GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 12, 2024

Nidhal Ghraib
Quality Care of Howell LLC
2820 N. Burkhard Road
Howell, MI 48855

RE: License #: AL470380719
Investigation #: 2024A0466035
Quality Care of Howell I (North Wing)

Dear Mr. Ghraib:

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) 284-9727.

Sincerely,

Julie Elkins

Julie Elkins, 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 #:	AL470380719
Investigation #:	2024A0466035
Complaint Receipt Date:	04/16/2024
Investigation Initiation Date:	04/18/2024
Report Due Date:	06/15/2024
Licensee Name:	Quality Care of Howell LLC
Licensee Address:	2820 N. Burkhard Road Howell, MI 48855
Licensee Telephone #:	(517) 579-2019
Administrator:	Nidhal Ghraib
Licensee Designee:	Nidhal Ghraib
Name of Facility:	Quality Care of Howell I (North Wing)
Facility Address:	2820 N. Burkhart Road Howell, MI 48855
Facility Telephone #:	(517) 579-2019
Original Issuance Date:	01/30/2017
License Status:	REGULAR
Effective Date:	07/30/2023
Expiration Date:	07/29/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED ALZHEIMERS

II. ALLEGATIONS:

	Violation Established?
Second and third shift direct care staff members who administer medications documented medication that is prescribed to one resident as administered when they are really administering that same medication to a different resident for whom the medication is not prescribed.	No
Additional Finding	Yes

III. METHODOLOGY

04/16/2024	Special Investigation Intake 2024A0466035.
04/18/2024	Special Investigation Initiated - Face to Face.
05/28/2024	Contact- telephone call made to DCW Allison Bona, interviewed.
05/28/2024	Contact- telephone call made to DCW Madilynn Faulkner, message left.
05/28/2024	Contact- document sent/received to/from LD Nidhal Ghraib requesting phone numbers and documents.
05/29/2024	Contact- document sent/received to/from LD Nidhal Ghraib requesting phone numbers and documents.
05/30/2024	Contact telephone call received from DCW Allison Bona interviewed second time.
05/30/2024	Contact- telephone call made to DCW Brandi Spilling, message left.
05/30/2024	Contact- telephone call made to DCW Janet Clark, message left.
05/30/2024	Contact- telephone call made to DCW Madilynn Faulkner, second message left.
05/30/2024	Contact- telephone call made to DCW Kimberly Lowler, message left.
06/03/2024	Contact- telephone call made to DCW Janet Clark, message left.
06/03/2024	Contact- telephone call made to DCW Jan Griggs, message left.

06/03/2024	Contact telephone call received from DCW Kimberly Lowler. interviewed second time.
06/03/2024	Contact-Face to face on site.
06/04/2024	Contact telephone call received from DCW Jan Griggs, interviewed.
06/06/2024	Contact- document recevied from licensee designee Nidhal Ghraib.
6/12/2024	Exit conference with licensee designee Nidhal Ghraib.
06/12/2024	APS Referral- not required as no allegations of neglect or abuse.

ALLEGATION: Second and third shift direct care staff members who administer medications passers document medication that is prescribed to one resident as administered when they are really administering that same medication to a different resident for who the medication is not prescribed.

INVESTIGATION:

On 04/16/2024, anonymous Complainant reported that second and third shift direct care staff members who administer resident medication have been documenting medication that is prescribed for one resident but administering to a different resident. Complainant also reported direct care staff will chart a medication pass and then wait several hours before administering the medication. Complaint reported that multiple complaints have been reported to the administrative team about these practices but the complaints are disregarded due to the administration team being friends with the shift lead direct care staff member. Complainant was anonymous, so no additional information or details regarding the allegation could be gathered.

On 04/18/2024, I conducted an unannounced investigation and I reviewed written incident reports (IR) from 03/01/2024-04/17/2024 and I did not find any incident reports documenting any medication errors including medication being given to a resident for whom it is not prescribed.

On 04/18/2024, I interviewed direct care worker (DCW) and trained medication passer Kimberly Lowler and DCW Sara Duke who both reported that they do not know of any medication errors in this facility nor are they aware of any direct care staff members administering medication prescribed to one resident to a different resident. DCW Lower and DCW Duke both denied any knowledge direct care staff will chart a medication as administered but then wait several hours to actually pass the medication.

DCW Katrina Seely denied being aware of any direct care staff administering medication prescribed to one resident to a different resident. DCW Seely denied having any knowledge that direct care staff will chart a medication pass and then wait several hours to actually pass the medication.

I reviewed medication administration records (MAR)s for March 2024 through April 17, 2024 for Resident A, Resident B, Resident C, Resident D and Resident E. I found no evidence to support direct care staff documenting medication as administered for one resident and giving it to another. I found no evidence direct care staff members chart a medication pass but then wait several hours before administering the medication.

