



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 29, 2022

Tracy Rucker
Peace of Mind Caregiving Facility LLC
19076 England Drive
Macomb, MI 48042

RE: License #: AS500395475
Investigation #: 2022A0617016
Peace of Mind Caregiving Facility

Dear Ms. Rucker:

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 dates 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 licensee or licensee designee and a date.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,

A handwritten signature in black ink, appearing to be 'EJ', written in a cursive style.

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500395475
Investigation #:	2022A0617016
Complaint Receipt Date:	04/25/2022
Investigation Initiation Date:	05/10/2022
Report Due Date:	06/24/2022
Licensee Name:	Peace of Mind Caregiving Facility LLC
Licensee Address:	19076 England Drive Macomb, MI 48042
Licensee Telephone #:	(586) 693-5693
Administrator:	Tracy Rucker
Licensee Designee:	Tracy Rucker
Name of Facility:	Peace of Mind Caregiving Facility
Facility Address:	3580 Denson Drive Sterling Heights, MI 48310
Facility Telephone #:	(586) 693-5693
Original Issuance Date:	04/11/2019
License Status:	REGULAR
Effective Date:	10/11/2021
Expiration Date:	10/10/2023
Capacity:	6
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B are prescribed several medications however they have tested negative for the prescribed medications in their system. There are concerns that the facility is not giving Resident A and Resident B their appropriate medications.	Yes

III. METHODOLOGY

04/25/2022	Special Investigation Intake 2022A0617016
04/25/2022	APS Referral Adult Protective Services (APS) referral received - not assigned.
05/10/2022	Inspection Completed On-site I conducted an unannounced onsite investigation of the facility. During the onsite investigation I interviewed licensee designee Mrs. Rucker, staff Jade Rucker, Resident A, Resident B, Resident C, and Resident F.
05/10/2022	Special Investigation Initiated - Face to Face I conducted an unannounced onsite investigation of the facility. During the onsite investigation I interviewed licensee designee Mrs. Rucker, staff Jade Rucker, Resident A, Resident B, Resident C, and Resident F.
05/10/2022	Contact - Telephone call made TC to Grace Hospice.
05/11/2022	Contact - Document Received Email received from Ms. Rucker
06/07/2022	Contact - Telephone call received I conducted an interview with social worker Elizabeth Paredes of Grace Hospice.
06/15/2022	Contact - Document Received Email received from Stephanie Olsen, general counsel for Grace Hospice

06/15/2022	Contact - Document Received email received from Mona Hanson of Grace Hospice
06/16/2022	Contact - Document Sent A written request for the toxicology report for Resident A and B was made with Grace Hospice.
06/17/2022	Exit Conference I held an exit conference with licensee designee Tracey Rucker informing her the findings of the investigation.
06/24/2022	Contact- Document Sent Email sent to Stephanie Olsen, general counsel for Grace Hospice
06/27/2022	Contact- Document Received I received and reviewed the toxicology reports for Resident A and Resident B.

ALLEGATION:

Resident A and Resident B are prescribed several medications however they have tested negative for the prescribed medications in their system. There are concerns that the facility is not giving Resident A and Resident B their appropriate medications.

INVESTIGATION:

On 04/25/22, I received a complaint on the Peace of Mind Caregiving facility. The complaint indicated Resident A and Resident B live at Peace of Mind Care Giving Facility license # AS500395475. The facility has been mismanaging medications. Residents A and B are prescribed several medications however have tested negative for them in their system, suggesting the facility is not giving them to the patients. There are concerns the facility is not giving Resident A and Resident B the appropriate medications.

On 05/10/22, I conducted an unannounced onsite investigation of the facility. During the onsite investigation I interviewed licensee designee Mrs. Rucker, staff Jade Rucker, Resident A, Resident B, Resident C, and Resident F.

At the start of the unannounced onsite investigation on 05/10/22, Ms. Rucker was asked to provide the Medication Administration Records (MAR) for Resident A and Resident B. While I was waiting for Ms. Rucker to gather the requested documents, I observed Ms. Rucker and staff Jade Rucker initialing the Medication Administration Records (MAR) for past dates for both Resident A and Resident B. Ms. Rucker admitted to filling out the Medication Administration Record (MAR) for past dates. Ms. Rucker stated that her husband recently passed away and she fell behind on filling out the MARS. I requested

that Ms. Rucker and staff Jade Rucker stop filling out the MARS until after I completed a medication review, however Jade Rucker refused to stop. Jade Rucker stated that she had recently administered medication and she was only initialing for the medications that she had just administered. I observed her filling out past dates on the MARS and she continued to initial.

