STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

January 24, 2023

Jill Lajoie
American House Grosse Pointe Cottage Ste 1600
161 Kercheval Ave
Grosse Pointe Farms, MI 48236

RE: License #: AH820397738
Investigation #: 2023A0784020
American House Grosse Pointe Cottage

Dear Ms. Lajoie:

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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L. Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820397738
Investigation #:	2023A0784020
Complaint Receipt Date:	12/06/2022
Investigation Initiation Date:	12/07/2022
Report Due Date:	02/04/2023
Licensee Name:	AH Grosse Pointe Subtenant LLC
Licensee Address:	C/oRenewReit One SeaGate Ste 1500 Toledo, OH 43804
Licensee Telephone #:	(248) 203-1800
Administrator/ Authorized Representative:	Jill Lajoie
Name of Facility:	American House Grosse Pointe Cottage
Facility Address:	Ste 1600 161 Kercheval Ave Grosse Pointe Farms, MI 48236
Facility Telephone #:	(313) 939-2631
Original Issuance Date:	08/13/2020
License Status:	REGULAR
Effective Date:	02/13/2022
Expiration Date:	02/12/2023
Capacity:	77
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was overmedicated by staff	Yes
Additional Findings	No

III. METHODOLOGY

12/06/2022	Special Investigation Intake 2023A0784020
12/07/2022	Special Investigation Initiated - Telephone Interview with administrator/authorized representative Jill Lajoie
12/07/2022	Contact - Document Sent Request for investigative documentation/information sent to Ms. Lajoie
12/08/2022	Contact - Document Received Investigative documents/information received from Ms. Lajoie via email
12/12/2022	Contact - Telephone call made Interview with Ms. Lajoie
12/12/2022	Contact - Document Received Email from Ms. Lajoie
12/12/202	Exit Conference Conducted with Ms. Lajoie

ALLEGATION:

Resident A was overmedicated by staff

INVESTIGATION:

The department received an incident report from the facility which indicated Resident A had been “repeatedly” over medicated with liquid Amantadine. Multiple medication technicians reportedly admitted having incorrectly administered the medication as they were unsure of the correct dosing. Resident A reportedly denied any adverse effects from the overdosing of medication.

On 12/07/2022, I interviewed administrator/authorized representative Jill Lajoie by telephone. Ms. Lajoie stated she is currently in the process of completing an investigation related to the med errors with Resident A and compiling documentation, she stated written statements from staff involved will be forwarded to the department. Ms. Lajoie stated that it was her understanding that the misadministration was due to a misunderstanding from the information provided on the physician's order.

On 12/08/2022, I received an email from Ms. Lajoie in which she provided details related to the investigation into the misadministration of Resident A's Amantadine. Regarding how the errors were discovered, Ms. Lajoie's email read "On 11/22/22, [Medication Technician 1(med tech 1)] was questioned by private aid to the resident, [Resident A private aid], about the different levels of the medication that she noticed was being administered each day. [Med tech 1] told her that she was not able to discuss medication with her as she was not the POA. [Private Aid] then contacted the nurse [Wellness Director] and let her know her findings. [Wellness Director] then reviewed orders to confirm the dosage. The med cups were pulled and reviewed for measurements and marked accordingly to the prescription to avoid any errors moving forward. All med techs were immediately reeducated on liquid dosage". Regarding the dates and times of mis administered doses of the medication Ms. Lajoie's email read "We were unable to determine specific dates and med-techs when the error may have occurred, but we were able to determine that there was a 473ml bottle received on 11/10 and that on 11/25 it was reported that there were 255ml remaining. There should have been 435.5mLs left, meaning 180.5MLs were over administered, resulting in an estimated 8 doses that were incorrectly administered". Regarding the specific names of each staff who mis administered the medications Ms. Lajoie's email read "We were unable to determine specific dates and med-techs when the error may have occurred. These are the administering med techs during the timeframe of the prescribed medication, [med tech 1, med tech 2, med tech 3, med tech 4, med tech 5, supervisor/med tech]. Regarding the reason for why the med techs mis administered the medication Ms. Lajoie's email read "The med techs were unsure of the correct measurement 2.5ml. vs. 25 mgs. and failed to inquire before dosing. All med techs in question were trained". Regarding how the facility addressed staff training and corrective actions Ms. Lajoie's email read "Reeducated on liquid medicine dosing and marked proper dosage on medicine cups and they are kept with resident's medicines. Additional Med Tech Training added to CAP for all Med Techs".

I reviewed Resident A's physicians order for *amantadine*, provided by Ms. Lajoie. *Directions* provided on the order read, in part, "take 2.5 milliliters by oral route daily".

I reviewed Resident A's MAR, provided by Ms. Lajoie. The directions provided on the MAR for Resident A's amantadine read "TAKE 2 and ½ ML (=25MG) BY MOUTH EVERY DAY".

On 12/12/2022, I received an email from Ms. Lajoie further clarifying the confusion of staff regarding Resident A's medication. The email read, in part, "The Wellness Director investigated and gathered statements from those medication technicians involved during the time specified in the report and it was determined that they were confused on the dosing directions in eMar [MAR] (TAKE 2 AND 1/2 ML (=25MG) BY MOUTH EVERY DAY). In addition, the medication cups have a measurement of 2.5 ml at the bottom and 25 ml at the top. Also, the physician's order dosing instructions and the eMar dosing instructions do not match verbatim"

I reviewed training documentation for med techs 1, 2, 3, 4 and 5 as well as the supervisor which read consistently with statements provided by Ms. Lajoie.

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.
For Reference:	**Definitions**
	(14) "Medication management" means assistance with the administration of a resident's medication as prescribed by a licensed health care professional.
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 department received an incident report from the facility which indicated Resident A had been “repeatedly” over medicated with liquid Amantadine. The investigation confirmed Resident A had been repeatedly overdosed on this medication due to a misunderstanding related to how the physicians' orders was dictated onto Resident A’s MAR as well as a lack of staff attention to detail as it pertains to the dosing cup measurement. Based on the findings, the facility is not in compliance with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L Clum 12/15/2022

Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 01/23/2023

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