GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 14th, 2024

Carol DelRaso
Senior Living Boulder Creek, LLC
7927 Nemco Way, Ste 200
Brighton, MI 48116

RE: License #: AH410406207
Investigation #: 2025A1021009
Boulder Creek Assisted Living & Memory Care

Dear Carol DelRaso:

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 (517) 284-9730.

Sincerely,
Kimberly Horst

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH410406207 |
| | |
| **Investigation #:** | 2025A1021009 |
| | |
| **Complaint Receipt Date:** | 10/22/2024 |
| | |
| **Investigation Initiation Date:** | 10/23/2024 |
| | |
| **Report Due Date:** | 12/21/2024 |
| | |
| **Licensee Name:** | Senior Living Boulder Creek, LLC |
| | |
| **Licensee Address:** | 7927 Nemco Way, Ste 200<br>Brighton, MI 48116 |
| | |
| **Licensee Telephone #:** | (616) 464-1564 |
| | |
| **Administrator:** | Josh Wood |
| | |
| **Authorized Representative:** | Carol DelRaso |
| | |
| **Name of Facility:** | Boulder Creek Assisted Living & Memory Care |
| | |
| **Facility Address:** | 6070 Northland Drive<br>Rockford, MI 49341 |
| | |
| **Facility Telephone #:** | (616) 866-2911 |
| | |
| **Original Issuance Date:** | 08/10/2021 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 07/03/2024 |
| | |
| **Expiration Date:** | 07/31/2024 |
| | |
| **Capacity:** | 108 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Facility attempted to administer incorrect medication. | Yes |
| Facility runs out of medications. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 10/22/2024 | Special Investigation Intake 2025A1021009 |
| 10/23/2024 | Special Investigation Initiated - Telephone interviewed complainant |
| 10/25/2024 | Inspection Completed On-site |
| 11/14/2024 | Exit Conference |

The complainant alleged Resident B was administered another resident's medication and medication that was wet and deteriorated. These allegations were investigated under 2024A1010031.

**ALLEGATION:**

**Facility attempted to administer incorrect medication.**

**INVESTIGATION:**

On 10/22/2024, the licensing department received a complaint with allegations Resident A was provided incorrect medication. The complainant alleged the facility administered Lorazepam without approval from the Hospice company. The complainant alleged employees at the facility told Resident A that he had to take the medication because it was ordered by the nurse. The complainant alleged this medication was to be started after hospice approval.

On 10/25/2024, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident A has an active order for Lorazepam 0.5mg as needed with instructions to administer every four hours as needed. SP1 reported this prescription came from Corsa Care Pharmacy. SP1 reported there were no orders or special instructions to contact the hospice company prior to administration of this medication. SP1 reported

at times Morphine medication will have this instruction but not Lorazepam. SP1 reported the medication administration record (MAR) now reflects that this medication requires hospice approval.

On 10/25/2024, I interviewed Resident A at the facility. Resident A reported he can refuse medications and has done so in the past. Resident A reported he is very particular about medications and wants to ensure he receives the correct medications. Resident A reported no other concerns with medications.

On 10/25/2024, I interviewed Corsa Care hospice nurse Traci Schroeder at the facility. Ms. Schroeder reported on this day this incident occurred; the hospice social worker visited Resident A at the facility. Ms. Schroeder reported the social worker reported to staff that an anti-depressant may need to be started with Resident A. Ms. Schroeder reported care staff took this as the PRN needed to be administered and staff attempted to administer the medication. Ms. Schroeder reported care staff reportedly told Resident A the medication was scheduled, and he had to take it. Ms. Schroeder reported the order now reflects that hospice is to be contacted prior to administration of this medication.

I reviewed Resident A's October 2024 Medication administration record (MAR). The MAR revealed Lorazepam was attempted administration on 10/11 at 1:56pm but was not administered. The MAR revealed an order was written that read,
*"You must contact hospice prior to administering. They will assist with getting (Resident A) to take it."*

The October MAR revealed Resident A had an active PRN order for Lorazepam that read,
*"give 1 tablet by mouth every four hours as needed for agitation or restlessness*."

I reviewed Resident A's service plan. The service plan revealed there was no mention of how Resident A exhibits agitation or restlessness. The service plan did not provide instruction on if the facility can use non-pharmacological approaches or when the administration of the medication is required.

I reviewed Resident A's supervision monitoring notes for 10/11. The notes revealed Resident A had no signs or symptoms of agitation or restlessness.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1932** | **Resident's 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:** | On 10/11/2024, staff members attempted to administer this medication when Resident A did not exhibit behaviors requiring the administration of this medication. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION**:

**Facility runs out of medications.**

**INVESTIGATION:**

The complainant alleged the facility has run out of Resident A's medications.

I reviewed Resident A's August, September, and October MARs. The MAR's revealed the following:

08/11: Prednisone Tab 10mg: awaiting med arrival from pharmacy
08/12: Prednisone Tab 10mg: awaiting med arrival from pharmacy
08/13: Prednisone Tab 10mg: awaiting med arrival from pharmacy
08/14: Fish Oil: awaiting med arrival from pharmacy
09/11: Aspirin 81mg: awaiting med arrival from pharmacy
09/11: Omega 3 acid cap: awaiting med arrival from pharmacy
09/13: Nitrofurantin Cap 100mg: awaiting med arrival from pharmacy
09/25: Glucos Cap: awaiting med arrival from pharmacy
09/26: Glucos Cap: awaiting med arrival from pharmacy
09/27: Aspirin 81 mg: awaiting med arrival from pharmacy
09/27: Glucos Cap: awaiting med arrival from pharmacy
09/27: Omega 3 Acid: awaiting med arrival from pharmacy
09/28: Aspirin 81mg: awaiting med arrival from pharmacy
09/28: Glucos Cap: awaiting med arrival from pharmacy
09/28: Omega acid: awaiting med arrival from pharmacy
09/29: Aspirin 81mg: awaiting med arrival from pharmacy
09/29: Glucos Cap: awaiting med arrival from pharmacy
09/29: Omega acid: awaiting med arrival from pharmacy
10/02: Silver Sulfa Cream: awaiting med arrival from pharmacy
10/03: Silver Sulfa Cream: awaiting med arrival from pharmacy
10/16: Glucos Cap: awaiting med arrival from pharmacy
10/17: Glucos Cap: awaiting med arrival from pharmacy

| 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:** | Review of Resident A's MARs revealed multiple instances in which the facility did not administer medications as prescribed by the licensed health care professional. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

While onsite, I learned the administrator was changed to Josh Wood approximately four weeks prior to my on-site visit.

| APPLICABLE RULE | |
|---|---|
| **R 325.1913** | **Licenses and permits; general provisions.** |
| | **(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.** |
| **ANALYSIS:** | The licensee did not appropriately notify the Department of the change in the administrator. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

11/14/2024

_____

Kimberly Horst — Date
Licensing Staff

Approved By:

11/14/2024

_____

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