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 #: 2024A1021033
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 #:	2024A1021033
Complaint Receipt Date:	01/29/2024
Investigation Initiation Date:	01/30/2024
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?
Resident B did not receive medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/29/2024	Special Investigation Intake 2024A1021033
01/30/2024	Special Investigation Initiated - Letter referral sent to APS
02/05/2024	Inspection Completed On-site
02/07/2024	Contact-Telephone call made Interviewed Katherine Sooter, PA office
02/07/2024	Contact-Telephone call made Interviewed Jared Langerak office
02/08/2024	Contact-Telephone call made Interviewed OneCare Pharmacy
02/16/2024	Exit Conference

ALLEGATION:

Resident B did not receive medication.

INVESTIGATION:

On 01/29/2024, the licensing department received a complaint with allegations Resident B did not receive medications. The complainant alleged the following medication errors occurred:

- Resident B did not receive medications on 10/26/2023-10/28/2023.
- Resident B did not receive Bupropion on various dates in October and November 2023.
- Resident B did not receive antibiotic in a timely manner for infected sebaceous cyst.

- Resident B did not receive B12 tablet and Nystop cream in November 2023
- Resident B did not receive Jardiance, Eliquis, Losartan, or Amantadine in November 2023
- Resident B did not receive 5:00pm medications on 11/05/2023.
- Resident B did not receive 5:00pm medications on 11/14/2023.
- Resident B received discontinued Trazadone on 12/13-12/27.
- Resident B did not receive Keflex 500mg in December.
- Resident B had revised order for Lasix on 12/22/2023 but did not receive revised medication order until 12/27/2023.
- Resident B did not receive Bupropion and Furosemide in December 2023.
- Resident B was out of the facility and did not receive 5:00pm medications on several occasions.

On 01/30/2024, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 02/05/2024, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident B admitted to the facility on 10/26/2023. SP1 reported Relative B1 brought Resident B's medications from home. SP1 reported prior to admission to the facility, Resident B was receiving medications from multiple pharmacies which made it difficult for the facility to obtain medications. SP1 reported at time of admission, the paperwork was not completed, and Resident B's medications were not put into the system. SP1 reported the facility cannot administer medications if the medication orders are not in the system. SP1 reported if there is a medication change, the facility cannot change the medication until the order is put into the system by the pharmacy. SP1 reported it can take a few days for the changes to be reflected in the electronic medication administration system (emar). SP1 reported the facility cannot accept a verbal order from a provider. SP1 reported the facility will update the EMAR if it is an antibiotic, psychological, or narcotic medication as those medications require immediate attention.

<u>Resident B did not receive medications on 10/26/2023-10/28/2023.</u>

I reviewed Resident B's October 2023 medication administration record (MAR). The MAR revealed the facility administered medications beginning on 10/28/2023. The MAR notes read,

"*10/27: Melatonin 5mg Meds not scheduled yet waiting for pharmacy*
10/27: Methocarbamol 500mg meds not scheduled yet waiting for pharmacy
10/27: Senna 8.6mg Meds not scheduled yet waiting for pharmacy

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

"10/29: (Relative B1) gave his night meds, she brought them from home. (Resident B) Tamsulosin HCL 0.4mg is at his fridge, (Relative B1) requested to leave them in the fridge at previous place lost those meds. Dominique agree said that ok.
10/29: (Relative B1) was upset because (Resident B) didn't receive his medications on Thursday, Friday, and Saturday. We didn't receive until Saturday

night and the med tech 1st shift did administered his morning and evening meds for today 10/29. She ask me which was the meds that 1st shift administered. I pull up the list on eMAR and show her, she said that there's meds missing, replay her back that I'm about to administer more med at 8pm and 9pm, she did want to see what meds. I show her see. She said that Trulicity 3mg is not schedule and its need to be just on MONDAYS also said that the NYSTAIN powder is not schedule and she gave wellness director Tamara a few bottles. I told her that she needs to come tomorrow and speak with Tamara."

Resident B did not receive Bupropion on various dates in October and November 2023.

