GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 10, 2023

Betty Holmes
Heavenly Realm Family Services
PO Box 3506
Saginaw, MI 48602

RE: License #: AS730370289
Investigation #: 2023A0576008
Heavenly Realm 5

Dear Ms. Holmes:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 643-7960.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730370289
Investigation #:	2023A0576008
Complaint Receipt Date:	11/14/2022
Investigation Initiation Date:	11/14/2022
Report Due Date:	01/13/2023
Licensee Name:	Heavenly Realm Family Services
Licensee Address:	2236 Hammel Street, Saginaw, MI 48601
Licensee Telephone #:	(989) 714-9046
Administrator:	Betty Holmes
Licensee Designee:	Betty Holmes
Name of Facility:	Heavenly Realm 5
Facility Address:	1814 Cherry Street, Saginaw, MI 48601
Facility Telephone #:	(989) 714-9046
Original Issuance Date:	04/08/2015
License Status:	REGULAR
Effective Date:	10/08/2021
Expiration Date:	10/07/2023
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's pill bottle of Olanzapine was missing several pills and staff could not account for the missing pills.	No
Additional Findings	Yes

III. METHODOLOGY

11/14/2022	Special Investigation Intake 2023A0576008
11/14/2022	APS Referral
11/14/2022	Special Investigation Initiated - Telephone Received call from Jessire Ramos, Saginaw County Adult Protective Services (APS)
11/23/2022	Contact - Document Received Email received from Jessire Ramos
12/29/2022	Inspection Completed On-site Interviewed Staff, Lewis Rutkowski, Resident B, and Resident C
01/09/2023	Contact - Telephone call made Interviewed Dawn Garrett, Hope Network Nurse
01/10/2023	Contact - Telephone call made Interviewed Resident A
01/10/2023	Exit Conference Conducted Exit Conference with Licensee Designee, Betty Holmes

ALLEGATION:

Resident A's pill bottle of Olanzapine was missing several pills and staff could not account for the missing pills.

INVESTIGATION:

On November 23, 2022, I received an email from Jessire Ramos, Saginaw County Adult Protective Services (APS). Ms. Ramos spoke to Dawn Garrett, Nurse from Hope Network on November 21, 2022, and Ms. Garrett reported that she contacted the pharmacy regarding Resident A's medication, Olanzapine. Ms. Garrett confirmed with the pharmacy that the medication was shorted pills due to delayed pick-up. The pill bottle should have had 26 pills, which it was. Ms. Garrett reviewed medications last week while at the home and there were no concerns noted. Ms. Ramos will be denying her investigation.

On December 29, 2022, I completed an unannounced on-site inspection at Heavenly Realm #5 and interviewed Staff, Lewis Rutkowski. Mr. Rutkowski reported he is live-in staff and has worked at the home for about 4 years. There are currently 5 residents who live in the home and Resident A is not home currently. Regarding the allegations, Mr. Rutkowski denied Resident A had any medications missing. There was a mix-up at the pharmacy and the pharmacy did not send 20 pills, which made it appear that there were medications missing. Resident A had recently moved into the home and his medications were filled by Rite-Aid initially and they use pill bottles. Currently, Resident A has his medications filled by the normal pharmacy the facility uses, and they provide 2 weeks' worth of medications in plastic packaging. Resident A has all his medications at this time, and he receives his medications as ordered. According to Mr. Rutkowski, Resident A and another resident have a nurse that comes in for them and she routinely checks the resident medications. While at the home, I viewed Resident A's medication and medication administration sheets and there were no concerns noted.

On December 29, 2022, I interviewed Resident B who reported he recently moved into the home, and it is good, and the food is good. Resident B takes medications, and he knows what medications he is prescribed. Resident B knows what medications he takes, what they look like, their dosage, and at what times. Resident B reported he receives his medications as they are prescribed, and he gets all his required medications. Resident B denied any current concerns.

On December 29, 2022, I interviewed Resident C who confirmed he is prescribed medications. Resident C gets his medications twice per day, in the morning and afternoon. Resident C does not know the names of his medications. Resident C reported he believes he receives his medications as prescribed.

