GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 27, 2022

Karen Williams
36611 Paddock Dr.
Clinton Township, MI 48035

RE: License #: AF500382058
Investigation #: 2022A0617018
Karen's Kare House

Dear Ms. Williams:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 (248) 975-5053.

Sincerely,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AF500382058 |
| | |
| **Investigation #:** | 2022A0617018 |
| | |
| **Complaint Receipt Date:** | 05/11/2022 |
| | |
| **Investigation Initiation Date:** | 05/13/2022 |
| | |
| **Report Due Date:** | 07/10/2022 |
| | |
| **Licensee Name:** | Karen Williams |
| | |
| **Licensee Address:** | 36611 Paddock Dr.<br>Clinton Township, MI 48035 |
| | |
| **Licensee Telephone #:** | (586) 303-5225 |
| | |
| **Administrator:** | N/A |
| | |
| **Licensee Designee:** | N/A |
| | |
| **Name of Facility:** | Karen's Kare House |
| | |
| **Facility Address:** | 36611 Paddock Dr.<br>Clinton Township, MI 48035 |
| | |
| **Facility Telephone #:** | (586) 303-5225 |
| | |
| **Original Issuance Date:** | 05/26/2017 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 11/26/2021 |
| | |
| **Expiration Date:** | 11/25/2023 |
| | |
| **Capacity:** | 5 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | Violation Established? |
|---|---|
| **Resident A's medications are not given as prescribed.** | **Yes** |

## III. METHODOLOGY

| | |
|---|---|
| 05/11/2022 | Special Investigation Intake<br>2022A0617018 |
| 05/13/2022 | Special Investigation Initiated - Telephone<br>TC placed to the facility. |
| 05/17/2022 | Contact - Telephone call made<br>TC- Interview with the Complainant. |
| 05/17/2022 | Inspection Completed On-site<br>Conducted an unannounced onsite investigation. Interviewed Licensee Karen Williams, staff Paige Ribic, Zeva Williams, and Resident A. |
| 05/23/2022 | Exit Conference<br>Held an exit conference with Ms. Karen Williams. |

**ALLEGATION:**

**Resident A's medications are not given as prescribed.**

**INVESTIGATION:**

On 05/11/22, I received a complaint on the Karen Kare House family home. The complaint indicated that there have been many incidents in which the facility caregivers are holding or giving extra medications that are not directly prescribed.

On 05/17/22, I conducted a phone interview with the complainant. According to the complaint, Resident A is a hospice patient. On 1/27/2022, Resident A had two reported episodes of diarrhea. Staff Zeva reported giving Resident A two doses of the medication Imodium AD. Resident A does not have an order for Imodium AD at that time, the registered nurse provided education to the staff and they were told to call Resident A's hospice with any concerns or questions regarding medications. The nurse suggested not to give Resident A any medications that are not prescribed without speaking to hospice first to obtain an order from physician. Staff Karen, Zeva and Paige verbalize understanding.

According to the complainant on 2/17/22, staff Zeva and Karen reported that Resident A was severely impacted the night before. Resident A was crying and uncomfortable, abdomen was distended. Resident A's hospice was not notified of situation. According to the complainant, staff Zeva stated that she administered two bisacodyl suppositories back-to-back as Resident A was very uncomfortable and not going to the bathroom. Karen states Zeva administered one suppository and Resident A did not go after a couple of minutes, Resident A was crying in pain, so Karen gave Zeva the "okay" to administer a second dose. According to the complainant, staff Zeva stated that Resident A had been receiving senna s tabs twice daily and one PRN dose of Lactulose daily the last two days and had not yet had a bowel movement. Resident A was placed on the commode after administering suppositories and he had an extra-large bowel movement per Zeva after a few minutes and immediate felt relief. Extensive education was provided regarding calling and notifying Hospice if Resident A is uncomfortable, in pain or with any changes. According to the complainant, the Licensee Karen stated, "well, what have you guys done". The nurse informed Karen that Resident A would have been visited and assessed by an on-call nurse and call physician if needed for new orders, as their goal is to ensure patients are comfortable. Nurse provided education regarding medication administration and instructed not to give any extra medications without speaking with a nurse from Hospice to obtain appropriate orders from physician. Nurse provided education on side effects of administering extra doses of medication (bisacodyl) if not administered properly. Karen verbalized understanding but continues to not follow Resident A's plan of care.

According to the complainant on 2/21/2022, Zeva reported giving Resident A two doses of Lactulose daily for the last couple of days instead of one daily per orders because it was not doing anything on its own. Nurse obtained order from Dr. Colman to increase Lactulose to twice daily and education was provided to Zeva to not make any changes on her own and to call Hospice with any concerns.

According to the complainant on 3/8/2022, Zeva reports applying medihoney to stage 2 coccyx that had reopened. Hospice was not notified that wound had reopened and treatment that was provided by staff was not appropriate for wound at the time. Education was provided to Zeva to call Hospice with any changes. New order obtained from Dr. Colman for skin prep and cover with comfort foam dressing.

According to the complainant on 3/14/2022, Karen reports giving an extra dose of Seroquel 25mg at bedtime to Resident A on Saturday evening because he was "cussing up a storm, very cranky and agitated." Nurse once again instructed Karen to call Hospice and not to give any extra medications without consulting with Hospice and obtaining physician order.

