GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 4, 2023

Rochelle Lyons
Grandhaven Living Center LLC
Suite 200
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL330237775
Investigation #: 2023A1033037
Grandhaven Living Center 1 (Pier)

Dear Ms. Lyons:

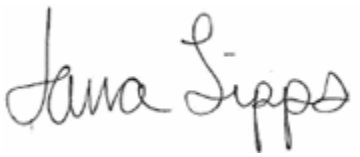
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9730.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330237775
Investigation #:	2023A1033037
Complaint Receipt Date:	03/15/2023
Investigation Initiation Date:	03/21/2023
Report Due Date:	05/14/2023
Licensee Name:	Grandhaven Living Center LLC
Licensee Address:	Suite 200 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(517) 420-3898
Administrator:	Rochelle Lyons
Licensee Designee:	Rochelle Lyons
Name of Facility:	Grandhaven Living Center 1 (Pier)
Facility Address:	3145 W Mt Hope Avenue Lansing, MI 48911
Facility Telephone #:	(517) 420-3898
Original Issuance Date:	02/12/2002
License **Status:**	REGULAR
Effective Date:	01/26/2021
Expiration Date:	01/25/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident J's medications were not administered as ordered due to awaiting delivery from the pharmacy for multiple days.	Yes

III. METHODOLOGY

03/15/2023	Special Investigation Intake 2023A1033037
03/21/2023	Special Investigation Initiated - Telephone Interview with Licensing Consultant, Julie Elkins, via telephone.
04/05/2023	Inspection Completed On-site- Interview with Operations Specialist, Bobbie Huizen. Review of resident MARs.
04/05/2023	Inspection Completed-BCAL Sub. Compliance
04/07/2023	Exit Conference conducted via telephone, with licensee designee, Rochelle Lyons. Voicemail message left.
04/10/2023	Contact – Document Sent Email sent to Operations Specialist, Bobbie Huizen, requesting CorsoCare Hospice nursing notes for Resident J.
04/12/2023	Contact – Document Received Email received from Ms. Huizen with requested documents. Documents reviewed today.
04/18/2023	Contact – Telephone Call Made Attempt to interview CorsoCare Hospice nurse, Sarah Smid. Telephone message left with receptionist.
04/24/23	Contact – Telephone Call Made Interview with CorsoCare Hospice RN, Sarah Smid, via telephone.

To maintain the coding consistency of residents across several investigations, the residents in this special investigation are not identified in sequential order.

ALLEGATION:

Resident J's medications were not administered as ordered due to awaiting delivery from the pharmacy for multiple days.

INVESTIGATION:

On 3/15/23 I received an online complaint regarding the Grandhaven Living Center 1 (Pier) adult foster care facility (the facility). The complaint alleged Resident J went without her prescribed medications for a week or more due to direct care staff not following up with the pharmacy on why the medications were not delivered. On 4/5/23 I completed an on-site investigation at the facility. I reviewed Resident J's Medication Administration Records (MARs) for the months of February 2023 and March 2023. On the February 2023 MAR I noted the following observations:

- Diltiazem CAP 240MG ER is documented as not being administered on 2/3/23 due to, "pharm contacted, meds not sent with cycle fill."
- Diltiazem CAP 240MG ER is documented as not being administered on the following dates due to, "Awaiting med arrival from pharmacy": 2/5/23 – 2/11/23, 2/13/23."
- Ferrous Sulf TAB 325MG EC is documented as not being administered on 2/3/23 due to "pharm contacted, meds not sent with cycle fill".
- Ferrous Sulf TAB 325MG EC is documented as not being administered on the following dates due to, "Awaiting med arrival from pharmacy": 2/5/23 – 2/11/23, 2/15/23, 2/18/23, 2/19/23, 2/21/23 – 2/27/23.
- Ferrous Sulf TAB 325MG EC is documented as not being administered on 2/13/23 due to, "on order".
- Furosemide TAB 20MG is documented as not being administered on the following dates due to, "Awaiting med arrival from pharmacy": 2/21/23 – 2/27/23.
- Prednisone TAB 5MG is documented as not being administered on 2/3/23 due to "pharm contacted, meds not sent with cycle fill".
- Prednisone TAB 5MG is documented as not being administered on the following dates due to, "Awaiting med arrival from pharmacy": 2/5/23, 2/22/23 – 2/27/23.
- Furosemide TAB 40MG is documented as not being administered on 2/3/23 due to, "pharm contacted, meds not sent with cycle fill".
- Furosemide TAB 40MG is documented as not being administered on the following dates due to, "Awaiting med arrival from pharmacy": 2/19/23, 2/21/23 – 2/27/23.
- Albuterol NEB 0.083% is documented as not being administered due to, "Awaiting med arrival from pharmacy" on the following dates: 2/8/23, 2/9/23, 2/11/23.

