GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 30, 2019

Melissa Peebles
Park Village Pines
2920 Crystal Lane
Kalamazoo, MI 49009

RE: License #: AH390236863
Investigation #: 2019A0461038
Park Village Pines

Dear Ms. Peebles:

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 (517) 284-9720.

Sincerely,

Karen Hodge

Karen Hodge, Licensing Staff
Bureau of Community and Health Systems
P.O. Box 1407
Benton Harbor, MI 49023
(269) 363-1742

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

I. IDENTIFYING INFORMATION

License #:	AH390236863
Investigation #:	2019A0461038
Complaint Receipt Date:	06/11/2019
Investigation Initiation Date:	06/13/2019
Report Due Date:	08/11/2019
Licensee Name:	The Kalamazoo Area Christian Retirement Assoc Inc
Licensee Address:	2920 Crystal Lane Kalamazoo, MI 49009
Licensee Telephone #:	(269) 372-1928
Authorized Representative/ Administrator:	Melissa Peebles
Name of Facility:	Park Village Pines
Facility Address:	2920 Crystal Lane Kalamazoo, MI 49009
Facility Telephone #:	(269) 372-1928
Original Issuance Date:	03/01/1975
License Status:	REGULAR
Effective Date:	03/31/2019
Expiration Date:	03/30/2020
Capacity:	215
Program Type:	ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Resident did not receive her medications correctly.	Yes

III. METHODOLOGY

06/11/2019	Special Investigation Intake 2019A0461038
06/13/2019	Special Investigation Initiated - Letter email to Melissa Peebles requesting service plan and MARs.
06/14/2019	Contact - Document Received MARs, Service Plan
07/25/2019	Contact - Telephone call made Relative A1
07/25/2019	Contact - Face to Face Samantha Bare, RN; Melissa Peebles, Administrator; Connie Eager, Resident Care Manager; Courtney Brooks, Medical Care Giver
07/25/2019	Inspection Completed On-site
07/30/2019	Inspection Completed-BCAL Sub. Compliance
08/01/2019	Exit Conference – by telephone Melissa Peebles

ALLEGATION:

Resident did not receive her medications correctly.

INVESTIGATION:

On 6/11/19, an on-line complaint was received alleging that Resident A did not receive ordered medications on 6/6/19 and 6/9/19. Complainant wrote that on both days, she was at the facility and witnessed the fact the medications were not administered. Complainant alleged Potassium and Codeine were not administered.

On 6/13/19, I requested service plans and medication administration records (MAR) from the facility which were received on 6/14/19.

On 6/14/19, I reviewed the MAR for June 2019 for Resident A. On 6/6/19, the MAR had the initials “CEB” in the box for Potassium and a time of 13:22. On 6/6/19, the MAR had the initials “CEB” in the box for Codeine and a time of 13:22. On 6/9/19, the MAR had the initials “SMR” in the box for Potassium and a time of 13:10. On 6/9/19, the MAR had the initials “SMR” in the box for Codeine and a time of 13:10. The order on the MAR read “Potassium Chloride, take 1 tablet by mouth 3 times daily”. The order on the MAR read “Codeine 30mg, ½ tab take a half tablet (15mg) by mouth two times daily at 8am and 2pm. The MAR read “may administer medication in applesauce or pudding”.

On 7/25/19, I interviewed Relative A1 by telephone. Relative A1 stated she received “conflicting stories” while at the facility regarding the administration of medications. Relative A1 stated on 6/6/19, the staff person on duty had to check to see if medications were passed and then gave the medications to Resident A after 4:00pm. Relative A1 stated she and Resident A had gone to lunch and then went outside the building. Relative A1 stated they returned to Resident A’s room shortly after 1:00pm. Relative A1 stated Resident A did not get her 2:00pm medications. Relative A1 stated she began to look for a staff member around 3:00pm. Relative A1 stated the day staff person had left by that time and the evening person had to check to see if the medications had been passed. Relative A1 stated she believed the medications had been documented as if they had been given. Relative A1 stated the evening staff person told her she had found the medications sitting on the medication cart. Relative A1 stated she expressed concern about administering the medications because she wasn’t sure if there was enough time to elapse before the next dose was due. Relative A1 stated the evening staff person told her she could administer the next medication dose later to accommodate for a late pass. Relative A1 stated the evening staff person told her she did not administer the medications on the cart “because they were mushy”. Relative A1 stated the evening staff person told her she had talked to the day staff person to confirm that the medications needed to be administered. Relative A1 stated that when Resident A does not get her medications on time she has “significant symptoms”. Relative A1 stated she reported this issue to the supervisor of Oakview Terrace which is the area of the building where Resident A resides.

On 7/25/19, I interviewed registered nurse and clinical care specialist Samantha Bare at the facility. Ms. Bare stated Relative A1 approached her to report that medications were not passed on 6/6/19. Ms. Bare stated she shared this information with administrator Melissa Peebles and resident care manager Connie Eager. Ms. Bare showed me the MAR for June in the electronic system. The computer MAR was consistent with the printed copy reviewed previously. Ms. Bare stated that the electronic record is color-coded so that any missed medications are identified in a different color than passed medications. Ms. Bare explained that the medication passer must click on the electronic record when the medication is prepped; ie, pulled from the bubble pack or bottle and placed into a medication cup for the resident. Ms. Bare stated then the medication is to be given to the resident

and there is another click when the medication pass is completed. Ms. Bare was able to see the medications on 6/6/19 and 6/9/19 were prepped and passed within minutes. Ms. Bare stated the electronic record reads that the medications were passed as ordered on 6/6/19 and 6/9/19.

