GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 2, 2022

Tamesha Porter
Safe Haven Assisted Living, LLC
981 Jolly Road
Okemos, MI 48864

RE: License #: AM330349436
Investigation #: 2022A0783030
Safe Haven Assisted Living

Dear Ms. Porter:

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,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM330349436
Investigation #:	2022A0783030
Complaint Receipt Date:	03/03/2022
Investigation Initiation Date:	03/03/2022
Report Due Date:	05/02/2022
Licensee Name:	Safe Haven Assisted Living, LLC
Licensee Address:	981 Jolly Road Okemos, MI 48864
Licensee Telephone #:	(517) 402-1802
Administrator:	Tamesha Porter
Licensee Designee:	Tamesha Porter
Name of Facility:	Safe Haven Assisted Living
Facility Address:	981 Jolly Road Okemos, MI 48864
Facility Telephone #:	(517) 574-4579
Original Issuance Date:	02/07/2014
License Status:	REGULAR
Effective Date:	07/29/2020
Expiration Date:	07/28/2022
Capacity:	12
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Marshadiki Wheeler gave Resident A Resident B's medication and Resident A had to be hospitalized as a result.	Yes
Resident A, 's prescribed morphine was not administered according to her physician's written order.	No
Staff member Marshadiki Wheeler yelled at Resident A.	No

III. METHODOLOGY

03/03/2022	Special Investigation Intake – 2022A0783030
03/03/2022	Special Investigation Initiated – Telephone call with Complainant
03/03/2022	Contact- Telephone call made to assigned APS Specialist
03/14/2022	Inspection Completed On-site
03/14/2022	Contact - Face to Face interviews with licensee designee Tamesha Porter and direct care staff members Rebecca Singleton and Darcy Ambs
03/14/2022	Contact - Telephone call made to former direct care staff member Marshadiki Wheeler, unsuccessful
03/14/2022	Contact - Document Received – Resident A's resident record
03/14/2022	Contact - Document Received – *Employee Documentations* for Marshadiki Wheeler
04/28/2022	Contact - Telephone call made to Marshadiki Wheeler, unsuccessful
04/28/2022	Contact - Telephone call made to direct care staff members Corrynn Eberly and Julie Briggs
04/29/2022	Contact - Telephone call made to Marshadiki Wheeler, unsuccessful

04/29/2022	Contact - Telephone call made to direct care staff member Kendall Graczyk
04/29/2022	Exit Conference with Tamesha Porter

ALLEGATION:

Direct care staff member Marshadiki Wheeler gave Resident A Resident B's medication and Resident A had to be hospitalized as a result.

INVESTIGATION:

On March 3, 2022, I received a complaint via centralized intake that stated Resident A suffers from congestive heart failure, diabetes, mental illness, history of mini-strokes, high blood pressure, and COPD. The written complaint stated on one occasion (date unknown), a staff member put medication next to Resident A's dinner plate that was not prescribed for Resident A, but another resident. The complaint stated Resident A took the medication and required medical attention in the hospital emergency room because of the change in her blood sugar levels caused from the medication she ingested. The written complaint stated the staff member was aware that the medication belonged to another resident and did not alert Resident A not to take the medication.

On March 3, 2022, I spoke to the assigned adult protective services (APS) investigator who said direct care staff member Marshadiki Wheeler told her that she was administering medication on February 9, 2022, at the same time she was serving a meal. APS Investigator said Ms. Wheeler told her she put Resident B's medication in a cup, turned around, and Resident A took the medication prescribed for Resident B. APS Investigator said Ms. Wheeler told her that she realized Resident A took Resident B's medication when Resident A informed her. APS Investigator said Ms. Wheeler immediately sought medical attention for Resident A. APS Investigator said Ms. Wheeler resigned from the facility on March 1, 2022.

On March 14, 2022, April 28, 2022, and April 29, 2022, I telephoned former direct care staff member Marshadiki Wheeler but was not able to reach her. Ms. Wheeler has not returned my call as of the date of this report.

