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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 26, 2022

Teresa Fowler
Vineyard Assisted Living, LLC
14420 S. Helmer Rd.
Battle Creek, MI 49015

RE: License #: AH390391941
Investigation #: 2022A1010053
Vineyard Assisted Living

Dear Ms. Fowler:

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) 241-1970.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH390391941
Investigation #:	2022A1010053
Complaint Receipt Date:	06/30/2022
Investigation Initiation Date:	07/01/2022
Report Due Date:	08/30/2022
Licensee Name:	Vineyard Assisted Living, LLC
Licensee Address:	8170 Vineyard Parkway Kalamazoo, MI 49009
Licensee Telephone #:	(269) 775-0001
Authorized Representative/Administrator:	Teresa Fowler
Name of Facility:	Vineyard Assisted Living
Facility Address:	8170 Vineyard Parkway Kalamazoo, MI 49009
Facility Telephone #:	(269) 775-0001
Original Issuance Date:	10/31/2018
License Status:	REGULAR
Effective Date:	04/30/2022
Expiration Date:	04/29/2023
Capacity:	85
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident B had an upper respiratory infection on 5/9/22 and tested positive for COVID-19 on 5/13/22.	No
Resident B's responsible person(s) were not notified of her behavioral change and urinalysis that was completed in April 2022.	Yes
Resident B's prescribed Namenda was incorrectly discontinued by staff at the facility.	Yes
Resident B had a urine-stained urine "catch hat" in her closet and her CPAP machine was not filled with water.	No

III. METHODOLOGY

06/30/2022	Special Investigation Intake 2022A1010053
07/01/2022	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
07/01/2022	APS Referral APS referral emailed to Centralized Intake
07/11/2022	Inspection Completed On-site
07/11/2022	Contact - Document Received Received resident service plan, MAR, staff notes, and physician orders
09/26/2022	Exit Conference Completed with licensee authorized representative Teresa Fowler

ALLEGATION:

Resident B had an upper respiratory infection on 5/9/22 and tested positive for COVID-19 on 5/13/22.

INVESTIGATION:

On 6/30/22, the Bureau received the allegations from the online complaint system. The complaint read Resident B was "sleeping a lot and not feeling well" on 5/9/22. Prior to going to urgent care on 5/9/22, Resident B's COVID-19 test was negative and she was diagnosed with an upper respiratory infection. The complaint read on 5/13/22, at approximately 10:30 am Resident B was "asleep sitting awkwardly on the couch with very raspy breathing." Staff had no taken Resident B's vitals or given her another COVID-19 test until they were asked to do so. Resident B's tested positive for COVID-19 at that time.

On 7/1/22, I emailed an Adult Protective Services (APS) to Centralized Intake. The referral was not assigned for APS investigation.

On 7/11/22, I interviewed director of resident care Monica Davis-Cruz at the facility. Ms. Davis-Cruz reported after Resident B was diagnosed with an upper respiratory infection on 5/9/22, she quarantined in her room after she returned to the facility from urgent care. Ms. Davis-Cruz stated during Resident B's time quarantining in her room, staff regularly checked on her and monitored her symptoms. Ms. Davis-Cruz said the facility has been following the local health department and Center for Disease Control (CDC) guidance regarding COVID-19 and COVID-19 testing practices.

On 7/11/22, I interviewed Staff Person 1 at the facility. Staff Person 1's statements were consistent with Ms. Davis-Cruz. Staff Person 1 reported staff and residents were tested weekly in accordance with CDC and health department guidelines because there was a COVID-19 outbreak in the facility. Staff Person 1 said COVID-19 testing for staff and residents was completed at the beginning of the week and of staff or residents displayed symptoms after their test at the beginning of the week, they were tested again.

On 7/11/22, I interviewed Staff Person 2 at the facility. Staff Person 2's statements were consistent with Ms. Davis-Cruz and Staff Person 1. Staff Person 2 reported since Resident B ate all her meals in her room while she was quarantined, staff observed her multiple times. Staff Person 2 stated a relative did come to the facility do take Resident B to a medical appointment on 5/13/22. Staff Person 2 said the relative requested Resident B take a COVID-19 test and it was positive. Staff Person 2 stated Resident B's COVID-19 test earlier in the week was negative. Staff Person 2 explained staff would have sought medical attention for Resident B if her symptoms worsened and she required emergent care.

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.
ANALYSIS:	The interviews with staff revealed the facility followed local health department and CDC guidelines regarding COVID-19 and COVID-19 testing practices. Resident B was tested twice for COVID-19 the week of 5/9/22 and tested positive on 5/13/22.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B's responsible person(s) were not notified of her behavioral change and urinalysis that was completed in April 2022.

INVESTIGATION:

On 6/30/22, the complaint read Resident B exhibited a change in her behavior that included an increase in confusion, such as believing she was changing rooms and pacing up and down the hallways with only a "spring bonnet on" on 4/2/2022 and 4/3/22. A urinalysis was ordered on 4/4/22 by staff at the facility because of this behavior change. Resident A's responsible person was not notified of the behavior change or of the urinalysis that was ordered.

