GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 26, 2022

Mary Boomer
215 South 12th St
Escanaba, MI 49829

RE: License #: AF210070598
Investigation #: 2022A0234004
Boomer AFC

Dear Mrs. Boomer:

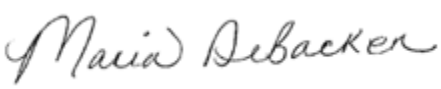
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (906) 226-4171.

Sincerely,



Maria DeBacker, Licensing Consultant
Bureau of Community and Health Systems
234 W. Baraga Ave.
Marquette, MI 49855
(906) 280-8531

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF210070598
Investigation #:	2022A0234004
Complaint Receipt Date:	03/03/2022
Investigation Initiation Date:	03/03/2022
Report Due Date:	05/02/2022
Licensee Name:	Mary Boomer
Licensee Address:	215 South 12th St Escanaba, MI 49829
Licensee Telephone #:	(906) 786-3336
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Boomer AFC
Facility Address:	215 South 12th St Escanaba, MI 49829
Facility Telephone #:	(906) 786-3336
Original Issuance Date:	06/11/1996
License **Status:**	REGULAR
Effective Date:	12/11/2020
Expiration Date:	12/10/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A passed away at the facility on 02/04/2022. Resident A was not checked in on every two to three hours as agreed upon as part of the safety plan.	No
Resident A's autopsy results indicate a well over the lethal dose of olanzapine also known as Zyprexa (an anti-psychotic drug), which Resident A was not prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/03/2022	Special Investigation Intake 2022A0234004
03/03/2022	Special Investigation Initiated - Telephone Phone call to Complainant.
03/15/2022	Contact - Face to Face Interview with Detective Sam Pouliot, Escanaba Public Safety.
03/15/2022	Contact - Face to Face Interview with Staff Chris Kleiman.
03/16/2022	Inspection Completed On-site
03/16/2022	Contact - Face to Face Interview with Licensee Mary Boomer, Resident B, and Guardian B.
03/24/2022	Contact - Telephone call made Phone call with Guardian A.

04/11/2022	Contact - Face to Face Interview with Licensee Mary Boomer and Morris Boomer.
04/12/2022	Contact - Telephone call received Interview with Delta County Medical Examiner Cary Gottlieb.
04/20/2022	Contact - Telephone call made Phone call to Lt. Gudwer, Escanaba Public Safety.
04/20/2022	Contact - Telephone call made Phone call to Detective Sam Pouliot.
04/20/2022	Contact - Telephone call made Phone call with Guardian A.
04/21/2022	Contact - Telephone call made Phone call with Licensee Mary Boomer.
04/21/2022	Exit Conference Exit interview with Licensee Mary Boomer.

ALLEGATION: Resident A passed away at the facility on 02/04/2022. Resident A was not checked in on every two to three hours as agreed upon as part of the safety plan.

INVESTIGATION: The complainant reports that a safety plan was developed between Guardian A and Licensee Mary Boomer to check on Resident A every 2 to 3 hours.

On 03/15/20200, an unannounced inspection was completed at the facility. Licensee Mary Boomer was not at the facility. Staff Chris Kleiman was interviewed. When question concerning Resident A's file, Ms. Kleiman stated, "The police took his whole file".

On 03/15/2022, a meeting with Detective Sam Pouliot was held. Resident A's file was reviewed at the Escanaba Public Safety Department.

HISTORY: Resident A was admitted to the Boomer AFC Home on 11/03/2021. Resident A came to Boomer's AFC from an inpatient psychiatric unit in lower Michigan. Resident A was diagnosed with Schizoaffective Disorder, PTSD, and Cannabis Abuse Disorder. Resident A's Assessment Plan (signed 11/03/2021) was reviewed, and Resident A was able to move independently in the community.

On 03/16/2022, Licensee Mary Boomer was interviewed. Ms. Boomer explained that Resident A was quiet and kept to himself. Ms. Boomer stated, "There was no safety plan". Resident A's file was reviewed, and no safety plan was present or indicated in any of the documents.

