GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 25, 2024

Achal Patel & Vivek Thakore
Divine Life Assisted Living Center 3 LLC
2045 Birch Bluff Drive
Okemos, MI 48864

RE: License #: AL330404952
Investigation #: 2024A1033031
Divine Life Assisted Living Center 3 LLC

Dear Mr. Patel & Mr. Thakore:

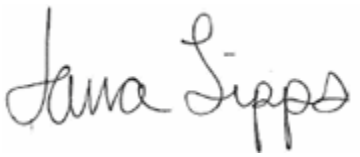
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9730.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330404952
Investigation #:	2024A1033031
Complaint Receipt Date:	03/14/2024
Investigation Initiation Date:	03/14/2024
Report Due Date:	05/13/2024
Licensee Name:	Divine Life Assisted Living Center 3 LLC
Licensee Address:	2045 Birch Bluff Drive Okemos, MI 48864
Licensee Telephone #:	(517) 339-2390
Administrator:	Achal Patel, Designee
Licensee Designee:	Achal Patel & Vivek Thakore
Name of Facility:	Divine Life Assisted Living Center 3 LLC
Facility Address:	2077 Haslett Road Haslett, MI 48840
Facility Telephone #:	(517) 339-2390
Original Issuance Date:	11/09/2020
License Status:	REGULAR
Effective Date:	05/09/2023
Expiration Date:	05/08/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff are not administering Resident A's medications as prescribed, leading to medication errors on 2/20/24 and 3/9/24, resulting in the need for emergency medical services for Resident A.	Yes

III. METHODOLOGY

03/14/2024	Special Investigation Intake 2024A1033031
03/14/2024	APS Referral- Currently assigned to APS, Steve Marchlewicz.
03/14/2024	Special Investigation Initiated – Letter- Email correspondence sent to APS, Steve Marchlewicz.
03/19/2024	Inspection Completed On-site- Interviews with direct care staff/home manager, Rose Benavidez, assistant home manager, Kaylynn Mitchell, review of resident records initiated.
03/19/2024	Inspection Completed-BCAL Sub. Compliance
03/20/2024	Exit Conference- Conducted via telephone with licensee designee, Achal Patel. Voicemail message left. Email correspondence also sent to Mr. Patel.

ALLEGATION: Direct care staff are not administering Resident A's medications as prescribed, leading to medication errors on 2/20/24 and 3/9/24, resulting in the need for emergency medical services for Resident A.

INVESTIGATION:

On 3/14/24 I received an online complaint regarding the Divine Life Assisted Living Center 3 LLC, adult foster care facility (the facility). The complaint alleged direct care staff members are not administering Resident A's medications as prescribed, leading to medication errors occurring on 2/20/24 and 3/9/24, resulting in the need for emergency medical services for Resident A. On 3/19/24 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/home manager, Rose Benavidez. Ms. Benavidez reported the Resident A had in fact been sent to the emergency department at Sparrow Hospital on 2/20/24 and 3/9/24. She

reported she was not present at the facility on either of these dates but received the following reports regarding these instances:

- 2/20/24: Ms. Benavidez reported that she was informed by direct care staff/assistant home manager, Kaylynn Mitchell, that on 2/20/24 a medication error occurred with three residents at 6am. She reported that there are three residents who all receive a thyroid medication at 6am each day so that the medication is administered prior to their breakfast meal. Ms. Benavidez reported that the overnight staff, who work 6pm to 6am, generally administer these 6am medications prior to their shift ending. Ms. Benavidez reported that on 2/20/24 direct care staff, Mithcell Tharp, had completed his shift at 6am and direct care staff, Katina Fisher started her shift at 6am this date. She reported that Ms. Fisher administered the 6am thyroid medications to Resident A, Resident B, and Resident C, as she checked the electronic *Medication Administration Record* (MAR) and these medications were not marked as being administered by Mr. Tharp. Ms. Benavidez reported that Ms. Fisher thought this was strange as the overnight shift usually administers these medications at 6am before they end their shift. Ms. Benavidez reported that Ms. Fisher spoke with Ms. Mitchell about the speculation that potentially all three residents may have been given a second dose of their thyroid medication on this date. Ms. Benavidez reported that Ms. Mithcell made a telephone call to Mr. Tharp, who reported that he had administered the thyroid medication for Resident A, Resident B, and Resident C, and that he had forgotten to mark it as administered in the electronic MAR. Ms. Benavidez reported that they became aware, after speaking with Mr. Tharp, that the three residents had received two doses of their thyroid medication at 6am on 2/20/24. Ms. Benavidez reported that the direct care staff were instructed to call the Careline Physician Services as they are the primary care providers for all three residents. Ms. Benavidez reported that the direct care staff were instructed to watch for any side effects, but that the residents should be fine. Ms. Benavidez reported that later in the afternoon on 2/20/24, Resident A was not acting like herself, leaning to the left, drooling, difficulty communicating so they had her sent to Sparrow Hospital for an evaluation. Ms. Benavidez reported that the results of the emergency department stay were inconclusive and did not indicate that her symptoms were caused by the additional dose of thyroid medication that morning. She reported that Resident A returned to the facility and has been back to her baseline.
- 3/9/24: Ms. Benavidez reported that on 3/9/24 direct care staff, Brenda Gonzalez, was working at the facility. She reported that Ms. Gonzalez had called Ms. Benavidez on the telephone to let her know that she had tried to administer Resident A's medication patches and found multiple medication patches on Resident A's body that had not been removed by prior direct care staff members. Ms. Benavidez reported that Resident A receives a Scopolamine patch every three days, behind her ear, and a Rivastigmine patch every day on her back. She reported that when the patches are changed it is the responsibility of the direct care staff member administering the new patch to remove the old patches. Ms. Benavidez reported that Ms.