I reviewed Resident B's MAR for October 2023. The MAR revealed there was no order for Bupropion. The MAR for November 2023 revealed the Bupropion order had a start date of 11/09 and the medication was administered on 11/10-11/30.

Resident B did not receive antibiotic in a timely manner for infected sebaceous cyst.

I reviewed Resident B's MAR for October 2023. The MAR revealed Resident B was prescribed Cephalexin 500mg capsule with instructions to take one capsule by mouth three times a day for 7 days. The order was written on 10/31/2023 and was administered once on 10/31/2023. I reviewed the MAR for November 2023. The MAR revealed Resident A's order for Cephalexin was administered on 11/03/2023. The medication was not administered 11/01-11/06 due to drug unavailable. The medication was re-entered into the system on 11/07 and was administered 11/07-11/13 for a total of nine days.

Resident B did not receive B12 tablet and Nystop cream in November 2023.

I reviewed Resident B's MAR for October and November 2023. The MAR revealed Resident B was prescribed Nystop powder with instruction to administer to affected area 2 times a day. This cream was applied on 10/31-11/07. It was discontinued on 11/07. The MAR revealed Resident B was prescribed Nystop powder with instructions to apply topically two times a day as needed.
The MAR for November 2023 revealed Resident B was prescribed B12 1000mcg and this was administered 11/08-11/30.

On 2/07/2024, I interviewed Jared Langerak, MD office. The office reported they sent the order for the powder to OneCare pharmacy on 10/30. The office reported that they do not prescribe B12 as it is an over-the-counter medication.

On 02/08/2024, I interviewed OneCare Pharmacy. The pharmacy reported the order for Nystop powder was changed to prn on 11/06/2023. The pharmacy reported they received the order for the B12 medication on 11/06/2023.

Resident B did not receive Jardiance, Eliquis, Losartan, or Amantadine in November 2023.

I reviewed Resident B's MAR for November 2023. The MAR revealed Resident B was prescribed Jardiance 10mg tablet. This medication was administered 11/01-11/30. The MAR revealed Resident B was prescribed Eliquis 5mg tablet. Resident B did not receive this medication on 11/4, 11/14, and 11/30 due to Resident B was out of the facility. Resident B was prescribed Losartan 50mg on 11/09. Resident B did not receive this medication on 11/4 due to Resident B was out of the facility. Resident B was prescribed Amantadine 100mg. This medication was not administered 11/4, 11/14, and 11/30 due to Resident B was out of the facility.

Resident B did not receive 5:00pm medications on 11/05/2023.

I reviewed Resident B's MAR for November 5th, 2023. The MAR revealed the mediation technician documented 5:00pm medications were administered.

Resident B did not receive 5:00pm medications on 11/14/2023.

I reviewed Resident B's MAR for November 14th, 2023. The MAR revealed Resident B did not receive Trazodone 50mg, Cephalexin 500mg, and Furosemide 40mg at 8:00pm on 11/14/2024 due to drug not available.

Resident B received discontinued Trazadone on 12/13-12/27.

I reviewed for the MAR for December 2023. The MAR revealed Resident B was prescribed Trazodone 50mg tablet with instruction to administer one tablet by mouth at bedtime. Resident B was administered this medication 12/1-12/19 and 12/24. I reviewed Resident B's daily log notes for this medication. The log notes read,
"12/14: Spoke with physician and she is recommending that we stop Trazadone and change the order on Bupropion. She will be faxing the order.
12/18: He is not supposed to be given Trazodone anymore and have new meds coming in.
12/20: (Resident B) stated that he is not supposed to be getting Trazodone anymore and have been keeping the pills in his room when they give it to him. I took 6 pills out of his room that he showed me on his dresser. I took and destroyed them he said he is not taking them and that they would need to stop bringing them to him I told him I would let the med tech know that he is refusing to take them to not pass it to him chart he refused.

