STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

September 7, 2021

Connie Clauson
Hume Home of Muskegon
1244 W Southern Avenue
Muskegon, MI 49441-2271

RE: License #: AH610236822
Investigation #: 2021A1028033
Hume Home of Muskegon

Dear Mrs. Clauson:

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 (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH610236822
Investigation #:	2021A1028033
Complaint Receipt Date:	07/26/2021
Investigation Initiation Date:	07/26/2021
Report Due Date:	08/25/2021
Licensee Name:	The Hume Home of Muskegon
Licensee Address:	1244 W Southern Ave. Muskegon, MI 49441
Licensee Telephone #:	(616) 285-0573
Administrator:	Sandra Becker
Authorized Representative:	Connie Clauson
Name of Facility:	Hume Home of Muskegon
Facility Address:	1244 W Southern Avenue Muskegon, MI 49441-2271
Facility Telephone #:	(231) 755-1715
Original Issuance Date:	01/01/2000
License **Status:**	REGULAR
Effective Date:	11/25/2020
Expiration Date:	11/24/2021
Capacity:	34
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility did not issue a discharge notice for Resident A consistent with rules.	No
Additional Findings	Yes

III. METHODOLOGY

07/26/2021	Special Investigation Intake 2021A1028033
07/26/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake - 2021A1028033
07/26/2021	APS Referral APS referral emailed to Centralized Intake - 2021A1028033
07/28/2021	Inspection Completed On-site 2021A1028033
07/28/2021	Contact - Face to Face Interviewed administrator, Sandra Becker, and care staff Tracey Frees and Belinda Gerard at facility.
07/28/2021	Contact - Telephone call made Interviewed regional director, Amanda Beechman, by telephone.
07/28/2021	Contact - Telephone call made Interviewed complainant by telephone.
08/17/2021	Contact – Telephone call made Interviewed Resident A’s authorized representative by telephone.

08/17/2021	Contact – Email requesting information sent Follow up email with Ms. Becker
08/18/2021	Contact – Received requested information from Ms. Becker via email
09/07/2021	Exit Interview

ALLEGATION:

The facility did not issue a discharge notice for Resident A consistent with rules.

INVESTIGATION:

On 7/26/21, the Bureau received the allegations from the online compliant system.

On 7/26/21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 7/28/21, I interviewed administrator Sandra Becker at the facility. Ms. Becker reported the facility issued a 30-day discharge on 6/30/21 for Resident A due to "[the authorized representative] and family making it very difficult for the facility to meet the medical needs of [Resident A]". Ms. Becker reported the authorized representative will not allow any staff to contact or communicate Resident A's physician or pharmacy, that all communication about Resident A "must go through [the authorized representative]." Ms. Becker reported due to the facility restriction of not being able to appropriately communicate with Resident A's physician or pharmacy, the facility cannot appropriately provide adequate care or meet the family's expectations of care for Resident A. Ms. Becker also reported the facility has been instructed by Resident A's authorized representative "to go through [the authorized representative] first for any of [Resident A's] care and we sometimes have difficulty getting ahold of [the authorized representative]." Ms. Becker reported if an emergency occurred with Resident A, Resident A's authorized representative would be contacted, but the facility would contact emergency services as well to ensure appropriate medical treatment for Resident A. Ms. Becker reported the authorized representative controls all Resident A's medications to include the picking up at the pharmacy and delivery of medication to the facility, as well as the ordering/reordering of Resident A's medications. Care staff are not allowed to communicate with the pharmacy for any of Resident A's medication needs. Ms. Becker reported the authorized representative's total control of Resident A's medical care resulted from a medication administration error of Resident A's medication that occurred in August 2020 [see special investigation 2020A0221016]. Ms. Becker

reported the facility was cited for improper medication administration and the facility has taken great measures since to prevent future medication administration errors for all residents. Ms. Becker reported no medication errors have occurred for Resident A since and new policy and procedures along with corrective measures remain in effect at the facility for all resident medication administration. Ms. Becker reported the restriction of access to Resident A's physician and medication places Resident A at risk for potential injury or harm and interferes with facility's ability to provide appropriate care and meet Resident A's needs. Ms. Becker reported she has been in consistent communication with the authorized representative and family about the restricted access to Resident A's physician and pharmacy and potential risk for Resident A. However, Ms. Becker reported the authorized representative "will not budge on allowing us to communicate with the doctor or pharmacy". Ms. Becker reported the management met with the authorized representative and family in person on 5/25 per the family's request; and again on 6/9 per Ms. Becker's request to discuss Resident A's ongoing medical needs and potential discharge due to the restrictions placed on the facility by the authorized representative concerning Resident A's care. Ms. Becker provided a copy of Resident A's admission contract, record notes, medication administration record (MAR), documentation of communication between the facility and the authorized representative, discharge notice and the service plan for my review.