On 7/11/22, Ms. Davis-Cruz at the facility. Ms. Davis-Cruz reported Resident B did experience a behavior change on 4/2/22 and 4/3/22 that resulted in a urinalysis that was ordered on 4/4/22. Ms. Davis-Cruz stated Resident B's urine was not collected or sent out for analysis until 4/20/22. Ms. Davis-Cruz stated the delay occurred because Staff Person 1 went on vacation after she called in the order for the urinalysis. Ms. Davis-Cruz explained the paperwork and other information related to the urinalysis was not seen by staff, therefore the Resident B's urine was not collected or sent out to be evaluated.

Ms. Davis-Cruz said Resident B's responsible person was not notified of Resident B's change in behavior, or the order for her urinalysis. Ms. Davis-Cruz reported this was not consistent with the facility's policy and procedure regarding incident reporting. Ms. Davis-Cruz reported she and Staff Person 1 did receive disciplinary action because of this miscommunication and the delay in the collection and evaluation of Resident B's urine.

Ms. Davis-Cruz reported a new urinalysis binder was created for staff to utilize to keep track of orders and ensure everything is collected, sent out for evaluation, and the process is completed.

On 7/11/22, Staff Person 1's statements were consistent with Ms. Davis-Cruz. Staff Person 1 explained after she called resident B's physician to order the urinalysis, she got all the supplies to collect Resident B's urine together and placed the items and label on a counter in the med room. Staff Person 1 stated she instructed floor staff they needed to collect urine from Resident B for the urinalysis. Staff Person 1 reported staff attempted to collect once or twice, however the sample was contaminated with Resident B's feces and there were instances when Resident B removed the collection "hat" from her toilet.

Staff Person 1 stated she then went on vacation and Resident B's urine was not collected while she was gone. Staff Person 1 reported when she returned and noticed Resident B's urine was not collected and sent out for evaluation, she ensured it got collected and sent out on 4/20/22. Staff Person 1 said Resident B's physician was notified of her change in behavior, however her responsible person was not notified.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, and elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.**
ANALYSIS:	The interviews with Ms. Davis-Cruz and Staff Person 1 revealed Resident B experienced a change in behavior in April 2022. Ms. Davis-Cruz and Staff Person 1 reported Resident B's responsible person was not notified of her change in condition or that a urinalysis was ordered on 4/4/22. Resident B's urine was not collected or sent out for evaluation until 4/20/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B's prescribed Namenda was incorrectly discontinued by staff at the facility.

INVESTIGATION:

On 6/30/22, the complaint read, “4/29/2022 requested medication list from Vineyard for [Resident B’s] upcoming visit with the psychiatrist to evaluate her behavior on April 2 and April 3 to determine if any changes need to be made to her care.” It was discovered Resident B’s “Namenda (Memantine HCL 5 mg0 twice a day was missing from the list. Namenda had been prescribed in September 2020.” The complaint read the complainant “reviewed the receipts from Hometown Pharmacy through September 2021 which Memantine had been filled at 5 mg twice a day.”

The complaint also read there was a “loose” 81 mg Aspirin tablet found in Resident B’s room on 5/4/22.

On 7/11/22, Ms. Davis-Cruz reported Resident B had a 30-day physician order for Namenda. Ms. Davis-Cruz stated when Staff Person 1 observed the 30 days was over, she contacted the facility’s “in house” pharmacy to have the medication discontinued. Ms. Davis-Cruz stated Staff Person 1 should have contacted Resident B’s physician to follow up regarding whether the medication needed to be refilled, not discontinued.

Ms. Davis-Cruz said she noticed this error when Resident B experienced her behavior change in the beginning of April 2022. Ms. Davis-Cruz reported she reviewed Resident B’s medications, as is her standard procedure when a resident experiences a behavioral change. Ms. Davis-Cruz stated she then noticed Resident B’s Namenda had been incorrectly discontinued. Ms. Davis-Cruz explained Resident B’s last dose of Namenda was on 12/23/22.

Ms. Davis-Cruz reported after the error was noticed, a new physician order for Resident B’s Namenda was received on 5/4/22. Ms. Davis-Cruz stated staff were educated to follow up with a resident’s physician anytime there is an order for 30 days of a prescribed medication. Ms. Davis-Cruz reported this follow up will ensure a resident medication gets refilled after the 30 days if need be.

Ms. Davis-Cruz denied knowledge regarding there being a lose Aspirin tablet found in Resident B’s room. Ms. Davis-Cruz reported staff who administer resident medications are trained to watch the resident ingest their medications when they are administered.

Ms. Davis-Cruz provided me with a copy of Resident B’s *Approved Prescription* for “memantine 10 mg tablet” that was dated 9/28/21 for my review. The *Quantity* section of the physician’s order read, “60 (sixty tablet(s).” The *SIG* section of the order read, “Take 1 tablet(s) twice a day by oral route for 30 days.” The *Refills Allowed* section of the order read, “5 refills.” The *Note to Pharmacy* section of the order read, “start this dose after completes one week of 5mg dose sent to pharmacy.”

