GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 16, 2021

Joseph Frazier
Welcome Home, Inc.
P. O. Box 40
Grand Ledge, MI 48837

RE: License #: AH230360690
Investigation #: 2021A1010045
Fairview Grand

Dear Mr. Frazier:

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 authorized representative 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) 356-0183.

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 #:	AH230360690
Investigation #:	2021A1010045
Complaint Receipt Date:	08/04/2021
Investigation Initiation Date:	08/10/2021
Report Due Date:	10/03/2021
Licensee Name:	Welcome Home, Inc.
Licensee Address:	11656 S. Hartel Road Grand Ledge, MI 48837
Licensee Telephone #:	(517) 290-3107
Authorized Representative:	Joseph Frazier
Administrator:	Barbara Frazier
Name of Facility:	Fairview Grand
Facility Address:	11656 Hartel Road Grand Ledge, MI 48837
Facility Telephone #:	(517) 622-1009
Original Issuance Date:	11/01/2016
License Status:	REGULAR
Effective Date:	04/14/2021
Expiration Date:	04/13/2022
Capacity:	35
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility over medicated Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

08/04/2021	Special Investigation Intake 2021A1010045
08/10/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
08/10/2021	APS Referral APS referral emailed to Centralized Intake
08/11/2021	Contact - Document Received Email received from assigned APS worker Carol Stahl
08/12/2021	Inspection Completed On-site
08/12/2021	Contact - Document Received Received Resident A's vitals documentation, staff notes, MARS, and service plan
08/23/2021	Contact - Telephone call made Message left for the complainant, a call back was requested
08/23/2021	Contact – Telephone call received Interviewed the complainant by telephone
08/30/2021	Contact – Email received Email from Ms. Stahl received
09/16/2021	Exit Conference Completed with licensee authorized representative Joseph Frazier

ALLEGATION:

The facility over medicated Resident A.

INVESTIGATION:

On 8/4/21, the Bureau received the complaint from the online complaint system. The complaint read, “Facility over drugged him with Ativan. Peed all over himself. July 11th picked him up for a pool party was over drugged again. July 30th asked not to come in to see him because he was sleepy. The next day she went in and vitals were 84/46 she took him to Dr., then went to hospital. He was drugged and dehydrated. This morning she called and he was in dinning room and he was sleepy, he sounded drugged, asked staff to take his blood pressure, it was 96/64. They want him out by Thursday. Farm Bureau is fighting over paying his bill.”

On 8/10/21, I emailed an Adult Protective Services (APS) complaint to Centralized Intake.

On 8/11/21, I received an email from assigned APS worker Carol Stahl. Ms. Stahl and I coordinated a joint investigation.

On 8/12/21, Ms. Stahl and I interviewed administrator Barbara Frazier at the facility. Ms. Frazier reported Resident A had some medication changes when he resided at the facility. Ms. Frazier explained Resident A was prescribed 75 mg Zyprexa at the time of his admission to the facility. Ms. Frazier stated Resident A’s physician prescribed Ativan on 6/29. Ms. Frazier said Resident A’s physician discontinued his Zyprexa on 7/29 and prescribed Seroquel that was started on 7/30.

Ms. Frazier explained Resident A received benefits as a result of a car accident he was in. Ms. Frazier reported those benefits primarily funded Resident A’s stay at the facility. Ms. Frazier said Relative A1 was his durable power of attorney (DPOA). Ms. Frazier reported Relative A1 did not follow through with some required documents for Resident A’s benefits to be continued, therefore they were terminated. Ms. Frazier stated as a result, Resident A could no longer afford a private room. Ms. Frazier reported once Resident A moved in with a roommate, he experienced behavioral changes.

Ms. Frazier stated after Resident A moved in with a roommate, he urinated in public areas in the facility, clogged toilets and sinks by putting food in them, was difficult to redirect, and combative towards staff. Ms. Frazier reported Resident A also became paranoid staff were stealing from him. Ms. Frazier said these incidents lead to Resident A’s medication changes.