- Amiodarone TAB 200MG is documented as not being administered on the following dates due to, “Awaiting med arrival from pharmacy”: 2/17/23, 2/18/23, 2/19/23, 2/21/23 – 2/27/23.
- Clopidogrel TAB 75MG is documented as not being administered on the following dates due to, “Awaiting med arrival from Pharmacy”: 2/17/23, 2/18/23, 2/19/23, 2/21/23 – 2/24/23.
- Docusate SOD CAP 100MG is documented as not being administered on 2/21/23 due to, “not in med cart”.
- Docusate SOD CAP 100MG is documented as not being administered on the following dates due to, “Awaiting med arrival from pharmacy”: 2/21/23 – 2/24/23.

On the February 2023 MAR there were notations of “Awaiting med arrival from the pharmacy”, on multiple dates, from the following direct care staff members:

- Alisha Lemle
- Arianna Shaw
- Brenda Lauderdale
- Brandy LaClair
- Bhakti Monger
- Celest Weakly
- Grace Amsterdam
- Leela Monger

On the March 2023 MAR I noted the following observations:

- Furosemide TAB 40MG is documented as not being administered on the following dates due to, “Awaiting med arrival from pharmacy”: 3/1/23.
- Diltiazem CAP 120MG ER was documented as not being administered on the following dates due to, “Awaiting med arrival from pharmacy”: 3/1/23.

During on-site investigation on 4/5/23 I interviewed Operations Specialist, Bobbie Huizen. Ms. Huizen reported Resident J died, under hospice care, on 3/4/23. Ms. Huizen reported Resident J was being cared for by Corso Care Hospice and when a resident receives hospice services the hospice switches their medication fills from a 30-day cycle refill to a 15-day refill to avoid medication waste. Ms. Huizen reported Resident J signed on for hospice services in December 2022. Ms. Huizen reported all residents receive their medications through the Corso Care Pharmacy. She reported there had been issues with residents’ prescriptions expiring and needing additional authorization from a medical provider and delays in this process. She reported she had worked out a system with the pharmacy where the pharmacy began sending her a monthly report of which residents would need prescription refills called into the provider so she could start making these calls in advance of prescriptions expiring. She reported these reports began to be distributed from the pharmacy to Ms. Huizen in January 2023. Ms. Huizen reported this new report is called *No Refills Remaining Report* and she was able to provide the reports for January 2023 and February 2023 for my review on 4/5/2023. According to my review

of the *No Refills Remaining Report,* Resident J did not have any refill concerns noted on either of these reports. Ms. Huizen stated she was not aware of where the error in the system occurred at the time of this investigation. She was able to note, after looking through pharmacy documentation the two direct care staff members, Mikey Allen and Crystal Smith, who had made efforts to obtain the refill requests for Resident J's medications. Ms. Huizen stated Mr. Allen contacted the pharmacy on 2/3/23 and Ms. Smith made contact on 2/21/23. I inquired of Ms. Huizen, what the process is for direct care staff when there is no medication to administer to a resident even when that medication appears on the MAR. Ms. Huizen reported she recently completed a training with direct care staff noting that medication refills are all direct care staff responsibility. Ms. Huizen reported she was unsure why eight direct care staff members had made notations of "Awaiting med arrival from pharmacy" without following through with contacting the pharmacy to determine the reason the medication had not been delivered. Ms. Huizen stated she could not find further information in Resident J's chart to demonstrate any of those direct care staff members attempted to communicate the medication missing with management or the pharmacy.