Gonzalez found Resident A to have two Scopolamine patches behind her ears and multiple patches on her back. Ms. Benavidez reported that the proper administration of these patches requires the direct care staff to date and initial the patch they are administering so that it can be determined when the patch was placed on Resident A. Ms. Benavidez reported that none of the patches administered to Resident A had initials or dates written on them. She was unsure when each of these patches were administered to Resident A. Ms. Benavidez reported that she called the Careline Physician Services office and reported the issue to their team. She reported that she was instructed to remove all patches from Resident A and send her to the hospital for an emergency evaluation. Ms. Benavidez reported Resident A was not acting herself on this date as she was leaning to the right and could not hold her cup of coffee independently. Ms. Benavidez reported she investigated the previous direct care staff who had documented on the MAR that they had administered the medication patches to Resident A. Ms. Benavidez reported that these direct care staff were Ms. Fisher and direct care staff, EJ Pierce. She reported she spoke with EJ Pierce who noted they did not see any other patches that required removal during the time they administered the patches to Resident A. Ms. Benavidez reported that Ms. Fisher stated she was unaware that the old patches were to be removed when a new patch was administered.

Ms. Benavidez reported that since these two medication errors were identified she has requested a training class for all direct care staff which will be led by a nurse through the Advance Pharmacy. She reported that EJ Pierce will be attending the first class offered on 3/21/24. Ms. Benavidez reported that they have since changed Resident A's MAR to include a task for removal of the previous patches administered when administering a new patch.

During the on-site investigation on 3/19/24 I interviewed Ms. Mitchell. Ms. Mitchell had the following information to report regarding the alleged medication errors:

- 2/20/24: Ms. Mitchell reported that she received a communication from Ms. Fisher on 2/20/24 that she felt Resident A, Resident B, and Resident C may have been administered a double dosage of their thyroid medication. She reported that Ms. Fisher had started her shift at 6am on 2/20/24, noticed the thyroid medications for these three residents were not documented as administered on the MARs and then administered the medications. She reported that Ms. Fisher started to think that she should double check this as the overnight direct care staff usually document these as administered prior to leaving their shift at 6am. Ms. Mitchell reported that she then called Mr. Tharp via telephone to discuss the medications. Ms. Mitchell reported that Mr. Tharp confirmed he had already administered the medications for Resident A, Resident B, and Resident C, and he forgot to document them as administered on the MARs. Ms. Mitchell reported that she then called the Careline Physician Services, who manage the primary care for all three residents and reported the medication errors. Ms. Mitchell reported that they were instructed

to just keep an eye on each resident for any potential adverse reactions. Ms. Mitchell reported that later this date, 2/20/24, Resident A was leaning to the left, drooling, and not able to communicate as she usually does. She reported that they sent Resident A to the hospital emergency department for evaluation. Ms. Mitchell reported that Resident A was assessed for a potential stroke while she was in the emergency department and there was not conclusive evidence to determine she had experienced a stroke. Ms. Mitchell reported that Resident A is now back at the facility and is functioning at her baseline status.

