GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

June 8, 2023

Lori McLaughlin
North Woods Village At Kalamazoo
6203 Stadium Dr
Kalamazoo, MI 49009

RE: License #: AH390394454
Investigation #: 2023A1028053
North Woods Village At Kalamazoo

Dear Ms. McLaughlin:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH390394454
Investigation #:	2023A1028053
Complaint Receipt Date:	05/24/2023
Investigation Initiation Date:	07/24/2023
Report Due Date:	06/23/2023
Licensee Name:	MITN, LLC
Licensee Address:	6203 Stadium Dr Kalamazoo, MI 49009
Licensee Telephone #:	(574) 247-1866
Administrator:	Amanda Buhl
Authorized Representative:	Lori McLaughlin
Name of Facility:	North Woods Village At Kalamazoo
Facility Address:	6203 Stadium Dr Kalamazoo, MI 49009
Facility Telephone #:	(269) 397-2200
Original Issuance Date:	03/11/2019
License **Status:**	REGULAR
Effective Date:	09/11/2022
Expiration Date:	09/10/2023
Capacity:	61
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
A staff member stole a resident's fentanyl patch.	Yes
Additional Findings	No

III. METHODOLOGY

05/24/2023	Special Investigation Intake 2023A1028053
05/24/2023	Special Investigation Initiated - Letter
05/24/2023	APS Referral APS referral made to Centralized Intake.
06/01/2023	Contact - Face to Face Interviewed Employee A at the facility.
06/01/2023	Contact - Face to Face Interviewed Employee B at the facility.
06/01/2023	Contact - Document Received Received Resident A's, Resident B's Resident C's, and Resident D's record from Employee A.
06/05/2023	Contact - Telephone call made Interviewed facility Admin/Amanda Buhl by telephone.
06/05/2023	Contact - Document Received Received additional documentation from Admin/Amanda Buhl.

The allegation of the facility being short staffed is a duplicate allegation and was recently addressed in special investigation 2023A1028044.

ALLEGATION:

A staff member stole a resident's fentanyl patch.

INVESTIGATION:

On 5/24/2023, the Bureau received the allegations anonymously from the online complaint system.

On 5/24/2023, Adult Protective Services (APS) made referral to Homes for the Aged (HFA) through Centralized Intake.

On 6/1/2023, I interviewed Employee A at the facility who reported no knowledge of any staff member stealing any medication from any resident. Employee A reported that would not be tolerated at the facility and if discovered would result in immediate termination and possible criminal charges as well. Employee A reported there are medication audits performed daily now for all medications and if there were any discrepancies, it would be noted on the medication administration sheets and in the electronic record as well. Discrepancies are reported to management and investigated. Employee A reported staff who administer medications are required to check the fentanyl patches every shift and sign and date the patches. Employee A reported staff that administer medications receive training at orientation and continually throughout the year to ensure knowledge and competency. The most recent training occurred two weeks ago. Employee A reported the facility is currently implementing a new electronic record system, so paper copies of the medication records have been kept ensuring accuracy as well. Employee A reported there are currently four residents in the facility who are administered fentanyl patches. Employee A provided me Resident A's, Resident B's, Resident C's, and Resident D's medication administration record (MAR) for my review.

On 6/1/2023, I interviewed Employee B at the facility who reported no knowledge of any medication being stolen by a staff member or any missing fentanyl patches. Employee B confirmed there are four residents who are currently administered fentanyl patches. Employee B reported medication audits are conducted daily and there is a discrepancy sheet completed if any medication errors occur. Employee B reported staff that administer fentanyl patches are required to check the fentanyl patches every shift and sign and date the patches. Employee B confirmed staff that administer medications receive training at orientation and continually thought the year. Employee B reported, "We just had a training about two weeks ago reviewing the med procedures." Employee B reported there are paper copies of the medication administration records for narcotics and the electronic records as well. Employee B reported a discrepancy sheet should have been completed if the fentanyl patch was not administered to a resident and the reason for not administering should have been documented in the electronic record as well.