On March 14, 2022, I interviewed licensee designee Tamesha Porter who said direct care staff member Marshadiki Wheeler made an "error" when administering medication on February 9, 2022. Ms. Porter said Ms. Wheeler put Resident B's medication in a "cup" and sat the cup down on the table in the common area. Ms. Porter said Resident A "grabbed" the medication cup containing Resident B's medication and took the medication while Ms. Wheeler was helping another resident. Ms. Porter said Ms. Wheeler called her immediately and explained what

happened and called 911 to seek medical attention for Resident A. Ms. Porter said it is against facility policy to leave medication unattended and she recorded a formal written disciplinary action in Ms. Wheeler's employee record, and she retrained Ms. Wheeler on the proper procedures for administering medication. Ms. Porter said Ms. Wheeler subsequently voluntarily terminated her employment at the facility.

On March 14, 2022, I interviewed direct care staff members Darcy Ambs and Rebecca Singleton who stated they administer medication as part of their responsibilities at the facility and are familiar with the proper protocol. Both staff members described administering each resident's medication one at a time and supervising the residents to ensure the medication was taken. Both staff members denied that they have ever left any resident's medication unattended, and both denied that they ever saw Ms. Wheeler leave any resident's medication unattended at the facility but were aware that Resident A ingested Resident B's medication while Ms. Wheeler was working.

On April 28, 2022 and April 29, 2022, I spoke to direct care staff members Corrynn Eberly, Julie Briggs, and Kendall Graczyk who also stated they have never left a medication unattended at the facility and denied that they ever saw Ms. Wheeler leave medication unattended at the facility but were aware that Resident A ingested Resident B's medication while Ms. Wheeler was working.

On March 14, 2022, I received a written *AFC Licensing Division – Incident/Accident Report* for Resident A dated February 9, 2022. The written incident report stated, "Meds given to wrong resident. (Resident grabbed another resident's medication." In the "action taken by staff" section of the written report it stated, "Checked [Resident A], called owner and manager, sent to ER for precaution. Contacted POA." In the "corrective measures" section of the written report it stated, "A review with medication policy." The written report was signed by direct care staff member Marshadiki Wheeler and Tamesha Porter.

On March 14, 2022, I received a written document entitled *Employee Documentations* which was signed by Tamesha Porter and Matshadiki Wheeler on February 9, 2022. The document indicated that Ms. Wheeler made a medication error and violet policy when "wrong medication given to resident." The written document indicated Ms. Wheeler was received a formal "warning," which was her second "warning."

On March 14, 2022, I received a written *After Visit Summary* from Sparrow Hospital for Resident A which stated Resident A was treated at the hospital that day for "Accidental drug ingestion, initial encounter," and "hypoglycemia." The written document indicated that Resident A's blood glucose was monitored several times via multiple means and Resident A was discharged with instructions to see her primary care physician within two days."

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on statements from Complainant and Ms. Porter along with written documentation at the facility I determined that Resident B's medication was left unattended by Ms. Wheeler which allowed Resident A to ingest the medication that was not prescribed to her. Precautions to ensure that prescription medication is not used by another person other than for whom the medication was prescribed were not taken when Resident B's medication was left unattended by Ms. Wheeler.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's prescribed morphine was not administered according to her physician's written order.

INVESTIGATION:

On March 3, 2022, I received a complaint via centralized intake that stated staff members at the facility do not administer Resident A's medications per physician's orders. The written complaint stated there were instances when staff members skipped Resident A's morphine doses which caused Resident A intense pain in her chest.

On March 3, 2022, I spoke to Complainant who said According to Relative A1 on several occasions Resident A's prescribed Morphine was "skipped," or not administered timely after her physician ordered that the medication be administered hourly. Complainant said she was not able to gather any documentation to confirm this allegation, that there were no concerns noted, and Complainant's case would be closed.