On 7/25/19, I interviewed Melissa Peebles at the facility. Ms. Peebles stated that family members of Resident A came to her on 6/6/19 regarding missed medications. Ms. Peebles stated she investigated and determined that a family member had taken Resident A outside and did not tell any staff person where they were going. Ms. Peebles stated the family member acknowledged that she did not alert anyone to the fact she was taking Resident A outside. Ms. Peebles stated she was told the staff person passing the medications, Cortney Brooks, prepared the medications and went to administer them and did not see Resident A in her room or in the nearby area, so she returned the medication to the cart to administer later. Ms. Peebles asked Ms. Brooks if she had seen Resident A return to her room or the area and Ms. Brooks stated she did not see her return. Ms. Peebles stated Ms. Brooks told her that she left the medication to be passed when Resident A returned. Ms. Peebles stated Ms. Brooks told her she communicated with the evening staff person, Kerry Nagy, to confirm that the medications had not been administered at 2:00pm and needed to be given. Ms. Peebles stated that Ms. Brooks told her that Ms. Nagy then administered the medications to Resident A. Ms. Peebles stated that this type of situation does not happen very often in this area of the building because residents require a significant amount of staff assistance and are not usually out in different areas of the building without staff being present. Ms. Peebles stated the other complication is because the medication pass is scheduled for 2:00pm, shift change occurs at 2:30pm and there is staff to staff reporting and other things happening during that time. Ms. Peebles confirmed that the correct process to be followed was for the medication to be prepped, with a click in the electronic MAR for prepping and then a second click is to be entered when the medication is passed. Ms. Pebbles stated that Ms. Nagy told her that she knew the medications were for Resident A because they had a cup placed over the medication cup with her name on it. Ms. Peebles acknowledged that Ms. Brooks did not follow the proper procedure for documenting the medication pass because the electronic record should be clicked at preparation time and after the pass and Ms. Brooks clicked it before the medication was passed. This matter has been dealt with internally with additional training and management oversight. Ms. Peebles stated on 6/9/19, the medication passer was Suzanne Rorick who is no longer employed at the facility. Ms. Peebles stated she had a conversation with Relative A2 on 6/10/19, and she investigated, determining that the medications had been passed as documented on the MAR. Ms. Peebles stated that Ms. Eager had a specific conversation with Ms. Rorick regarding medication passes on 6/10/19. Ms. Peebles stated she was told by Ms. Eager that Ms. Rorick clearly remembers passing medications as documented in the MAR. Ms. Peebles stated Ms. Rorick recalled multiple family members being present for a private family lunch. Ms. Peebles stated Ms. Rorick recalled administering

medications to Resident A while no family members were present. Ms. Peebles does not know why there was a question about this, other than that the medications were passed when Complainant was out of the room. Ms. Peebles stated that a number of family members were visiting on 6/9/19.

On 7/25/19, Ms. Peebles provided observation notes from the resident file. On 6/6/19, a note was entered by medical caregiver Courtney Brooks which read "unable to pass resident's 2pm medications, due to resident being on walk with family. Will have 2nd shift MCG pass, once resident returns".

On 7/25/19, I interviewed Courtney Brooks at the facility. Ms. Brooks acknowledged that on 6/6/19, she prepped medication for Resident A. Ms. Brooks stated she went to administer medications to her and discovered Resident A and Relative A1, who was visiting, were not in Resident A's room or nearby. Ms. Brooks stated she returned to the medication room. Ms. Brooks stated she found out from the resident care givers that Resident A was on a walk outside the building. Ms. Brooks stated the medication was already crushed and placed in applesauce, per normal procedures. Ms. Brooks stated she returned the medication to the medication cart and asked the second shift staff person, Kerry Nagy, to pass the medication when Resident A returned. Ms. Brooks stated her shift ends at 2:30pm and there is a lot to do which makes the 2:00pm administration of medication more complex. Ms. Brooks stated she received a text some time later from Ms. Nagy asking if the medication still needed to be passed since she had reviewed the MAR and it looked as if it was administered. Ms. Brooks stated she told Ms. Nagy the medication, which was still in the cup in applesauce, still needed to be passed. Ms. Brooks stated she was aware the medication was getting passed late because she had taken a nap after work and didn't get a text from Ms. Nagy until after she woke up.

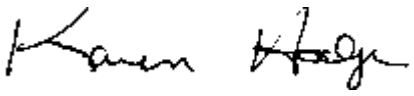
Several attempts were made to reach Ms. Nagy but were unsuccessful as of the writing of this report.

APPLICABLE RULE	
R 325.1932	Resident medications.
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.**

	(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given. **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	On 6/6/19, Resident A's medications were prepped for administration and she was not present to receive them. Medications were then placed on the medication cart and left for one to two hours. Medications were not administered immediately after preparation. The MAR was initialed as if medications were administered at 13:22 when they were not. Medications were later administered by another staff person who did not prepare the medications, but instead used medications that were pre-set on the medication cart. Medications were administered well after 13:22 but the actual administration time and person was not documented. For these reasons, the facility is not in compliance with this rule. There was insufficient evidence that medications were not administered accurately on 6/9/19.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

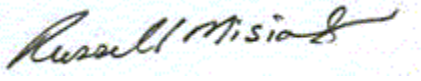
Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the status of the license.



8/1/19

Karen Hodge — Date
Licensing Staff

Approved By:



8/1/19

Russell Misiak — Date
Area Manager