GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 16, 2024

Marina Galu
American House Wyoming
5812 Village Dr SW
Wyoming, MI 48519

RE: License #: AH410402896
Investigation #: 2024A1021031
American House Wyoming

Dear Marina Galu:

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, 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 #:	AH410402896
Investigation #:	2024A1021031
Complaint Receipt Date:	01/29/2024
Investigation Initiation Date:	01/29/2024
Report Due Date:	03/28/2024
Licensee Name:	AH Wyoming Subtenant LLC
Licensee Address:	STE 1600 One Towne Square Southfield, MI 48076
Licensee Telephone #:	(248) 827-1700
Administrator:	Tamara Monks
Authorized Representative:	Marina Galu
Name of Facility:	American House Wyoming
Facility Address:	5812 Village Dr SW Wyoming, MI 48519
Facility Telephone #:	(616) 421-2675
Original Issuance Date:	11/05/2020
License Status:	REGULAR
Effective Date:	05/05/2023
Expiration Date:	05/04/2024
Capacity:	166
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Relative A1 administered medications.	Yes
Service plan was not developed with family.	Yes
Resident A's service plan not reflective of current care needs.	Yes
Resident A fell and family was not notified.	No
Resident A received incorrect medications.	Yes
Additional Findings	No

III. METHODOLOGY

01/29/2024	Special Investigation Intake 2024A1021031
01/29/2024	Special Investigation Initiated - Letter email sent to complainant for additional information
02/05/2024	Inspection Completed On-site
02/08/2024	Contact-Telephone call made Interviewed SP2
02/08/2024	Contact-Telephone call made Interviewed OneCare Pharmacy
02/16/2024	Exit Conference

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Relative A1 administered medications.

INVESTIGATION:

On 01/29/2024, the licensing department received a complaint with allegations of medication issues. The complainant alleged on 08/10/2023, she came to the facility to visit Resident A. The complainant alleged there were issues with Resident A receiving her medication. The complainant alleged she went to the medication technician, requested to have the medication, and administered the medication herself. The complainant alleged she did not sign the medications out of the system. The complainant alleged on 08/13/2023, she also administered Resident A's medications. The complainant alleged the medication technician initialed the medications administered but the medication technician did not administer the medications.

On 02/07/2024, I interviewed staff person 1 (SP1) at the facility. SP1 reported Relative A1 was upset with the medication administration times for Resident A. SP1 reported Resident A's family took over the administration of the medication. SP1 reported while this is a rare occurrence, it does occur at the facility.

I reviewed Resident A's service plan. The service plan read,

> *"The community assisted with medication(s) administration per physician orders. Staff to report if any unauthorized medication are found within the resident suite. Staff to report to nurse if resident has changes in ability to take medications as prescribed."*

I reviewed Resident A's daily log notes. The notes read,

> *"08/24: Relative A1 requests that we administer MiraLAX, milk of magnesia, and Systane eye drops on Tues, Thurs, Sat, and Sun. MAR changed to reflect this and staff notified.*
> *08/24: (Resident A)'s (Relative A1) gives her, her medication lately. This morning (Resident A) was offered Milk of Magnesia and Polyethylene with a refusal. (Resident A) said she had a dentist appointment today. MT asked what time. She didn't know. In the process MT didn't check the offered in eMAR. She refused both.*
> *08/31: (Relative A1) came to give medication today. (Resident A) seems to be satisfied with this agreement."*

I reviewed Resident A's MAR notes for 08/10 and 08/13. The MAR revealed medication technician initialed that medications were administered.

I reviewed Resident A's medication administration record (MAR) August notes. The MAR revealed on 08/14/2024, Resident A's evening medications were not administered due to "Drug Not Given." On 08/15/2024, at 0800 the facility administered Milk of Magnesia. The facility did not administer any medications from 08/15/2024-08/31/2024. The August MAR notes read,

08/11: Refused resident stated her (Relative A1) already put her eye drops in
08/14: (Relative A1) has medication
08/15: family administering medication
08/15: refused stated (Relative A1) gave her medication already.
08/16: (Relative A1) took all meds
08/16: (Relative A1) took her medicine
08/17: (Relative A1) gives meds
08/18: her (Relative A1) took her meds

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R 325.1901	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Review of documentation and interviews conducted revealed the facility was to administer Resident A's medications. On or around August 14th, Relative A1 became upset with the administration of medications and took over the administration. This was not documented in Resident A's daily log until 08/24/2024 and Resident A's service plan was not updated to reflect this change. The facility lacked an organized program of protection to ensure Resident A received her medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Service plan was not developed with family.

INVESTIGATION:

The complainant alleged Resident A's service plan was not developed with family.

On 02/05/2024, I interviewed administrator Marylyn Leavitt at the facility. Ms. Leavitt reported Resident A admitted to the facility prior to her involvement with the facility. Ms. Leavitt reported Resident A provided the facility with a 30-day discharge notice. Ms. Leavitt reported the facility did not issue a discharge notice and did not provide any notice to the family as the discharge was per the request of the resident. Ms. Leavitt reported she was unable to obtain any signed copies or documentation of the initial service plan. Ms. Leavitt reported the State of Michigan had completed an investigation regarding Resident A and the facility was found in compliance.

I reviewed State of Michigan internal documentation system and the facility field file. I did not find any special investigations regarding Resident A.

