GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 1st, 2022

Beth Covault
Samaritas Senior Living Grand Rapids Woods
1900-32nd Street, SE
Grand Rapids, MI 49508-1583

RE: License #: AH410236832
Investigation #: 2022A1021038
Samaritas Senior Living Grand Rapids Woods

Dear Ms. Covault:

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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410236832
Investigation #:	2022A1021038
Complaint Receipt Date:	03/21/2022
Investigation Initiation Date:	03/21/2022
Report Due Date:	05/20/2022
Licensee Name:	Samaritas
Licensee Address:	8131 East Jefferson Avenu Detroit, MI 48214-2691
Licensee Telephone #:	(231) 936-1012
Administrator/Authorized Representative:	Beth Covault
Name of Facility:	Samaritas Senior Living Grand Rapids Woods
Facility Address:	1900-32nd Street, SE Grand Rapids, MI 49508-1583
Facility Telephone #:	(616) 452-4470
Original Issuance Date:	02/15/1994
License Status:	REGULAR
Effective Date:	02/28/2022
Expiration Date:	02/27/2023
Capacity:	61
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents did not receive medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/21/2022	Special Investigation Intake 2022A1021038
03/21/2022	Special Investigation Initiated - Letter Referral sent to APS
03/22/2022	Inspection Completed On-site
03/22/2022	Contact-telephone call made Interviewed SP2
03/23/2022	Contact - Telephone call made Interviewed administrator
03/23/2022	Contact - Document Received received MAR and policies
04/01/2022	Exit Conference Exit conference with authorized representative Beth Covault

ALLEGATION:

Residents did not receive medications.

INVESTIGATION:

On 3/21/22, the licensing department received a complaint with allegations due to lack of internet, residents did not receive medications. The complainant alleged on 3/17/22, the facility lost internet connection. The complainant alleged Resident B spit out medications and staff were unable to re-attempt to administer these medications because staff members were unable to access the electronic medication administration records (MAR).

On 3/22/22, I interviewed the wellness director Mary Mazurek at the facility. Ms. Mazurek reported the facility lost internet around 12:00pm on 3/17/22. Ms. Mazurek reported she came into the facility around 3:00pm to attempt to print off paper MARs for staff to administer medications. Ms. Mazurek reported she was able to print off the MARs and staff were able to administer medications as prescribed. Ms. Mazurek reported the internet was restored the next day around 10:00am. Ms. Mazurek reported she is unsure if any residents missed medications.

On 3/22/22, I interviewed staff person 1 (SP1) at the facility. SP1 reported the facility lost internet around 11:30am and it was restored the following day. SP1 reported Resident B's medications are to be crushed in pudding. SP1 reported when she went to administer Resident B's 12:00pm medications, Resident B spit out the medications. SP1 reported she would have re-attempted to administer the medications but was unable to do so because she could not access Resident B's MAR. SP1 reported all other residents were administer medications as prescribed.

On 3/22/22, I interviewed SP2 by telephone. SP2 reported she worked second shift on 3/17/22. SP2 reported when she reported to work around 2:30pm the facility still did not have paper MARs printed off. SP2 reported the paper MARs were distributed around 6:00pm that evening.

On 3/23/22, I interviewed administrator Michelle DuBridge by telephone. Ms. DuBridge reported when the facility lost internet, they worked with the IT department on getting hot spots hooked up to access the MARs. Ms. DuBridge reported the hot spots were unable to connect to Point Click Care, the medication system. Ms. DuBridge reported the facility then went to the backup system of printing MARs. Ms. DuBridge reported the paper MARs were able to be printed and provided to staff around 5:00pm. Ms. DuBridge reported the following day the internet was restored. Ms. DuBridge reported no medications were missed and all residents received their medication.

I reviewed the paper MAR for Resident B. The MAR revealed Resident B refused noon medications on 3/17/22. Resident B was administered medications during the internet outage and did not miss any medications.

I reviewed the paper MAR for Resident C. The MAR revealed on 3/17/22, Resident C was not administered Ativan 1mg tablet and Tramadol 37.5-325mg tablet.

I reviewed the paper MAR for Resident D. The MAR revealed on 3/17/22, Resident D was not administered Ativan 0.5mg tablet, Hydralazine HCl 10mg tablet, and Biofreeze gel.

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:	Interviews with employees revealed the facility lost internet connection which resulted in the facility inability to administer medications. Due to this, medication technicians were unable to re-attempt to administer medications to Resident B. In addition, Resident C and Resident D were not administered medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed the facility Emergency Backup eMAR Report Printing. The policy read,

> *"Protocol:*
> *Every attempt should be made to establish a connection to the Internet including calling the IT service Desk at 844-200-4848. However, if no one can connect to PointClickCare, after one hour (between 0600 and 2000) or two hours (all other times), paper MARs and TARS should be printed."*

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents**
For Reference: R 325.1901	**(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety,**

	and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	The facility lost internet connection around 12:00pm on 3/17/22. However, paper MARs were not printed and distributed to staff members until 5:00-6:00pm. The facility did not appropriately follow their policy to ensure employees were able to administer medications to residents. The facility did not take swift and reasonable action to ensure the well-being of their residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/1/22, I conducted an exit conference with authorized representative Beth Covault by telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Kimberly Horst 3/24/22

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 03/31/2022

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