GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 16, 2022

Catherine Reese
New Friends Dementia Community, LLC
3700 W Michigan Ave
Kalamazoo, MI 49006

RE: License #: AL390299685
Investigation #: 2022A1024056
Vibrant Life Senior Living Kalamazoo 1

Dear Ms. Reese:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390299685
Investigation #:	2022A1024056
Complaint Receipt Date:	09/21/2022
Investigation Initiation Date:	09/21/2022
Report Due Date:	11/20/2022
Licensee Name:	New Friends Dementia Community, LLC
Licensee Address:	3700 W Michigan Ave Kalamazoo, MI 49006
Licensee Telephone #:	(734) 819-7790
Administrator:	Laurel Space
Licensee Designee:	Catherine Reese
Name of Facility:	Vibrant Life Senior Living Kalamazoo 1
Facility Address:	3700 W. Michigan Ave. Kalamazoo, MI 49006
Facility Telephone #:	(269) 372-6100
Original Issuance Date:	06/21/2011
License **Status:**	REGULAR
Effective Date:	12/21/2021
Expiration Date:	12/20/2023
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A went for hours without getting his morphine administered to him as prescribed.	No

III. METHODOLOGY

09/21/2022	Special Investigation Intake 2022A1024056
09/21/2022	Special Investigation Initiated – Telephone with Relative A1
09/23/2022	Contact - Telephone call made hospice nurse Lisa Matthews
09/23/2022	Contact - Telephone call made with administrator Laurel Space
09/23/2022	Contact - Document Received Resident A's MAR
09/23/2022	Contact - Telephone call made with nursing director Laticia Scott
09/26/2022	Contact - Telephone call made with direct care staff member Ashley Ebling
09/26/2022	APS Referral-Not made as it does not meet APS criteria
10/25/2022	Inspection Completed On-site with staff member Alexis Craft
11/14/2022	Exit Conference with license designee Catherine Reese

ALLEGATION:

Resident A went for hours without getting his morphine administered to him as prescribed.

INVESTIGATION:

On 9/21/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged Resident A went for hours without getting his morphine administered to him as prescribed.

On 9/21/2022, I conducted an interview with Relative A1 regarding this allegation.

Relative A1 stated her spouse passed away two weeks ago and prior to his death he was supposed to take morphine every hour for pain but this did not take place on 8/30/2022. Relative A1 stated a staff member informed her Resident A ran out of the morphine medication during the nighttime hours and the hospice nurse was not called in to replace or refill the medication. Relative A1 stated when she visited Resident A the next morning, she saw a staff member administer Resident A morphine medication which led her to believe another resident's morphine medication was administered to Resident A given he had allegedly run out of the medication during the previous evening and it had not yet been replaced. Relative A1 stated she spoke with direct care staff member Asley Ebeling on the morning of 08/31/2022 who, according to Relative A1 also agreed this was a possibility. Relative A1 stated hospice nurse Lisa Matthews was present during this time when they both spoke to the staff members regarding this issue. Relative A1 stated Ms. Matthews was very concerned that Resident A did not get his morphine medication as scheduled and was not notified when he ran out.

On 9/23/2022, I conducted an interview with hospice nurse Lisa Matthews who stated Resident A never went without his pain medication morphine, including during the nighttime hours of 08/30/2022, and is prescribed to take morphine as needed. Ms. Matthews stated she witnessed Relative A1 express concerns to staff members about not getting his medication every hour and possibly being administered another resident's medication. Ms. Matthews stated she tried to explain to Relative A1 that Resident A's morphine medication is a PRN medication which means direct care staff are not required to administer the medication every hour unless Resident A needs to have it. Ms. Matthews stated she also tried to explain to Relative A1 that Resident A has a comfort kit care package which includes extra bottles of morphine medication that only specific direct care staff members can access if Resident A requires more medication. Ms. Matthews stated she visited with Resident A regularly and reviewed his MAR regularly and had no concerns for the care that was provided to him or the morphine medication that was administered to him.

On 9/23/2022, I conducted an interview with administrator Laurel Space who stated she received constant complaints from Relative A1 during the last several weeks of Resident A's stay at the facility prior to him passing away. Ms. Laurel stated direct care staff members tried to accommodate Relative A1's request of administering Resident A morphine every hour as Relative A1 wanted to ensure that Resident A was comfortable and did not experience any pain during his last days of life. However, Ms. Laurel stated the prescription directions stated the morphine should be administered as needed only. Ms. Laurel stated on 8/30/2022, a staff member did not administer Resident A his morphine at 5am because the staff member stated Resident A was sound asleep and he did not appear to be in any pain. Ms. Laurel stated Relative A1 was very upset by this and began making false accusations against staff. Ms. Laurel stated they did their best to try to work with Relative A1 and repeatedly met with Relative A1 along with hospice to address any concerns she had.

