GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 24, 2024

Carol Del Raso
Senior Living Boulder Creek, LLC
7927 Nemco Way, Ste 200
Brighton, MI 48116

RE: License #: AH410406207
Investigation #: 2024A1010031
Boulder Creek Assisted Living & Memory Care

Dear Licensee:

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) 241-1970.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410406207
Investigation #:	2024A1010031
Complaint Receipt Date:	01/31/2024
Investigation Initiation Date:	02/02/2024
Report Due Date:	04/01/2024
Licensee Name:	Senior Living Boulder Creek, LLC
Licensee Address:	7927 Nemco Way, Ste 200 Brighton, MI 48116
Licensee Telephone #:	(616) 464-1564
Administrator:	Mallory Holloman
Authorized Representative:	Rochelle Lyons
Name of Facility:	Boulder Creek Assisted Living & Memory Care
Facility Address:	6070 Northland Drive Rockford, MI 49341
Facility Telephone #:	(616) 866-2911
Original Issuance Date:	08/10/2021
License Status:	REGULAR
Effective Date:	02/10/2023
Expiration Date:	02/09/2024
Capacity:	108
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident B is often given the wrong medication from staff.	Yes
Resident B was given a dirty washcloth to wash his face with.	No
Additional Finding	Yes

III. METHODOLOGY

01/31/2024	Special Investigation Intake 2024A1010031
02/02/2024	APS Referral APS referral emailed to Centralized Intake
02/02/2024	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
02/05/2024	Inspection Completed On-site
02/05/2024	Contact - Document Received Received resident service plan and MAR
02/08/2024	Contact - Document Received Email from Mr. Kahler received
02/15/2024	Contact - Telephone call received Interviewed Relative B1 by telephone
02/15/2024	Contact - Telephone call made Interviewed SP1 by telephone
03/07/2024	Contact – Document Received Received Resident B's medication error incident report via email
05/24/2024	Exit Conference

ALLEGATION:

Resident B is often given the wrong medication from staff.

INVESTIGATION:

On 1/31/24, the Bureau received the allegations from an anonymous complainant. The complaint read, "[Resident B] was given meds by [Staff Person (SP1)] and he didn't recognize one of them. Refused to take it, he sat it aside to show [Relative B1] and sure enough this wasn't one of his prescribed meds. After bringing it to the supervisors attention [SP2] came in and got on her knees and begged him not to tell anyone that residents meds were switched- one resident got his and he was given someone else's. Then [SP2] proceeded to tell him he was lying and it never happened." Due to the complainant being anonymous, I was unable to gather additional information.

On 2/2/24, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 2/5/24, assigned Kent County APS worker Bryan Kahler and I interviewed SP2 at the facility. SP2 reported that approximately two weeks ago, SP1 found "a large pill" on the floor near Resident B's recliner chair. SP2 stated SP1 informed her of the incident, so she entered Resident B's room to examine the pill. SP2 explained the pill appeared to be somewhat dissolved, as if it had been in Resident B's mouth. SP2 stated she determined the pill was one of Resident B's prescribed potassium tablets. SP2 said SP1 did not attempt to administer another resident's medications to Resident B that morning.

SP2 reported Resident B requested to keep the pill to show Relative B1. SP2 stated she gave the pill to Resident B per his request. SP2 explained Resident B has a lot of "anxiety" regarding his prescribed medications and asks staff a lot of questions regarding them when they are administered. SP2 said Resident B often sends Relative B1 pictures of his medications while they are being administered by staff so he can verify what he is taking.

SP2 reported Resident B's medications are secured in a drawer in his room. SP2 stated Resident B's prescribed norco medication is not kept in his room because it is a narcotic. SP2 said this medication is secured in a locked lock box in the medication cart so staff can count it and ensure it is not available to other residents or visitors.

SP2 reported Resident B often yells at staff and his hospice aides. SP2 stated Resident B began hospice services approximately one month ago. SP2 said Corso Care is Resident B's hospice provider. SP2 reported hospice staff are in weekly to see Resident B. SP2 stated Resident B cannot bear his own weight and uses a wheelchair to ambulate.

