GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 9, 2024

Kimberly Lawler
PO Box 187
Port Sanilac, MI 48469

RE: License #: AM760402427
Investigation #: 2024A0572014
Carols A.F.C. Home

Dear Ms. Lawler:

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,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AM760402427
Investigation #:	2024A0572014
Complaint Receipt Date:	12/12/2023
Investigation Initiation Date:	12/14/2023
Report Due Date:	02/10/2024
Licensee Name:	Kimberly Lawler
Licensee Address:	7795 W. Weidman Rd. Weidman, MI 48893
Licensee Telephone #:	(810) 404-1010
Administrator:	Kimberly Lawler
Licensee Designee:	N/A
Name of Facility:	Carols A.F.C. Home
Facility Address:	7252 Cedar Street Port Sanilac, MI 48469
Facility Telephone #:	(810) 622-8009
Original Issuance Date:	04/06/2020
License **Status:**	REGULAR
Effective Date:	10/06/2022
Expiration Date:	10/05/2024
Capacity:	12
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 12/08/2023, Caregiver Kim Place gave Resident A another resident's medication.	Yes
On 12/09/2023, Resident A was full code and AFC staff did not attempt resuscitation or call emergency services.	Yes

III. METHODOLOGY

12/12/2023	Special Investigation Intake 2024A0572014
12/14/2023	Special Investigation Initiated - On Site
12/14/2023	Contact - Face to Face Staff, Lea Lawler and Staff, Sherry Marsack.
02/07/2024	Contact - Telephone call made Complainant.
02/07/2024	Contact - Telephone call made Hospice Nurse, Christina Hazzard.
02/07/2024	Contact - Telephone call made Resident A's Family Member #1.
02/07/2024	Contact - Telephone call received Licensee, Kimberly Lawler.
02/07/2024	Inspection Completed-BCAL Sub. Compliance
02/08/2024	Contact - Telephone call made Resident A's Family Member #1.
02/09/2024	Exit Conference Licensee, Kimberly Lawler.

ALLEGATION:
On 12/08/2023, Caregiver Kim Place gave Resident A another resident's medication.

INVESTIGATION:
On 12/12/2023, the local licensing office received a complaint for investigation. There were no other investigative entities involved with this investigation.

On 12/14/2023, I made an unannounced onsite at Carols A.F.C. Home, located in Sanilac County Michigan. Interviewed were Staff, Lea Lawler and Staff, Sherry Marsack. Residents were observed and appeared to be receiving appropriate care and supervision.

On 12/14/2023, I interviewed Staff, Lea Lawler regarding the allegation. Lea Lawler informed that Haldol was in Resident A's care package, and they were told that as long as it's the same dosage, they can use another resident's medication while they wait for Resident A's medication to be filled. Resident A was taking Zofran for anti-nausea, but it wasn't working so they contacted hospice. Staff were waiting for further instructions because Resident A was constantly gaging on phlegm. After Resident A was administered the Haldol from another resident's Comfort Pack, Resident A was able to hold down fluids.

On 12/14/2023, I interviewed Staff, Sherry Marsack regarding the allegation. Sherry Marsack was not sure about Resident A being administered another resident's medication as she was not working. Sherry Marsack informed that she did hear about Resident A having nausea. Resident A had only been there a few days and was complaining about not being able to swallow. Kimberly Lawler may have borrowed the Haldol from another resident's Comfort Pack because she knew that Resident A was going to be prescribed the same medication. The Comfort Pack is a small amount of emergency medications from hospice that contains Morphine, Ativan, Suppositories and Haldol.

On 02/07/2024, I called the Complainant regarding the allegation. The Licensee, Kim Lawler told one of the hospice nurses that she gave Resident A another resident's Haldol because she wanted to try to see if that would work. Resident A was not on Haldol at the time. The Haldol was prescribed after the fact. Kimberly Lawler admitted to given two doses of Haldol to Resident A. Resident A passed away the next day on 12/09/2023.

On 02/07/2024, in speaking with Hospice Nurse, Kim Place, in her professional opinion Haldol would suppress Resident A's respiration. Resident A's death was very abrupt and unexpected.

