RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

December 20, 2017

Lauren Reenders
Seminole Shores Assisted Living Center
850 Seminole Road
Muskegon, MI 49441-3430

RE: License #: AH610255010
Investigation #: 2018A1010009
Seminole Shores Assisted Living Center

Dear Ms. Reenders:

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.

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 (616) 356-0100.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa, N.W. 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 #:	AH610255010
Investigation #:	2018A1010009
Complaint Receipt Date:	12/18/2017
Investigation Initiation Date:	12/18/2017
Report Due Date:	02/17/2018
Licensee Name:	Seminole Shores Operating Company
Licensee Address:	950 Taylor Avenue Grand Haven, MI 49417
Licensee Telephone #:	(616) 842-2425
Administrator:	Judi Delis
Authorized Representative:	Lauren Reenders
Name of Facility:	Seminole Shores Assisted Living Center
Facility Address:	850 Seminole Road Muskegon, MI 49441-3430
Facility Telephone #:	(231) 780-2944
Original Issuance Date:	07/24/2003
License Status:	REGULAR
Effective Date:	06/11/2017
Expiration Date:	06/10/2018
Capacity:	129
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's Phenobarbital was incorrectly discontinued by staff without a physician order. Resident A had a seizure on 11/26.	Yes

III. METHODOLOGY

12/18/2017	Special Investigation Intake 2018A1010009
12/18/2017	Special Investigation Initiated - On Site
12/18/2017	Inspection Completed On-site
12/18/2017	Contact - Document Received Resident A's service plan, staff notes, and physician orders received
12/19/2017	APS Referral APS complaint emailed to Centralized Intake
12/20/2017	Exit conference

ALLEGATION:

Resident A's Phenobarbital was incorrectly discontinued by staff without a physician order. Resident A had a seizure on 11/26.

INVESTIGATION:

On 12/18/17, I reviewed the facility file and incident report that was previously submitted. The *Investigation* section of the report read, "[Resident A] was taking Phenobarbital 32.4 one tab by mouth twice daily and Phenytoin 100 mg two capsules by mouth daily. On November 7th Jennifer received an order to discontinue Phenytoin and an order to change Phenytoin to 100 mg one capsule daily x14 days then discontinue. Jennifer changed the Phenytoin to 100 mg one capsule daily x14 days then discontinue. Then she discontinued Phenobarbital."

The report also read, "November 26th 2017 at 7:30 am [Resident A] was observed on the floor laying on her right side, shaking and short of breath. She was sent to ER. She returned November 26th 2017 at 12:30 pm with diagnosis of seizure and was started on Keppra."

On 12/18/17, I interviewed administrator Judi Delis at the facility. Ms. Delis reported the facility's clinical coordinator Jennifer Marne incorrectly discontinued Resident A's Phenobarbital without a physician order on 11/7. Ms. Delis' statements were consistent with the incident report.

Ms. Delis stated Ms. Marne was disciplined after the incident. Ms. Delis reported the facility's resident service coordinator Candy Bitson now reviews and approves all medications before they are discontinued in the facility's computer system.

On 12/18/17, I interviewed Ms. Marne at the facility. Ms. Marne stated she did not know what led her to discontinue Resident A's Phenobarbital without a physician order on 11/7. Ms. Marne reported the names of the medication are similar, and that may have caused her to incorrectly discontinue the Phenobarbital. Ms. Marne's statements were consistent with the incident report and Ms. Delis.

Ms. Marne reported the facility received a discontinue order for Phenobarbital several days after she accidently discontinued it in the facility's computer system.

On 12/18/17, I interviewed Quality Assurance Coordinator Kelly Busch at the facility. Ms. Busch's statements were consistent with the incident report, Ms. Delis, and Ms. Marne.

Ms. Busch provided Resident A's November medication administration record (MAR) for my review. The MAR read the last dose of Phenobarbital that Resident A received was on 11/7. Resident A did not receive her prescribed Phenobarbital from 11/7 until the medication was discontinued on 12/1.

On 12/18/17, I interviewed Resident A at the facility. Resident A reported staff do a good job and she had no concerns. Resident A stated staff administer her medications every day and there have been no issues that she was aware of.

Resident A reported she is prescribed two seizure medications. She was unable to recall the names of the medication. Resident A said she had a seizure during Thanksgiving weekend because her medication dose was too low. Resident A reported her physician recently increased the dose because of her seizure. Resident A stated she has not had a seizure since her medication changed.

Ms. Delis provided Resident A's physician orders for Phenytoin and Phenobarbital for my review. The order dated 11/7 read "Phenytoin 100 mg capsule one at bedtime for 14 days then stop." The discontinue order dated 11/7 read to discontinue Phenytoin 100 mg two at bedtime.

Ms. Delis also provided me with Resident A's physician order to discontinue Phenobarbital. The order was dated 12/1 and read, "Phenobarbital 32.4 mg tablet this medication has been discontinued."

On 12/19/17, I made an Adult Protective Services (APS) complaint with Centralized Intake.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Interviews with Ms. Delis, Ms. Marne, and Ms. Busch, along with review of Resident A's incident report revealed Resident A's Phenobarbital was incorrectly discontinued on 11/7. As a result, Resident A did not receive her prescribed Phenobarbital from 11/7 until the medication was discontinued on 12/1. The facility was out of compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Lauren Reenders on 12/20.

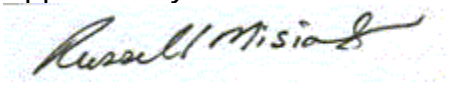
IV. RECOMMENDATION

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

12/19/17

Lauren Wohlfert — Date
Licensing Staff

Approved By:



12/19/17

Russell B. Misiak — Date
Area Manager