Ms. Boomer reported that Resident A's death was deemed 'a natural death' due to cardiac issues, as per his guardian.

When questioned about going into the community, unsupervised, Ms. Boomer stated that "(Resident A) would take long walks in the community." Ms. Boomer stated she did not know where he would go on these walks.

On 03/24/2022 and on 04/20/2022 Guardian A was interviewed. Guardian A stated there was no formal 'safety plan'. Guardian A narrated the events of Thursday 02/03/2022 and 02/04/2022:

Guardian A stated that Resident A had called her Thursday, 02/03/22 at 8:25AM stating he did not feel good. She stated she arrived at the facility around 9:30AM and was told by Ms. Boomer that Resident A had gone to his bedroom to sleep. Guardian A observed Resident A sleeping and snoring. Guardian A stated she called Ms. Boomer at 11:30AM and 1:30PM and was told he was still sleeping. Guardian A explained to this consultant that Resident A had experience some anxiety the days previous and stated he hadn't been sleeping well. Guardian A stated she contacted Pathways Mental Health and Resident A's therapist and was told it was 'good to have him sleep'. Guardian A stated she told Ms. Boomer to 'let him sleep'. Resident A slept through the night.

Guardian A stated on Friday, 02/04/2022, she called Ms. Boomer at 8:00AM. Ms. Boomer reported that Ms. Boomer stated that Resident A was still sleeping, however, he had gotten up to use the restroom during the night as his basket was moved in his room. Guardian A stated that Ms. Boomer said that Resident B told her that Resident A had made a phone call as well. Guardian A stated she called again at 10:00AM and then 12:00PM, and Resident A was still sleeping. Guardian A stated she instructed Ms. Boomer to let him TO sleep as per instructions of his therapist and Pathways Mental Health personnel. Guardian A stated she called Ms. Boomer at 3:00PM and Ms. Boomer stated Resident A's breathing was 'not sounding right". Guardian A instructed Ms. Boomer to wake up Resident A. Guardian A stated Ms. Boomer stated to her that 'she was not comfortable waking him up herself'. Guardian A then went to the home arriving around 5:00PM and both her and Ms. Boomer went into Resident A's room and found him deceased.

Concerning moving independently in the community, Guardian A stated that Resident A was allowed to go into the community by himself. She stated, “He just went for walks as he had no money or no phone.”

APPLICABLE RULE	
R 400.1416	**Resident health care.**
	(1) A licensee, in conjunction with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician with regard to such items as medications, special diets, and other resident health care needs that can be provided in the home.
ANALYSIS:	The allegation states there was a “safety plan” in place that instructs Licensee Mary Boomer to check on Resident A every 2 to three hours. Ms. Boomer states she was unaware of a ‘safety plan’ and there is no document available to support this. There was constant communication with Guardian A on 02/03/2022 and 02/04/2022, instructing Ms. Boomer.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A’s autopsy results indicate a well over the lethal dose of olanzapine also known as Zyprexa (an anti-psychotic drug), which Resident A was not prescribed.

INVESTIGATION: The complainant reports that Resident A’s autopsy was completed and there was a high amount (30+ pills) of the anti-psychotic drug Zyprexa found in his body. The complainant further explained that Resident A was not prescribed Zyprexa. The complainant questioned whether the Zyprexa may have been given to Resident A by Resident B.

On 03/16/2022, Resident A’s Medication Administration Records (MARS) were reviewed. Resident A was not prescribed Zyprexa. He was prescribed 2 other anti-psychotic medications – Seroquel and Fluphenazine. The MARS indicate that medications were given, per physician’s order (Except from 01/18/2022, when Guardian A instructed to change doses) (See Other Findings). In addition, medications were not given on 02/03/2022

On 03/16/2022, Resident B was interviewed. Resident B has resided in the Boomer AFC for 16 years. Resident B is prescribed Zyprexa - 10 mg. in the AM and 10 mg. in the PM. Resident B denied giving Resident A any medication. Resident B stated Resident A never asked him for medications or any other drugs. Resident B stated

Resident A ‘was to himself a lot.’ Resident B stated he would see him in the community walking but did not ‘hang out with him.’ Resident B stated Resident A would play video games sometimes with him in the home.