- 3/9/24: Ms. Mitchell reported that on 3/9/24 Ms. Gonzalez reported to Ms. Benavidez that Resident A had multiple Scopolamine patches and Rivastigmine patches administered on her person. She reported that Resident A had a change in her mental and physical status on this day as she was leaning to the right, could not sit up straight, or hold her cup of coffee independently. Ms. Mitchell reported that Careline Physician Services were called, and the direct care staff were instructed to take the patches off from Resident A's person and call for emergency medical services. Ms. Mitchell reported that Resident A was sent to the hospital on this date. She reported that the proper procedure for administering Resident A's medication patches is for the direct care staff to initial and date each patch when it is administered and to remove the previous patch. Ms. Mitchell reported that it was identified that two direct care staff members, Ms. Fisher and EJ Pierce had not followed this protocol for Resident A.

During the on-site investigation on 3/19/24 I reviewed the following documents:

- MARs for Resident A for the months of February 2024 and March 2024. Resident A is prescribed the following medications and instructions for administration:
    - Levothyroxine Tab 25mcg: Take 1 tablet by mouth daily every morning (half hour to one hour before any meal/meds). Administration time, 6am. On 2/20/24 this medication is noted as being administered by Ms. Fisher.
    - Rivastigmine DIS 9.5mg/24: Apply 1 patch topically to left or right upper or lower back, chest, or upper arm daily *rotate application sites, remove before applying, and place date on patch before application*. The MAR has a space to indicate the *site* of the patch placement for each administration. On the February 2024 MAR there were no notations in the *site* section of the MAR to indicate where the patch was placed. On the March 2024 MAR the *site* section began reporting notations of where the direct care staff were administering the patch on 3/10/24 and forward.
    - Scopolamine DIS 1mg/3day: Apply 1 patch topically every 72 hours "Alternate behind left and right ear on hairless area. Remove before applying*. The MAR has a space to indicate the *site* of the patch placement for each administration. On the February 2024 MAR there were no notations in the *site* section of the MAR to indicate where the

patch was placed. On the March 2024 MAR the *site* section began reporting where the direct care staff were administering the patch on 3/15/24 and forward.

- *After Visit Summary*, from Sparrow Hospital, dated 2/20/24, for Resident A. On page 1, under section, *Instructions*, it reads, “Your thyroid was enlarged and your thyroid blood work was abnormal. Follow-up with your primary care doctor for further evaluation, including possible thyroid ultrasound.” Under the section, *Reason for Visit*, it reads, “Weakness”. Under the section, *Diagnoses*, it reads, “Generalized weakness. Thyroid mass.”
- *After Visit Summary*, from Sparrow Hospital, dated 3/9/24, for Resident A. On page 1, under section, *Instructions*, it reads, “Follow-up with your primary care provider in 1 week for repeat chest x-ray and repeat evaluation. Be careful combining multiple medications that can cause sleepiness this may result in oversedation, stopping in breathing, and ultimately death.” Under the section, *Reason for Visit*, it reads, “fatigue”. Under the section, *Diagnosis*, it reads, “Polypharmacy”.
- Employee consultation form for Mr. Tharp, dated 2/20/24. This document indicated it was a “written warning” for a “medication error”. In section *1* of the document it reads, “On Feb. 20 2024 [Mr. Tharp] passed his 6am meds, however he did not follow company policy and did not scan them out which in place caused an extra pill being passed to three of our residents”. Under section *3* it reads, “[Mr. Tharp] will follow med pass procedure and policy to help eliminate med errors.” Under section *4* it reads, “Any med errors could result in disciplinary action.” This form is signed by Mr. Tharp on 2/26/24 and signed by Ms. Benadvidez on 2/22/24.
- *AFC Licensing Division – Incident/Accident Report*, for Resident A, dated 2/20/24. This document was signed by licensee designee, Vivek Thakore, and Ms. Mitchell. Under section, *Explain what happened/Describe Injury*, it reads, “[Mr. Tharp] passed 6am meds but did not sign them. [Ms. Fisher] passed 6am meds again. Under the section, *Action taken by staff/treatment given*, it reads, “When brought to my attention I called [Mr. Tharp] he stated he passed them but did not sign them out I called careline they instructed us to monitor them.” Under section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, “Educated [Mr. Tharp] he needs to sign meds out as he passes them.”
- *AFC Licensing Division – Incident/Accident Report,* for Resident A, dated 3/9/24. Under the section*, Explain What Happened/Describe Injury,* it reads, “Notice [Resident A] could not hold her cup of coffee or eat her breakfast she was leaning to the right she couldn’t sit up straight. I did notice she has had 2 patches one on each ear, when I giving [sic] [Resident A] her meds I did remove them.” Under section, *Action taken by staff treatment given*, it reads, “Call Careline, they instructed to send her out to Sparrow.” Under section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, “The facility has put in a task to remove the old patch with specific placing instruction before placing the new one on, in the MARs.” This document was

signed by Mr. Thakore (no date was written next to this signature) and Ms. Gonzalez, on 3/9/24.

