RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

June 19, 2018

Marcia Curtiss
Lifehouse Crystal Manor Operations LLC
Suite 115
21800 Haggerty Rd.
Northville, MI 48167

RE: License #: AL410302932
Investigation #: 2018A0355057
Addington Place of Grand Rapids Bay Pointe

Dear Mrs. Curtiss:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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 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 (616) 356-0183.

Sincerely,

Grant Sutton, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4437

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410302932
Investigation #:	2018A0355057
Complaint Receipt Date:	06/13/2018
Investigation Initiation Date:	06/13/2018
Report Due Date:	08/12/2018
Licensee Name:	Lifehouse Crystal Manor Operations LLC
Licensee Address:	Suite 115 21800 Haggerty Rd. Northville, MI 48167
Licensee Telephone #:	(616) 262-1792
Administrator:	Marcia Curtiss
Licensee Designee:	Marcia Curtiss
Name of Facility:	Addington Place of Grand Rapids Bay Pointe
Facility Address:	1171 68th Street S.E. Grand Rapids, MI 49508
Facility Telephone #:	(616) 281-8054
Original Issuance Date:	04/05/2010
Status:	REGULAR
Effective Date:	09/26/2016
Expiration Date:	09/25/2018
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's medications ran out and he did not receive them for approximately a week, causing confusion as one was for Alzheimer's.	Yes

III. METHODOLOGY

06/13/2018	Special Investigation Intake 2018A0355057
06/13/2018	APS Referral
06/13/2018	Special Investigation Initiated - Telephone Licensee designee
06/18/2018	Inspection Completed On-site Interviewed staff; reviewed Resident A's medication logs
06/18/2018	Exit Conference Designee

ALLEGATION: Resident A's medications ran out and he did not receive them for approximately. a week, causing confusion as one was for Alzheimer's.

INVESTIGATION: On 06/13/2018, I received a complaint filed on behalf of Resident A by his son reporting that Resident A had been out of several medications for approximately one week. Due to this, the son had observed increased confusion in Resident A during this period.

On 08/18/2018, I conducted an on-site investigation and interviewed staff Janine Hayes and the licensee designee, Marcia Curtiss. While on-site, I reviewed Resident A's medication logs and related information.

Ms. Hayes stated that Resident A was out of the medications Donepezil (for Alzheimer's), Memantine (for Alzheimer's) and Terazosin (treats hypertension) from June 1 – 11, 2018. Ms. Hayes stated that the electronic medication system indicated that staff had notified the pharmacy on 6/5/2018, but since Resident A's medications are provided by the VA, they were not filled at that time. Ms. Hayes stated that the pharmacy was aware that Resident A's medications come from the VA but the pharmacy did not respond to the request at the time. Ms. Hayes stated that Resident A's health, in general, was not negatively affected aside from the

increased confusion described by the complainant. Ms. Hayes indicated that Resident A's son visits Resident A on nearly a daily basis and is a reliable reporter.

Mrs. Curtiss stated that Resident A recently moved from another facility in the vicinity due to remodeling at that facility. Mrs. Curtiss pointed out that the move will be permanent due to the current facility's ability to better meet Resident A's needs. Mrs. Curtiss stated that the process for handling Resident A's medications has been that staff notify Resident A's son when the medications need to be reordered and the son reorders the medications from the VA. Mrs. Curtiss stated that in the future, staff may discuss with the son the possibility of staff ordering the medications from the VA directly. Mrs. Curtiss stated that when the issue was discovered, the facility physician prescribed an emergency 5-day supply of medications for Resident A and the pharmacy filled that order while the regular order was placed to the VA. Mrs. Curtiss stated that Resident A is receiving all his medications currently. Mrs. Curtiss acknowledged that the staff responsible for passing Resident A's medications should have followed up when it was clear that Resident A was out of the medications identified but this was not done. Mrs. Curtiss stated that part of the corrective action that she has already taken is that she receives a daily 'exception' report which identifies if any residents are out of a medication so she can follow up immediately. Mrs. Curtiss stated that the training process for passing medications is being reviewed in general, and medication passing training with the staff involved, in particular is being addressed as a part of the corrective action.

My review of the medication logs indicated that Resident A is currently receiving his medications, as prescribed.

On 06/18/2018, I conducted an exit conference while on-site with the licensee designee, Marcia Curtiss. Mrs. Curtiss acknowledged the seriousness of this situation and feels the licensee will follow up appropriately to prevent this from occurring in the future.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	The licensee designee, Marcia Curtiss, acknowledged that from June 1-11, 2018, Resident A did not receive three of his prescribed medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend that the status of the license remain unchanged.

06/19/2018

Grant Sutton Date
Licensing Consultant

Approved By:

06/19/2018

Jerry Hendrick Date
Area Manager