GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 20, 2021

Destiny Saucedo-Al Jallad
Turning Leaf Res Rehab Svcs., Inc.
P.O. Box 23218
Lansing, MI 48909

RE: License #:	AM610301443
Investigation #:	2022A0356002
	Northridge

Dear Ms. Saucedo-Al Jallad:

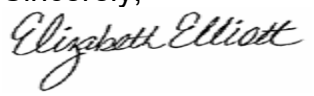
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM610301443
Investigation #:	2022A0356002
Complaint Receipt Date:	10/29/2021
Investigation Initiation Date:	10/29/2021
Report Due Date:	12/28/2021
Licensee Name:	Turning Leaf Res Rehab Svcs., Inc.
Licensee Address:	621 E. Jolly Rd. Lansing, MI 48909
Licensee Telephone #:	(517) 393-5203
Administrator:	Destiny Saucedo-Al Jallad
Licensee Designee:	Destiny Saucedo-Al Jallad
Name of Facility:	Northridge
Facility Address:	788 Marquette Ave. Muskegon, MI 49442
Facility Telephone #:	(231) 760-5195
Original Issuance Date:	10/02/2009
License Status:	REGULAR
Effective Date:	04/10/2020
Expiration Date:	04/09/2022
Capacity:	7
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's medications are not documented on the medication administration record and not administered as prescribed.	Yes

III. METHODOLOGY

10/29/2021	Special Investigation Intake 2022A0356002
10/29/2021	Special Investigation Initiated - Telephone Dan Scanlon, HealthWest supervisor and Marie Comreid, case manager.
10/29/2021	Contact - Document Received Large packet of documents received in office.
11/30/2021	Contact - Telephone call made Carmen Levelston Strong.
11/30/2021	Contact - Telephone call made Marie Comreid, HealthWest case manager.
12/01/2021	Contact - Document Received Carmen Levelston-Strong, documents.
12/20/2021	Exit Conference-Licensee Designee, Destiny Al Jallad.

ALLEGATION: Resident A's medications are not documented on the medication administration record and not administered as prescribed.

INVESTIGATION: On 10/29/2021, I received Health West (Muskegon County Community Mental Health) Incident Report (IR) written by Marie Comried, LLBSW, supports coordinator for Resident A. The IR documents the following information, *'(Resident A) passed away early morning of 09/13/2021, CM (case manager) was notified by Carmen Strong-Levelston director of the AFC. On 09/13/2021, RN (registered nurse) received a MAR (medication administration record) printed on 09/01/2021 and medications (for Resident A). RNs completed a med count for med received. Among them were #14 (14 pills) Percocet 5/325, #6 (6 patches) Fentanyl patches 25 mcg and #52 (52 pills) Gabapentin 100mg. CM requested RMA (Registered Medical Assistant) to contact Walgreens to obtain pick up dates and released counts of Fentanyl patches and Percocet. When the CM asked Carmen about Fentanyl not being on the MAR it was stated that it wasn't filled at IPSG*

(pharmacy) therefore was not put on the MAR. Carmen reports that she will have staff find the documentation for Fentanyl patches. It should be noted that Percocet 5/325 was also not filled by IPSG and the Percocet was indicated on the MAR from August and September (2021). Fentanyl was a scheduled medication which was to be replaced every 3 days. Oxycodone (Percocet) is a PRN to be administered up to 4 times daily. Concern: While waiting for specialized placement the team provided multiple daily med drops to (Resident A). With the Fentanyl patch (Resident A) accepted a minimum of 2 Percocet daily. The CM met with (Resident A) on 08/24/2021, she was laying down and indicated that she is in pain and out of pain meds. CM asked about the Fentanyl pain patch as this is a scheduled med she reports that she has to ask for this to be administered. CM asked if staff had called Walgreens about the Percocet, they report that they have but it is not there- according to MAPS (Michigan Automated Prescription System) it was billed to insurance on 08/23/2021. Per a hospital report from 09/11/2021 a tox screen was completed by Mercy (hospital) and there was no Percocet or Fentanyl in her (Resident A's) system. (Facility) MAR indicated Percocet was given on 09/09/2021 at 7:11a.m, 09/10/2021 at 10:15a.m., 09/10/2021 at 7:18p.m., 09/11/2021 at 8:36a.m., 09/12/2021 at 2:13p.m. Pharmacist reports if someone is taking Percocet consistently traces should be in her system for a minimum of 48 hours. There were no concerns for Gabapentin counts. Walgreens pharmacy Percocet pick up, 08/26/2021, #56, billed to insurance 08/23/2021, 08/13/2021, #28, billed to insurance 08/12/2021, 08/05/2021, #24, billed to insurance 08/05/2021. Fentanyl pick up on 08/06/2021, #10, billed to insurance 08/05/2021. On 09/15/2021, CM and RN compared MAR sheets with Percocet and Fentanyl. Fentanyl was not listed on the MAR. Percocet counts should equal #35 HW (HealthWest) received #14 indicating that #21 tablets are missing. CM contacted Carmen and requested documentation for Fentanyl administration. Carmen stated that she can provide this tomorrow, it is not in the MAR as their pharmacy did not fill this RX (prescription). On 09/16/2021, CM received what appears to be a shift log, 08/05/2021 "(Resident A) took her two Tylenol @ 12 midnight and back to bed. (Resident A) asked for 2 Tylenol and was given she also has a pain patch on her back." "08/06/2021 changed (Resident A's) Fentanyl patch on her shoulder out 5:30p.m.." "08/23/2021, (Resident A) left with her mom at 9:50a.m. and returned around 12:10p.m. requesting Fentanyl patch and received." "08/26/2021, (Resident A) had 1 oxycodone at 12:37p.m., (Resident A) had gotten a Fentanyl patch." This still leaves #1 Fentanyl patch unaccounted for.'