SP2 denied getting on her knees to "beg" Resident B not to tell anyone about the potassium pill found on his floor. SP2 reported she always lowers herself in front of Resident B while speaking with him to be eye level with him. SP2 denied knowledge

regarding Resident B being given the wrong medication by SP1 the day his potassium pill was found on the floor. SP2 stated Resident B's medications are administered as prescribed. SP2 denied ever accusing Resident B of "lying."

SP2 provided me with a copy of Resident B's January medication administration record (MAR) for my review. The MAR read Resident B's medications were administered as prescribed.

On 2/5/24, Mr. Kahler and I interviewed Relative B1 by telephone. Relative B1 reported there have been issues with Resident B's medication since he moved into the facility in November 2022. Relative B1's statements regarding the potassium pill found on the floor in Resident B's room were consistent with SP2. Relative B1 reported Resident B did save the pill and showed it to him.

Relative B1 explained that prior to Resident B's admission to the facility, he was at Mary Free Bed Hospital. Relative B1 reported while at Mary Free Bed, Resident B was prescribed several medications. Relative B1 said when Resident B was admitted to the facility, he went through Resident B's medication list with staff at the facility to ensure the medications Resident B no longer was prescribed were removed from the list. Relative B1 said the medications Resident B was no longer prescribed were not removed, therefore staff continuously tried to administer them to Resident B.

Relative B1 reported this is why Resident B began sending him pictures of the medications staff attempted to administer to him. Relative B1 said when he received the pictures from Resident B, he verified the medications he was prescribed. Relative B1 explained one of the medications that was discontinued that was not removed from Resident B's MARs was Eliquis. Relative B1 reported staff attempted to give Resident B Eliquis, along with "baby Aspirin." Relative B1 said the effects of taking these two medications together could have had severe side effects for Resident B.

Relative B1 stated he has had to actively participate by telephone each time Resident B is administered his medications to ensure they are correct. Relative B1 said he has had multiple discussions with management staff regarding Resident B's medications, however there are still issues that occur.

Relative B1 denied knowledge regarding SP2 "begging" Resident B not to report any medication issues. Relative B1 also denied knowledge regarding SP2 accusing Resident B of "lying" about his medications.

On 2/5/24, Mr. Kahler and I interviewed Resident B at the facility. Resident B's statements were consistent with Relative B1. Resident B reported SP2 did not get on her knees and beg him not to tell anyone about issues with his medication. Resident B stated SP2 also never accused him of "lying" about issues with his medication.

On 2/8/24, I received an email from Mr. Kahler. Mr. Kahler reported staff at the facility "gave [Resident B] the wrong pill again, they had an employee that gave [Resident B] a Tramadol and not his Norco."

On 2/15/24, I interviewed Relative B1 by telephone. Relative B1 stated he received a telephone call from a staff person at the facility on 2/8/24 regarding Resident B receiving another resident's Tramadol and not Resident B's prescribed Norco. Relative B1 reported the staff person stated Resident B's physician was notified of the error and there were no adverse side effects. Relative B1 expressed concern regarding the continued issues regarding mismanagement of Resident B's medications.

On 2/15/24, I interviewed SP1 by telephone. SP1's statements regarding Resident B's potassium pill were consistent with SP2. SP1's statements regarding SP2 lowering herself to be eye level with Resident B while speaking to him were consistent with SP2. SP1 denied knowledge regarding Resident B ever being administered another resident's medications.

On 3/7/24, I received the incident report regarding Resident B's medication error via email from SP2 for my review. The *Medication Incident form* dated 2/7/24 read, "A dose of #16's Tramadol 50mg was given to resident #22, instead of a dose of #22's Hydrocodone 5/325mg in the 8pm med pass." The *Describe Your Actions Following the Incident (Including any notifications)* section of the form read, "Error was caught at 2nd/3rd shift change at 10:06 pm. 3rd shift team lead notified."

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.

