GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 9, 2025

Harish Sathri
Elderly Solutions, Inc.
100 Santure Road
Monroe, MI 48162

RE: License #: AS580291609
Investigation #: 2025A0116009
Elderly Solutions Inc - II

Dear Mr Sathri:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS580291609
Investigation #:	2025A0116009
Complaint Receipt Date:	12/04/2024
Investigation Initiation Date:	12/04/2024
Report Due Date:	02/02/2025
Licensee Name:	Elderly Solutions, Inc.
Licensee Address:	100 Santure Road Monroe, MI 48162
Licensee Telephone #:	(734) 240-2374
Administrator:	Harish Sathri
Licensee Designee:	Harish Sathri
Name of Facility:	Elderly Solutions Inc - II
Facility Address:	100 Santure Rd #2 Monroe, MI 48162
Facility Telephone #:	(734) 240-2374
Original Issuance Date:	09/12/2007
License Status:	REGULAR
Effective Date:	04/09/2024
Expiration Date:	04/08/2026
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff administered Seroquel to Resident A after it had been discontinued.	Yes

III. METHODOLOGY

12/04/2024	Special Investigation Intake 2025A0116009
12/04/2024	Special Investigation Initiated - On Site Interviewed staff, Brandy Bray and Amanda Mills.
12/04/2024	Contact - Telephone call made Spoke with the complainant.
12/04/2024	Contact - Telephone call made Interviewed Vini Voggu, board member, and previous licensee designee.
12/04/2024	APS Referral Not required as the incident occurred over 5 months ago and the resident no longer resides in the facility.
12/08/2024	Contact - Document Received Received and reviewed Resident A's medication administration records (MARs), health care appraisal, and assessment plan.
12/08/2024	Inspection Completed-BCAL Sub. Compliance
12/19/2024	Exit Conference With licensee designee, Harish Sathri.

ALLEGATION:
Staff administered Seroquel to Resident A after it had been discontinued.

INVESTIGATION:

On 12/04/24, I conducted an unscheduled on-site inspection and interviewed staff, Brandy Bray and Amanda Mills. Ms. Bray reported that Resident A's son moved him out of the facility on 06/14/24 and reported he had lived there for about seven months. Ms. Bray reported that she is not aware of any issues pertaining to Resident A being given a medication that had been discontinued.

I interviewed staff, Amanda Mills and she reported that she remembers that Resident A had to be sent out a couple times due to lethargy and compromised breathing but had no knowledge of it being tied to his prescribed Seroquel medication. I asked to review Resident A's records and Ms. Mills reported that licensee designee, Harish Sathri, had come to the facility and retrieved the file a few days ago. Ms. Mills further reported that if she recalls correctly Resident A was not on Seroquel when he was admitted on November 7, 2023, but was later prescribed it by the house doctor, Dr. Bhurgri. Ms. Mills could not recall the date.

Ms. Bray called the pharmacist in my presence and asked the pharmacist, who fills and delivers medications to the facility, when Resident A was prescribed Seroquel and the dosage. The pharmacist confirmed that Dr. Bhurgri prescribed 25mg of Seroquel to be taken twice per day on February 23, 2024, and reported that the medication was last filled on 06/14/24.

On 12/04/24, I spoke with the complainant, and he confirmed the allegations as reported. The complainant reported that it is unacceptable to be given a written order from a doctor discontinuing a medication, and the staff disregard that and continue to administer it. Complainant reported his belief that the hospitalizations were a result of Resident A being given the Seroquel. Complainant reported after Resident A's hospitalization in June of 2023, he did not return him to the facility.

On 12/04/24, I interviewed Vini Voggu, licensee designee at the time of the incident and current board member/shareholder. Ms. Voggu reported that when the incident occurred, she was the licensee designee and reported having contact with Resident A's son regarding the matter. Ms. Voggu reported that Resident A was hospitalized on May 31, 2024, and returned to the facility on June 4, 2024. Ms. Voggu reported that the discharge instructions were not reviewed by the staff on shift, and she administered both the a.m. and p.m. dose of Seroquel, although it had been discontinued. Ms. Voggu reported the following day June 5, 2024, Resident A was demonstrating poor responsiveness and was sent back to the hospital. Ms. Voggu reported he did not return to the facility. Ms. Voggu reported the managers were due to review the discharge orders during their shift and update the MARs as needed. Ms. Voggu admits the error was the fault of the home/staff and reported she completed an emergency in-service with all staff regarding medications and the importance of immediate review of discharge instructions upon a residents return to the home from a hospital admission.

On 12/09/24, I received and reviewed Resident A's health care appraisal, assessment plan and MARs. The MARs reviewed were from November 2023 through June 2024. I confirmed that Resident A began taking the 25mg of Seroquel in the evening of 02/24/24. I also confirmed that Resident A was hospitalized on May 31, 2024, and the May and June MARs reflected that by staff entering leave of absence (LOA) in the spaces normally reserved for staff initials after administration of medication. The LOA was documented from May 31, 24 through June 3, 2024, then on June 4, 2024, staff administered and initialed that Resident A was given his a.m. and p.m. 25mg dose of Seroquel. On June 5, 2024, the MAR reflected LOA again, as Resident A was hospitalized and did not return back to the facility.

On 12/19/24, I conducted the exit conference with licensee designee, Harish Sathri and informed him of the findings of the investigation, Mr. Harish reported an understanding of the rule violation and reported that he was not initially aware of the matter, as he recently was appointed as licensee designee and administrator. Mr. Sathri reported understanding the seriousness of the matter and will be working with staff to prevent a re-occurrence.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.

ANALYSIS:	Based on the findings of the investigation, which included interviews of the complainant, staff, Amanda Mills, board member, Vini Voggu, and my review of Resident A's MARs, I am able to corroborate the allegation that Resident A was administered Seroquel, after it was no longer required and discontinued. The complainant voiced frustration and concern regarding the staff disregard of a doctors written order discontinuing a medication that he believed was causing Resident A distress. Board member, Vini Voggu admitted that the staff did not review the hospital discharge orders, and her failure to do so, resulted in Resident A being administered two doses of 25mg Seroquel medication that was discontinued and therefore no longer required. My review of Resident A's MARs confirmed that he was administered an a.m. and p.m. 25mg dose of Seroquel on June 4, 2024, a day after the medication was discontinued and no longer required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/09/25

Pandrea Robinson
Licensing Consultant

Date

Approved By:

01/09/25

_____

Ardra Hunter
Area Manager

Date