STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

June 4, 2024

Cheryl Clark
6451 Sherwood Lane
Cadillac, MI 49601

RE: License #: AM830092406
Investigation #: 2024A0870029
Pointe East

Dear Cheryl Clark:

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 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,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM830092406
Investigation #:	2024A0870029
Complaint Receipt Date:	05/28/2024
Investigation Initiation Date:	05/28/2024
Report Due Date:	07/27/2024
Licensee Name:	Cheryl Clark
Licensee Address:	6451 Sherwood Lane Cadillac, MI 49601
Licensee Telephone #:	(231) 876-0847
Name of Facility:	Pointe East
Facility Address:	6451 Sherwood Lane Cadillac, MI 49601
Facility Telephone #:	(231) 876-0847
Original Issuance Date:	07/23/2001
License Status:	REGULAR
Effective Date:	11/28/2022
Expiration Date:	11/27/2024
Capacity:	10
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Facility staff are giving the wrong medications to Resident A.	Yes

III. METHODOLOGY

05/28/2024	Special Investigation Intake 2024A0870029
05/28/2024	APS Referral This referral came from MDHHS APS.
05/28/2024	Special Investigation Initiated - Telephone Email case discussion with Michigan Department of Health and Human Services, Adult Protective Services worker Jesica Kroes.
05/30/2024	Inspection Completed On-site Interview with Licensee Cheryl Clark.
05/30/2024	Inspection Completed-BCAL Sub. Compliance
05/30/2024	Exit Conference Completed with Licensee Cheryl Clark.

ALLEGATION: Facility staff are giving the wrong medications to Resident A.

INVESTIGATION: On May 28, 2024, I spoke, via email communication, with Michigan Department of Health and Human Services, Adult Protective Services (APS) worker Jesica Kroes. She informed me that she has opened an APS investigation into this issue and has already met and interviewed Resident A. She noted that Resident A did inform her that her physician is “trying to wean her off of some of her medications.” Ms. Kroes also noted that she had spoken to staff member “Scott” who stated that “they keep changing her medications” referencing Resident A. I informed Ms. Kroes that I would be opening a licensing special investigation into this allegation.

On May 30, 2024, I conducted an unannounced on-site special investigation at the Pointe East AFC home. I met with Licensee Cheryl Clark and informed her of the above stated allegation. Ms. Clark informed me that Resident A had been hospitalized from May 10, 2024, through May 18, 2024, and returned to the hospital on May 22, 2024, for that day. Ms. Clark noted that Community Mental Health staff typically call her with any medication changes for Resident A. Ms. Clark provided

me with a copy of Resident A's May 2024 medication administration record and a copy of Resident A's hospital discharge “after visit summary” for her hospitalization of May 10, 2024, through May 18, 2024.

The “after visit summary" notes that Resident A should “start taking” Haloperidol (Haldol), should “change how you are taking” Lorazepam (Ativan), and “stop taking” Haloperidol Decanoate Im, Hydroxyzine (Vistaril), Ibuprofen (Motrin), Prazosin (Minipress), Quetiapine (Seroquel XR), and Sertraline (Zoloft).

Resident A's medication administration record shows that Resident A was provided with the discontinued, as of May 18, 2024, medications Hydroxyzine (Vistaril) on May 19-22, 2024, Ibuprofen (Motrin) on May 18 through 29, 2024, Prazosin (Minipress) on May 19 and 20, 2024, and Sertraline (Zoloft) on May 19-21, 2024.

After I pointed out to Ms. Clark that the medication administration record shows that she, or her staff, continued to provide several medications to Resident A, which were discontinued as of May 18, 2024, she acknowledged the medication error. We discussed, after my recommendation, that Ms. Clark contact the CMH nurse to discuss and clarify what medications Resident A is prescribed. She agreed to call the nurse and will include that in the corrective action plan she will develop regarding these medication errors.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	Resident A's hospital “after visit summary” lists several medications that were to be discontinued or “stop taking”, as of May 18, 2024. Resident A's medication administration records shows that Pointe East AFC staff continued to administer several medications to Resident A that are listed on the “after visit summary” as “stop taking.” The Licensee failed to follow the instructions and recommendation of Resident A's physician in regard to her medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 30, 2024, I provided Licensee Cheryl Clark with an exit conference. I explained my findings as noted above. Ms. Clark acknowledged the medication error, stated she understood my findings and indicated she would develop and submit a corrective action plan addressing the above established rule violations. She had no further information to provide and had no additional questions to ask concerning this special investigation.

IV. RECOMMENDATION

I recommend, contingent upon the submission of an acceptable corrective action plan, that the status of the license remain unchanged.

June 4, 2024

Bruce A. Messer Date
Licensing Consultant

Approved By:

June 4, 2024

Jerry Hendrick Date
Area Manager