Ms. Frazier reported Resident A experienced fatigue after he started his Seroquel. Ms. Frazier said when Relative A1 took Resident A on an outing recently, he was lethargic. Ms. Frazier reported Relative A1 took Resident A to urgent care as a result. Ms. Frazier said urgent care identified that Resident A was dehydrated.

Ms. Frazier stated Resident A continued to be lethargic and had low blood pressure, therefore his physician was contacted. Ms. Frazier explained Resident A's physician ordered Resident A's blood pressure medication to be held because it continued to be low. Ms. Frazier reported staff monitored Resident A's blood pressure.
Ms. Frazier said Resident A's medications were administered as prescribed. Ms. Frazier reported Resident A was not "over drugged," rather he experienced side effects of his prescribed Seroquel.

Ms. Frazier provided me with copies of Resident A's physician orders for Ativan and Seroquel for my review. An order dated 6/29 read, "ATIVAN 0.5 #60 BID PRN. An order dated 7/30 read, D/C Ativan D/C Olamzapine R/T ineffectiveness. Another order dated 7/30 read, "1) Zoloft 50mg PO daily R/T increased behaviors 2) Seroquel 50mg PO twice daily R/T increased behaviors."

Ms. Frazier provided me with a copy of Resident A's July and August medication administration records for my review. The MAR read Resident A's medications were administered as prescribed.

Ms. Frazier provided me with a copy of Resident A's service plan for my review. The *Medication Administration* management section of the plan read, "Staff will be administering medications. Using psychotropic medications related to specific behavior: See MAR for medications. The *Psychotropic Medications – Using* section of the plan read, "Behaviors will be monitored for effectiveness, appropriate use and possible adverse effects of the PRN medications."

Ms. Frazier provided me with a copy of Resident A's vitals for 7/25 through 8/12 for my review. The vitals read Resident A had low blood pressure on 7/31 and 8/1. Ms. Frazier provided me with a copy of Resident A's staff notes for my review. A note dated 7/31 read, "[Resident A] was very difficult to awaken this am and was left to sleep in. He was at the tabel [sic] for lunch and eating well. When Relative A1 arrived he stopped eating and she let us know she wa [sic] him out for the rest of the day. His BP was low and [Relative A1] was advised to visit with [Resident A] in the building instead of taking him out. She did not feel it was an issue and took [Resident A] out. within an hour I received a phone call from [Relative A1] stating she had [Resident A] at Redi Care because he was shaking. I advised her that she have returned to Fairview to which she had no response."

Notes dated 8/1 read, "BP was checked this morning at 9am before taking medications and read well at 138/80; received all meds. At 3pm I attempted to wake [Resident A] up for supper but he was too tired to wake up, so decided to take BP. BP at this time was 81/49 so Rose was notified and let her know he has drank [sic] at least 3 cups of water today as reported he may be dehydrated. She will be discussing his medications with Dr. Roth in the next day or two. Called Dr. Roth in regards to low BP. He wants us to hold both blood pressure meds until he comes in tomorrow afternoon."

Notes dated 7/18, 7/19, 7/21, 7/22, 7/24, 7/26, 7/27, 7/30, 7/31, and 8/2 read Resident A was combative with staff and non-compliant during the provision of his care. Notes dated 7/30and 8/4 read Resident A urinated in public areas of the facility.

On 8/12/21, Ms. Stahl and I interviewed manager Wendy Kenney at the facility. Ms. Kenney's statements were consistent with Ms. Frazier.

On 8/12/21, I was not able to interview Resident A because he no longer resided at the facility.

On 8/23/21, I interviewed the complainant by telephone. The complainant reported she believed staff "over medicated" Resident A. The complainant stated she believed Resident A was "over medicated" because he became incontinent at the facility and he was often lethargic. The complainant said she observed Resident A fall asleep at a dining room table in the facility and his blood pressure was low. The complainant stated Resident A also had a hard time holding conversations due to being "over medicated."

The complainant reported the facility moved Resident A in with a roommate who was Vietnamese to "get him to act out. The complainant stated Resident A was in the Vietnam war and having a Vietnamese roommate was not a good option for him. The complainant said Resident A did begin to exhibit behaviors after he moved in with a roommate.