According to the complainant on 4/11/2022, licensee Karen reported Resident A had diarrhea since Friday, 3-4 loose bowels daily. Staff withheld Resident A's bowel meds, Senna lax Tablets and Lactulose since Friday without notifying Hospice. Nurse collaborated with Dr. Colman, order to hold Lactulose for two days and reassess. Nurse

provided extensive education at time of visit on the importance of notifying Hospice with any changes. Karen verbalized understanding.

According to the complainant on 5/2/2022, Resident A's scheduled 4 PM Seroquel 25mg dose was not given at 4pm for the last couple of days. Karen reports giving Resident A receives a PRN Lorazepam instead and states it was effective. Facility omitted to give Seroquel as ordered. Education was provided to call Hospice once again with any changes or concerns.

On 05/17/22, I conducted an unannounced onsite investigation at the Karen Kare house family home. I interviewed Licensee Karen Williams, staff Paige Ribic, staff Zeva Williams and Resident A.

According to staff Zeva Williams, she did give Resident A the medication Imodium AD without an order. She stated that she was unaware that she could not give over the counter medications without an order. She administered the medication one time and after she was notified that she could not do that she has not since.

According to staff Zeva Williams, on 02/17/22, she gave Resident A two suppositories back-to-back. The medication order for the medication Bisacodyl Sup 10MG, indicates to unwrap and insert one suppository rectally once a day for constipation. Zeva reported that she did not reach out to Hospice prior to administering the additional dose. The medication Bisacodyl Sup 10MG was not listed on the Medication Administration Registry (MARS).

According to staff Zeva Williams, she gave Resident A two doses of Lactulose on 02/21/22. The medication order indicates to give one daily. Zeva stated that she administered additional doses because it was not doing anything on its own.

According to staff Zeva Williams, she put the ointment Medihoney on Resident A's wound and was not aware that she was not supposed to administer it. Zeva reported that the Medihoney was provided to the facility by Hospice and they did not indicate it could not be administered onto the wound. The facility did not have a medication order for the Medihoney at the time of the investigation.

According to the licensee Ms. Karen Williams, on 03/14/22, she gave Resident A an extra dose of Seroquel 25 MG. Ms. Williams stated that Resident A's primary care physician said that Resident A could have between 75 MG and 100 MG of Seroquel per day. The facility did not have a medication order to support the claim that Resident A could have an increased dose of the Seroquel medication at the time of the investigation.

According to Ms. Karen Williams, she withheld Resident A's bowel meds, Senna lax Tablets and Lactulose for several days without notifying Hospice. Resident A had diarrhea and she did not believe it was a good idea to administer laxative medication while Resident A had diarrhea. Ms. Williams did not notify Hospice.

According to Ms. Williams, the facility has not missed any scheduled doses for Resident A' s medication Seroquel 25mg. According to Resident A's Medication Administration Registry (MARS), Resident A's scheduled 4 PM Seroquel 25mg dose was given at 4pm from 05/1/22- 05/13/22.

According to Resident A's Medication Administration Registry (MARS), Resident A is prescribed the following medications: Aspirin 81mg, Omeprazole 20mg, Quetiapine (Seroquel) 25mg, Quetiapine (Seroquel) 100mg, Senna- Plus 8.6-50mg, Trazadone 100mg, Vitamin D2 2.5mg, Haloperidol 2mg/ml, Hyoscyamine sub 0.125mg, Lorazepam 1mg, Morphine sulfate sol 20mg/ml, and Prochlorperazine Tab 10mg. The medications, Imodium AD, Medihoney and Bisacodyl Sup 10MG were not listed on the Medication Administration Registry (MARS) but administered to Resident A. The facility did not have medication orders for the medications, Imodium AD and Medihoney at the time of the investigation. Resident A's medication record had not been initialed since 05/13/22. Facility staff stated they have administered Resident A's medications daily.

On 05/23/22, I held an exit conference with licensee Karen Williams to inform her of the results of the investigation.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.1418** | **Resident medications.** |
| | **(2) Medication shall be given pursuant to label instructions.** |
| **ANALYSIS:** | Based on the information gathered through my interviews and documentation reviews, the facility has not administered Resident A's medication pursuant to label instructions. There have been many incidents in which the facility's direct care staff are holding, adjusting doses or giving extra medications that are not directly prescribed. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **APPLICABLE RULE** | |
|---|---|
| **R 400.1418** | **Resident medications.** |
| | **(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions:**<br>**(a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.** |

| | |
|---|---|
| | **(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:** | Based on the information gathered through my interviews and documentation reviews, the facility has not administered Resident A's medication pursuant to label instructions. There have been many incidents in which the facility's direct care staff are holding, adjusting doses or giving extra medications that are not directly prescribed.<br><br>The medications, Imodium AD, Medihoney and Bisacodyl Sup 10MG were not listed on the Medication Administration Registry (MARS) but administered to Resident A. The facility did not have medication orders for the medications, Imodium AD and Medihoney at the time of the investigation. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

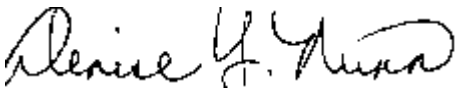
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

05/24/22

_____

Eric Johnson Date
Licensing Consultant

Approved By:



05/27/2022

_____

Denise Y. Nunn Date
Area Manager