I reviewed service plan for Resident A. The service plan revealed Resident A's move in date was 03/23/2023. The last assessed date was 04/19/2023. The effective date of the service plan was 05/02/2023. The last modified date was 07/02/2023. The service plan was not signed.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(2) The admission policy shall specify all of the following: **(c) That the individual seeking admission and his or her authorized representative, if any, shall participate in the development of the individual's service plan.**
ANALYSIS:	Interviews conducted and review of documentation revealed the facility was unable to provide evidence that the service plan was developed with Resident A and/or authorized representative.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's service plan not reflective of current care needs.

INVESTIGATION

The complainant alleged Resident A's service plan contradicts itself. The complainant alleged Resident A is listed as having depression and anxiety but then lists no depression or anxiety.

I reviewed Resident A's service plan. The service plan read,

> *"Current Anxiety: (Resident A) has current or history of occasional anxiety. (Resident A) is on scheduled anti-anxiety medication prescribed by PCP. Resident displays anxiety by pacing in room. Please provide resident reassurance and attempt to reduce anxiety by re-directing resident to quiet area, offering a hand massage, or turning on soothing music in apartment.*
> *Current: Depression: (Resident A) has current depression. Resident is prescribed an antidepressant taken daily. Resident displays depression by becoming socially withdrawn, reduced intake, and increased sleeping. Staff to provide resident with encouragement to participate actively in daily tasks and to provide supportive listening.*
> *History: Anxiety: Resident does not have history of anxiety. Staff to report to nurse if resident is observed to have change in anxiety.*
> *History: Depression: Resident does not have history of depression. Staff to report to nurse if resident is observed to have change in depression, including expressions of feeling down, withdrawn, or tearful."*

APPLICABLE RULE	
R 325. 1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of Resident A's service plan revealed Resident A was described as having depression and anxiety as well as a history of anxiety and depression. The service plan lacks a clear description of Resident A's psycho-social needs and staff responsibility to meet the needs of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Family not notified of Resident A's fall.

INVESTIGATION:

The complainant alleged Resident A had a fall at the facility resulting in a black eye. The complainant alleged Resident A's family was informed of the fall two days later by SP2.

SP1 reported no knowledge of any fall with Resident A. SP1 reported the facility had no incident report or documentation of any fall or any injury from a fall at the facility.

On 02/08/2024, I interviewed SP2 by telephone. SP2 reported no knowledge of a fall or telling family about a fall. SP2 reported there should be documentation in Resident A's chart if there was a fall.

I reviewed Resident A documentation. I did not find any documentation on a fall.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	Interviews conducted and review of documentation revealed lack of evidence to support the allegation Resident A had a fall and family was not notified.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A received incorrect medication.

INVESTIGATION:

The complainant alleged on 05/04/2024, Resident A was prescribed Cefdinir and Fluconazole for 10 days. The complainant alleged this medication was also administered in June 2023. The complainant alleged in July 2023, Resident A did not receive Clonazepam medication**.** The complainant alleged in April 2023, Resident A's Venlafaxine medication dosage was changed and was incorrectly discharged in the system.

I reviewed Resident A's MAR for May 2024. The MAR on 05/05/2024, Resident A was prescribed Cefdinir 300mg capsule with instructions to administer one capsule by mouth 2 times a day for 10 days. Resident A was administered this medication 05/05-05/14. On 05/05/2024, Resident A was prescribed Fluconazole 100mg tablet with instruction to administer one tablet by mouth every day for 10 days. Resident A was administered this medication 05/06-05/19, 05/21-05/23, 05/28, and 05/31. I reviewed Resident A's June MAR. The MAR revealed Fluconazole medication was administered on 06/02, 06/06-06/09, 06/11. The June MAR notes read,

"06/03: Finished
06/04: Finished drug
06/05: N/A
06/10: Med not available, contacted pharmacy
06/12: Old order needs to be removed from Yardi. WD Notified
06/13: Order discontinued"

I reviewed Resident A's MAR for July 2024. The MAR revealed Resident A was prescribe Clonazepam 0.5mg tablet with instruction to administer one tablet by mouth two times a day. The MAR revealed Resident A did not receive this medication on 07/24 at 5:00pm due to drug not available.

I reviewed Resident A's MAR for April 2024. The MAR revealed Resident A was prescribed Venlafaxine 150mg. Resident A received this medication 04/01-04/13. Resident A's dosage increased to 225mg, and this medication was administered on 04/13-04/18. The MAR revealed the medication was discontinued on 04/18-04/26 and then re-started and administered 04/27-04/30.

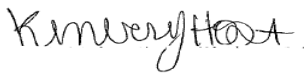
On 02/08/2024, I interviewed OneCare Pharmacy. OneCare Pharmacy reported Resident A's dosage increased on 04/13 and the new dosage was sent to the facility EMAR system on 04/13. The pharmacy reported Resident A was prescribed Venlafaxine225mg 04/13 and was not discontinued in April 2023.

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:	Review of Resident A's MAR revealed: Resident A received additional doses of Fluconazole Resident A did not receive Clonazepam 0.5mg tablet on 07/24/2023 Resident A did not receive dosage of Venlafaxine 04/18/2023-04/26/2023.

CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



02/08/2024

Kimberly Horst Date
Licensing Staff

Approved By:

02/15/2024

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