GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 13, 2021

Laura Kelling
American House Wyoming
5812 Village Dr SW
Wyoming, MI 48519

RE: License #: AH410402896
Investigation #: 2022A1010002
American House Wyoming

Dear Ms. Kelling:

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) 356-0100.

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 #:	AH410402896
Investigation #:	2022A1010002
Complaint Receipt Date:	10/06/2021
Investigation Initiation Date:	10/07/2021
Report Due Date:	12/05/2021
Licensee Name:	AH Wyoming Subtenant LLC
Licensee Address:	STE 1600 One Towne Square Southfield, MI 48076
Licensee Telephone #:	(248) 827-1700
Authorized Representative/ Administrator:	Laura Kelling
Name of Facility:	American House Wyoming
Facility Address:	5812 Village Dr SW Wyoming, MI 48519
Facility Telephone #:	(616) 622-2420
Original Issuance Date:	11/05/2020
License Status:	REGULAR
Effective Date:	05/05/2021
Expiration Date:	05/04/2022
Capacity:	166
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her prescribed medications because they were 'out of stock'. Her MAR was changed/altered to show it was administered.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/06/2021	Special Investigation Intake 2022A1010002
10/07/2021	Special Investigation Initiated – Telephone Interviewed the complainant by telephone
10/08/2021	Contact – Document Received Received resident MARs from the complainant via email
10/18/2021	Inspection Completed On-site
10/18/2021	Contact – Document Received Received resident service plan, MARs, and staff notes
12/13/2021	Exit Conference Completed with licensee authorized representative Laura Kelling

ALLEGATION:

Resident A did not receive her prescribed medications because they were 'out of stock'. Her MAR was changed/altered to show it was administered.

INVESTIGATION:

On 10/6/21, the Bureau received the allegations from Adult Protective Services (APS). The complaint was not assigned for APS investigation.

On 10/7/21, I interviewed the complainant by telephone. The complainant reported Resident A's medication administration record (MAR) for September read her heart medication was not administered because they were "out of stock." The complainant stated Resident A's MARs were requested again and they were altered to show Resident A's medication was administered. The complainant expressed concern that

Resident A's MAR had been altered by staff to reflect her medication was administered when it was not.

The complainant stated Resident A was prescribed heart medication that she went several days without. The complainant expressed concern regarding the effects of Resident A going several days without her prescribed medications.

On 10/8/21, I received an email from the complainant that contained the copies of Resident A's MARs that he received for my review.

On 10/18/21, I interviewed wellness director Sarah Howe at the facility. Ms. Howe reported she was new in her position, therefore she did not have any knowledge regarding Resident A's medications or her MAR or her MARs being altered.

Ms. Howe stated she recently spoke to Resident A's physician about Resident A's prescribed heart medication because there was a recent change. Ms. Howe reported to her knowledge, Resident A's medications were administered as prescribed.

On 10/18/21, I interviewed administrator Laura Kelling at the facility. Ms. Kelling denied knowledge regarding Resident A's prescribed medications not being administered as prescribed. Ms. Kelling also denied knowledge regarding Resident A's MAR being altered. Ms. Kelling reported she had not received any complaints from Resident A or Resident A's responsible persons regarding her prescribed medications.

Ms. Kelling provided me with a copy of Resident A's service plan for my review. The *Medications INTERVENTION* section read, "Staff to assist resident in setup, timing or administration of meds. Staff to be aware of resident's use of PRNs."

Ms. Kelling provided me with a copy of Resident A's September MAR for my review. The MAR read Resident A's prescribed "DiltiaZEM ER CAP 120MG" was not administered 9/3 through 9/6 or 9/8 and 9/13 because the medication was "not available." Resident A's prescribed "KAPSPARGO SPRINKLE CAP 50MG" was not administered 9/1 through 9/19 or 9/22, 9/23, 9/25, and 9/29 because the medication was "not available." Resident A's prescribed "MELATONIN TAB 5MG" was not administered on 9/7 and 9/9 because the medication was "not available." Resident A's prescribed "OMEPRAZOLE CAP 20MG" was not administered on 9/3, 9/5 through 9/10, 9/12 through 9/15, 9/17, 9/18, 9/20, 9/24, and 9/26 through 9/28 because the medication was "not available." Resident A's prescribed "OXYBUTYNIN TAB 5MG" was not administered 9/3 through 9/6 because the medication was "not available." Resident A's prescribed "PRESERVISION AREDS CAP" was not administered 9/1 through 9/6, 9/8, 9/10, 9/12, and 9/17 because the medication was "not available." Resident A's prescribed "SENNA TAB 8.6MG" was not administered on 9/8 and 9/25 because the medication was "not available." Resident A's prescribed "ELIQUIS TAB 2.5 MG" was not administered on 9/11 because the medication was "not available."