- Employee consultation form for EJ Pierce, dated 3/18/24. This document noted a “verbal counseling” for EJ Pierce related to a “med error”. Under section *1*, it reads, “[EJ Pierce] applied [Resident A] Rivastigmine Patch on her back on 3/7/24 but did not remove the patch that was placed on 3/6/24. [EJ Pierce] also applied Scopolamine patch on 3/6/24 behind [Resident A] ear but did not remove the patch that was placed on 3/3/24.” Under section *3*, it reads, “[EJ Pierce] will be taking the med class on 3/21/24 @ 4pm at our Dewitt location.” Under section *4*, it reads, “[EJ Pierce] was educated on the importance of making sure each patch is removed as [Resident A] had to many patches on which resulted in her being over medicated and going to the ER.” This document was signed by EJ Pierce and Ms. Mitchell on 3/18/24.
- Employee consultation form for Ms. Fisher, dated 3/12/24. This document noted a “verbal counseling” for reasons of “failure to follow instructions” and “med errors”. Under section *1*, it reads, “[Ms. Fisher] on March 8th administered meds to [Resident A] and didn’t realize the double patch that was already there, beforehand. Which caused an overdose.” Under section *3*, it reads, “Employee more mindful and aware of all patches prior to administering the next dose.” This document was signed by Ms. Fisher and Ms. Benavidez on 3/12/24.

On 3/22/24 I reviewed the employee training documents for Mr. Tharp, Ms. Fisher, and EJ Pierce. There was documentation available that each of these direct care staff had been trained in medication administration prior to the medication errors on 2/20/24 and 3/9/24.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based upon interviews with Ms. Benavidez & Ms. Mitchell, as well as review of Resident A's resident record and the medication administration training documents for Mr. Tharp, Ms. Fisher, and EJ Pierce, it can be determined that on the date 2/20/24 Ms. Fisher administered an additional dose of Thyroid medication to Resident A, Resident B, and Resident C, since Mr. Tharp had previously administered these medications this same date but had neglected to document these administered doses in the electronic MAR. Even though the facility has a standard protocol for the overnight direct care staff members to administer this Thyroid medication to these three residents prior to them completing their shift at 6am, Ms. Fisher readministered this medication to Resident A, Resident B, and Resident C, without confirming that the dose had not already been administered. This duplicate dosing by Ms. Fisher resulted in a need for an emergency medical intervention for Resident A. Additionally, on 3/9/24 it was noted that Ms. Gonzalez discovered Resident A's Scopolamine patches and Rivastigmine patches were not being removed by direct care staff members prior to administering the new dose of these medications for Resident A. Resident A was found to be in an altered mental status on 3/9/24 and had multiple Scopolamine and Rivastigmine patches applied to various parts of her back and behind her ears. It is not clear that these patches were the cause of her altered mental status, however the MAR indicates a directive to remove the previous patch before administering a new patch and to date the patch. It was noted by Ms. Benavidez and Ms. Mitchell that there were no dates listed on any of the patches found on Resident A's person and that the two direct care staff, EJ Pierce and Ms. Fisher, indicated they either did not have knowledge the patch needed to be removed prior to administration of a new patch or they did not see the old patches in order to remove them from Resident A's person. Based on this information it can be established that the direct care staff members did not administer Resident A, B, and C's medications as prescribed and did not follow label instructions or proper medication administration protocols.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Based upon interviews with Ms. Benavidez and Ms. Mithcell, as well as review of Resident A's resident record and the employee consultation form, dated 2/20/24, which Mr. Tharp signed, it can be determined that Mr. Tharp administered medications to Resident A, Resident B, and Resident C on 2/20/24 at 6am and did not document this administration on the MARs for any of these residents. This failure to document medication administration for these three residents resulted in Ms. Fisher administering a second dose of medication to Resident A, Resident B, and Resident C on 2/20/24. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Continent upon receipt of an approved corrective action plan, no change to the current status of the license recommended at this time.

3/22/24

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Jana Lipps Date
Licensing Consultant

Approved By:

03/25/2024

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Dawn N. Timm Date
Area Manager