On 10/29/2021, I interviewed Health West case manager, Marie Comreid and supervisor, Dan Scanlon via telephone. Mr. Scanlon and Ms. Comreid stated Resident A resided at the facility from 08/05/2021 until 09/13/2021 and required staff to administer all of her medications. After a review of the facility MARs and a count of the medications left over, there is concern regarding the medications Percocet and Fentanyl and the documentation of the medications showing they were administered as prescribed. I reviewed the above complaint information with Ms. Comreid and Mr. Scanlon and they confirmed this information is accurate and outlines their concerns.

On 10/29/2021, I received and reviewed the staff notes reported in the complaint. The staffing notes dated 08/05/2021, 08/06/2021, 08/23/2021 and 08/26/2021 documents Resident A getting a Fentanyl patch administered except on 08/05/2021, the notes document that Resident A had a patch on already.

On 10/29/2021, I received and reviewed a copy of the prescription for Fentanyl 25 MCG/HR patch dated 08/05/2021 in the amount of 10 patches, no refills, written by B. Newberry, PA (Physician's Assistant).

On 10/29/2021, I received and reviewed the medication intake and discharge summary documenting that upon Resident A's discharge from the facility on 09/13/2021, Ms. Strong-Levelston produced 6 Fentanyl patches and 14 Percocet tablets to HealthWest RN Nicholas Dykman.

On 10/29/2021, I received and reviewed the MAPS summary that documented on 08/05/2021, 10 Fentanyl patches was filled through Walgreens Pharmacy for Resident A upon her move into the facility. The MAPs document shows that Fentanyl was prescribed as early as 07/15/2021 to Resident A prior to her moving into this facility but the last Fentanyl prescription prior to admission to this facility was on 07/31/2021 in the amount of 2 patches. On 08/12/2021, 28 Oxycodone-Acetaminophen (Percocet) 5-325 was filled through Walgreens Pharmacy and on 08/23/2021, 56 Oxycodone-Acetaminophen (Percocet) 5-325 was filled through Walgreens Pharmacy for Resident A for a total of 84 Percocet tablets prescribed while Resident A was in care at the facility. The MAPs document showed that Resident A was prescribed Percocet as early as 11/24/2020 prior to moving into the facility and the last prescription of Percocet just prior to moving into this facility was dated 07/31/2021 and Resident A received 24 tablets.

On 10/29/2021, I received and reviewed a Mercy Health Emergency Department Note dated 09/11/2021 by Dr. Christopher Towns, DO. The document shows Resident A's medication/prescription list that included, '*Fentanyl (Duragesic) 25 MCG/HR, apply 1 (one) patch topically every 3 days. Make sure to remove old patch before applying new one.'* The list also included, '*Oxycodone Acetaminophen (Percocet) 5-325 MG per tablet, take 1 tablet by mouth every 6 (six) hours if needed for breakthrough pain.'*

On 10/29/2021, I received and reviewed a Mercy Health toxicology screen dated 09/11/2021 by Dr. Towns. The toxicology screen documents the opiate screen urine as negative. Percocet (Oxycodone/Acetaminophen) and Fentanyl are in the opioid family.

On 10/29/2021, I received and reviewed medication counts sheets for the months of August and September 2021 for Oxycodone 5-325 (Percocet). The medication count sheets documented the date, time, staff signatures and a countdown of the medications after administration. The document for August 2021, starts on 08/13/2021 with a count number of 28 Percocet/Oxycodone tablets and counts down

to 4 tablets left on the last documentation on 08/20/2021. The September 2021 countdown sheet began on 09/01/2021 and documented 40 Percocet/Oxycodone tablets and counts down to 14 tablets left when Resident A died on 09/13/2021.

On 10/29/2021, I reviewed Resident A's MARs for the months of August and September 2021. Neither MAR documents the Fentanyl patch as a prescribed medication and there is no documentation on the MARs that the patch was administered to Resident A during either August or September 2021. A review of the MARs showed Percocet/Oxycodone/APAP tab 5-325, mg, take one tablet by mouth every 6 hours as needed for pain (not to exceed 3 gm acetaminophen/24hrs), the order was written on 08/05/2021. The MAR documents during the months of August and September that the Percocet medication was administered to Resident A as a PRN (as needed). The MARs document the number of times the medication was given to Resident A with staff initials attached to the MARs in the PRN pass notes. The MARs also document HealthWest Registered Medical Assistant Michelle Biggs' documentation of the counts of the Percocet medications and notes that 14 Percocet tablets were returned to HealthWest and 21 tablets of Percocet are unaccounted for.

