GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 13, 2024

Kory Feetham
Reed City Fields Assisted Living
219 Church St
Auburn, MI 48611

RE: License #: AL670398222
Investigation #: 2024A0009024
Reed City Fields Assisted Living III

Dear Mr. Feetham:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the 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 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 (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL670398222
Investigation #:	2024A0009024
Complaint Receipt Date:	04/29/2024
Investigation Initiation Date:	04/30/2024
Report Due Date:	05/29/2024
Licensee Name:	Reed City Fields Assisted Living II
Licensee Address:	22109 Professional Dr. Reed City, MI 49677
Licensee Telephone #:	(231) 465-4371
Administrator:	Kory Feetham
Licensee Designee:	Kory Feetham, Designee
Name of Facility:	Reed City Fields Assisted Living III
Facility Address:	22110 Professional Dr. Reed City, MI 49677
Facility Telephone #:	(231) 465-4371
Original Issuance Date:	07/27/2020
License Status:	REGULAR
Effective Date:	01/27/2023
Expiration Date:	01/26/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED & ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive two of her prescribed medications during a four-day period.	Yes

III. METHODOLOGY

04/29/2024	Special Investigation Intake 2024A0009024
04/30/2024	Inspection Completed On-site Interview with home manager Kristina Holmes and Face to face contact with Resident A
05/08/2024	APS Referral
05/08/2024	Contact – Telephone call made to Resident A's Family Member, left message
05/08/2024	Contact – Telephone call made to Megan Adams, nurse with Corwell Health Hospice, left message
05/09/2024	Contact – Document (email) received from Adult Foster Care intake and support unit
05/09/2024	Contact – Telephone call received from Resident A's Family Member
05/09/2024	Contact – Telephone call made to Megan Adams, nurse with Corwell Health Hospice
05/09/2024	Contact – Telephone call made to home manager Kristina Holmes
05/10/2024	Exit conference with licensee designee Kory Feetham

ALLEGATION: Resident A did not receive two of her prescribed medications during a four-day period.

INVESTIGATION: I conducted an unannounced site visit at the Reed City Fields Assisted Living III adult foster care home on April 30, 2024. I spoke with home manager Kristina Holmes at that time. I asked her about the report of Resident A not receiving some of her medication the week before. Ms. Holmes explained that Resident A receives hospice services through Corwell Health Hospice. There were

some changes in the medication orders and the hospice nurse called in the new prescription for those medications on April 19, 2024. Ms. Holmes stated that it was her understanding that the medications were supposed to be picked up by Resident A's Family Member on April 20, 2024. For some reason, that did not happen. Resident A's Family Member did eventually pick them up on April 23, 2024. The administration of those medications resumed at that time. She was not sure exactly how this was missed for so many days and believed that the hospice nurse would know more about how it happened in that manner.

I asked Ms. Holmes if she could provide me with the Medication Administration Record (MAR) for Resident A for April of 2024. I noted on the MAR record that staff initials were circled for two medications, Metoprol and Torsemide, during the time-period in question. Ms. Holmes explained that staff initials being circled were an "exception" and that the reason for that exception was recorded elsewhere. She then provided me with the MAR exception log for April of 2024. I noted that both Metoprol and Torsemide had several exceptions recorded for Resident A between April 19 and April 24, 2024. Each exception had the following reason during that time-period "*Medication not Delivered by Pharmacy/Family*". There were several instances of this exception during those days, six for Metoprol and eight for Torsemide. Ms. Holmes agreed that it looked as if Resident A had not received those medications starting the afternoon of April 19 or morning of April 20, 2024 and resuming the afternoon of April 23 or morning of April 24, 2024.

I received an email from the Adult Foster Care intake and support unit on May 9, 2024. It had been reported through the complaint system that Resident A had died on May 7, 2024.