ANALYSIS:	The interview with Resident B and Relative B1 revealed there have been multiple incidents in which staff attempted to administer the incorrect medications to Resident B. Relative B1 stated he has had to be involved most times when staff administer Resident B's medications to ensure they are the correct ones. Review of Resident B's *Medication Incident form* dated 2/7/24 revealed Resident B's was administered another resident's prescribed Tramadol pills rather than Resident B's prescribed Norco. Therefore, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B was given a dirty washcloth to wash his face with.

INVESTIGATION:

On 1/31/24, the complaint read that the evening Resident B's potassium pill was found on the floor, "[SP1] had [Resident B] in tears, after only providing [Resident B] a washcloth to wash his face before bed with feces on it- and would not give him a new one."

On 2/5/24, SP2 stated she was present in Resident B's room when SP1 was assisting Resident B with some of his hygiene needs the same morning Resident B's potassium pill was found on his floor. SP2 reported she heard Resident B say there was feces on the washcloth SP1 was using to wash his face. SP2 said she personally examined the washcloth and observed there was not feces on it.

SP2 stated SP1 did get a new washcloth to wash Resident B's face. SP2 explained she then removed all Resident B's laundry, including towels and washcloths, from his room and placed them in the laundry room to be washed. SP2 reported staff know not to use dirty washcloths when assisting residents with their activities of daily living (ADLs).

SP2 stated Resident B was not upset or tearful at any point when she was in his room. SP2 reported she observed SP1 was appropriate during her interactions with Resident B. SP2 said she did not hear SP1 say anything inappropriate to Resident B.

On 2/5/24, Resident B reported he thought there was feces on a washcloth SP1 used to wash his face the same day the potassium pill was on his floor. Resident B stated he thought the washcloth had feces on it because he observed "a brown spot"

on it. Resident B said the washcloth did not have a foul odor. Resident B stated SP1 did get a new washcloth to finish washing his face.

On 2/5/24, I inspected Resident B's room, specifically observing the washcloths and towels in his bathroom. I observed the towels and washcloths were clean, there were no stains. There were no foul odors in Resident B's rooms. I observed there was an adequate supply of towels and washcloths for residents in the facility.

On 2/15/24, SP1's statements were consistent with SP2.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(2) The home shall assure the availability of clean linens, towels, and washcloths. The supply shall be sufficient to meet the needs of the residents in the home. Individually designated space for individual towels and washcloths shall be provided.
ANALYSIS:	The interviews with SP1, Resident B, and SP2 revealed there was likely a stain on a washcloth SP1 was going to use to wash Resident B's face. SP1 and SP2 reported there was not feces on the washcloth. On 2/5/24, I observed the towels and washcloths in Resident B's room were clean and free from stains. I also observed there was an adequate supply of towels and washcloths for residents in the facility. There is insufficient evidence to suggest the facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 2/5/24, I observed Resident B's prescribed "Osmotic Laxative" was left on the counter by the sink in the kitchenette area of his room. Resident B's prescribed non-narcotic medications are stored in the secured bottom drawer of the cabinetry in the kitchenette area. I observed the lock on the drawer, however Resident B's prescribed laxative was left out.

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.**
ANALYSIS:	Resident B's non-narcotic prescribed medications are to be secured in the bottom drawer of his kitchenette cabinetry. On 2/5/24, I observed Resident B's prescribed "Osmotic Laxative" was left on the countertop by his kitchenette sink. This is not consistent with an organized program of protection.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 2/5/24, SP2 provided me with a copy of Resident B's service plan for my review. Instruction to store Resident B's prescribed non-narcotic medications in a locked drawer in his room was not outlined. Resident B's behavior of consulting with Relative B1 regarding his medications during their administration was also not outlined.

I also observed care instructions for Resident B, such as specific dressing/grooming tasks, catheter bag maintenance, repositioning, and supervision/monitoring were outlined in his MAR rather than his service plan. Resident B's service plan lacked specific details as to what assistance Resident B requires.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

ANALYSIS:	The review of Resident B's service plan revealed it lacked specific information as to how staff are to meet his care needs. On 2/5/24, I observed Resident B's specific care needs were outlined in his MAR. These care instructions were not documented in Resident B's service plan, therefore the facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Carol Del Raso.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

03/08/2024

Lauren Wohlfert Date
Licensing Staff

Approved By:

05/23/2024

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