During the onsite investigation, I completed a medication review for Resident A and observed the following errors:

- The medication Ciprofloxacin HCL 250MG is prescribed one tab twice daily. The medication was not listed on Resident A's Medication Administration Record (MAR).
- The medication Loperamide HCL 2MG po cap which is prescribed on a as needed basis, was initialed on the Medication Administration Record (MAR) for the dates of 05/01-05/03/22, with no recorded reasons. Resident A's prescribed as needed medications did not have recorded reasons charted.
- The medication Dexamethasone Tab 4MG was prescribed on a as needed basis on 10/14/21. On 03/17/22, Resident A's doctor changed the prescription to one tab by mouth daily in the AM. The Medication Administration Record (MAR) indicates to give two tabs by mouth once daily as needed.

The following medications were missing staff initials on the Medication Administration Record (MAR) for Resident A:

- The medication Tylenol is prescribed twice daily. The MAR is initialed on 05/10 and 05/11 for Resident A's 7 PM dosage, however the onsite inspection occurred midday on 05/10/22.
- The medication Meloxicam 7.5MG is initialed on the MAR for the 7 AM dose on 05/11/22, however the onsite inspection occurred midday on 05/10/22. The medication is also initialed for the 7 PM dose on 05/10, 05/11, and 05/12/22.
- The medication Biofreeze gel 3oz is prescribed three times daily. The medication is not initialed on the MAR on 05/05-05/10/22.
- The medication Ferrous Sulfate 325MG, is not initialed on the MAR on 05/05-05/10/22.
- The medication Omeprazole 20MG, is not initialed on the MAR on 05/05-05/10/22.
- The medication Nystop 100,000 powder is prescribed twice daily. The medication is not initialed on the MAR on 05/04-05/10/22.
- The medication Ondansetron HCL 4MG is not initialed on the MAR on 05/04-05/10/22.
- The medication Melatonin 5MG is not initialed on the MAR on 05/04-05/10/22.

During the onsite investigation, I completed a medication review for Resident B and observed the following errors:

- The medication Ferrous Sulfate 325MG tab is prescribed one tab twice daily. The Medication Administration Record (MAR) indicates to give once daily.

The following medications were missing staff initials on the Medication Administration Record (MAR) for Resident B:

- The medication Trazodone Hydrochloride 50MG is not initialed on the MAR from 05/04-05/10/22.
- The medication Potassium Chloride 7PM dose was not initialed from 05/04-05/09/22.
- The medication Docusate Sodium 100MG 7AM dose was not initialed from 05/04-05/10/22.
- The medication Docusate Sodium 100MG 7PM dose was not initialed from 05/04-05/09/22.
- The medication Quetiapine Fumarate 25MG 7AM dose was not initialed from 05/04-05/10/22.
- The medication Quetiapine Fumarate 25MG 7PM dose was not initialed from 05/04-05/09/22.
- The medication B-Complex po tab was not initialed from 05/04-05/10/22.
- The medication Bupropion HCL 75MG was not initialed from 05/04-05/10/22.
- The medication Benadryl was not initialed from 05/04-05/10/22.
- The medication Biofreeze was not initialed from 05/04-05/10/22.
- The medication Betamethasone Clotrimazole 0.05% - 1% was not initialed from 05/04-05/10/22.
- The medication Hydrocortisone Acetate 30MG was not initialed from 05/04-05/10/22.
- The medication Hydrocortisone 2.5% cream was not initialed from 05/04-05/10/22.
- The medication Protocone HC 2.5% was not initialed from 05/04-05/10/22.
- The medication Loperamide HCL 2MG po cap which is prescribed on a as needed basis, was initialed on the Medication Administration Record (MAR) for the dates of 05/01-05/04/22, with no recorded reasons. Resident B's prescribed as needed medications did not have recorded reasons charted.

During the onsite investigation, I completed a medication review for Resident D. Resident D's Medication Administration Record (MAR) was observed to be blank with no signatures for the entire month of May up until the date of the onsite investigation. Resident D is prescribed the following medications:

- Losartan Potassium 50MG
- Trazodone Hydrochloride 50MG
- Verapamil 120MG
- Lovastatin 20MG
- Loperamide 2MG (PRN)
- Acetaminophen Hydrocodone 325MG (PRN)

During the onsite investigation, I interviewed Resident A. According to Resident A, staff are nice and they take really good care of him. Resident A stated that he believes he gets all of his medications on time. Resident A had no issues or concerns to report with regards to his care or the care of any of his housemates.

During the onsite investigation, I attempted to interviewed Resident B but she was unable to answer questions due to cognitive impairments. I observed Resident B positioned comfortably in bed. Resident B was observed sitting up in her bed watching television. Resident B was also observed showing love and affection to Ms. Rucker by grabbing her hand and kissing/hugging it. Resident B was observed smiling and appeared happy.