The complainant stated Resident A did not do well on Ativan, therefore his medication was switched to Seroquel. The complainant reported after this medication change, Resident A's blood pressure was low. The complainant said Resident A went to the urgent care on 7/30 because he was "delirious" and white in color. The complainant stated Resident A was given "three bags of saline" because he was dehydrated.

On 8/30/21, I received an email from Ms. Stahl. Ms. Stahl stated she is not substantiating her APS case.

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:	The interview with Ms. Frazier, along with review of Resident A's MARs and physician orders revealed his medications were administered as prescribed. Review of Resident A's staff notes revealed there were several incidents when Resident A was non-compliant during the provision of his care, including medication administration. Despite this non-compliance, staff communicated Resident A's condition to his physician and followed the physicians' orders.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 8/4/21, the complaint read, "they want him out by Thursday."

On 8/12/21, Ms. Frazier reported due to Resident A's behaviors and inability to pay for a private room, it was identified the facility was unable to meet his care needs and keep staff and other residents safe. Ms. Frazier stated the facility's authorized representative Joseph Frazier communicated with Relative A1 via text message about Resident A's less than 30-day discharge. Ms. Frazier said Mr. Frazier maintained communication with Relative A1 regarding Resident A.

On 8/23/21, the complainant stated text messages were received regarding Resident A's need to move out of the facility in less than 30 days. The complainant reported the text messages were from Mr. Frazier and "were threatening."

The complainant provided me with the text messages from Mr. Frazier regarding Resident A's less than 30 day discharge for my review. The text messages read, "As previously discussed and documented, [Resident A] continues exhibiting uncontrollable negative behaviors toward other and himself. Due to concerns for the safety of all our residents, your concerns for [Resident A's] well being and safety as well as your lack of trust in our abilities to treat [Resident A] adequately to control these behaviors, I have reviewed this case with my state licensing consultant and am left with no other option but to notify you of a 24 hours emergency discharge for [Resident A]. You have until 4 o'clock Thursday to cooperate and comply with his discharge from Fairview or I will have no other choice but to contact adult protective services to intervene and assist in his relocation. Their involvement could be rather complicating and they will be required to assess his care and your capabilities to remain his Medical Durable Power of Attorney. It is completely your decision to cooperate or refuse but I will have no choice but to involve them should the need arise. Please contact me this afternoon so we can arrange for his transfer details."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(16) A home that proposes to discharge a resident for any of the reasons listed in subrule (15) of this rule shall take all of the following steps before discharging the resident: **(a) The home shall notify the resident, the resident's authorized representative, if any, and the agency responsible for the resident's placement, if any, not less than 24 hours before discharge. The notice shall be verbal and issued in writing. The notice of discharge shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged.** **(iv) The right of the resident to file a complaint with the department.** **(b) The department and adult protective services shall be notified not less than 24 hours before discharge in the event of either of the following:** **(i) A resident does not have an authorized representative or an agency responsible for the resident's placement.** **(ii) The resident does not have a subsequent placement.** **(c) The notice to the department and adult protective services shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged, if known.**

	(d) If the department finds that the resident was improperly discharged, then the resident may return to the first available bed in the home that can meet the resident's needs as identified in the resident's service plan. **(e) The resident shall not be discharged until a subsequent setting that meets the resident's immediate needs is located.**
ANALYSIS:	The interview with Ms. Frazier and the complainant, along with review of the text messages the complainant received from Mr. Frazier, revealed a formal written discharge notice was not sent by the facility. Also, the text messages the complainant received did not include information regarding her right to file a complaint with the department.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Joseph Frazier by telephone on 9/16. Mr. Frazier and I discussed the need to issue a formal written discharge notice for residents moving forward. Mr. Frazier was informed any future written discharge notices must be filed in the resident's record.

IV. RECOMMENDATION

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

9/13/21

Lauren Wohlfert — Date
Licensing Staff

Approved By:

9/13/21

Russell B. Misiak — Date
Area Manager