On 02/07/2024, I interviewed Hospice Nurse, Christina Hazzard regarding the allegation. Christina Hazzard informed that during her normal cite visits, Licensee, Kimberly Lawler told her that she borrowed Haldol from another resident and gave it

to Resident A. Resident A was not prescribed this medication. Kimberly Lawler informed that Resident A was struggling with nausea symptoms, and she wanted to try the Haldol out. Christina Hazzard is not sure if this caused the death, but it can cause Respiratory depression. Resident A was not having respiratory depression prior to this day. Kimberly Lawler was educated on the importance of not borrowing meds from another resident.

On 02/07/2024, I interviewed Resident A's Family #1 regarding the allegation. Family Member #1 indicated that they were informed by Hospice of the medication error but was also told by hospice that they were going to prescribe the same exact medication later, so Family Member #1 is not sure if the Haldol actually caused the death. Resident A was having dry heaves and was vomiting, so the family was trying to figure out what medication Resident A was previously on that helped with the symptoms. Family Member #1 called hospice and they had mentioned Haldol and after asking other family if Haldol was the medication that Resident A was previously on, they concluded that this was in fact the medication, so the family reached out to hospice to see if they could prescribe the Haldol to Resident A.

On 02/07/2024, I received a return call from Licensee, Kimberly Lawler regarding the allegation. Kimberly Lawler informed that when Resident A came to her home from the hospital as an emergency placement, Resident A was having trouble swallowing and was not eating very well. Resident A was to have soft mushy liquids according to verbal instructions that she had received as she had not received all of the paperwork. Resident A's first bite of applesauce, Resident A threw it up and also threw up the medication. Resident A only would take one pill at a time. If Resident A threw up the medication, Resident A would refuse the rest of the medications. Kimberly Lawler explained that normally when she works with hospice, they have a comfort packet ready with a small amount of medications that are not yet prescribed. This hospice company was new to her, and they did not have a Comfort Pack for Resident A, so she borrowed Haldol from another Resident's Comfort Pack who was also on hospice, but with a different hospice agency. Kimberly Lawler informed that she did not know that this was against the rules as she was taught that as long as it's the same exact medication and dosage, it would be fine. Kimberly Lawler informed that Resident A was in the process of being prescribed Haldol and was going to replace the Haldol once it was prescribed to Resident A.

On 02/09/2024, I reviewed all of the residents' med sheets and it appears that all of the residents are being administered their medications timely and in accordance with their prescriptions.

On 02/09/2024, I reviewed order the Physician's Modified Order. Resident A was prescribed 2mg of Haldol every 4 hours on 12/08/2024.

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:	Based on my interviews of staff, hospice nurse, Family Member #1 and review of medication sheets, there is enough evidence to establish a licensing rule violation. All those who were interviewed confirmed that Licensee, Kimber Lawler administered medication that belong to another resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
On 12/09/2023, Resident A was full code and AFC staff did not attempt resuscitation or call emergency services.

INVESTIGATION:
On 12/14/2023, I interviewed Staff, Lea Lawler regarding the allegation. Lea Lawler informed that from her understanding, the day after taking the Haldol, Resident A was fine and wanted to get up and play cards. Resident A was eating, drinking, and talking. Resident A suddenly started complaining about phlegm in chest. Kimberly Lawler called the hospice nurse to inform that Resident A's voice was raspy and there was crackling in Resident A's chest. While Kimberly Lawler was on the phone with hospice, Resident A stopped breathing. Hospice made it to the home two and a half hours later. The facility was unaware that they were to perform CPR. Paperwork from Resident A's doctor indicates that Resident A was full code, but with Resident A being on hospice, they were not sure what to do as the hospice nurse never gave them any instructions.

On 12/14/2023, I interviewed Staff, Sherry Marsack regarding the allegation. Sherry Marsack received a phone call from Licensee, Kimberly Lawler that she believed that Resident A just passed away. The on-call hospice nurse was called and was enroute. Sherry Marsack does not know if hospice gave any instructions after Resident A had stopped breathing. Resident A was not DNR. Sherry Marsack remember during Resident A's admission to Carol's AFC Home and hospice that Resident A stated, "I want everything. I want to be kept alive."

