GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 30, 2023

Lisa Sikes
Care Cardinal Kentwood
4352 Breton Rd SE
Kentwood, MI 49546

RE: License #: AH410413166
Investigation #: 2024A1021005
Care Cardinal Kentwood

Dear Mrs. Sikes:

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) 284-9730.

Sincerely,
Kimberly Horst

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410413166
Investigation #:	2024A1021005
Complaint Receipt Date:	10/17/2023
Investigation Initiation Date:	10/19/2023
Report Due Date:	12/16/2023
Licensee Name:	CSM Kentwood LLC
Licensee Address:	1435 Coit Ave. NE Grand Rapids, MI 49505
Licensee Telephone #:	(616) 308-6915
Administrator:	Diana Billow
Authorized Representative:	Lisa Sikes
Name of Facility:	Care Cardinal Kentwood
Facility Address:	4352 Breton Rd SE Kentwood, MI 49546
Facility Telephone #:	(616) 288-4151
Original Issuance Date:	04/13/2023
License Status:	TEMPORARY
Effective Date:	04/13/2023
Expiration Date:	10/12/2023
Capacity:	131
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A received incorrect medication.	No
Additional Findings	Yes

III. METHODOLOGY

10/17/2023	Special Investigation Intake 2024A1021005
10/18/2023	APS Referral referral came from APS. APS not investigating allegations
10/19/2023	Inspection Completed On-site
10/20/2023	Contact-Telephone call made Interviewed SP1
10/20/2023	Contact-Telephone call made Interviewed SP3
11/30/2023	Exit Conference

ALLEGATION:

Resident A received incorrect medication.

INVESTIGATION:

On 10/17/2023, the licensing department received a complaint from Adult Protective Services (APS) with allegations Resident A received incorrect medication. APS denied investigating the allegations.

On 10/19/2023, I interviewed administrator Diana Billow at the facility. Ms. Billow reported on 10/17/2023, she was rounding on residents and Resident A approached her with the incorrect medication concern. Ms. Billow reported that Resident A reported on 10/16/2023, her medication colors appeared different, and she questioned staff person 1 (SP1) if she was receiving the correct medications. Ms. Billow reported she explained to Resident A that medication colors change and that it appeared the correct medications were given. Ms. Billow reported Resident A appeared satisfied with the explanation. Ms. Billow reported no other staff members have brought these concerns to her attention.

On 10/19/2023, I interviewed SP2 at the facility. SP2 reported she was just made aware of the situation and had not investigated the allegations.

On 10/19/2023, I interviewed Resident A at the facility. Resident A reported on second shift on 10/16, SP1 brought her medications to her, and the medication colors were different with the Gabapentin medication. Resident A reported the medication color is typically a dark orange and this time it was yellow. Resident A reported SP1 reported the manufacture of the medications might have changed and therefore the color of the medications would have changed. Resident A reported there was also a large white pill that she questioned. Resident A reported SP1 left the room and returned without the large white pill. Resident A reported she then took the medications. Resident A reported the following morning she questioned SP3 on her medications as the Gabapentin medication was now the normal color. Resident A reported SP3 reviewed the medication blister packs and showed her the yellow Gabapentin medication pill was another resident's lower dose of Gabapentin.

On 10/19/2023, I reviewed at the facility Resident A's Gabapentin medication blister pack. The blister pack revealed the medication was brunt orange color as described by Resident A. I observed Resident B's Gabapentin medication blister pack and the medication color was yellow as described by Resident A.

On 10/20/2023, I interviewed SP3 by telephone. SP3 reported that she provided medications to Resident A on 10/17 and Resident A reported she received the incorrect medications. SP3 reported she explained the color of the medication pills and it appeared Resident A could have received a lower dose of Gabapentin medication. SP3 reported she did not administer the medications on 10/16 and therefore cannot confidently say that Resident A received the incorrect medications. SP3 reported she reported this to Ms. Billow and SP2 on 10/17 around 0900.

On 10/20/2023, I interviewed SP1 by telephone. SP1 reported he typically does not administer medications to Resident A. SP1 reported he attempted to administer medications and Resident A questioned him about the color of the medications. SP1 reported he reported to Resident A that it is common to have medications change color. SP1 reported as he is typically not assigned to Resident A's hallway, he was not aware of the medication colors. SP1 reported Resident A took the medications and there was no medication error.

I reviewed Resident A's medication administration record (MAR). The MAR revealed Resident A started a revised medication dose of Trazadone on 10/16 on second shift. In addition, the MAR showed no reflection of any medication error and SP1 successfully completed the medication log for the medications administered on 10/16.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Interviews conducted and review of documentation revealed lack of evidence to support the allegation Resident A received incorrect medications.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of SP1's employee record revealed SP1 was classified as a medication technician. The record had documentation titled *Medication Administration Training Course.* The course consisted of an online examination, skills demonstration, and medication administration observations. The document was to qualify whether the individual named successfully completed the requirements of the facility approved Medication Administration Training Course. The document revealed SP1 completed and passed the Online Examination. SP1 did not complete the other required components to be classified as a medication technician.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(g) Medication administration, if applicable.**
ANALYSIS:	Review of SP1's employee record revealed SP1 did not successfully complete the Medication Technician training course.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

10/31/2023

Kimberly Horst Date
Licensing Staff

Approved By:

11/30/2023

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