On 4/12/23 I received an email from Ms. Huizen, with requested CorsoCare Hospice documentation for Resident J. I reviewed the *Plan of Care* document dated 1/28/23. This document was digitally signed by Sarah Smid, RN (1/28/23), and Albert Klemptner, MD (2/5/23). Resident J was ordered the following medications, as noted on pages 6-8 of the Plan of Care document:

- Clopidogrel Bisulfate Oral Tablet 75 mg (start date 1/24/23)
- PreserVision AREDS 2 Oral Tablet Chewable (start date 1/24/23)
- Diltiazem HC1 ER Beads Oral Capsule Extended Release 24 Hour 120 MG (start 1/24/23)
- Docusate Sodium Oral Capsule 100 MG (start 1/24/23)
- Lisinopril Oral Tablet 5MG (start 1/24/23)
- Ferrous Fumarate Oral Tablet 325 MG (start 1/24/23)
- Promethzine HCL Oral Tablet 12.5 MG (start 1/24/23)
- Lasix (Furosemide) Oral Tablet 40MG (start 1/24/23)
- Prednisone Oral Tablet 5 MG (start 1/24/23)
- Albuterol Sulfate Inhalation Nebulization Solution (start 1/24/23)
- Amiodarone HCL Oral Tablet 200 MG (start 1/24/23)
- Aspirin Oral Tablet Chewable 81 MG (start 1/24/23)
- Atorvastatin Calcium Oral Tablet 10 MG (start 1/24/23)
- Morphine Sulfate (Concentrate) Oral Solution 20 MG (start 1/24/23)
- Lorazepam Oral Tablet 0.5 MG (start 1/24/23)
- Tylenol Oral Tablet 325 MG (start 1/24/23)
- Levsin/SL Sublingual Tablet 0.125 MG (start 1/24/23)
- Dulcolax Rectal Suppository 10 MG (start 1/24/23)

Eight of these ordered medications are medications that are noted as not being available to administer to Resident J on the above stated dates.

On 4/12/23 I reviewed the CorsoCare *Hospice RN Initial Assessment* document, dated 1/24/23, and signed by Emily Stoddard, RN. On page 25 of this document under section, *Summary/Comments* it reads, “[Resident J] is a high risk for aspiration due to dysphagia with solids and liquids and remaining on a comfort diet. Her comorbidities include atrial fibrillation, hypertension, chronic kidney disease stage III, hyperlipidemia, stroke, and dysphagia. On admission [Resident J] complains of feeling short of breath, albuterol nebulizer was PRN, orders received from Dr. Klemptner to scheduled BID, prednisone and Lasix all ordered for comfort and symptom management.”

On 4/12/23 I reviewed the CorsoCare Hospice RN – *Skilled Nursing Visit* note dated 1/31/23, and signed by Sarah Smid, RN. Under section, *Assessment/Instruction/Performance* it reads, “Patient on service for end-stage COPD with secondary atrial fibrillation. She is received walking into her bedroom, states no one has helped her this morning and she wants to get dressed. RN notes skin is fragile, clean, and intact. Bruising noted to her right shin with a bandaid dated 1/27. She has on her compression sleeves to VLE, when RN questions if these are to stay on or come off, she states, “they come off during the day.” After dressing she returns to her chair and RN assesses vitals, they are unremarkable. She remains on continuous O2, dyspnea at rest, has weak raspy voice. Lungs are diminished bilateral bases with expiratory wheezes noted. At visit end she walks with support of 4WW to sit in the hallway for a change of scenery. Per Arianna [direct care staff, Arianna Shaw], patient frequently sits in the hall, she has had multiple checks from staff this morning, and her compression sleeves are to be on during the day and off at night. RN requests Arianna to place her compression sleeves on as they are currently off. No further concerns to address.”

On 4/12/23 I reviewed the CorsoCare Hospice RN – *Skilled Nursing Visit* note dated 2/10/23 and signed by Heather Woodworth. Under section, *Assessment/Instruction/Performance* it reads, “This nurse was informed of skin tear to left posterior thigh. Informed she needed to see wound. Patient stood up and this nurse assisted left posterior thigh. This nurse was unable to see wound r/t pants not coming down far enough and patient wanting to sit back down. Collaborated with Deborah, HHA who just showered patient. Stated patient had a dressing on and it was clean, dry, and intact, denies redness around wound. Patient denies pain and shortness of breath. Active bowel sounds. No unmanaged symptoms noted.”