On 7/11/22, Staff Person 1 reported she did not know how Resident B’s Namenda was discontinued. Staff Person 1 stated she contacted the facility’s “in house” pharmacy and staff there reported they also did not know how the medication was discontinued.

Staff Person 1 reported the facility now requests that resident physicians do not write orders for 30 days. Staff Person 1 stated if there is an order for 30 days of a resident medication, staff must contact the physician to get clarification on the medication order. Staff Person 1 said Resident B’s prescribed Namenda should have been a continuous medication, it should not have been discontinued.

Staff Person 1’s statements regarding the lose Aspirin tablet in Resident B’s room were consistent with Ms. Davis-Cruz.

On 7/11/22, Staff Person 2 said she was a medication technician (med tech) at the facility. Staff Person 2 denied knowledge regarding Resident B’s prescribed Namenda being incorrectly discontinued.

Staff Person 2’s statements regarding the lose Aspirin tablet in Resident B’s room were consistent with Ms. Davis-Cruz and Staff Person 1. Staff Person 2 reported she had not seen any lose medications in resident rooms as staff were trained to watch the resident ingest their medications when they are administered. Staff Person 2 denied ever leaving medications in a resident’s room or seeing staff do this.

On 7/11/22, I observed several resident rooms throughout the facility. I did not observe any lose medications during my inspection of the rooms.

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:	The interviews with Ms. Davis-Cruz and Staff Person 1 revealed Resident B’s prescribed Namenda should not have been discontinued. Resident B went several months without this medication as a result. Review of Resident B’s physician order dated 9/28/22 revealed she had five refills of Namenda. Staff did not contact the prescribing physician to get clarification regarding the order.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B had a urine-stained urine “catch hat” in her closet and her CPAP machine was not filled with water.

INVESTIGATION:

On 6/30/22, the complaint read there was a “urine-stained catch hat, an empty specimen bottle with bio bag” in Resident B’s room on 5/4/22.

On 7/11/22, Ms. Davis-Cruz reported Resident B moved her dirty urine “catch hat” to the closet in her room. Ms. Davis-Cruz stated Resident B was independent with dressing and toileting, therefore she was able to move the catch basin. Ms. Davis-Cruz stated resident rooms are cleaned weekly by housekeeping staff and more often as needed. Staff did not intentionally leave the catch basin in Resident B’s room.

Ms. Davis-Cruz reported Resident B required distilled water in her CPAP machine. Ms. Davis-Cruz stated staff refill Resident B’s CPAP machine at night before she goes to bed. Ms. Davis-Cruz reported the instructions for how staff were to maintain Resident B’s CPAP machine were outlined on her medication administration record (MAR).

Ms. Davis-Cruz provided me with a copy of Resident B’s MAR for my review. The MAR read, “CPAP MACHINE Fill C-pap reservoir with distilled water, fill to fill line. Make sure mask is secure on head. Ms. Davis-Cruz reported on one occasion, resident B’s family member who was visiting informed staff that Resident B’s CPAP machine was empty. Ms. Davis-Cruz stated she then went and filled the machine herself.

Ms. Davis-Cruz explained all residents who have CPAP machines have maintenance instructions outlined in the MARS. Ms. Davis-Cruz reported staff follow the CPAP instructions as outlined in the resident’s MARs.

On 7/11/22, Staff Person 1’s statements regarding Resident B’s “catch hat” and resident room cleaning were consistent with Ms. Davis-Cruz.

Staff Person 1’s statements regarding staff filling resident CPAP machines were consistent with Ms. Davis-Cruz and Resident B’s MAR.

On 7/11/22, Staff Person 2’s statements were consistent with Ms. Davis-Cruz and Staff Person 1.

On 7/11/22, I interviewed Staff Person 3. Staff Person 3 stated she is one of the facility’s housekeeping staff. Staff Person 3’s statements regarding resident room cleaning were consistent with Ms. Davis-Cruz, Staff Person 1, and Staff Person 3.

Staff Person 3 explained there have been instances when Resident B refused to allow herself and other housekeeping staff in to clean her room. Staff Person 3 said if staff were aware there was a dirty catch basin in Resident B's room, they would remove it.

On 7/11/22, I observed several resident rooms were clean. The facility overall was clean and I did not observe any concerns.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	The interviews with staff, along with my inspection of resident rooms and the overall facility revealed no concerns regarding cleanliness of the facility. Staff had instruction how to maintain Resident B's CPAP machine on her MAR.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I shared the findings of this report with licensee authorized representative Teresa Fowler by telephone on 9/26/22. Ms. Fowler reported the corrective actions the facility already put in place will be outlined in the corrective action plan.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Lauren Wohlfert 07/19/2022

Lauren Wohlfert Date
Licensing Staff

Approved By:

Andrea Moore 09/26/2022

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