GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 3, 2021

Rebecca Lopez
Residential Opportunities, Inc.
1100 South Rose Street
Kalamazoo, MI 49001

RE: License #: AS390392120
Investigation #: 2021A0581054
New Post

Dear Ms. Lopez:

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) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390392120
Investigation #:	2021A0581054
Complaint Receipt Date:	09/27/2021
Investigation Initiation Date:	09/27/2021
Report Due Date:	11/26/2021
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	Sara Anglemyer
Licensee Designee:	Rebecca Lopez
Name of Facility:	New Post
Facility Address:	612 Landsdowne Ave. Portage, MI 49002
Facility Telephone #:	(269) 375-6265
Original Issuance Date:	11/08/2018
License Status:	REGULAR
Effective Date:	05/06/2021
Expiration Date:	05/05/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her preventative urinary tract infection prescription for approximately three months, as required and prescribed by her physician.	Yes

III. METHODOLOGY

09/27/2021	Special Investigation Intake 2021A0581054
09/27/2021	Special Investigation Initiated - Telephone Kalamazoo Recipient Rights, Lisa Smith, sent me the Incident Report containing additional information.
09/27/2021	Referral - Recipient Rights Kalamazoo Recipient Rights is investigating the allegations; therefore, a referral is not necessary.
09/29/2021	Contact - Telephone call made Interview with staff via MiTeams.
09/30/2021	Contact - Telephone call made Interview with direct care staff, Indiasha Parker, via MiTeams with Ms. Smith, RRO.
10/01/2021	Contact - Telephone call made Received documents from facility.
10/06/2021	Inspection Completed On-site Attempted interview of Resident A.
10/08/2021	Inspection Completed-BCAL Sub. Compliance
10/21/2021	Exit conference with licensee designee, Rebecca Lopez.

ALLEGATION:

Resident A did not receive her preventative urinary tract infection prescription for approximately three months, as required and prescribed by her physician.

INVESTIGATION:

On 09/27/2021, I received this complaint as a referral from Kalamazoo Recipient Rights. The complaint alleged Resident A did not receive antibiotics for two months despite staff having a prescription from Resident A's doctor. The complaint alleged the antibiotic was not obtained or put into Resident A's Medication Administration Record (MAR).

On 09/27/2021, I confirmed with Kalamazoo Recipient Rights Officer (RRO), Lisa Smith, she had also received the allegations and was investigating. She indicated she would set up interviews with direct care staff via Microsoft MiTeams. Ms. Smith also forwarded me the *AFC Licensing Division – Incident / Accident Report* (IR), dated 09/23/2021. The IR indicated on 09/22/2021 the facility's Administrator, Sara Anglemyer, was reviewing records when she discovered Resident A had not been receiving her medications, Hiprex 1mg, D-Mannose(a probiotic, aka Cranberry), as prescribed and directed on 06/25/2021 for her urinary health maintenance. Ms. Anglemyer indicated in the IR she contacted Resident A's physician/physician's office concerning the error and they indicated no harm had taken place and advised to have Resident A start taking the medication at her next scheduled dose. Ms. Anglemyer indicated in the IR direct care staff, Martell Brown, would receive a written reprimand for not following the facility's protocol for medical appointments. She also indicated protocols for medical appointments would be reviewed with all staff at the next staff meeting on 09/30/2021.

On 09/29/2021, Ms. Smith and I interviewed the facility's Administrator and home manager, Sara Anglemyer, assistant program coordinator, Eric Hall, and direct care staff, Martell Brown via Microsoft Teams.

Ma. Anglemyer stated after being on medical leave for the entire summer she returned to work on 09/22/2021 and was informed by Mr. Hall there was an issue with Resident A not receiving her UTI preventative medication. She stated Mr. Hall had also been on medical leave for the summer and was not present when the initial error occurred back in June 2021. Ms. Anglemyer stated Resident A has a long history of getting UTI's; therefore, she is on a preventative medication for them. She stated, based on Resident A's "report of consultation" (ROC), 06/25/2021, which is a document facility staff have doctor's complete at a resident's medical appointment, Resident A's physician ordered the continuation of Resident A's medication, Hiprex 1 mg; however, Ms. Anglemyer indicated Mr. Brown discontinued the medication on Resident A's MAR causing her not to receive it throughout the summer until the error was caught on 09/22/2021.