I interviewed licensee designee/administrator Nidhal Ghraib who denied that there were any medications errors. Licensee designee Ghraib denied that DCWs document medication for one resident but give it to another resident. Licensee designee Ghraib denied that DCWs chart medications as administered but pass that medication at a later time.

On 05/28/2024, I interviewed Allison Bona DCW and medication passer who denied being aware of any DCW administering medication prescribed to one resident to a different resident. DCW Bona denied having any knowledge of DCWs charting a medication pass but then waiting several hours before administering the medication.

On 06/04/2024, I interviewed DCW Jan Griggs, shift manager who denied that there were any medications errors. DCW Griggs denied that DCWs document medication being administered for one resident but give it to another resident. DCW Griggs reported that every narcotic needs to be witnessed to chart it in the electronic medication administration system (EMAR) system and on the midnight shift there is just one DCW on shift. DCW Griggs reported that when day shift comes in, they have to witness that the narcotics that were administered while they were not on shift as that is how the EMAR computer is set up. Consequently, narcotic medications that were administered timely and as prescribed may not be able to be charted as administered until hours later when a witness/second DCW is available. DCW Griggs stated this may explain why DCWs may be assuming that medications are being held or not administered as prescribed on second and third shift.

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:** **(i) The medication.** **(ii) The dosage.**

	(iii) Label instructions for use. **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.** **(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.**
ANALYSIS:	Although anonymous Complainant reported that second and third shift DCWs were documenting medication that is prescribed to one resident as administered when they are really administering that same medication to a different resident for whom the medication is not prescribed, I could find no evidence to support this allegation. These allegations were also denied by DCW Lowler, DCW Duke, DCW Seely, DCW Griggs and licensee designee/administrator Ghraib. Therefore, there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 04/18/2024, I reviewed Resident A's MAR from March 2024 which documented that the following medications were not available to be administered:

- "Fluoxetine HCL 10 mg capsule, take 3 capsules every morning for depression prescribed 08/07/2023 with and end date of 04/01/2024." This medication was "waiting on delivery" on 03/01/2024, 03/02/2024, 03/03/2024, 03/04/2024,03/05/2024,03/06/2024 and 03/07/2024 and was not administered as prescribed on those dates.
- "Olanzapine 7.5 mg tablet, take 1 tablet by mouth for psychosis prescribed on 12/27/2023" with no end dated. This medication was "waiting on delivery" 03/01/2024, 03/02/2024, 03/03/2024, 03/04/2024,03/05/2024,03/06/2024, 03/07/2024 and 03/08/2024 and was not administered as prescribed on those dates.
- "Baclofen 10 mg tablet, take ½ tablet by mouth every morning for muscle spasms prescribed 08/30/2023" with no end date. This medication was "waiting on delivery" 03/02/2024 and 03/03/2024 and not administered as prescribed on those dates.
-

I reviewed Resident A's MAR from April 1, 2024 through April 17, 2024 which documented that the following medications were not available to be administered:

- Vitamin D3 1,000-unit tablet, take 2 tablets by mouth every day prescribed on 12/7/2023 and stopped 4/16/2024. This medication was "waiting on delivery"

04/08/2024, 04/09/2024 and 04/10/2024, 04/11/2024, 4/12/2024 4/13/2024, 4/14/2024, 4/15/2024 and 4/16/2024 and not administered as prescribed on those dates. Additionally, the prescription changed to 1 pill per day on 04/16/2024 and documented as administered on 04/17/2024 and 04/18/2024 as prescribed.

I reviewed Resident B's MAR from March 2024 which documented that the following:

- "Dorzolamide HCL 2% eye drops, instill 1 drop into both eyes 3 times a day for glaucoma, prescribed 09/26/2023 with a stop date of 11/6/2023. The medication was administered three times on 03/01/2024, twice on 03/02/2024, once on 03/03/2024, twice on 03/04/2024, twice on 03/05/2024, twice on 03/06/2024, once on 03/07/2024, once on 03/08/2024, once on 03/09/2024, twice on 03/10/2024, and once on 03/14/2024."
  The following exceptions were documented: 03/02/2024 8:40pm, physically unable to take, 03/03/2024 8:18pm physically unable to take, 03/03/2024 9:55pm waiting on delivery,03/04/2024 10:21am, resident refused, 03/05/2024 10:30pm resident refused, 03/06/2024 11:36 am waiting on delivery, 03/07/2024 9:48 am resident refused, 03/07/2024 9:00pm, waiting on delivery, 03/08/2024, 10:57, waiting on delivery, 03/08/2024 7:44 pm waiting on delivery, 03/09/2024, 7:48 am waiting on delivery, 03/09/2024, 12:17 pm waiting on delivery, 03/10/2024, 2:15 pm waiting on delivery, 3/11/2024, 10:08am resident refused, 3/11/2024 12:55 pm resident refused, 3/11/2024 10:13 pm, physically unable to take, 3/12/2024 9:27 am resident refused, 3/12/2021 10:56 am waiting on delivery, 3/12/2024, 9:35pm physically unable to take, 3/13/2024 8:30 am, waiting on delivery, 03/13/2024 12:29 pm waiting on delivery and 9:26 pm waiting on delivery 03/14/2024 11:01 am resident refused. According to the MAR this medication had been discontinued and should not have been administered at all.