On 02/07/2024, I called the Complainant regarding the allegation. The Complainant informed that the facility was well aware that Resident A was full code but did not resuscitate or call 911.

On 02/07/2024, I interviewed Hospice Nurse, Christina Hazzard regarding the allegation. Christina Hazzard indicated that the on-call nurse informed that she was enroute. The on-call nurse called back to check on Resident A. The on-call nurse was told that she was put on oxygen and that she believes that she had just passed away, but then Kim Lawler said, “Oh no, she hasn’t.” The hospice nurse called back again because she had a very long commute and was told again that Resident A had passed away. The on-call nurse told Kimberly Lawler that Resident A was full code and Kimberly Lawler responded, “Oh, shit!” Kimberly Lawler should have known that Resident A was full code when admitted to hospice as hospice would ask if the staff were trained in CPR. The family was made aware of the situation and the doctor was not happy about this incident.

On 02/07/2024, I interviewed Resident A’s Family #1 regarding the allegation. Family #1 informed that Resident A was definitely supposed to receive CPR as Resident A definitely wanted to be kept alive.

On 02/07/2024, I received a return call from Licensee, Kimberly Lawler regarding the allegation. Kimberly Lawler informed that she was on the phone with hospice when Resident A passed away but was never give any instructions. There was no paperwork that she could recall that said Resident A was full code. Kimberly Lawler was on the phone with hospice for 5-10 while Resident A was gurgling. Kimberly Lawler explained this to the hospice nurse and then Resident A stopped breathing. Had the nurse told her to perform CPR, she would have, but she was not instructed to. The hospice nurse only told her that she will be there in about 2 hours. The ambulance arrived, so hospice must had called because she did not call 911. The protocol for hospice patients is to call hospice, await instructions and hospice will call 911. There was confusion because nothing was clear. Resident A left the hospital, and they were given a med list, but the med list on the Assessment Plan was different and she did not know that Resident A was full code.

On 02/07/2024, I called Resident A’s Family #1 again regarding the cause of death. Family #1 informed that the Death Certificate indicated that the cause of death was of natural causes. They never questioned it because Resident A was 85 years old, fell and broke back on two different occasions and was not eating.

On 02/08/2024, I reviewed the Incident Report regarding Resident A’s death. According to the Incident Report, Kimberly Lawler got Resident A up and noticed that Resident A was very congested and have a hard time breathing. Took vitals, blood pressure was 104/55, heart rate 57, temperature 97.7, oxygen 82. Called hospice. Took Resident A to recliner in room. Resident A was able to answer questions. The nurse called back, Resident A took a breath. The congestion sound stopped, then two more quick breaths. Checked Resident A and there was no pulse or reaction. The ambulance came and the hospice nurse came, funeral home came to pick Resident A up.

On 02/09/2024, I reviewed Resident A's file. It indicates that Resident A is 85 years old, and it contained documentation to support that Resident A was receiving hospice care at the time of death. There was no DNR (Do Not Resuscitate) located in the file.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Based on my interviews of staff, hospice nurse and Family Member #1, there is enough evidence to establish a licensing rule violation. Licensee, Kimberly Lawler informed that she was not aware that Resident A was full code, however; Hospice informed that this was discussed during admission and Kimberly Lawler informed that paperwork from hospital indicated that Resident A was full code. Staff, Sherry Marsack also informed that Resident A wanted to be kept alive. Kimberly Lawler indicated that she was on the phone with hospice when Resident A passed away and did not receive any instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/09/2024, an Exit Conference was held with Licensee, Kimberly Lawler regarding the results of the special investigation.

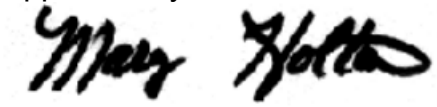
IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this medium sized adult foster care facility, pending the receipt of an acceptable corrective action plan (Capacity 1-12).

02/09/2024

Anthony Humphrey — Date
Licensing Consultant

Approved By:



02/09/2024

Mary E. Holton — Date
Area Manager