GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 23, 2023

Jenna Tolbert
Sherwood Care Facilities Inc
P.O. Box 503
Lennon, MI 48449

RE: License #: AM250008267
Investigation #: 2023A0779036
Sherwood Care Duffield Road Home

Dear Ms. Tolbert:

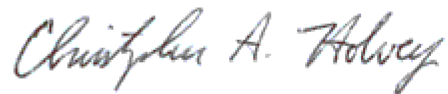
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 643-7960.

Sincerely,



Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250008267
Investigation #:	2023A0779036
Complaint Receipt Date:	04/03/2023
Investigation Initiation Date:	04/04/2023
Report Due Date:	06/02/2023
Licensee Name:	Sherwood Care Facilities Inc
Licensee Address:	5503 Duffield Rd, Flushing, MI 48433
Licensee Telephone #:	(810) 659-5421
Administrator:	Jenna Tolbert
Licensee Designee:	Jenna Tolbert
Name of Facility:	Sherwood Care Duffield Road Home
Facility Address:	5503 Duffield Rd, Flushing, MI 48433
Facility Telephone #:	(810) 659-7345
Original Issuance Date:	01/30/1992
License **Status:**	REGULAR
Effective Date:	05/08/2022
Expiration Date:	05/07/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's medications are coming up missing.	Yes

III. METHODOLOGY

04/03/2023	Special Investigation Intake 2023A0779036
04/04/2023	Special Investigation Initiated - Telephone Spoke to complainant.
04/04/2023	Contact - Telephone call made Spoke to Resident A's GHS case manager.
04/04/2023	Contact - Telephone call made Interview conducted with Resident A.
04/04/2023	APS Referral Complaint was received from APS centralized intake.
04/06/2023	Inspection Completed On-site
05/16/2023	Contact – Telephone call made. Spoke to licensee designee, Jenna Tolbert.
05/16/2023	Exit Conference Held with licensee designee, Jenna Tolbert

ALLEGATION:

Resident A's medications are coming up missing.

INVESTIGATION:

On 4/4/23, a phone conversation took place with Complainant. She stated that Resident A has reported that she has a few different medications at this home that are coming up missing but did not say which medications they are. Complainant reported that Resident A does not like living at this home and has been trying to move for a while now.

On 4/4/23, a phone call was made to Resident A's case manager, Briana Hayes. She stated that Resident A has said that she does not take her pain medications very often

and that she recently saw that there were only a few left, so she is assuming that someone is taking them. Ms. Hayes stated that Resident A does not want to stay at this home and does have a history of making false allegations against this home.

On 4/4/23, a phone interview was conducted with Resident A. She stated that some of her PRN (as needed) medications started coming up missing a while back. She claims that she does not take her PRN medications very often, but she focused on her prescription for Ibuprofen, stating that there are only a few pills left. Resident A stated that she does not know where the missing pills are going, and she could not state how often she takes each medication.

On 4/6/23, an on-site inspection was conducted, and Resident A's medications and medication logs were reviewed. All Resident A's medication that are prescribed to be taken daily were accounted for and appeared to be passed as prescribed. A review of Resident A's 3 PRN medications did reveal that a portion of each of these medications are not accounted for and are described as follows:

- Zofran (Ondansetron) was last filled on 1/16/23 for a quantity of 15 pills. The log shows that 12 pills were signed out as taken and there were 2 pills remaining; therefore, there were 1 pill unaccounted for.
- Antivert (Meclizine) was last filled on 8/30/22 for a quantity of 30 pills. The log shows that 22 pills were signed out as taken and there were 0 pills remaining; therefore, there were 8 pills unaccounted for.
- Motrin (Ibuprofen) was filled on 12/19/22 and 1/17/23 for a quantity of 120 pills. The log shows that there 39 pills were signed out as taken and there were 70 pills remaining; therefore, there were 11 pills unaccounted for.

On 4/6/23, an interview was conducted with home manager, Tamekia Miller. She stated that she works primarily all the 1st shifts. She stated that Resident A has not voiced her concerns about her medications missing to her. Ms. Miller denied taking any of Resident A's medications and stated that she has no idea where the unaccounted medications have gone. Ms. Miller stated that they have a lot of new staff and that she believes that staff are actually passing the medications and then forgetting to sign the medication logs documenting that the meds were passed.

There was a random review of other resident's medications other than Resident A's, including narcotic medications. All other resident's medications appeared to be accounted for and passed as prescribed, including all narcotic medications.

Licensee designee, Jenna Tolbert, was present on 4/6/23 when resident medications were reviewed. She did not have an answer for Resident A's unaccounted medications. Ms. Tolbert stated that Resident A has a habit of insisting on getting a PRN medication when she knows the staff is busy helping other residents, so she would like to think that staff are giving Resident A her PRN medications and just forgetting to sign the logbook. Ms. Tolbert pointed out that the medications that are missing are not typically the kind of

medications that someone would want to steal. She stated that people would generally steal the much stronger narcotic medications, which have all been accounted for.

On 5/16/23, Ms. Tolbert stated that she has spoken to all her staff and that they all deny taking Resident A's unaccounted for medications. She stated that staff claim that they are passing Resident A's PRN medications, but that they are busy and admitted to not always signing/initially the medication log documenting that they passed the medication. Ms. Tolbert stated that she has a lot of new staff that she will be providing more training too.

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:	Upon review of Resident A's medications and medication logbook, it was found that several pills of three separate PRN medications, Zofran, Meclizine, and Ibuprofen, were unaccounted for. The number of pills left in each prescription bubble pack did not match the number that staff initialed and/or documented administering to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/16/23, an exit conference was held with licensee designee, Jenna Tolbert. She was informed of the outcome of this investigation and that a written corrective action plan is required.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

5/23/2023

Christopher Holvey — Date
Licensing Consultant

Approved By:

5/23/2023

Mary E. Holton — Date
Area Manager