Ms. Anglemyer stated the normal protocol for discontinuing a resident medication is to review a resident's ROC after a doctor appointment to ensure the discontinuation was written and then direct care staff would draw a line through the medication on the resident's MAR, followed up by writing "DC" (i.e., discontinued) on it. Ms. Anglemyer indicated the staff would also request a DC order from the physician's office. Ms. Anglemyer stated staff did not contact the pharmacy or the resident's physician's office to confirm the medication was discontinued. She indicated when new MARs were received in July and August staff continued to write DC on the MAR rather than confirm with the pharmacy, which is the facility's policy if the MAR appears incorrect.

Mr. Hall's statement to me was consistent with Ms. Anglemyer's statement to me. Mr. Hall stated when he found the error with the medication, he contacted the pharmacy and requested the most recent prescription and the physician's office, which confirmed the medication should have been continued rather than discontinued. Mr. Hall also stated the medication continued to be delivered to the facility with the last delivery on 08/15/2021. Mr. Hall stated Resident A did not have any UTI's while she did not receive the UIT preventative medication.

Ms. Smith and I also interviewed direct care staff, Martell Brown. He confirmed taking Resident A to her June doctor's appointment. He stated the doctor completed the ROC, but he stated he recalled the physician verbally discontinuing the medication. Mr. Brown denied writing "DC" on Resident A's MAR and indicated it was direct care staff, Indiasha Parker, who did it. Mr. Brown's statement to me regarding the process for discontinued medications was also consistent with Mr. Hall's statement to me.

On 09/30/2021, Ms. Smith and I interviewed direct care staff, Indiasha Parker, via Microsoft Teams. Ms. Parker denied writing "DC" in Resident A's MAR for the Hiprex medication and stated it was Mr. Brown who made the error. Ms. Parker confirmed she wrote DC in the July and August MARs since she was copying what was inputted for June. Ms. Parker's statement to me regarding the facility's policy on discontinuing medication was consistent with the previous staff's statements to me. She had no explanation for why the discontinuation of the medication was not confirmed with the pharmacy or the physician's office.

On 10/01/2021, Ms. Anglemyer sent via email a copy of Resident A's ROC, dated 06/25/2021, which confirmed the Hiprex and D-Mannose were to be continued. Ms. Anglemyer also provided Resident A's June, July, and August 2021 MARs, which showed "DC" had been written on June's MAR where the Hiprex medication was listed. Resident A's MARs indicated one, 1 mg Hiprex tablet, was to be taken twice daily. The "DC" notation continued in July and August until the medication restarted on 08/22/2021.

Ms. Anglemyer also provided a copy of facility's staff meeting agenda, dated 09/30/2021, which indicated staff were spoken to about ROC's, how to fill them out,

what should be done when returning from a physician's appointment, and how and when to DC a resident medication. The documentation indicated direct care staff, Eric Hall and Indiasha Parker were both present during this meeting.

On 10/06/2021, I conducted an unannounced on-site at the facility as part of my investigation. I attempted to interview Resident A; however, she was unable to answer my questions. Resident A appeared clean and well cared for. Ms. Anglemyer indicated she would soon be submitting Mr. Brown's written reprimand to the licensee's HR department.

APPLICABLE RULE	
R 400.14310	**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:	Based on my investigation, which included interviews with the facility's home manager, Sara Anglemyer, direct care staff, Eric Hall, Martell Brown, and Indiasha Parker, my review of the facility's report of consultation, dated 06/25/2021, and my review of Resident A's Medication Administration Records (MAR) for June, July, and August 2021, facility staff did not follow Resident A's physician's order from her 06/25/2021 medical appointment. On 06/25/2021, Resident A's physician recommended Resident A continue taking her Hiprex medication, a urinary tract infection prevention medication, but facility staff discontinued the medication on her MAR by writing "DC" on it. Facility staff continued not following physician's orders for the entire month of July and part of August until the error was caught by direct care staff, Eric Hall on 08/22/2021. Subsequently, direct care staff did not follow Resident A's physician's orders, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	On 06/25/2021, Resident A's physician ordered Resident A continue taking her Hiprex medication; however, in error, direct care staff discontinued the medication on Resident A's Medication Administration Records causing staff to not administer the twice daily scheduled medication. Subsequently, Resident A did not receive her medication, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/21/2021, I attempted to conduct an exit conference with the licensee designee, Rebecca Lopez, via telephone; however, she was unavailable. She left me message on 10/22/2021 stating she agreed with my findings and indicated staff would be retrained. She did not indicate she had additional questions.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

Cathy Cushman

10/29/2021

_____

Cathy Cushman — Date
Licensing Consultant

Approved By:

Dawn Timm

11/03/2021

_____

Dawn N. Timm — Date
Area Manager