GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 1, 2023

Christina Cotton
Sojourner Aid OPCO, LLC
5364 Greenmeadow
Kalamazoo, MI 49009

RE: License #: AH390378211
Investigation #: 2023A1010075
LakeHouse Kalamazoo

Dear Licensee:

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 authorized representative 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) 241-1970.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH390378211
Investigation #:	2023A1010075
Complaint Receipt Date:	07/19/2023
Investigation Initiation Date:	07/19/2023
Report Due Date:	09/18/2023
Licensee Name:	Sojourner Aid OPCO, LLC
Licensee Address:	Ste. 3700 330 N. Wabash Chicago, IL 60611
Licensee Telephone #:	(312) 725-7000
Administrator:	Sandra Frankhauser
Authorized Representative:	Christina Cotton
Name of Facility:	LakeHouse Kalamazoo
Facility Address:	5364 Greenmeadow Kalamazoo, MI 49009
Facility Telephone #:	(269) 353-0416
Original Issuance Date:	04/24/2017
License Status:	REGULAR
Effective Date:	10/24/2022
Expiration Date:	10/23/2023
Capacity:	61
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
A second shift staff person was sleeping during her shift.	No
Residents are not receiving their prescribed medications.	Yes

III. METHODOLOGY

07/19/2023	Special Investigation Intake 2023A1010075
07/19/2023	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
07/19/2023	APS Referral APS referral emailed to Centralized Intake
07/20/2023	Contact - Document Received Emailed received from assigned Kalamazoo Co APS worker Lauren Crock
08/09/2023	Inspection Completed On-site
08/09/2023	Contact - Document Received Received resident MARs and physician orders
11/01/2023	Exit Conference

ALLEGATION:

A second shift staff person was sleeping during her shift.

INVESTIGATION:

On 7/19/23, The Bureau received the allegations from the online complaint system. The complaint read a second shift female staff person was “found sleeping in the library, video proof and everything, and [Staff Person 1 (SP1)] still is having her work third shift with two other girls that we keep telling her are sleeping as well.” The complainant was anonymous; therefore, I was unable to gather additional information.

On 7/19/23, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 7/20/23, I received an email from assigned Kalamazoo County APS worker Lauren Crock. Ms. Cook reported she was assigned to investigate the allegations and will be going to the facility to interview staff and residents this week.

On 8/9/23, I interviewed director of health and wellness Katrina Adams at the facility. Ms. Adams reported she received a video of what appears to be an individual sitting in a chair in the library room of the facility. Ms. Adams stated a kitchen staff person provided her with the video. Ms. Adams explained the room is dark and the individual's identity cannot be confirmed. Ms. Adams reported because the individual's face is difficult to see, it cannot be determined if the individual is asleep.

Ms. Adams reported the video is from third shift in the early morning hours of 7/13/23. Ms. Adams stated if the individual in the video is a staff person, the individual may have been on a break. Ms. Adams said she was unable to conclude who the individual was; however, she did report the incident to management staff. Ms. Adams stated she did not know if management staff took further action.

Ms. Adams played the video she received for my review. I observed the video was consistent with Ms. Adams' statements. I was unable to observe the individual's face as it was dark in the room, therefore it is unknown if the individual was asleep. I observed the video was very short and no conclusions could be made.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	The interview with Ms. Adams, along with my review of the video of an individual in the library room of the facility, revealed a determination of who the individual was or whether they were sleeping could not be made.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not receiving their prescribed medications.

INVESTIGATION:

On 7/19/23, the complaint read Resident A's Torsemide and Potassium were discontinued "around the 15th or 17th of June." The complaint read Ms. Adams was informed the medication was discontinued but "still showing in the MAR" and the medications were still in the cart from when family brought it in. The medications continued to be administered for approximately seven days after they were discontinued. The complaint also read Resident B's medications were not given, but his MAR (medication administration record) showed they were administered in June.

On 8/9/23, Ms. Adams stated Resident A's physician discontinued her prescribed Potassium and Torsemide on 6/19/23. Ms. Adams reported this order was sent directly to Resident A's pharmacy, and not to the facility. Ms. Adams reported because the facility did not receive the discontinue order, the medications were not removed from Resident A's MAR or the medication cart. Ms. Adams said as a result, staff continued to administer the Potassium and Torsemide. Ms. Adams said when the facility received a shipment of Resident A's medications a few days later, staff observed Resident A's Potassium and Torsemide were not present so they followed up with Resident A's pharmacy. Ms. Adams said staff at Resident A's pharmacy reported Resident A's potassium and Torsemide were not included in Resident A's medication shipment because they received the discontinue order from Resident A's physician on 6/19/23.

