GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 20, 2021

Ramchandra Mishra
Kozy Komfort Battle Creek AFC LLC
439 W Columbia Ave
Battle Creek, MI 49015

RE: License #: AS130403443
Investigation #: 2022A1030008
Kozy Komfort Battle Creek AFC LLC

Dear Mr. Mishra:

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,

Nile Khabeiry, LMSW

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130403443
Investigation #:	2022A1030008
Complaint Receipt Date:	11/03/2021
Investigation Initiation Date:	11/04/2021
Report Due Date:	01/02/2022
Licensee Name:	Kozy Komfort Battle Creek AFC LLC
Licensee Address:	261 Beachfield Dr Battle Creek, MI 49015
Licensee Telephone #:	(269) 359-5606
Administrator:	Ramchandra Mishra
Licensee Designee:	Ramchandra Mishra
Name of Facility:	Kozy Komfort Battle Creek AFC LLC
Facility Address:	261 Beachfield Dr Battle Creek, MI 49015
Facility Telephone #:	(269) 964-4580
Original Issuance Date:	11/17/2020
License Status:	REGULAR
Effective Date:	05/17/2021
Expiration Date:	05/16/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL, ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident medications were not properly dispensed.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/03/2021	Special Investigation Intake 2022A1030008
11/04/2021	Special Investigation Initiated - Telephone Phone call with complainant
11/04/2021	Contact - Face to Face Interview with Resident A
11/04/2021	Contact - Face to Face Interview with Relative A1
11/04/2021	Contact - Face to Face Interview with Tancy Vosburg
11/04/2021	Contact - Face to Face Interview with Licensee Ramchandra Mishra
12/06/2021	Exit Conference- Exit conference by phone with licensee designee

ALLEGATION:

Resident medications were not properly dispensed.

INVESTIGATION:

On 11/4/2021, I spoke with Complainant regarding the allegation. Complainant reported she is concerned about the AFC and potential problems with the administration of medication to Resident A. Complainant reported she found a pink pill (Divalproex Sodium 250mg) in Resident A's wheelchair, but it is not a medication prescribed to Resident A. Complainant reported she is also concerned because Resident A's pacemaker machine became unplugged in August 2021. Complainant reported she visited Resident A last week (end of October 2021) and Resident A's pacemaker was unplugged again. Complainant voiced concern regarding Resident A's mail as well stating a letter was mailed to Resident A but it never was given to Resident A or her family. Complainant reported Resident A has lived at Kozy Komfort for four years and does not want to move her as that may be traumatizing.

On 11/4/2021, I interviewed Resident A regarding the allegations. Resident A reported she likes living at Kozy Komfort AFC and the staff are “good to her.” Resident A reported she feels safe and does not want to move. Resident A denied any knowledge of medication errors or another resident’s medication being found in her wheelchair. Resident A reported she does get mail but was unsure how often as her daughter usually gets the mail.

On 11/4/2021, I interviewed Resident A’s relative, Relative A1, who was visiting Resident A. Relative A1 reported she does not have any concerns about the care Resident A receives at Kozy Komfort AFC. Relative A1 reported there are communication problems on both sides meaning between the AFC staff and Relative A1. Relative A1 reported the facility should alert the family when a resident receives mail and is concerned that a letter from the pacemaker company was sent to the facility in August and was not given to the family for over a month. Relative A1 reported she does not believe her mother was given the wrong medication and is receiving good care from the direct care staff. I toured the facility with licensee designee Ramchandra Mishra and noted the home was neat and clean. I also toured Resident A’s bedroom and observed her pacemaker machine. I also noted Resident A has a hospital bed. Mr. Mishra reported the cord from the pacemaker had been wrapped around the sliding arm of the hospital bed which resulted in the unit becoming unplugged. Mr. Mishra reported he removed the cord from around the arm of the hospital bed to prevent the pacemaker machine from becoming unplugged from the wall in the future.

