GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 12, 2022

Pamela Hurley
Innovative Lifestyles, Inc.
P.O. Box 1258
Clarkston, MI 48347

RE: License #: AS630074810
Investigation #: 2023A0991003
Kurtz Home

Dear Ms. Hurley:

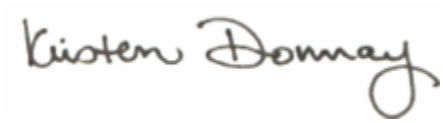
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630074810
Investigation #:	2023A0991003
Complaint Receipt Date:	11/02/2022
Investigation Initiation Date:	11/03/2022
Report Due Date:	01/01/2023
Licensee Name:	Innovative Lifestyles, Inc.
Licensee Address:	5490 Dixie Hwy Suite 1 Waterford, MI 48329
Licensee Telephone #:	(248) 623-8898
Licensee Designee:	Pamela Hurley
Name of Facility:	Kurtz Home
Facility Address:	1499 Kurtz Road Holly, MI 48442
Facility Telephone #:	(810) 373-6123
Original Issuance Date:	01/15/1997
License Status:	REGULAR
Effective Date:	08/22/2021
Expiration Date:	08/21/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Per incident report, Resident C missed his 2:00am medications on 11/02/22 because staff did not read the communication log regarding medication changes.	Yes

III. METHODOLOGY

11/02/2022	Special Investigation Intake 2023A0991003
11/03/2022	Special Investigation Initiated - Telephone Call to home manager
11/03/2022	Referral - Recipient Rights Call to Office of Recipient Rights (ORR) worker, Katie Garcia
11/04/2022	Inspection Completed On-site Unannounced onsite inspection - interviewed home manager and Resident C
11/04/2022	Contact - Document Received Medication log, staff communication log, health care chronological
11/09/2022	Contact - Telephone call made Left message for staff, Trisha Lyons
12/09/2022	Contact - Telephone call made Left message for staff, Trisha Lyons
12/09/2022	Contact - Telephone call received Interviewed staff, Trisha Lyons
12/09/2022	Contact - Telephone call made To licensee designee, Pam Hurley- voicemail full
12/12/2022	Exit Conference Held via telephone with licensee designee, Pam Hurley

ALLEGATION:

Per incident report, Resident C missed his 2:00am medications on 11/02/22 because staff did not read the communication log regarding medication changes.

INVESTIGATION:

On 11/02/22, I received an incident report from Kurtz Home which indicated that Resident C did not receive his medications at 2:00am due to staff not reading about his medication change in the communication log. I created a special investigation intake, which was assigned to me for investigation. I initiated my investigation on 11/03/22 by contacting the Office of Recipient Rights (ORR) worker, Katie Garcia.

On 11/04/22, I conducted an unannounced onsite inspection at Kurtz Home. I interviewed the home manager, Brittany Rogers. Ms. Rogers stated that Resident C was recently hospitalized from 10/25/22-10/31/22. Resident C has been having ongoing health issues lately. Staff noticed a change in Resident C's character, and he appeared pale and seemed dehydrated. He was diagnosed with dehydration due to C-Diff, and he had bacteria in his urine. Resident C returned home from the hospital on 10/31/22. He was prescribed two new antibiotics, Ciprofloxacin HCL 500mg- take one tablet by mouth every twelve hours, and Vancomycin 125mg- take one capsule by mouth every six hours for fourteen days. Ms. Rogers stated that the Ciprofloxacin HCL was being administered at 2:00am and 2:00pm, and the Vancomycin was being administered at 2:00am, 8:00am, 2:00pm, and 8:00pm. Prior to being released from the hospital, Resident C was not receiving any medications at 2:00am. Ms. Rogers stated that she wrote about the medication changes on Resident C's health care chronological (HCC), in the medication book, and on the staff log. There is a white dry erase board in the home where she made a note for staff to check the medication book for changes. Staff are supposed to read the staff log and health care chronological when they come in for their shift. It is expected that staff check the medication book for any changes. On 11/02/22, direct care worker, Trisha Lyons was working the midnight shift with direct care worker, Sharon Luxton.

Ms. Rogers stated that Ms. Luxton is a new staff and has not completed training, so she is not allowed to pass medications. Ms. Rogers stated that she did not verbally tell staff about the medication change, it was just written in the log and medication book. Ms. Rogers stated that they contacted Resident C's primary care physician regarding the missed medications. They skipped the 2:00am dose and administered the next scheduled dose. Resident C did not have any adverse reactions. Ms. Rogers reviewed the procedures for checking for new medications with Ms. Lyons. She stated that there is a staff meeting scheduled for Monday, 11/05/22, and she plans to review the procedures with all staff.

During the onsite inspection, I observed Resident C in his wheelchair in the living room area. Resident C stated that he was in the hospital, and he is feeling better now. When asked if staff give him his medications, Resident C stated that he does not take any medications at the home. He then stated that staff do wake him up at night to give him medications.

On 12/09/22, I interviewed direct care worker, Trisha Lyons. Ms. Lyons stated that she has worked at Kurtz Home for five months. She stated that 11/02/22 was the first time that she was the assigned medication passer on shift, because she was working with another staff person who was not fully trained. Ms. Lyons stated that she did not know that she was supposed to check the medication book or staff log for medication changes. Nobody verbally told her about Resident C's medication change and she did not check the books, so she did not know that Resident C was supposed to receive medications at 2:00am. Ms. Lyons stated that she realized the error when she went to pass medications in the morning. The home manager came in around 8:00am and they discussed it. Ms. Lyons stated that Resident C did not have any negative side effects from missing the medications. Ms. Lyons was written up for the medication error. She now knows to review the staff log and medication book at the beginning of every shift.

During the investigation, I reviewed a copy of the staff log and Resident C's HCC. Both documents indicate that Resident C received two new medications, Vancomycin 125mg- take one capsule by mouth every six hours at 2am, 8am, 2pm, and 8pm for fourteen days, and Ciprofloxacin HCL 500mg- take one tablet by mouth every twelve hours at 2am and 2pm until gone. I also observed a note written on the dry erase board in the home that said, "check med book for changes."

I reviewed Resident C's November 2022 medication administration record (MAR). The MAR shows an "M" written in red ink for "missed" on 11/02/22 for the 2:00am dose of Vancomycin 125mg and Ciprofloxacin HCL 500mg tab. I reviewed the medications for the other residents in the home. No other discrepancies were noted.

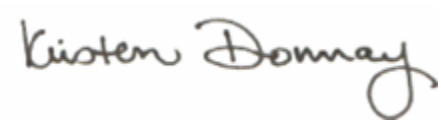
On 12/12/22, I conducted an exit conference via telephone with the licensee designee, Pam Hurley. Ms. Hurley stated that she would submit a corrective action plan to address the violation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident C did not receive his medication as prescribed on 11/02/22 at 2:00am.

	Direct care worker, Trisha Lyons, did not review Resident C's medication administration record or the staff communication log. She was unaware that Resident C was prescribed new medications. Therefore, she did not pass Resident C's Ciprofloxacin HCL 500mg or Vancomycin 125mg at 2:00am on 11/02/22.
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.



12/12/22

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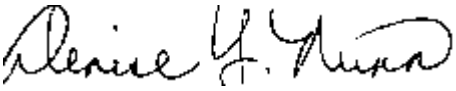
Kristen Donnay Date
Licensing Consultant

Approved By:



12/12/2022

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Denise Y. Nunn Date
Area Manager