GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 19, 2022

Michael Clark
Northern Springs Management Co.
6361 Myers Rd. NE
Kalkaska, MI 49646

RE: License #: AM400282377
Investigation #: 2023A0870012
Walnut Street AFC

Dear Mr. Clark:

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 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 (231) 922-5309.

Sincerely,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM400282377
Investigation #:	2023A0870012
Complaint Receipt Date:	12/01/2022
Investigation Initiation Date:	12/02/2022
Report Due Date:	01/30/2023
Licensee Name:	Northern Springs Management Co.
Licensee Address:	6361 Myers Rd. NE Kalkaska, MI 49646
Licensee Telephone #:	(231) 632-7565
Administrator:	Michael Clark
Licensee Designee:	Michael Clark
Name of Facility:	Walnut Street AFC
Facility Address:	417 Walnut St. Kalkaska, MI 49646
Facility Telephone #:	(231) 258-9478
Original Issuance Date:	08/25/2006
License Status:	REGULAR
Effective Date:	03/27/2021
Expiration Date:	03/26/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A hasn't had her medications in four days. These medications are Pepcid 20mg and Fluoxetine 60mg.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/01/2022	Special Investigation Intake 2023A0870012
12/02/2022	APS Referral This referral was made by the Michigan Department of Health and Human Services, Protective Services Centralized Intake Unit.
12/02/2022	Special Investigation Initiated - Telephone Telephone call to Licensee Designee Mike Clark.
12/07/2022	Inspection Completed On-site Interviews conducted with Licensee Designee Mike Clark and Staff Cody Thompson.
12/19/2022	Contact - Telephone call made Telephone interview with Guardian Rhonda Wurtz.
12/19/2022	Inspection Completed-BCAL Sub. Compliance
12/19/2022	Exit Conference Completed with Licensee Designee Mike Clark.
12/19/2022	Corrective Action Plan Requested and Due on 01/04/2023

ALLEGATION: Resident A hasn't had her medications in four days. These medications are Pepcid 20mg and Fluoxetine 60mg.

INVESTIGATION: On December 2, 2022, I conducted a telephone interview with Licensee Designee Mike Clark. I informed him of the above stated allegation. Mr. Clark stated he had not heard that Resident A had missed any medications and he would call the pharmacy, speak with staff member Cody Thompson, and call me back later this day.

On December 2, 2022, I spoke with Mr. Clark by telephone. He explained that Resident A uses a different pharmacy than the other facility residents and that her guardian, Rhonda Wurtz typically picks up the medications and delivers them to the AFC home. Mr. Clark stated that staff member Cody Thompson told him that he had called the pharmacy to refill these two prescriptions on November 25, 2022, and Ms. Wurtz failed to pick them up and deliver them to the AFC home. Mr. Clark stated that Resident A went without these two prescription medications from November 28 through November 30, 3022.

On December 7, 2022, I conducted an on-site special investigation at the Walnut Street AFC home. I met with Mr. Clark and Mr. Thompson. Mr. Thompson stated that Resident A's guardian, Ms. Wurtz, had thought that because she had signed paperwork with "the old pharmacy" which previously filled Resident A's prescriptions, to change to "the new pharmacy" which the facility uses for all of its residents, that Resident A's medications were "all set." Mr. Thompson stated the new pharmacy still needed insurance information to refill Resident A's prescriptions. He further noted that when he called the pharmacy to refill Resident A's prescriptions on November 25, 2022, the pharmacy sent a text message to Ms. Wurtz informing her that the prescriptions were ready for pickup. Mr. Thompson stated he believed Ms. Wurtz would pick up the prescriptions and deliver them to the AFC home. He further noted that he called and left a voicemail meesage for Ms. Wurtz asking if she was picking up the prescriptions but never heard back from her. He acknowledged that he did not follow-up with the pharmacy to see if the prescriptions were ready or were picked up. Mr. Thompson further stated that he did not follow-up with another phone call to Ms. Wurtz. He stated Resident A ran out of her Pepcid and Fluoxetine medications on November 28, 2022. Mr. Thompson stated that these medications were delivered on December 2, 2022, by Ms. Wurtz and dispensed to Resident A that same day. Ms. Clark stated that he had called Ms. Wurtz on December 2, 2022, following this Consultants phone call to him on that same day regarding the allegations noted above.

On December 19, 2022, I conducted a telephone interview with Rhonda Wurtz. She stated that she had always picked up Resident A's medications from the pharmacy and delivered them to the AFC home since the time Resident A was admitted into the facility in April 2022. Ms. Wurtz noted that she was told by Mr. Thompson that she could change Resident A's prescriptions to another pharmacy, and then the medications would be automatically delivered to the AFC home. She noted she signed paperwork with the AFC home in October 2022, "to do just that." Ms. Wurtz stated that Mr. Thompson told her "Its all set." She stated she was not called by the pharmacy, or the home, to pick up Resident A's medications, the end of November 2022, and if she had been called, she "could have easily done that" so Resident A would not have run out of her medicine.

APPLICABLE RULE	
R 400.14312	**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:	The Licensee failed to ensure that Resident A had her prescription medications refilled and delivered to the home. Resident A went four days without her prescription medications Pepcid and Fluoxetine. The Licensee did not provide Resident A with her prescription medication as prescribed by her licensed physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: During the course of this special investigation, I noted staff member Cody Thompson had placed his initial "C" on Resident A's medication log for November 28, 29, 30 and December 1, 2022. By initialing the medication log, this indicates that the medication had been dispensed to Resident A. The log also showed that Mr. Thompson's initial had been crossed out, with a line through the "C", on those dates. As noted above, Mr. Thompson stated that Resident A's Pepcid and Fluoxetine were not dispensed to Resident A on those dates because those two medications had "run out" and a new supply had not been received until December 2, 2022.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(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: (b) Complete an individual medication log that contains all of the following information:

	(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Staff member Cody Thompson failed to properly, and accurately, complete the medication log for Resident A by initialing, and then crossing out his initials, when he had not dispensed Resident A's Pepcid and Fluoxetine medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

On November 19, 2022, I conducted an exit conference with Licensee Designee Mike Clark. I explained my findings as noted above. Mr. Clark stated he understood and that he had no further information to provide concerning this special investigation. He noted that he will be closing the facility effective January 1, 2023. I stated that since the facility and license would be closing prior to the corrective action plan submission due date, no corrective action plan would need to be submitted. I further explained that should the home not close on January 1, 2023, a corrective action plan would need to be submitted by January 4, 2023.

IV. RECOMMENDATION

I recommend the facility, and license, be allowed to be closed by the Licensee in lieu of submitting a corrective action plan.

December 19, 2022

Bruce A. Messer Date
Licensing Consultant

Approved By:

December 19, 2022

Jerry Hendrick Date
Area Manager