On March 14, 2022, I interviewed licensee designee Tamesha Porter who said Resident A was placed on hospice services on February 18, 2022 and Morphine was prescribed as – needed (PRN). Ms. Porter said Resident A's family members wanted the morphine to be administered every hour, but the physician did not sign an order to that effect until March 1, 2022. Ms. Porter stated staff members always administered Resident A's prescribed Morphine according to the written physician's order. Ms. Porter said when the Morphine was prescribed as – needed staff

members would ask Resident A if she needed her pain medication and monitor her facial expression and body movements to assess for pain. Ms. Porter said after the medication was changed to a scheduled hourly dose, staff members administered the medication hourly within five to ten minutes round the clock.

On March 14, 2022, I interviewed direct care staff member Darcy Ambs who stated she has worked at the facility for six years, administers medication as part of her job responsibilities, and is familiar with Resident A. Ms. Ambs said approximately a week to two weeks prior to Resident A's death on March 3, 2022, her prescribed Morphine was administered hourly round-the-clock per her physician's written orders. Ms. Ambs said no doses were ever "skipped," nor "missed" while she was working nor that she was aware of. Ms. Ambs said prior to the Morphine being scheduled hourly staff members regularly assessed Resident A's pain and administered the medication as – needed.

On March 14, 2022, I interviewed direct care staff member Rebecca Singleton who stated she has worked at the facility for seven years, administers medication as part of her job responsibilities, and is familiar with Resident A. Ms. Singleton said Resident A was placed on hospice services on February 18, 2022 and she passed away on March 3, 2022 and that there were "rapid changes" with Resident A's prescribed Morphine during that time. Ms. Singleton stated when Resident A was first placed on hospice services the Morphine was prescribed as – needed and staff members regularly assessed Resident A's pain level and administered the medication when Resident A needed or requested the medication. Ms. Singleton stated "a few days" prior to Resident A's death on March 3, 2022, her physician changed the Morphine prescription to be administered every hour scheduled. Ms. Singleton said no does were ever "skipped," nor "missed" while she was working nor that she was aware of.

On April 28, 2022, I spoke to direct care staff member Corrynn Eberly who stated she has worked at the facility for one year, administers medication as part of her job responsibilities, and is familiar with Resident A. Ms. Eberly stated when Resident A was first placed on hospice services the Morphine was prescribed as – needed and staff members regularly assessed Resident A's pain level and administered the medication when Resident A needed or requested the medication. Ms. Eberly stated, "towards the end of" Resident A's life her physician changed the Morphine prescription to be administered every hour scheduled. Ms. Eberly said no does were ever] "skipped," nor "missed" while she was working nor that she was aware of.

On April 28, 2022, I spoke to direct care staff member Julie Briggs who said she has worked at the facility for five years, administers medication as part of her job responsibilities, and is familiar with Resident A. Ms. Briggs stated when Resident A was first placed on hospice services the Morphine was prescribed as – needed and staff members regularly assessed Resident A's pain level and administered the medication when Resident A needed or requested the medication. Ms. Briggs stated days prior to Resident A's death her physician changed the Morphine prescription to

be administered every hour scheduled. Ms. Briggs said no does were ever “skipped,” nor “missed” while she was working nor that she was aware of.

On April 29, 2022, I spoke to direct care staff member Kendall Graczyk who said she has worked at the facility for nearly two years, administers medication as part of her job responsibilities, and is familiar with Resident A. Ms. Graczyk stated when Resident A was first placed on hospice services the Morphine was prescribed as – needed and staff members regularly assessed Resident A’s pain level and administered the medication when Resident A needed or requested the medication. Ms. Graczyk said if Resident A was in pain, she would indicate so by wincing, clenching her jaw or tightening her other muscles. Ms. Graczyk stated days prior to Resident A's death her physician changed the Morphine prescription to be administered every hour scheduled. Ms. Graczyk said no does were ever “skipped,” nor “missed” while she was working nor that she was aware of. Ms. Graczyk described staff members as “diligent” about administering Resident A’s prescribed Morphine hourly.

On March 14, 2022, I received a written physician’s order for Resident A dated March 1, 2022, which stated 2 Morphine Concentrate, 0.5 ml, was to be administered “every hour scheduled for pain and dyspenia.”

