STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

October 4, 2018

Marcia Curtiss
Homestead Management
Suite 115
21800 Haggerty Rd.
Northville, MI 48167

RE: License #:	AL410305473
Investigation #:	2018A0356050 Whispering Woods #5

Dear Mrs. Curtiss:

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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410305473
Investigation #:	2018A0356050
Complaint Receipt Date:	08/06/2018
Investigation Initiation Date:	08/06/2018
Report Due Date:	10/05/2018
Licensee Name:	Homestead Management
Licensee Address:	Suite 115 21800 Haggerty Rd. Northville, MI 48167
Licensee Telephone #:	(616) 949-9500
Administrator:	Marcia Curtiss
Licensee Designee:	Marcia Curtiss
Name of Facility:	Whispering Woods #5
Facility Address:	3964 Whispering Way Grand Rapids, MI 49546
Facility Telephone #:	(616) 949-9500
Original Issuance Date:	03/22/2011
License Status:	REGULAR
Effective Date:	10/07/2017
Expiration Date:	10/06/2019
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was given the wrong medication to manage low blood sugar level.	Yes

III. METHODOLOGY

08/06/2018	Special Investigation Intake 2018A0356050
08/06/2018	APS Referral
08/06/2018	Special Investigation Initiated - Telephone APS worker Zach Blevins.
08/08/2018	Contact - Document Received Incident Report
08/09/2018	Contact-Face to Face Marcia Curtiss @ the facility
08/28/2018	Inspection Completed On-site Jeannine Hayes, regional nurse. Kat Hartley, Admin.
08/28/2018	Contact - Document Received Medication info.
09/01/2018	Contact - Face to Face
10/03/2018	Contact-Telephone call made Licensee Designee, Marcia Curtiss
10/04/2018	Exit Conference Marcia Curtiss-Licensee Designee

ALLEGATION: Resident A was given the wrong medication to manage low blood sugar level.

INVESTIGATION: On 08/06/2018, I received an APS (Adult Protective Services) Intake Referral that reported Resident A arrived at the emergency room on 08/04/2018 due to a fall at the facility, Resident A reportedly fell out of bed due to low blood sugar. Resident A is diabetic and reportedly her blood sugar was checked at the facility, it was low, yet Resident A was given all her medications including

insulin. The concern is that Resident A was given insulin despite having a low blood sugar reading.

On 08/06/2018, I spoke to Zac Blevins, Kent County Adult Protective Services worker. Mr. Blevins had already begun following up on this complaint and reported Resident A was not administered insulin but rather Metformin, which is part of Resident A's morning medications. Mr. Blevins stated his concern is even though Resident A was not administered insulin as reported to the hospital, she was still given Metformin that is used to help control high blood sugar when in fact, her blood sugar was low.

On 08/08/2018 I received and reviewed an Incident Report (IR) dated 08/04/2018 @ 8:40AM, written by Direct Care Worker (DCW) Cathena Holmes and signed by Leslie Redmon, facility nurse and Marcia Curtiss, Licensee Designee/Administrator. The IR documents the following information: "*Med tech stated bs (blood sugar) 67, told (Resident A's) husband to give wife a snack and exited the room. Upon re-entry med tech observed resident on floor. Called nurse, called doctor, informed family and supervisor. Sent resident to ER*."

On 08/28/2018, I conducted an onsite inspection at the facility and met with Regional Nurse, Jeannine Hayes. Ms. Hayes stated the information relayed to the ER is erroneous, Resident A was not given insulin prior to going to the ER on 08/04/2018. Resident A was administered her morning medications that included Metformin prior to leaving for the hospital but was not given insulin because that medication is not to be administered until evening. Ms. Hayes stated at 8:24AM, med tech/DCW Ms. Holmes tested Resident A's blood sugar level and it was 67, which is low. Ms. Hayes stated Ms. Holmes instructed Resident A to eat something and she would come back and test her blood sugar again. Ms. Hayes stated when Ms. Holmes came back to Resident A's room, she found Resident A on the floor near her bed with a knot on her head. Ms. Hayes stated Resident A was sent to ER for evaluation and treatment however; the morning medications were administered prior to Resident A going to ER. Ms. Hayes stated the doctor's instructions on the MAR are if a resident's blood sugar is below 70 or above 250, the prescriber, doctor, Dr. Gary Sackett should be notified. Ms. Hayes stated Dr. Sackett was not contacted and Ms. Holmes should have waited to administer the Metformin medication. Ms. Hayes stated after this incident, Ms. Holmes is not being allowed to administer resident medications until she has been retrained.

