following medications to myself; Citrucel Powder, Biofreeze Gel 1%, Ipratropium Bromide Solution 0.06%, my family orders my medication I self administer from Meijer."

On 10/1/24, I interviewed Resident F at the facility. Resident F reported there has been some confusion regarding her medication because she gets some medication from the facility's pharmacy and some from Relative F1. Resident F denied concerns regarding the administration of her medications. Resident F stated she had nasal spray, eye drops, colace, and Vicks Vapor rub in her room. I observed these items were in Resident F's room.

On 10/11/24, I interviewed the APS complainant by telephone. The APS complainant reported a medication technician (med tech) at the facility recently attempted to administer Resident F's magnesium pill at the incorrect time of day and it was not cut in half. The APS complainant said Resident F did question the med tech and knows her right to refuse a medication if she feels it is incorrect.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) A service plan must identify prescribed medication to be self-administered or managed by the home.
ANALYSIS:	The interview with the administrator, along with review of Resident F's service plan, revealed Resident F has physician orders to store and self-administer some of her prescribed medications. Resident F's plan read Resident F can store and self-administer her prescribed, "Citrucel Powder, Biofreeze Gel 1%, Ipratropium Bromide Solution 0.06%." I observed Resident F had her prescribed eye drops and Colace in her room that she self-administers. These medications were not outlined as prescribed medications Resident F can store and self-administer. As a result, Resident F's service plan was not consistent with the medications she had in her room and was self-administering. This was not consistent with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Michelle Robbins on 11/14/24

IV. RECOMMENDATION

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

11/07/2024

Lauren Wohlfert Date
Licensing Staff

Approved By:

11/13/2024

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