Resident B was asked if he put his medication in a kitchen drawer when he returned from his Guardian’s home. Resident B showed where he put the dose that he did not take in the kitchen drawer. Resident B stated, “I always do that when I come back (from a visit at the Guardian’s home)”.

Ms. Boomer stated Resident B does put his medication that is not taken when he returns in a drawer in the kitchen. Ms. Boomer states she always looks in the drawer and returns the medication to the locket cabinet.

Guardian A reported that Resident A was on Zyprexa 2 years ago but stated Resident A did not like how it made him feel.

On 04/11/2022 another on-site inspection was completed with Detective Sam Pouliot. Mary Boomer was questioned on medications that have been discontinued or no longer needed by residents. Ms. Boomer stated she stores them in a locked room in the basement and then her husband, Morris burns them in a burn barrel in the backyard. Ms. Boomer showed us the locked room where she keeps the non-needed medications until they are burned. There were no medications in the room at the time on 04/11/2022. Mr. Boomer states he does burn the medications.

On 04/12/2022 an interview was conducted with Delta County Medical Examiner Cory Gottlieb. Dr. Gottlieb conducted the autopsy and reported there was a minimum of 160, 20mg., Zyprexa tablets in Resident A’s system. Dr. Gottlieb stated these medications had to be taken in a ‘very short period of time’.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(5) Prescription medication shall be kept in the original pharmacy-supplied and pharmacy-labeled container, stored in a locked cabinet or drawer, refrigerated if required, and labeled for the specific resident.

ANALYSIS:	It is unknown where the large amount of Zyprexa that Resident A ingested came from. During the 4/11/2022 inspection, medication was observed in a locked cabinet, but 3 days of medications were pre-set in paper cups for all the residents out of the original pharmacy-supplied containers. Ms. Boomer stated she does that 'just for a few days ahead of time'. (Pre-sets medications). In addition, Resident B places his unused medications in an unlocked kitchen drawer when he returns from his visits with his guardian.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During the course of the investigation, it was discovered that Ms. Boomer adjusted Resident A's medication doses per instructions from Guardian A.

There were handwritten notes in the file instructing medication increases and additions. Ms. Boomer stated that Guardian A had written and instructed her to change the dosages and times of prescribed medications. i.e., add Seroquel 25mg. at bedtime and other change in times of administration for other medications. Ms. Boomer stated she did follow the instructions given by Guardian A.

On 04/20222, Guardian A stated that she did hand write changes in medications for Resident A. Guardian A explained that Pathways and Dr. Cote would tell her of the changes and then she would write down the changes and give to Ms. Boomer. Guardian A did not know that medication changes need to be supported by a physician order.

Ms. Boomer was informed this could not be done without physician instructions. Ms. Boomer stated, "I thought (Guardian A) was qualified to do this."

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4)(b) Not adjust or modify a resident's prescription medication without agreement and instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record in

	writing any adjustments or modifications of a resident's prescription medication.
ANALYSIS:	Ms. Boomer did adjust Resident A's prescribed medications as per Guardian A instructed her to do. There were no physician orders to do this. Ms. Boomer also did not administer medications to Resident A on 02/03/2022 or 02/04/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/21/2022 an exit interview was conducted with Licensee Mary Boomer. Ms. Boomer was informed of the findings of this report and the expectation of an acceptable corrective action plan.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.

Maria DeBacker 4/26/2022

Maria DeBacker Date
Licensing Consultant

Approved By:

Mary Holton 4/26/2022

Mary E Holton Date
Area Manager