On March 14, 2022, I received Resident A’s written medication administration records (MAR) for March 2022. According to the written MAR Resident A was prescribed Morphine with the written directions, “place 0.5 ml (10 mg) under the tongue every hour.” The written MAR documented that between March 1, 2022, when the order was written and March 3, 2022, when Resident A passed away the Morphine was administered hourly, as prescribed. According to the MAR the medication was administered by Julie Briggs, Marshadiki Wheeler, Darcy Ambs, Rebecca Singleton, Tamesha Porter, and Kendall Gracyzek.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on statements from Complainant, Ms. Porter, Ms. Ambs, Ms. Singleton, Ms. Eberly, Ms. Briggs, and Ms. Graczyk along with documentation from Resident A’s resident record there is lack of evidence to indicate that Resident A did not receive her prescribed Morphine hourly once it was prescribed that way by her physician on March 1, 2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff member Marshadiki Wheeler yelled at Resident A.

INVESTIGATION:

On March 3, 2022, I received a complaint via centralized intake that stated staff members yelled at Resident A for multiple incidents, including the incident when Resident A accidentally took another resident's medication.

On March 3, 2022, I spoke to the assigned APS investigator who said she was told the only staff member who yelled at Resident A was Marshadiki Wheeler. Complainant said she interviewed direct care staff member Marshadiki Wheeler who said she never yelled at Resident A.

On March 14, 2022, April 28, 2022, and April 29, 2022, I telephoned direct care staff member Marshadiki Wheeler and was not able to reach her. Ms. Wheeler has not returned my telephone call as of the date of this report.

On March 14, 2022, I interviewed licensee designee Tamesha Porter who said Resident A told her that when Resident A ingested Resident B's medication Ms. Wheeler was "startled and raised her voice," but it was not directed toward Resident A. Ms. Porter said Resident A told her Ms. Wheeler asked her, "Why did you take that?" Ms. Porter said when Ms. Wheler called her immediately following the incident she sounded "scared," but not angry and no negative emotions were directed at Resident A. Ms. Porter denied that Resident A, Resident A's family members, nor any other resident or staff member ever indicated that Ms. Wheeler yelled at Resident A nor any other resident. Ms. Porter denied that any other staff member has ever been accused of yelling at Resident A nor any other resident.

On March 14, 2022, I interviewed direct care staff members Darcy Ambs and Rebecca Singleton who both stated they worked with Ms. Wheeler and never heard her yell at Resident A nor any other resident. Ms. Ambs and Ms. Singleton both denied that they ever yelled at Resident A nor any other resident. Both staff members denied that any resident, family member nor staff member has ever indicated that Ms. Wheeler yelled at Resident A nor any other resident.

On April 28, 2022 and April 29, 2022, I spoke to direct care staff members Corrynn Eberly, Julie Briggs, and Kendall Graczyk who all stated they worked with Ms. Wheeler and never heard her yell at Resident A nor any other resident. All three staff members denied that they ever yelled at Resident A nor any other resident. All three staff members denied that any resident, visitor, staff member etc. ever reported that they heard Ms. Wheeler yell at anyone.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule one (1) of this rule.**
ANALYSIS:	Based on statements from Complainant, Ms. Porter, Ms. Ambs, Ms. Singleton, Ms. Eberly, Ms. Briggs, and Ms. Graczyk there is lack of evidence to prove that Ms. Wheeler yelled at Resident A nor that any other staff member yelled at Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On March 3, 2022, I received a complaint via centralized intake that stated Resident A's family member asked for a payment extension at the facility in order to pay for Resident A's death expenses, and the licensee designee would not give an extension. The complaint cited concern that the licensee designee would "kick [Resident A] out while she is dying." This portion of the complaint was not officially investigated as LARA has no administrative rules pertaining to payment extensions. There are no administrative rules placing restrictions on when a 30 – day discharge notice can be issued, and the resident passed away under hospice care at the facility on March 3, 2022.

IV. RECOMMENDATION

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

04/29/2022

_____

Leslie Herrguth — Date
Licensing Consultant

Approved By:

05/02/2022

_____

Dawn N. Timm — Date
Area Manager