On 6/1/2023, I reviewed Resident A's, Resident B's, Resident C's, and Resident D's medication administration record which revealed the following:

- Resident A was not administered the fentanyl patch on 4/6/2023. There is no reason documented in the electronic record as to why Resident A did not receive the fentanyl patch. There is no associated discrepancy sheet for the missed medication.

- Review of Resident B's record revealed Resident B was not administered the fentanyl patch on 4/19/2023. There is no reason documented in the electronic record as to why Resident B did not receive the fentanyl patch. There is no associated discrepancy sheet for the missed medication.
- Review of Resident C's record revealed no discrepancies with medication administration.
- Review of Resident D's record revealed no discrepancies with medication administration.

On 6/5/2023, I interviewed the facility administrator, Amanda Buhl, by telephone who reported no knowledge of any missing medication or any recent medication discrepancy reports, especially for fentanyl patches. Ms. Buhl reported medication audits are completed daily and she signs the medication discrepancy reports as well. Ms. Buhl reported no staff have reported any missing fentanyl patches or any other medication errors to her. She reported if a narcotic was missing and it was suspected that a staff member took it, the staff member would immediately be sent for a drug test and suspended pending an investigation. Ms. Buhl confirmed staff that administer medications are required to check the fentanyl patches every shift and sign and date the patches. Ms. Buhl reported the facility provides continuing education and training for all staff who administer medications, with facility staff recently completing one. When requested, Ms. Buhl was unable to locate Resident A's paper copy MAR for the fentanyl patch but was able to locate a copy of Resident B's narcotic paper copy MAR for the fentanyl patch for my review.

I reviewed Resident B's paper copy MAR for the fentanyl patch and it shows Resident B was administered the fentanyl patch on 4/19/2023 at 19:00 and it was signed by staff as being administered.

ADDENDUM:

On 6/12/2023, I received additional information from Ms. Buhl pertaining to this allegation. Ms. Buhl reported via email the paper copy MAR for Resident A's fentanyl patch was located for April 2023 and provided me a copy of it for my review.

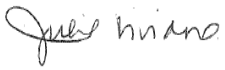
I reviewed the paper copy MAR for Resident A's fentanyl patch which revealed staff signed off on administering Resident A the fentanyl patch on 4/6/2023.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.

ANALYSIS:	It was alleged a staff member stole a resident's fentanyl patch. Interviews, on-site investigation, and review of documentation reveals four residents are currently administered fentanyl patches at the facility. Review of the residents MAR revealed Resident A's electronic MAR demonstrated Resident A did not receive the fentanyl patch on 4/6/2023. No reason was documented in the electronic MAR as to why Resident A did not receive this medication. The investigation revealed the facility also keeps paper copies of narcotic MARs that are administered in the facility, but when requested to review, the paper copy of Resident A's narcotic MAR for April 2023, it could not originally be located. However, on 6/12/2023. Ms. Buhl was able to locate the paper copy of Resident A's April 2023 narcotic MAR and provide it for my review. The review revealed staff signed off on administering Resident A the fentanyl patch on 4/6/2023. However, Resident A's electronic MAR and paper MAR do not match when compared. Also, review of Resident B's electronic MAR and paper MAR do not match when compared. Resident B's electronic MAR reveals Resident B was not administered the fentanyl patch on 4/19/2023 and there is no reason documented in the electronic record as to why Resident B did not receive the fentanyl patch. However, Resident B's paper MAR reveals Resident B received the fentanyl patch on 4/19/2023 at 19:00 and it was signed administering staff. The facility is in violation because it cannot be determined if Resident A and Resident B actually received the fentanyl patches as prescribed due to the (prior) missing and conflicting documentation between the electronic MARs and the paper copy MARs. It cannot be assumed the facility took reasonable precautions to ensure appropriate medication administration and that the medication was not used by a person other than Resident A or Resident B due to the documentation being inconsistent.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the license remain unchanged.



6/8/2023
Addendum 6/12/2023

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Julie Viviano Date
Licensing Staff

Approved By:

08/17/2023

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