On 11/4/2021, I interviewed licensee designee Ramchandra Mishra regarding the allegations. Mr. Mishra reported Resident A has been living at Kozy Komfort for years and gets good care from the direct care staff. Mr. Mishra reported all resident family members know to check with direct care staff about mail received and acknowledged Resident A’s pacemaker machine became unplugged but was plugged back in as soon as it was discovered. Mr. Mishra reported the cord was wrapped around the arm of the hospital bed and was removed and plugged into the wall. Mr. Mishra acknowledged a medication error occurred. Mr. Mishra denied contacting Resident B’s primary care physician regarding the medication error.

On 11/4/2021, I interviewed direct care staff member, Tancy Vosburg regarding the allegations. Ms. Vosburg reported Complainant visited Resident A on 11/2/2021 in the morning and was upset that Resident A was still in bed because she expects direct care staff members to have Resident A out of bed and ready for the day by 7:00am. Ms. Vosburg reported Complainant wanted to see Resident A’s *Medication Administration Record* (MAR) and began writing on it on pencil as she does not want Resident A to be given aspirin on an empty stomach. Ms. Vosburg reported she told Complainant not to write on the MAR and she “yelled at me.” Ms. Vosburg reported she raised her voice in response but did not yell at Complainant. Ms. Vosburg reported Complainant has a history of swearing at Ms. Vosburg and other direct care staff.

Ms. Vosburg reported Complainant did find another resident's medication in Resident A's wheelchair and Ms. Vosburg took responsibility for the error. Ms. Vosburg reported she mistakenly transferred Resident B into Resident A's wheelchair on Monday 11/1/2021 as the wheelchairs resemble each other even though their names are on the backs of the wheelchair. Ms. Vosburg reported Resident B is prescribed Divalproex Sodium and was given the medication however one of her pills must have fallen into the creases of Resident A's wheelchair cushion. Ms. Vosburg denied contacting Resident B's primary care physician about the medication error.

On 11/4/2021, I reviewed Resident A's and Resident B's *Medication Administration Records* (MAR) and noted Resident B is prescribed Divalproex Sodium and Resident A is not prescribed that medication. Direct care staff member, Tancy Vosburg documented in Resident B's MAR that all medications were passed on 11/1/2021. I also noted the MARs were accurate for each resident and matched the medications on hand.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation which included my personal observations of the facility, interviews with Complainant, Resident A, Relative A1, Tancy Vosburg, Ramchandra Mishra and review of Resident A's and Resident B's Medication Administration Records (MARs) this violation will be established. Complainant observed a medication not prescribed to Resident A in her wheelchair. Direct care staff member, Tancy Vosburg acknowledged she transferred Resident B into Resident A's wheelchair by accident and passed medications to Resident B while she was in Resident A's wheelchair. Ms. Vosburg further acknowledged the medication (Divalproex Sodium) is prescribed to Resident B and must have fallen into Resident A's wheelchair when it was passed on 11/1/2021. Ms. Vosburg was unaware Resident B did not take this medication or that it had fallen into the seat of the wheelchair. Consequently, Ms. Vosburg documented the medication as having been administered in Resident B's MAR when it had not been administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/4/2021, I conducted an onsite investigation at Kozy Komfort and spoke with direct care staff member Tancy Vosburg and licensee designee Ramchandra Mishra regarding a medication error. Ms. Vosburg took responsibility for the error as she transferred Resident B into Resident A's wheelchair on 11/1/2021 by mistake. Ms. Vosburg then passed medications to Resident B and did not supervise appropriately Resident B to assure she swallowed the and one of her pills fell into the creases of Resident A's wheelchair. Both Ms. Vosburg and Mr. Mishra denied contacting Resident B's primary care physician for guidance and instruction after realizing Resident B had not actually taken the prescribed medication.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	Based on my investigation which included my personal observations of the facility, interviews with Complainant, Resident A, Relative A1, Tancy Vosburg, Ramchandra Mishra and review of Resident A's and Resident B's Medication Administration Record (MAR) this violation will be established. A medication error was discovered on 11/2/2021 and neither direct care staff member Tancy Vosburg nor licensee designee Ramchandra Mishra contacted Resident B's primary care physician for further instruction or guidance.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Based on an acceptable correction action plan, I recommend no change in the current license status.

12/7/2021

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Nile Khabeiry Date
Licensing Consultant

Approved By:

12/20/2021

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Dawn N. Timm Date
Area Manager