January 9, 2023, I interviewed Dawn Garrett, Nurse from Hope Network regarding the allegations. Ms. Garrett reported that she spoke to Rite Aid Pharmacy on November 21, 2022, regarding one of Resident A's medications, Olanzapine. The pharmacy gave her the wrong information initially, so she was concerned about missing medication. Upon talking with the pharmacy again, it was determined that the pharmacy did not provide as many pills as previously thought and there were no missing pills. Ms. Garrett is routinely at Heavenly Realm #5 as she has 2 clients who live at the home, and she

reviews resident mediations. Ms. Garrett denied having concerns regarding resident medications.

On January 10, 2022, I interviewed Resident A regarding the allegations. Resident A stated he is prescribed medications and he receives them daily during the day and at night. Resident A did not know what medications he is prescribed or how many. Staff administer Resident A his medications and he believes he is receiving the medication he is supposed to. Resident A did not have any concerns about his medications.

On January 10, 2023, I interviewed Licensee Designee, Betty Holmes regarding Resident A and the allegations. Ms. Holmes reported Resident A moved into the home about 3-4 months ago and he came with his medications. Ms. Holmes advised there was no medication missing and there was an error on the part of the pharmacy. Ms. Holmes advised that Resident A receives his medications as ordered and he is currently getting his prescriptions filled at the pharmacy that the home uses.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	It was alleged that Resident A was missing several pills of Olanzapine. Upon conclusion of investigative interviews and an unannounced on-site inspection, there is not a preponderance of evidence to conclude a rule violation. Resident A recently moved to Heavenly Realm #5 and was getting his medications switched to the pharmacy the facility uses. There was a concern that Resident A's pill bottle of Olanzapine did not have the number of pills it should have. Resident A's nurse from Hope Network, Dawn Garrett called the pharmacy and confirmed the bottle was not missing any medications. Ms. Garrett advised she is routinely at the home and reviews medications and has no concerns with the home or their handling of resident medications. I also viewed resident medications and medication administration sheets during an unannounced on-site inspection and there were no concerns noted.

	There is not a preponderance of evidence to conclude the licensee is not taking reasonable precautions to ensure prescription medication is not used by a person other than the resident for whom it is prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On November 14, 2022, I interviewed Jessire Ramos, Saginaw County Adult Protective Services (APS) who reported when she visited the home for her investigation on November 9, 2022, there was no staff present at the facility. After several minutes, Staff, Lewis Rutkowski arrived and stated he went to the store. Ms. Ramos advised there were residents at the home alone, including Resident A during the time staff was gone to the store.

On December 29, 2022, I completed an unannounced on-site inspection at Heavenly Realm #5 and interviewed Staff, Lewis Rutkowski. Mr. Rutkowski was asked about when APS came to the home in November 2022 and there were no staff present. Mr. Rutkowski reported he went to the store to get tea and lottery tickets. No residents were with him, and residents were left at the home without staff supervision. Mr. Rutkowski reported the store is only a couple blocks away and he “hardly ever” leaves residents alone. Mr. Rutkowski reported it was the second time he left residents alone to go to the store.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	On November 9, 2022, APS Investigator, Jessire Ramos conducted a visit to the home and discovered no staff at the facility for the supervision of the residents. Ms. Ramos reported Resident A was home alone and staff, Lewis Rutkowski arrived a short time later.

	I interviewed Mr. Rutkowski on December 29, 2022, and he confirmed he has left residents home alone on at least 2 occasions. There is a preponderance of evidence to conclude the licensee did not always have sufficient direct care staff on duty for the supervision and protection of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On January 10, 2023, I conducted and Exit Conference with Licensee Designee, Betty Holmes. I advised Ms. Holmes I would be requesting a corrective action plan with regards to the cited rule violation.

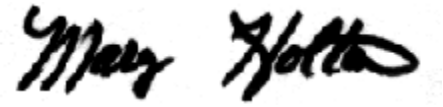
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in the license status is recommended.

1/10/2023

Christina Garza Date
Licensing Consultant

Approved By:



1/10/2023

Mary E. Holton Date
Area Manager