On 10/29/2021, I received and reviewed Ms. Biggs' documentation of the dates that Resident A's fentanyl patch should have been administered if the patch had been administered as prescribed. The dates are 08/06/2021, 08/09/2021, 08/12/2021, 08/15/2021, 08/18/2021, 08/21/2021, 08/24/2021, 08/27/2021, 08/30/2021, 09/02/2021, 09/05/2021, 09/08/2021 and 09/11/2021.

On 11/30/2021, I interviewed Ms. Levelston via telephone. Ms. Levelston confirmed that Resident A was admitted to the facility on 08/05/2021 and died on 09/13/2021. Ms. Levelston stated neither the Fentanyl nor the Percocet medications were included on the MARs (Percocet was included on the MARs). Ms. Levelston stated even though Resident A's Fentanyl patch was not documented on the MAR staff did administer the patch to Resident A. Ms. Levelston stated a total of 10 Fentanyl patches were received at the facility when Resident A was admitted on 08/05/2021, 6 were returned and 4 patches were used. Ms. Levelston stated there is no documentation on the MAR for the Fentanyl patches and the only documentation of the Fentanyl patches being administered to Resident A are in the staff notes. Ms. Levelston stated the Percocet was a PRN medication and Resident A was taking that medication on a regular basis. Ms. Levelston stated Ms. Comreid picked up the Fentanyl and Percocet medications and dropped them off at the facility because those medications were through the Walgreen's pharmacy, all other prescriptions for this facility were through IPSG pharmacy and that is why the medication(s) were not included on the MARs. Ms. Levelston stated that Resident A's Percocet medication was discontinued as of 08/21/2021 after a doctor's appointment that Resident A's guardian took her to on that date. Ms. Levelston stated the Percocet medication was not renewed, not refilled and that is why the medication was not in her system when the hospital completed the drug screen on 09/11/2021.

On 11/30/2021, I interviewed Ms. Comreid via telephone. Ms. Comreid stated she did not pick up the medications for Resident A from Walgreens and that the Percocet was included on the MARs that were reviewed by HealthWest but the Fentanyl did not show up on anything, except for the staff notes showing the patch was administered a few times while Resident A was in the facility, definitely not every 72 hours as prescribed. Ms. Comreid added that neither the Fentanyl patch or the Percocet were new prescriptions for Resident A and therefore, she is not sure why one medication was on the MAR and the other was not. Ms. Comreid stated on 09/11/2021 the hospital completed a drug screen on Resident A and the Percocet was not found in her system even though the MAR documents the medication was administered to Resident A in the days prior to the drug screen. Ms. Comreid reiterated that the MAR indicated Percocet was given on 09/09/2021 at 7:11a.m, 09/10/2021 at 10:15a.m., 09/10/2021 at 7:18p.m., 09/11/2021 at 8:36a.m., 09/12/2021 at 2:13p.m. Ms. Comreid stated the pharmacist stated if someone is taking Percocet consistently traces should be in their system for a minimum of 48 hours. Ms. Comreid stated there was no indication of Fentanyl in Resident A's system either.

On 12/20/2021, I conducted an Exit Conference with Licensee Designee, Destiny All Jallad via telephone. Ms. Al Jallad stated she will review this report with Ms. Levelston and will submit a corrective action plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being §333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Resident A's prescribed Fentanyl patches were to be administered topically every 3 days. Resident A admitted to the facility with 10 patches on 08/05/2021 and on 09/13/2021 had 6 patches left, showing that the Fentanyl patch was not administered as prescribed. Resident A's Percocet medication was documented on the MAR as administered as prescribed on a PRN/as needed basis however, the count conducted by HealthWest using the number of pills provided by the pharmacy and the number of

	pills documented as administered to Resident A on the MAR for August and September 2021 do not add up. In addition, the MAR shows Percocet as administered on the days prior to a toxicology screen at the hospital and the screen shows no sign of Fentanyl or Percocet in Resident A's system. Therefore, a violation of this applicable rule is established as Resident A's medication Fentanyl and Percocet were not administered as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	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: (b) Complete an individual medication log that contains all of the following information: (i) The medication. (ii) The dosage. (iii) Label instructions for use. (iv) Time to be administered. (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. (vi) A resident's refusal to accept prescribed medication or procedures.
ANALYSIS:	There is no documentation of Resident A's Fentanyl patch on a Medication log for either August or September 2021, which is the entire time Resident A was in the facility. There is no documentation for Resident A's Fentanyl patch that contains the medication, the dosage, label instructions for use, time to be administered or the initials of staff showing that the medication was administered as prescribed. A violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/20/2021

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

12/20/2021

Jerry Hendrick — Date
Area Manager