Ms. Kelling provided me with a copy of Resident A's staff observation notes. A note dated 9/5 read, "Resident has quite a few meds out, (Kapspargo cap 50mg, Prevision, Oxybutynin, Diltiazem cap 120mg) family notified no answer will continue to f/u." A note dated 9/6 read, "f/u with residents family around 10a, Son stated he will bring meds in later today/tomorrow."

On 10/18/21, I interviewed shift supervisor Jurlene Branch at the facility. Ms. Branch reported Resident A's medications were administered as prescribed. Ms. Branch stated Resident A's son Relative A1 is her responsible person. Ms. Branch said Relative A1 ordered and brought Resident A's medications to the facility. Ms. Branch explained she had a difficult time getting a hold of Relative A1 by telephone when Resident A's medications got low and needed to be re-ordered. Ms. Branch reported there were instances when staff were unable to get a hold of Relative A1 to re-order Resident A's medications, therefore there were some instances when she went days without it being administered.

Ms. Branch stated since this issue was identified, Relative A1 recently switched to using the facility's in house pharmacy. Ms. Branch reported since Resident A began using the facility's in house pharmacy, there have not been any issues with the supply of Resident A's medications.

On 10/18/21, I interviewed Resident A at the facility. Resident A stated she was unable to recall if she went several days without receiving any of her prescribed medications. Resident A reported staff administered her prescribed medications daily, however Relative A1 used to be responsible for ordering them and bringing them into the facility. Resident A said Relative A1 recently made the choice to start using the facility's in house pharmacy so he no longer orders and brings her medications to the facility. Resident A denied concerns regarding her medication management at the facility.

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 interviews with Ms. Branch, the complainant, and review of Resident A's MAR revealed she went several days without some of her prescribed medications because they were "not available." When Relative A1 was not available, the facility did not have a plan how to address the medications that were "not available," therefore Resident A went several days without her medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 10/18/21, I observed Resident A's service plan did not address who was responsible for supplying Resident A's medications.

APPLICABLE RULE	
R 325. 1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

FOR REFERENCE: R 325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	The interviews with staff revealed Relative A1 was initially responsible for ordering and bringing Resident A's prescribed medications to the facility. The interviews with staff and Resident A also revealed Relative A1 recently switched to allowing the facility's in house pharmacy to order and supply Resident A's medications. This was not clearly outlined in Resident A's service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Laura Kelling by telephone on 12/13. Ms. Kelling reported the facility had a medication supply policy in place for residents and/or their responsible persons who do not use the facility's contracted pharmacy. Ms. Kelling stated she was educated on the policy and will ensure it is enforced. Ms. Kelling reported the policy will be referenced in the corrective action plan.

IV. RECOMMENDATION

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

11/10/21

Lauren Wohlfert Date
Licensing Staff

Approved By:

11/10/2021

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section

ADDENDUM TO SPECIAL INVESTIGATION REPORT 2022A1010002

INVESTIGATION:

The original investigation report contained the allegation that Resident A's MAR was changed/altered by staff to show her medications that were out of stock were administered when they were not. This allegation was not addressed in the original investigation report.

On 10/18/21, I reviewed Resident A's September MAR. I observed the MAR was not altered or changed by staff. The MAR documented the day and what medications Resident A did not receive because they were "not available."

APPLICABLE RULE	
R 325. 1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

FOR REFERENCE: R 325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	The interviews with staff revealed Relative A1 was initially responsible for ordering and bringing Resident A's prescribed medications to the facility. The interviews with staff and Resident A also revealed Relative A1 recently switched to allowing the facility's in house pharmacy to order and supply Resident A's medications. This was not clearly outlined in Resident A's service plan. Review of Resident A's September MAR revealed it was not altered or changed by staff to show all of her medications were administered. The MAR accurately documented the days Resident A did not receive some of her prescribed medications because they were "not available." There was insufficient evidence to suggest staff altered or changed Resident A's MAR.
CONCLUSION:	**VIOLATION ESTABLISHED**

V. RECOMMENDATION

The findings of the original report remain unchanged.

12/20/21

Lauren Wohlfert Date
Licensing Staff

12/20/21

Andrea Moore, Manager Date
Long-Term-Care State Licensing Section