On 08/28/2018, I reviewed Resident A's Medication Administration Record (MAR) for the month of August 2018. On 08/04/2018 Metformin tab 500MG ER, take 2 tablets by mouth twice daily was administered and signed for by CH-Cathena Holmes with the remainder of Resident A's AM medications. Documented on the MAR as administered on the evening of 08/04/2018 is Lantus Inj Solostar, inject 10 units subcutaneously daily at bedtime and signed as administered by DCW, TM-Tocarra Means. The MAR has a blood glucose chart that documents, '*check and record blood sugar twice a day **if below 70 or above 250 notify MD.*' On the 08/04/2018, at

the 8:00AM hour, Ms. Holmes documented Resident A's blood glucose level tested at 67.

On 08/28/2018, I reviewed the charting notes for Resident A on 08/04/2018 at 10:13AM documented by Ms. Holmes. Ms. Holmes documents the following information: "*She fell getting out of bed this morning her BG was 67. I told her to get up and eat. She said she would. I left out of the room to finish other BG reading, while in other room I was informed she (Resident A) fell, went into the room and sure enough she was on the floor with a knot on her head, took all vitals."*

On 08/28/2018, I reviewed the charting notes for Resident A on 08/04/2018 by Ms. Redmon. Ms. Redmon documents the following information: "*8:50 received call stating resident fell out of bed, hit her head and was refusing to go to ER. This nurse instructed EMS must be called, this nurse arrived 10:00 and received a call from the hospital nurse stating someone had given resident insulin with an already low BS* (blood sugar) *this am, and she was going to have to call APS. This nurse called Executive Director* (administrator) *and then the Regional director and spoke to the Med Tech. Med Tech did not give insulin per report. Always follow the MAR orders for low or high BG* (blood glucose). *Never give any other BG med until Dr. is called first including Metformin. If a resident has a low BG 70-30 follow protocol, DO NOT LEAVE RESIDENT call for help. Call for additional help from supervisor, another med tech, nurse or RA* (resident aide). *Every med tech is required to know and must follow the Hypoglycemia guidelines."*

On 10/01/2018, I interviewed Resident A and Relative #1 at the facility. Resident A and Relative #1 stated Resident A's sugar was "really low" and "someone" came to the room and told Relative #1 to give Resident A a "cookie." Relative #1 stated the DCW left the room and as he was getting Resident A a cookie, she would not wait in bed, tried to get up and fell on the floor. Resident A reiterated that she wasn't even able to stand up but as she tried, she fell out of bed and "banged myself up good!" Resident A stated she thinks she took her morning medications prior to going to the hospital on 08/04/2018. Relative #1 stated Resident A took her morning medications prior to going to the hospital on 08/04/2018.

On 10/03/2018, I reviewed the information gathered during this investigation with Ms. Curtiss via telephone. Ms. Curtiss confirmed the information and confirmed that Ms. Holmes was not allowed to administer medications until she was re-trained on medications which has been completed.

10/04/2018, I conducted an Exit Conference with Marcia Curtiss. Ms. Curtiss understands the information, analysis and conclusion of this applicable rule and agrees to submit an acceptable corrective action plan.

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 {333.1101 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:	APS worker, Zac Blevins stated Resident A was not administered insulin as reported but was given Metformin which is used to help control high blood sugar when in fact, her blood sugar was low. Ms. Hayes stated Ms. Holmes tested Resident A's blood sugar at 67 on the morning of 08/04/2018, and administered Resident A's morning Metformin, not insulin. Ms. Hayes stated the doctor's instructions on the MAR are if a resident's blood sugar is below 70 or above 250, the doctor should be notified. Ms. Hayes stated Ms. Holmes did not contact the doctor and administered Resident A's Metformin. Resident A's MAR documents Metformin tab was administered and signed for by Ms. Holmes on the morning of 08/04/2018. Resident A's MAR documents a blood glucose chart with the following information, '*check and record blood sugar twice a day **if below 70 or above 250 notify MD.*' On the 08/04/2018, at the 8:00AM hour, Ms. Holmes documented Resident A's blood glucose level tested at 67. Ms. Redmon documents on the charting notes the DCWs must always follow the MAR orders for low or high BG (blood glucose). Never give any other BG med until Dr. is called first including Metformin. Resident A and Relative #1 stated Resident A took her morning medications prior to going to the hospital.

	Ms. Holmes did not follow Resident A's individual special medical procedure as prescribed by a licensed physician when she failed to call and consult the doctor upon getting a 67-blood sugar reading and administering Resident A's Metformin. Therefore; a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/04/2018

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

10/04/2018

Jerry Hendrick — Date
Area Manager