I spoke with Resident A's Family Member by telephone on May 9, 2024. I asked him about his mother not receiving two medications for several days between April 19 and April 24, 2024. Resident A's Family Member said that he was aware of that issue and did not find out about it until April 23, 2024. On that day, he went to the facility to visit his mother. She was having breathing problems at the time and he learned that she had not received two of her medications. Resident A's Family Member denied that he had been told before that time that she was out of medication or that he had been asked by anyone to pick up her medication. He said that he would have done that. He said that he had been told that there were two staff at the facility who were supposed to make sure that medication was refilled and they did not do that. Resident A's Family Member did not know the names of the staff who were supposed to do that. Resident A's Family Member stated that he had been his mother's representative before her death.

I spoke with hospice nurse Megan Adams by telephone on May 9, 2024. She is employed by Corwell Health Hospice. She said that she saw Resident A on May 19, 2024. Staff at the Reed City Fields Assisted Living facility told her that Resident A was either out of two of her medications or about to be out. Ms. Adams said that she completed a refill prescription at that time and left it in the office for the staff

there to “fax” it to the pharmacy. She said that is how they always do it. This occurred in the early afternoon of May 19, 2024. The refill prescription was for Pharma-Script which is a mail-order prescription service which sends medications the day they receive them. The medications then arrive by mail the next day. Ms. Adams said that she has since contacted the pharmacy to try to determine what went wrong in this instance. They told her that they had not received the prescription until after hours on April 19, 2024 so no one there saw it until April 20, 2024. Ms. Adams said that she does not know why the medication did not arrive at the facility until April 23, 2024. Ms. Adams acknowledged that Resident A was in some distress with shortness of breath during the timeframe that she did not receive the medication. She said that she did not believe that Resident A’s distress was a result of her not receiving the Torsemide and Metoprol medications.

I spoke again with home manager Kristina Holmes by telephone on May 9, 2024. I asked her if she had been able to figure out where the break down had occurred that caused Resident A to go without two of her medications. She said that part of the issue was that there had been a transition between hospice nurses which may have contributed to the issue. Pharma-script had been unable to fill the prescription because they did not have an agreement signed by Resident A’s Family Member and because the hospice doctor had not signed the refill order. The prescription was also sent to a local pharmacy but Resident A’s Family Member never picked it up after being contacted. I told her that he reported that he had never been contacted about his mother not having her medication or that he needed to pick anything up prior to April 23, 2024. Ms. Holmes reported that their records showed that he had been to the facility to visit his mother on both April 21 and April 23, 2024. I asked about the hospice nurse saying that she had left the order for them in the early afternoon of April 19, 2024 to send to Pharma-script. Ms. Holmes denied that account and said that her record showed that the nurse had “escribed” (e-prescribed) those prescriptions to the pharmacy on that date. Ms. Holmes said that another administrator at Reed City Fields Assisted Living, LaTasha Elton, did message the hospice nurse inquiring about Resident A not having her medication on April 20, 2024. She notified the nurse that Resident A did not have her medication yet. The nurse replied to her on that day that it had been ordered. I spoke with Ms. Holmes about having a fail-safe system in place that might utilize the medication passer on-site and their on-call management person to make sure these types of situations do not occur. I told her that I recognize that she does not have control over the hospice agency, pharmacy or family members but should do all they can each day a resident is missing medication. This might include contact with each of these entities each day to try to figure out how to overcome whatever issue is preventing the medication from being available.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given,

	taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Resident A went without two of her medications, Metoprol and Torsemide, for several days between April 19 and April 24, 2024. There are slightly varying accounts regarding why this occured. Staff at the facility were aware that Resident A was out of these medications at least twice each day when they entered information into the MAR system noting this. There was no system in place to contact on-call management for the facility or on-call at the hospice agency to overcome this issue in a timely manner. It was confirmed through this investigation that Resident A did not receive her prescribed medications for several days as required in the above cited rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with licensee designee Kory Feetham by telephone on May 10, 2024. I told him of the findings of my investigation and gave him the opportunity to ask questions.

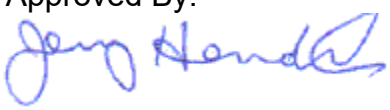
IV. RECOMMENDATION

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

05/13/2024

Adam Robarge, Licensing Consultant Date

Approved By:



05/13/2024

Jerry Hendrick, Area Manager Date