On 02/07/2024, I contacted Resident B's physician Katherine Sooter. The office reported on 12/13 the Trazadone medication was discontinued but the office is not certain how this information was provided to the facility. The office reported on 12/22, an updated medication list was faxed to the facility with order to stop the Trazodone medication and revise Bupropion order.

Resident B did not receive Keflex 500mg in December.

I reviewed Resident B's MAR for December 2023. The MAR revealed Resident B was prescribed Cephalexin (Keflex) 500mg capsule with instruction to administer one capsule by mouth 3 times a day for 7 days (antibiotic). This medication was

entered twice in the MAR and medication was administered 12/22-12/30 for a total of nine days.

Resident B did not receive Bupropion and Furosemide in December 2023.

I reviewed Resident B's MAR for December 2023. The MAR revealed Resident B was prescribed Bupropion HCL 150mg with a start date of 12/23. This medication was not administered until 12/25.

I reviewed Resident B's MAR for December 2023. The MAR revealed Resident B's medication order for Furosemide 40mg tablet (Lasix) was changed. Resident B original order was for 40mg in the morning, and this was administered 12/1-12/22. The order was changed to 80mg in the morning and 40mg in the evening. The 40mg tablet at 9:00pm was not administered on 12/23 for unknown reasons and on 12/30 because drug was not available. The MAR revealed the 80mg tablet had a start date of 12/25 but was not administered under 12/27-12/31.

Resident B was out of the facility and did not receive 5:00pm medications on several occasions.

I reviewed Resident B's MAR notes for November and December 2023. The notes revealed when Resident B was out of the facility (LOA), Relative B1 refused to take medications with them. The following dates Resident B was on LOA and did not receive medications:
11/4 5:12pm, 11/14 5:00pm, 11/23 8:30, 11/30 5:00pm, 12/27 9:00pm, 12/26 5:00pm, and 12/23 8:00pm.

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 Resident B's MARs and daily log notes revealed the following medication errors occurred: • Resident B did not receive medications 10/26-10/27. • Resident B did not receive Trazodone 50mg, Cephalexin 500mg, and Furosemide 40mg at 8:00pm on 11/14/2024 due to drug not available. • Facility continued to administer Trazadone medication even after medications were found in Resident B's room and the provider reported to the facility the medication was to be discontinued.

	• Resident B received Cephalexin 500mg capsule for a total of nine days not seven days as prescribed. • Resident B was prescribed Bupropion HCL 150mg on 12/22. This medication was not administered on 12/22-12/23 for unknown reasons. • Resident B did not receive Furosemide 40mg tablet on 12/23 and 80mg tablet for two days after the start date.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the individual who administered the prescribed medication.**
ANALYSIS:	Review of Resident B's daily log on 12/20 revealed Resident B was not taking Trazodone medication and six tablets were found in his room. Review of Resident B's December MAR revealed the medication technician initialed this medication was administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(c) Contact the appropriate licensed health care professional when the prescribed medication has not been administered in accordance with the label instruction, an order from a health care professional, medication log, or a service plan**.

ANALYSIS:	Review of Resident B's MAR for October, November, and December revealed multiple medications that were not administered in accordance with the label instructions and the facility did not contact the appropriate health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(4) If a resident requires prescription or over-the-counter medication or medications while out of the home, and medication or medications are not identified as self-administered, staff responsible for the medication management shall ensure that the resident, or the person that assumes responsibility for the resident, has all appropriate information, medication, and instructions.
ANALYSIS:	Review of Resident B's MAR for November and December revealed multiple days in which Resident B was out of the facility. As a result, Resident B was not in the facility for his medications. The facility did not ensure Resident B had his medications when he left the facility nor administer medications when he returned to the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(6) For a resident who is identified as self-administered in his or her service plan, the home must have a policy to offer a secured method of storage for medications if desired by the resident and to notify the applicable health care professional or legal representative if there is a change in a resident's capacity to self-medicate.

ANALYSIS:	Review of Resident B's daily log revealed Resident B's Tamsulosin medication was placed in Resident B's refrigerator. This refrigerator was not a secure method of storage for medication.
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