I interviewed care staff person (CSP) Tracey Frees at the facility. Ms. Frees reported Resident A's family orders and delivers all Resident A's medications. Ms. Frees reported staff are not allowed to communicate with Resident A's physician or the pharmacy "for any reason". Ms. Frees stated "this puts us in a sticky situation if something were to happen with [Resident A]. We are being told we have to go through [the authorized representative] for everything." Ms. Frees reported "the family has been difficult since the citation we received last fall. I understand why they are upset though, but the situation was fixed and has not happened since. We need to be able to speak with the doctor and pharmacy if needed. We cannot just go with what a family member says the doctor said. We have to be able to speak with the doctor to verify orders." Ms. Frees reported the family delivers Resident A's medications at the facility and films care staff when delivering the medications. Ms. Frees stated "staff do not want to be filmed and I am concerned they might also film another resident in the background as well, which is against HIPPA rules." Ms. Frees reported the family has been caught taking Resident A out of the facility without informing staff or visiting Resident A without an appointment (due to Covid restrictions) or after visiting hours are over. Ms. Frees reported staff have been very accommodating with the family for visitations and following their requests about Resident A's care, despite the restrictions placed on staff by the authorized representative.

I interviewed CSP Belinda Gerard at the facility. Ms. Gerard's statements are consistent with Ms. Frees statements. Ms. Gerard reported "the family is still seems very upset about the medication citation from last fall concerning [Resident A], even though the facility corrected it and it has not happened since." Ms. Gerard reported

“staff are consistently reminded by the family they are not allowed to talk to [Resident A’s] doctor or pharmacy.” Ms. Gerard confirmed family films staff at the facility accepting the delivery of Resident A’s medications. Ms. Gerard also confirmed family has come into the facility after visiting hours, without an appointment, and has taken Resident A out of the facility without informing care staff. Ms, Gerard reported staff “really need to be able to speak with the doctor or pharmacy if there are questions about orders or medications. The family really cannot answer medical questions about orders or medications.”

I interviewed the facility regional director Amanda Beecham by telephone. Ms. Beecham’s statements are consistent with Ms. Becker’s statements. Ms. Beecham reported the authorized representative has restricted all facility access to Resident A’s physician and pharmacy. Ms. Beecham reported the facility conferenced with Resident A’s authorized representative and family to try and find a resolution so the facility can appropriately and safely meet Resident A’s needs, but no resolution resulted. Ms. Beecham reported the facility offered to assist the family in finding a more appropriate placement due to the family not being happy with the care the facility is providing. Ms. Beecham reported the family was given the opportunity to collaborate with the facility about Resident A’s care prior to the 30-day discharge being issued, but the authorized representative and family continue to refuse. Ms. Beecham reported the authorized representative and family member were notified of the potential of a 30-day discharge during the care conference on 5/25 and on 6/9 if a resolution could not be found. Ms. Beecham reported no resolution resulted from the care conferences.

On 7/28/21, I interviewed the complainant by telephone. The complainant reported the facility issued a 30-day discharge for Resident A “in retaliation for the medication citation that occurred against the home last year”. The complainant stated they wanted the department “to intercede immediately before [Resident A] is put out on the street”. The complainant acknowledged the facility is not allowed to have any communication with [Resident A’s] physician or the pharmacy and that this was stated in the discharge notice. The complainant reported that they do not see an issue with facility being unable to communicate with Resident A’s physician or pharmacy and that “care of [Resident A] should not be affected because of this.” The complainant reported they “do not feel the facility offered any alternatives for Resident A concerning the 30-day discharge.” However, the complainant also reported Resident A “likes being there” at the facility.

On 8/17/21, I interviewed Resident A’s authorized representative by telephone. The authorized representative reported in the fall of 2020, the facility was cited for medication administration errors specifically concerning Resident A’s pain medication. The authorized representative reported that to due this citation the family decided to start ordering and delivering Resident A’s medications to the facility. The authorized representative reported no care staff are allowed to speak with the physician or pharmacy because of the medication administration error that occurred in the fall 2020. Care staff are allowed to administer Resident A’s