On 9/23/2022, I reviewed Resident A's *Medication Administration Record* (MAR) for August 2022 and September 2022. According to this MAR Resident A was prescribed Morphine 20 mg solution to take for pain as needed.

On 9/23/2022, I conducted an interview with nursing director Laticia Scott who stated Resident A always had his medications administered as prescribed and no staff member administered another resident's medication to him. Ms. Scott stated staff members routinely gave Resident A morphine medication every hour for pain closer to his last days of life. Ms. Scott stated the morphine medication was prescribed to administer to Resident A as needed. Ms. Scott stated on 8/30/2022 Resident A did not receive any morphine medication at 5am and 6am as Resident A was sleeping according to direct care staff and would not wake up to take the medication. Ms. Scott stated when Relative A1 was notified by direct care staff that Resident A did not receive any morphine for two hours, Relative A1 became very upset with staff and made false accusations that staff ran out of medications and used another resident's morphine medication that had the same dosage. Ms. Scott stated she and the hospice nurse had a meeting with Relative A1 regarding her concerns and tried to explain to Relative A1 that those accusations were not true. Ms. Scott stated if Resident A had a need for extra medication, staff were to notify her and Ms. Scott would have retrieved extra morphine medication for Resident A that is included in his hospice comfort pack. Ms. Scott stated this extra medication is located in a locked designated area only accessible to specific staff members. Ms. Scott stated she tried to explain this to Relative A1 and the hospice nurse also met with Relative A1 to alleviate any concerns. Ms. Scott stated Resident A received his medications as prescribed.

On 9/26/2022, I conducted an interview with direct care staff member Ashley Ebling who stated that she believes all the staff members are covering up what happened to Resident A's morphine during the night of 8/30/2022. Ms. Ebling did not provide any information to validate her statement of a cover up rather she only cited Relative A1's allegation of Resident A running out of morphine during the nighttime hours of 08/30/2022 and another resident's morphine medication being administered to Resident A. Ms. Ebling did not provide any information to verify this occurred. Ms. Ebling stated she believes Resident A is supposed to take his morphine medication every hour. Ms. Ebling further stated she has not observed any staff member administer another resident's medication to any resident however believes there is something "fishy" going on at the facility which is why she no longer is an employee with this home. It should be noted Ms. Ebling did not further elaborate on why she believed there was something "fishy" going on at the facility.

On 10/25/2022, I conducted an onsite investigation at the facility with staff member Alexis Craft who stated Resident A was administered his medications as prescribed including his morphine medication which was prescribed to be taken as needed for pain. Ms. Craft stated Relative A1 requested staff administer Resident A morphine medication every hour and became upset when it was reported to her that Resident A did not receive his morphine medication for two hours during the time he was

asleep during nighttime hours from 08/30/2022 through morning hours of 08/31/2022. Ms. Craft stated the hospice nurse and social worker visited with Resident A regularly and monitored his medications. Ms. Craft further stated there was never any issues with Resident A receiving his medications as prescribed despite what Relative A1 reported and alleged.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on my investigation which included interviews with Relative A1, hospice nurse Lisa Matthews, administrator Laurel Space, nursing director Laticia Scott, direct care staff members Ashley Ebling and Alexis Craft and a review of Resident A's MARs, there is no evidence Resident A went for hours without getting his morphine administered to him as prescribed. Ms. Space, Ms. Scott. Ms. Craft and Ms. Matthews all stated Resident A was administered his morphine medication as needed for pain regularly. Per the physician order and my review of Resident A's MARs, Resident A was not required to receive morphine every hour rather it was only as needed. Ms. Scott, Ms. Space and Ms. Craft further stated staff did not administer Resident A's morphine medication for two hours on 8/30/2022 due to Resident A sleeping and not needing medication. Hospice RN Lisa Matthews visited with Resident A and reviewed his MAR regularly and had no concerns for the care that was provided to him or the medication that was administered to him. Resident A was administered his medication as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend the current license status remain unchanged.

11/4/2022

Ondrea Johnson
Licensing Consultant

Date

Approved By:

11/16/2022

Dawn N. Timm
Area Manager

Date