- "Timolol Maleate .5 % eye drops instill 1 drop in each eye 2 times a day for glaucoma prescribed on 11/17/2023 and stopped 3/14/2024." The following exceptions were documented:3/02/2024 8:40 physically unable to take, 03/03/2024 8:18pm, physically unable to take, 03/04/2024 10:21 am, resident refused, 03/07/2024 9:48am resident refused and 3/7/2024 7:44 pm, waiting on delivery, 03/08/2024 7:44 pm waiting on delivery, 03/09/2024 7:48am, waiting on delivery, 3/11/2024 10:08am resident refused and 10:12pm resident refused, 3/12/2024 9:27 am resident refused, 3/14/2024, 11:01 am resident refused." This medication was not administered as prescribed on many of the above dates because it was not available in the facility.

In the "exception" area where the resident refusal was noted on the MAR there are columns listed as "date/time, medication/treatment, reason details" and "notes." All of these were filled out except "details and notes" were blank in both Resident A and Resident B's MAR.

On 06/03/2024, DCW Lowler reported that medications are not always available to administer to the residents as prescribed. DCW Lowler reported that medications with refills are refilled automatically by the pharmacy however the DCW must get new prescriptions from the physician for narcotics. DCW Lowler reported that she has observed some MARs documented “waiting on the medication”, then the “resident refused” and then again “waiting on medication.” DCW Lowler reported that she does not believe that all DCWs trained to administer resident medication know to document “waiting on medication” and that is why they document “resident refused.” DCW Lowler reported that medications are never delivered on the weekends. DCW Lowler reported that she has no knowledge of if anyone contacts the residents health care professional if a medication error occurs or when a resident refuses prescribed medication as she reported that she has never done that.

On 06/03/2024, I went to the facility unannounced and interviewed licensee designee Ghraib who reported that when DCWs order medication refills, they are typically delivered that same evening. Licensee designee Ghraib reported that if there are no refills prescribed then the pharmacy has to wait for the physician to submit/sign the prescription to refill the medication. Licensee designee Ghraib reported that he is not sure why resident medications would be “waiting on delivery” for 3-8 days. Licensee designee Ghraib reported that when a resident refuses medication that he is in verbal contact with the residents family and physician about the resident. Licensee designee Ghraib reported that the house physician in in the building frequently and that their interaction is verbal and there is no written documentation. Licensee designee Ghraib reported that when a resident is continually refusing medications typically a medication change is made by the prescribing physician.

On 06/04/2024, I interviewed DCW Griggs who reported that medications are not always available to administer to the residents as prescribed. DCW Griggs reported that medications with refills are refilled automatically filled by the pharmacy however new prescriptions from the physician are required for narcotic refills. DCW Griggs reported that she has observed some MARs documented “waiting on the medication”, then the “resident refused” and then again “waiting on medication.” DCW Griggs reported that when medication is administered it prompts a drop-down box where you must click on the message. DCW Griggs reported that DCWs need to be careful when using the mouse and reporting this information from the drop-down box as it is very sensitive. DCW Griggs reported that medications are never delivered on the weekends and that they have had a lot of pharmacy mistakes. DCW Griggs reported that if anyone contacts the residents health care professional if a medication error occurs or when a resident refuses prescribed medication it would be licensee designee Ghraib. DCW Griggs reported that she is in contact with the hospice nurses and reports information to them when they are the facility but that she does not document this information.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	After review of Resident A and Resident B's March 2024 through April 17, 2024 MAR it was determined that several medications were "waiting on delivery" for 3-8 days. All resident medications were not available and therefore could not be administered as prescribed.
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: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	MARs for March 2024 through April 17, 2024, were reviewed for Resident A and Resident B, and although there were resident medication refusals, documentation that a resident's health care professional was contacted to report each refusal was not available for review. Therefore, there was no medical guidance documented as received by the health care professional to ensure the medical needs of the residents were met.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 04/18/2024, I reviewed Resident A, Resident C, Resident D and Resident E's MARs from March 2024 which all documented medications were refused by each resident without documentation that a medical professional had been contacted about each resident refusal of medication.