medications at the facility, but cannot speak with the physician or pharmacy and cannot order medications for Resident A. The authorized representative reported Resident A goes to the doctor every six months and family schedules all doctor appointments and provides transport for Resident A. The authorized representative reported family visits every day and they have "no intention of moving [Resident A]." The authorized representative reported they speak with staff every visit and often with Ms. Becker. The authorized representative reported "Ms. Becker has never tried to reach a solution about the medication situation that occurred last fall, so this is why we decided to handle everything for [Resident A]." The authorized representative reported they did not provide the facility a written statement or formal document stating the facility is not allowed to contact the physician or pharmacy. The authorized representative instructed the facility the family would handle all Resident A's medical care and staff are not to call the physician or pharmacy for anything "because we can't trust them." The authorized representative denies meeting with Ms. Becker to discuss alternatives for the care of Resident A prior to the issuance of the 30-day discharge. The authorized representative reports the discharge was served in retaliation due to the previous facility citation in the fall 2020 concerning Resident A's medication error. The authorized representative reported the 30-day discharge is not enforceable because it is an improper discharge and that Resident A is still currently at the facility.

On 8/17/21, I reviewed the facility 30-day discharge notice dated 6/30/21 which revealed the reason for discharge as *"Hume Home is discharging due to the fact we are unable to meet the family's expectations in the care of [Resident A]. The family refuses to allow Hume Home staff to communicate with residents PCP and refuses to allow staff to manage any of [Resident A's] medications."* The review revealed the effective discharge date as 7/30/21 and the right to contact the department for concerns about the discharge. The discharge also offers to assist the authorized representative in finding an alternative placement for Resident A.

I reviewed Resident A's MAR from February 2021 to June 2021, which revealed appropriate medication administration for Resident A from care staff along with record notes about communication with Resident A's authorized representative concerning Resident A's medications and care.

On 8/18/21, I received a follow-up email from Ms. Becker in which she confirmed per Resident A's authorized representative and family request, she and Ms. Beecham met with them in person on 5/25 to conference about Resident A's care. Ms. Becker reported that she, Ms. Gerard, and Resident A's authorized representative met in person again on 6/9 per Ms. Becker's request to conference about Resident A's care. Ms. Becker reported the family has not provided anything in writing restricting the facility from contacting the physician or pharmacy. However, Ms. Becker reported "*when the staff calls the Family about medications, we ask if we can call and they say no we are taking care of all of the Medications and physician needs. you are not to call them."*

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following: **(a) The reasons for discharge.** **(b) The effective date of the discharge.** **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**
ANALYSIS:	Interviews with the administrator, care staff, and Resident A's authorized representative and family reveal Resident A was issued a 30-day discharge on 6/30/21. The discharge was issued by the facility due to the facility being restricted from contacting Resident A's physician and pharmacy. The facility reports it cannot provide appropriate and adequate care for Resident A because of the restricted communication with Resident A's physician and pharmacy. Review of facility documentation along with the discharge reveals the discharge fulfills the requirements for issuing a discharge. The 30-day discharge issued for Resident A stated the reason for discharge, the effective date of the discharge, the right of the authorized representative to contact the department, and that APS and the department were contacted as well upon issuance. The facility issued a 30-day discharge in consistent with the rules.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

Additional Findings:

On 8/17/21, Resident A's authorized representative reported never signing a service plan for Resident A and was unsure of the current service plan in place.

On 8/18/21, in a follow up email to Ms, Becker, she confirmed that I was in possession of the most recent service plan and that it is not signed by the authorized

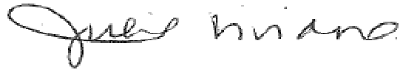
representative. Ms. Becker reported the service plan has not been updated due to the issuance of the recent 30-day discharge being on 7/30 and the service plan expiring on 7/21.

Review of Resident A's service revealed the service plan is updated quarterly and was valid from 3/21/21 to 7/21/21. The service plan revealed Resident A requires assistance with feeding, dressing, bathing, grooming, and toileting. Resident A uses a motorized wheelchair for ambulation and is a two person assist with a sit to stand lift. The service plan reads to ask Resident A about pain each interaction using the one to ten pain scale.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Interviews with staff and Resident A's authorized representative along with review of Resident A's service plan reveal that while there is a service plan in place for Resident A, it is not signed by the authorized representative, and it is expired. It has an expiration date of 7/21/21 with Ms. Becker reporting it is the most recent service plan for Resident. Also, the service plan does not reflect the authorized representative's request that the ordering and delivery of all Resident A's medications will be handled by the authorized representative and family or the authorized representative's request that the facility staff is to have no contact or communication with Resident A's physician or pharmacy. The facility does not have an up-to-date service plan in place reflective of the authorized representative's requests or that demonstrates Resident A's required current level of care.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, it is recommended this license remain unchanged.



8/20/21

Julie Viviano | Date
Licensing Staff

Approved By:

9/3/21

Russell B. Misiak | Date
Area Manager