GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 22, 2024

Connie Clauson
Baruch SLS, Inc.
Suite 203
3196 Kraft Avenue SE
Grand Rapids, MI 49512

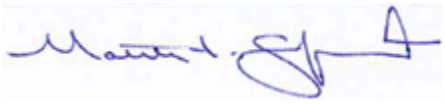
RE: License #: AL200337124
Investigation #: 2024A0360024
Northern Pines Assisted Living

Dear Mrs. Clauson:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
931 S Otsego Ave Ste 3
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL200337124
Investigation #:	2024A0360024
Complaint Receipt Date:	09/23/2024
Investigation Initiation Date:	09/24/2024
Report Due Date:	11/22/2024
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Connie Clauson, Designee
Licensee Designee:	Connie Clauson, Designee
Name of Facility:	Northern Pines Assisted Living
Facility Address:	130 Mary Ann Street Grayling, MI 49738
Facility Telephone #:	(989) 344-2010
Original Issuance Date:	06/25/2013
License Status:	REGULAR
Effective Date:	12/25/2023
Expiration Date:	12/24/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A received more than she was prescribed of Morphine and Norco.	No
Direct care staff Janelle Muscat is not properly trained in medication administration.	No

III. METHODOLOGY

09/23/2024	Special Investigation Intake 2024A0360024
09/24/2024	Special Investigation Initiated - Telephone complaint source
09/24/2024	APS Referral online complaint
10/01/2024	Inspection Completed On-site Resident Care Director Andrea Ashton, DCS Janelle Muscatt
10/07/2024	Contact - Document Received Andrea Ashton
10/11/2024	Contact - Document Received Andrea Ashton Medication Training Log
10/21/2024	Contact - Telephone call received Relative A
10/29/2024	Contact - Face to Face Mary Laforge, Carelinc Hospice
10/29/2024	Inspection Completed On-site Andrea Ashton, Resident's B, C, D.
11/18/2024	Contact - Telephone call made Darla Ames, Compassus Hospice
11/22/2024	Exit Conference

ALLEGATION:

Resident A received more than she was prescribed of Morphine and Norco.

INVESTIGATION:

On 9/24/24, I contacted the complaint source by telephone. They stated they had concerns with the facility staff administering a large dose of Morphine and Norco on 6/12/24. They stated Resident A is no longer at the facility and was transferred to another facility.

On 10/1/24, I conducted an unannounced onsite inspection at the facility. I interviewed the resident care director Andrea Ashton. Ms. Ashton provided me with the medication administration records for June 2024 for Resident A. Ms. Ashton denied that medications were administered more than the prescribed dosage.

On 10/1/24, I reviewed the medication administration records (MARS) for Resident A. The MARS for 6/12/24 documented that Resident A received three doses of Norco one each at 4:42, 13:20, and 21:48 which is within the prescribed amount of one every 6 hours. It also documented that Resident A received two doses of Morphine one at 20:39 and another at 21:54 which was not within the prescribed timeframe of one dose every four hours as needed for pain.

On 10/21/24, I received a phone call from Relative A. Relative A stated she was very concerned with the amount of pain medications administered on 6/12/24 including both the Norco and Morphine. She stated Resident A has now passed away while receiving care at the McReynolds Hall nursing home in Gaylord.

On 10/29/24, I conducted another unannounced onsite inspection at the facility. Ms. Ashton and I reviewed the 6/12/24 medication administration. Ms. Ashton stated that on 6/12/24 Resident A was prescribed an additional dose of Morphine every hour as needed. She provided me with both the Compassus Hospice physician order increasing the morphine dosage as well as the staff notes documenting the increase.

On 11/18/24, I contacted Darla Ames from Compassus Hospice by telephone. Ms. Ames stated Northern Pines is one of the best facilities that she works with. She stated she has no concerns about the medication administration at the facility. Ms. Ames reviewed the documentation from Compassus Hospice and the communication between the staff at Northern Pines on 6/12/24 ordering the increase in Morphine. Ms. Ames stated they were contacted at 5 a.m. in the morning on 6/12/24 regarding Resident A being in additional pain. Ms. Ames stated a hospice nurse was at the facility at 6 a.m. and ordered the increase dosages of Morphine for pain management. Ms. Ames stated the facility staff provided multiple updates to

hospice staff throughout the day and into the evening. She stated she has no concerns regarding the medication being administered as prescribed.

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:	Interviews with Ms. Ashton, Relative A, Ms. Ames and medication administration records review revealed that Resident A was not administered a higher dose of Norco or Morphine than she was prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Direct care staff Janelle Muscat is not properly trained in medication administration.

INVESTIGATION:

On 10/1/24, I conducted an unannounced onsite inspection at the facility. Ms. Ashton stated that she provides the medication administration training for all staff. Ms. Ashton stated this includes multiple days of observation of medication administration as well as being observed. Ms. Ashton also stated that Hometown Pharmacy also provides an annual in-service training in medication management that all the staff attend. Ms. Ashton could not provide me with documentation of direct care staff Janelle Muscat's medication training. She stated that they typically go through an entire checklist with the staff. She stated she would find the documentation for Ms. Muscat and email it.

On 10/1/24, while at the facility I interviewed DCS Janelle Muscat. Ms. Muscat stated she has four years' experience administering medication. She stated the medication training at the facility included 1-2 weeks of observing medication administration

followed by staff observing her medication administration. She stated they are trained in medication preparation, passing, and effectiveness. She stated they are training on making sure the medication is for the right person, the right medication, the right dosage. Ms. Muscat stated that Hometown Pharmacy also provided her with an in-service training on medication passing in February 2024.

On 10/7/24, I received a medication training checklist from Ms. Ashton by email. The blank medication training checklist documented over 40 areas of medication administration that staff are evaluated.

On 10/11/24, I received by email a Hometown Pharmacy medication in-service training sheet from Ms. Ashton documenting that Ms. Muscat was signed in as an attendee.

On 10/29/24, I conducted another unannounced onsite inspection at the facility. I interviewed Carelinc Hospice staff Mary Laforge. Ms. Laforge stated she has several patients in the facility and does not have any concerns regarding the medication administration of the staff.

On 10/29/24, While at the facility I interviewed Resident's B, C, and D. All three residents reported that they are administered the medications they are prescribed. They reported no concerns with staff being trained in medication administration.

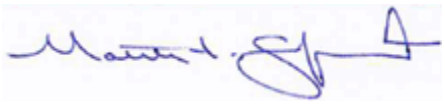
On 11/18/24, I contacted Darla Ames from Compassus Hospice by telephone. Ms. Ames stated Northern Pines is one of the best facilities that she works with. She stated she has no concerns about the medication administration at the facility.

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: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Interviews with Ms. Ashton, Ms. Muscat, Ms. Laforge, Ms. Ames, Residents B, C, D, and documentation from Hometown Pharmacy revealed no evidence that staff are not trained in medication administration.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 11/22/24 I conducted an exit conference with Connie Clauson. Ms. Clauson concurred with the findings of the investigation.

IV. RECOMMENDATION

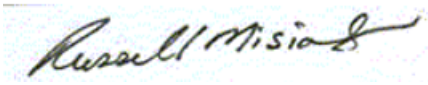
I recommend no change in the status of the license.



11/22/24

Matthew Soderquist Date
Licensing Consultant

Approved By:



11/22/24

Russell B. Misiak Date
Area Manager