I reviewed Resident A, Resident B, Resident C and Resident D's MARs from April 2024 through 04/17/2024 which documented that the medications were refused by

each resident without documentation that a medical professional had been contacted about each resident for each refusal of medication.

On 06/03/2024, DCW Lowler reported that she has no knowledge if any DCW contacts a resident's health care professional when a resident refuses a prescribed medication as she reported that she has never done that nor has she reviewed any documentation about that.

On 06/03/2024, I went to the facility unannounced and interviewed licensee designee Ghraib who reported that when a resident refuses medication that he is in verbal contact with the residents family and physician about the resident. Licensee designee Ghraib reported that the house physician sees each resident every 4-6 weeks and that his interaction with the physician is typically verbal. There are some physician contact records documenting physician medication changes but there is not documentation available for review for every medication refusal. Licensee designee Ghraib reported that sometimes there are text messages. Licensee designee Ghraib reported that when a resident is continually refusing medications typically a medication change is made by the prescribing physician.

On 06/03/2024, licensee designee Ghraib sent the following email/documents regarding Resident C:

- Email sent from licensee designee Ghraib on 04/04/2024 titled "new prescription needed" which stated, "Please see attached and reply back to OneCareRX pharmacy regarding [Resident C's] gabapentin medication. No refills remaining needs a new prescription from a doctor."
- Communication Record from Harmony Cares Medical Group dated 4/10/2024, "Establish patient follow up. Med and vital review. Start Lasix 20 mg as directed. Start Dulcolax today Magcitrate tomorrow if needed."
- Communication Record from Harmony Cares Medical Group dated 4/24/2024," Establish patient follow up. Med and vital review. Stop Lidocaine and Midodrine. Please continue to check patients' blood pressure daily. If BP is greater than 110 systolic or greater than 70 diamoric and/or if patient has symptoms of low B.P.(dizziness) please contact the office."

I reviewed the MAR for Resident C for a second time and noted medication refusals. (Please note that this MAR had medication administration dates from 04/01/2024-04/18/2024 as that was the date of the onsite unannounced investigation.) Resident C's medication refusals were on 04/01/2024, 04/03/2024, 04/04/2024 (refused Polyethylene Glycol and Bisacodyl which were not noted in email above) 04/05/2024, 04/06/2024, 04/07/2024, 04/08/2024, 04/09/2024, 04/11/2024, 04/12/2024, 04/13/2024, 04/15/2024, 04/16/2024, 04/17/2024 and 04/18/2024. Licensee designee Ghraib did not provide documentation that the appropriate health care professional was contacted for each resident refused prescribed medication therefore there was no documented procedures to follow and no record of instructions given.

On 06/04/2024, I interviewed DCW Griggs who reported that she and other

DCWs who administer medications and reports medication refusals to licensee designee Ghraib. DCW Griggs has no knowledge of what happens from there. DCW Griggs reported that if anyone contacts a resident's health care professional when a resident refuses prescribed medication it would be licensee designee Ghraib. DCW Griggs reported that she is in contact with the hospice nurses and reports information to them when they are the facility but that she does not document this information.

On 06/04/2024, licensee designee Ghraib sent an email regarding Resident B which was a *Client Coordination Note Report* dated 06/06/2024 and completed by Madison Rowley, RN. The attached email documented that the *Client Coordination Note* was from 4/18/2024 but that date was not located anywhere on the attachment. The document stated:

"Facility staff states patient was non-compliant with her medications this AM. Patient spit them out at CG. Reminded to call careline 24/7 with questions, concerns, change in patient condition, falls or symptoms not controlled."

I reviewed the April 2024 MAR for Resident C for a second time and noted medication refusals on 04/01/2024, 04/03/2024, 04/07/2024, 04/08/2024, 04/09/2024, 04/11/2024, 04/12/2024, 04/14/2024, 04/15/2024, 04/16/2024 and 04/18/2024.

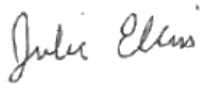
In the "exception" area where the resident refusal was noted on each of the MARs there are columns listed as "date/time, medication/treatment, reason details" and "notes." All of these were filled out except "details and notes" were blank in both Resident A and Resident B's MAR.

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: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**

ANALYSIS:	MARs for March 2024 through April 17, 2024 were reviewed for Resident A, Resident C, Resident D and Resident E's and although there were resident medication refusals, there was not documentation that a resident's health care professional was contacted to report each refusal. Therefore, there was not medical guidance provided by the health care professional to ensure the medical needs of the residents were met.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



06/10/2024

_____

Julie Elkins Date
Licensing Consultant

Approved By:

06/12/2024

_____

Dawn N. Timm Date
Area Manager