During the onsite investigation, I interviewed Resident C. According to Resident C, she does not have any issues or concerns with the care she receives in the facility. Resident C stated that she gets all of her medication on time.

During the onsite investigation, I interviewed Resident D. According to Resident D, she enjoys living in the facility and has no issues or concerns at this time.

During the onsite investigation, I interviewed Resident F. According to Resident F, he has no issues with his care at the facility or receiving his medications.

During the onsite inspection, I interviewed Licensee Designee Ms. Rucker. According to Ms. Rucker, all of the residents get all of their medications on time as prescribed. She stated that she fell behind with filling out the resident's MARS due to her husband passing away recently. According to Ms. Rucker, most of Resident A's medications are on a prescribed as needed basis. With regards to Resident B, Ms. Rucker provided me with a copy of a letter written by Resident B's son. The letter request that the facility and hospice no longer give his mother any Norco medications as of 03/23/22. The letter further indicates that the medication has caused a change in Resident B's mood and behavior, while the pain is still present.

On 06/07/22, I conducted an interview with social worker Elizabeth Paredes of Grace Hospice. According to Ms. Paredes, the facility has been mismanaging medications. Resident A and Resident B are prescribed several medications however, they have tested negative for them in their system, suggesting the facility is not giving medications as prescribed to the patients. There are concerns the facility is not giving Resident A and B the appropriate medications.

On 06/27/22, I received and reviewed the toxicology reports for Resident A. The toxicology reports were completed by Dr. Mikhaell Mounir. The toxicology test has a detection window of 1 to 2 days. According to the toxicology report dated 03/17/22, the following prescribed medications were not found in Resident A's system:

- Duloxetine (Cymbalta) 60mg- prescribed 10/13/21
 - Take one capsule by mouth daily
- Hydrocodone (Norco) 325mg- prescribed 10/13/21
 - Take one tab by mouth at 8am and 8pm

On 06/27/22, I received and reviewed the toxicology reports for Resident B. The toxicology reports were completed by Dr. Mikhaell Mounir. The toxicology test has a

detection window of 1 to 2 days. According to the toxicology report dated 03/30/22, the following prescribed medications were not found in Resident B's system:

- Citalopram (Celexa) 20mg- prescribed 01/12/22
 - Take one tab by mouth every morning
- Hydrocodone (Norco) 325mg – prescribed 02/23/22
 - Take 4 times daily
- Lorazepam (Ativan) 1mg- prescribed 02/23/22
 - Take 2 times daily

On 6/17/22, I contacted licensee designee Tracey Rucker for the exit conference to inform her of the findings of the investigation. Ms. Rucker did not answer, therefore I left her a voice message.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	<p>During my onsite investigation on 05/10/22, I observed a multitude of medication errors (as listed above). The MARS were incorrectly filled out and had several missing staff signatures. Ms. Rucker stated that her husband had recently passed away, causing her to fall behind with regards to the care of the residents.</p> <p>On 06/27/22, I received and reviewed the toxicology reports for Resident A and Resident B. According to the toxicology reports, there were several prescribed medications that were not found in both resident's system. The toxicology test has a detection window of 1 to 2 days.</p>
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14312	Resident medications.
	<p>(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:</p> <p style="padding-left: 40px;">(b) Complete an individual medication log that contains all of the following information:</p> <p style="padding-left: 80px;">(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.</p>

	(c) Record the reason for each administration of medication that is prescribed on an as needed basis.
ANALYSIS:	<p>During my onsite investigation on 05/10/22, I observed a multitude of medication errors (as listed above). The MARS were incorrectly filled out and had several missing staff signatures. While I was waiting for Ms. Rucker to gather the requested documents, I observed Ms. Rucker and staff Jade Rucker initialing the Medication Administration Records (MAR) for past dates for both Resident A and Resident B. Ms. Rucker admitted to filling out the Medication Administration Record (MAR) for past dates.</p> <p>Resident A and Resident B are prescribed several medications on an as needed basis. Resident A and Resident B's prescribed medications on an as needed basis, did not have recorded reasons charted.</p> <p>Resident D's Medication Administration Record (MAR) was observed blank with no signatures for the entire month of May up until the date of the onsite investigation.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan (CAP) I recommend a six-month provisional license.

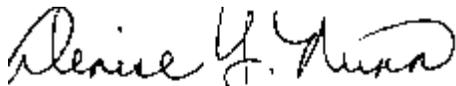


06/28/22

Eric Johnson
Licensing Consultant

Date

Approved By:



06/29/2022

Denise Y. Nunn
Area Manager

Date