Ms. Adams provided me with copies of Resident A's *E-Rx Cancel Prescription* documents for my review. The documents read Resident A's prescribed "torsemide 20 mg tablet (Demadex)" and "POTASSIUM CL ER TAB 10 MEQ" were discontinued on 6/19/23.

Ms. Adams provided me with a copy of Resident A's June MAR for my review. The MAR read Resident A's prescribed "Torsemide 20mg tablet take 2 tablets 5x weekly Mon, Wed, Thurs, Fri, Sat" was administered on Friday 6/2/23, Saturday 6/3/23, Monday 6/5/23, Wednesday 6/7/23, Friday 6/9/23, Saturday 6/10/23, Monday 6/12/23, Wednesday 6/14/23, Thursday 6/15/23, Friday 6/16/23, and Saturday 6/17/23. The MAR read Resident A's prescribed "Torsemide 20mg tablet take 1 tablet 2x weekly Sunday and Tuesday" was administered on Sunday 6/4/23, Tuesday 6/6/23, Sunday 6/11/23, Tuesday 6/13/23, and Sunday 6/18/23. The MAR read Resident A's prescribed "Torsemide 20mg take 3 tabs by mouth daily = 60mg 6/18/23 was administered 6/19/23-6/28/23 D/C Received order 6/23/23."

The MAR read Resident A's prescribed "Torsemide 20mg tab 2 tabs 4 times weekly Mon, Wed, Fri DC'd 6/9/23" was administered on Friday 6/2/23, Saturday 6/3/23, Monday 6/5/23, Wednesday 6/7/23, and Friday 6/9/23." The MAR read Resident A's prescribed "Torsemide 20mg tab 1 tab 3 times weekly Sun, Tues, Thurs DC'd 6/9/23" was administered on Thursday 6/1/23, Sunday 6/4/23, Tuesday 6/6/23, and Thursday 6/8/23. The MAR read Resident A's prescribed "Potassium 10 meq take 1 tablet by mouth daily 6/18/23 DC'd 6/23/23" was administered 6/18/23-6/23/23.

Ms. Adams reported there was some confusion regarding Resident B's prescribed medications because he was seeing a physician through the Veteran's Administration and the facility's "in house" physician. Ms. Adams said some of Resident B's prescribed medications that were shipped to the facility "disappeared" and staff were unable to locate them in May 2023. Ms. Adams stated this incident occurred before she started working at the facility, therefore she did not have any additional information.

Ms. Adams provided me with a copy of Resident B's May MAR for my review. Resident B's May MAR read his prescribed medications were not administered 5/3/23-5/31/23 because he was admitted to the hospital.

Resident B's June MAR read his prescribed "Voltaren anthritis pain 1% topical gel apply 1 gram to affected area two times daily 6/2/23" was not administered on 6/13/23, 6/17/23, 6/18/23, 6/23/23, and 6/30/23 because it was not available. The MAR read Resident B's prescribed "Senna 8.6mg tab 1 tabby mouth two times daily" was not administered on 6/7/23, 6/15/23, 6/17/23, 6/18/23, 6/20/23, 6/23/23, and 6/30/23.

On 8/9/23, I was unable to interview Resident A because she no longer resides in the facility.

On 8/9/23, I attempted to interview Resident B at the facility. I observed Resident B was asleep in his bed and did not want to be interviewed.

On 8/9/23, I interviewed Resident C at the facility. Resident C is Resident B's wife and they reside together in the facility. Resident C stated she was not aware of any medication issues or medications not being available for Resident B. Resident C said Relative B1 "handles all of" Resident B's medications, therefore she did not have any additional information.

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.

ANALYSIS:	The interview with Ms. Adams, along with review of Resident A's June MAR, revealed there were changes in the orders for Resident A's prescribed Torsemide and Potassium. Resident A's June MAR read her prescribed "Torsemide 20mg take 3 tabs by mouth daily = 60mg 6/18/23 was administered 6/19/23-6/28/23 D/C Received order 6/23/23." This medication was administered for five days after the discontinue order was received on 6/23/23. The interview with Ms. Adams, along with review of Resident B's June MAR, revealed he went several days without his prescribed "Voltaren anthritis pain 1% topical gel apply 1 gram to affected area two times daily 6/2/23" and "Senna 8.6mg tab 1 tabby mouth two times daily" because it was "not available."
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Christina Cotton on 11/1/23.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

09/18/2023

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Lauren Wohlfert Date
Licensing Staff

Approved By:

10/31/2023

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