On 4/12/23 I reviewed the CorsoCare Hospice RN – *Skilled Nursing Visit* note dated 2/15/23, and signed by Sarah Smid, RN. Under section, *Assessment/Instruction/Performance* it reads, “Patient on service for end-stage COPD with secondary atrial fibrillation. Patient received sitting in her chair, feet elevated. She vocalizes that she is having difficulty breathing. PRN morphine given before assessment started, for patient comfort. Vitals assessed are indicative of ongoing hypotension, slightly improved with dc’ing of lisinopril last week. Will continue to monitor for optimized BPs. Remainder of vitals are unremarkable. Wound dressing to her left posterior calf is removed, area is left open to air with

small area resolving, wound bed is pink and intact, scattered bruising to posterior calf is resolving, edema to BLE is decreased to +1 today, patient shares her legs have been elevated all morning. New pants and shirt are place, no further concerns noted with her skin assessment. NO new findings of concern to address. RR improved by visit end, morphine effective at symptom management for dyspnea."

On 4/12/23 I reviewed the CorsoCare Hospice RN – *Skilled Nursing Visit* note dated 2/17/23, and signed by Sarah Smid, RN. Under section, *Assessment/Instruction/Performance* it reads, "Patient received resting in her chair, les on the floor. Edema to BLE +3, feet elevated. Vitals assessed indicate systolic slightly increased, diastolic remains low. Pt had an unwitnessed fall last night with a skin tear and significant bruising to her forearm. Wound care completed with new orders given. Patient also has bruising to her left ribcage and right ribcage. After speaking with Arianna about details of her fall, it was determined that patient had unwitnessed fall last night as well as the evening of 2/15. Arianna noted bruising and redness to patient's right rib cage and mid back on Wednesday evening, picture shown to RN. RN recalls changing the patient's shirt on 2/15 with no noted bruising at that time, suspect patient fell and got up on her own without notifying staff. Tab alarm ordered and discussed moving patient's room closer to caregiver station due to poor safety awareness and increased falls."

On 4/12/23 I reviewed the CorsoCare Hospice RN – *Skilled Nursing Visit* note dated 2/22/23, and signed by Sarah Smid, RN. Under section, *Assessment/Instruction/Performance* it reads, "Patient received sitting in her chair, anxious. Reports she has to use the toilet, had been on her call light with no assistance. Patient was incontinent and continent of BM. New brief, pants, and cleansing completed. Patient SBA to and from toilet. Was in respiratory distress after ambulation back to her chair. PRN morphine given with no relief after 15 minutes. Orders received from C. Gettings to give additional 0.25ml and increase PRN dose of morphine to 0.5ml. Patient given prn lorazepam and breathing tx along with additional morphine. Symptoms resolved by visit end. Orders submitted to facility and pharmacy. RN educated Brenda and Arianna on dosing changes. Son, [Relative A1] also updated on event and updated plan of care."

On 4/12/23 I reviewed the CorsoCare Hospice RN – *Skilled Nursing Visit* note dated 2/28/23, and signed by Sarah Smid, RN. Under section, *Assessment/Instruction/Performance* it reads, "Patient received asleep in her bed. Caregiver, June, shares patient was up at 4am for toileting. Used call light for assistance. She was dyspneic after toileting, prn albuterol nebulizer given. This did not resolve her symptoms, prn morphine and lorazepam given, patient has been sleeping comfortably since then. RN completes assessment, patient does not wake with voice or touch from RN. Lung sounds unchanged. Edema to BLE is decreased due to leg elevation. BP remains low. Will discuss med changes with NP."

On 4/12/23 I reviewed the CorsoCare Hospice RN – *Skilled Nursing Visit* note dated 3/02/23, and signed by Sarah Smid, RN. Under section, *Assessment/Instruction/Performance* it reads, “Patient received sitting in her chair, daughter and grandson are visiting. RN was called earlier in the afternoon due to observed weeping of fluid, secondary to increased edema, to her bilateral thighs. Wound care completed, vitals assessed, new med orders received for ongoing respiratory symptoms not relieved by breathing treatment. PRN morphine and lorazepam were affective, pt now to get q6 hours. Education to daughter, grandson, and facility staff.”

On 4/12/23 I reviewed the CorsoCare Hospice *Discharge-Death* note, for Resident J, dated 3/4/23. On this date Resident J was pronounced deceased.

Of the eight CorsoCare Hospice documents I reviewed for Resident J, there was no notation observed where any of the unadministered medications, listed above, were discontinued, or otherwise instructed to not administer, by the hospice medical director/hospice team.

On 4/24/23 I interviewed CorsoCare Hospice RN, Sarah Smid, via telephone. Ms. Smid reported that she had been the primary nurse for Resident J, while she received hospice services. Ms. Smid reported that she had discovered during a visit to the facility on 2/28/23 that Resident J had not been receiving four of her ordered routine medications and had not received them since 2/21/23. She reported these medications to be:

- Amiodarone HCL Oral Tablet 200 MG (start 1/24/23)
- Ferrous Fumarate Oral Tablet 325 MG (start 1/24/23)
- Lasix (Furosemide) Oral Tablet 40MG (start 1/24/23)
- Prednisone Oral Tablet 5 MG (start 1/24/23)

She further reported that she had also discovered that the direct care staff had been administering three medications that were discontinued on 2/2/23. She reported these medications to be:

- Docusate Sodium Oral Capsule 100 MG (start 1/24/23)
- Clopidogrel Bisulfate Oral Tablet 75 mg (start date 1/24/23)
- Atorvastatin Calcium Oral Tablet 10 MG (start 1/24/23)

Ms. Smid reported that she discovered these medication issues while she was making a routine nursing visit to Resident J and happened to be looking over the shoulder of the direct care staff (name she could not recall) as she entered information into Resident J’s MAR. Ms. Smid reported that she had not received any contacts from the direct care staff or facility administration regarding the missing medications. Ms. Smid reported that she reported these medication issues to her manager, CorsoCare Hospice, Hospice Administrator, Dana Schultz, via email on 2/28/23. When questioned about how not receiving these medications would have impacted Resident J’s end of life symptom management, Ms. Smid did not have a comment and noted she was uncertain that missing the medications would have changed the progression of the disease. Ms. Smid reported she was uncertain whether the direct care staff attempted to make contact with the pharmacy to

remedy the issue with the missing medications, but she noted she made multiple visits to the facility in the month of February 2023 and not one staff member brought to her attention that the medications were missing and not available to administer.

On 7/26/22, Special Investigation #2022A0466045 cited a rule violation of Rule R 400.14312 (2)Medication shall be given, taken or applied pursuant to label instructions. The *Corrective Action Plan* (CAP) for this investigation, was dated for 8/25/22 and completed by licensee designee, Rochelle Lyons. This CAP noted, "Operations Specialist, Crystal Smith, will complete education with all care staff on medication administration policy to ensure all orders are administered as directed by physician order." It further stated, "Operations Specialist, Crystal Smith, will complete one-on-one education with care coordinators regarding order processing and approval in QuickMar to ensure all meds are administered by physician order." The CAP noted, "Executive Director, Brandy Shumaker, will intermittently monitor MAR for accuracy for 3 months."

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon my review of Resident J's MARs for February 2023 and March 2023 as well as my interview with Ms. Huizen and Ms. Smid, it can be determined multiple direct care staff members continued to note that nine of Resident J's medications were "Awaiting arrival from pharmacy", and otherwise were not on-site to administer on multiple days during the months of February 2023 and March 2023. There were eight direct care staff members who made notations on the MARs reviewed regarding the missing medications and there was only documentation of two attempts to resolve the issues with the missing medications. Ms. Smid reported making multiple nursing visits and contacts with direct care staff and received no verbal or written acknowledgement that they were having issues obtaining Resident J's routine medications. Resident J continued to miss medications prescribed to her during the time she was receiving hospice services.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2022A0466045 AND CAP DATED 8/25/22]**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable and approved corrective action plan, no change to the status of the license recommended at this time.

04/24/2023

Jana Lipps Date
Licensing Consultant

Approved By:

05/02/2023

Dawn N. Timm Date
Area Manager