GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 3, 2024

Jeanette Glasscoe
Loving Care & Comfort MJB LLC
414 Leland Place
Lansing, MI 48917

RE: License #: AS330403577
Investigation #: 2024A1033040
Loving Care & Comfort (MJB) LLC

Dear Ms. Glasscoe:

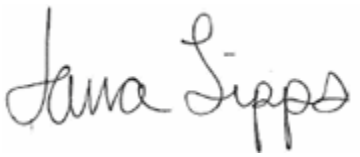
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS330403577
Investigation #:	2024A1033040
Complaint Receipt Date:	05/06/2024
Investigation Initiation Date:	05/07/2024
Report Due Date:	07/05/2024
Licensee Name:	Loving Care & Comfort MJB LLC
Licensee Address:	414 Leland Place Lansing, MI 48917
Licensee Telephone #:	(517) 391-4572
Administrator:	Jeanette Glasscoe, Designee
Licensee Designee:	Jeanette Glasscoe, Designee
Name of Facility:	Loving Care & Comfort (MJB) LLC
Facility Address:	1611 William Street Lansing, MI 48915
Facility Telephone #:	(517) 391-4572
Original Issuance Date:	06/19/2020
License **Status:**	REGULAR
Effective Date:	12/19/2022
Expiration Date:	12/18/2024
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff cannot produce a *Medication Administration Record* for Resident A for the month of April 2024.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/06/2024	Special Investigation Intake 2024A1033040
05/06/2024	Contact - Telephone call made- Attempt to interview Complainant.
05/07/2024	Special Investigation Initiated – Telephone call made. Interview with Complainant, via telephone.
05/07/2024	Contact - Telephone call made Interview with Registered Nurse, Dalila Herronen, through Clinton-Eaton-Ingham Community Mental Health (CEI-CMH) Older Adult Services, via telephone.
05/20/2024	Inspection Completed On-site Interview with direct care staff, China Roberts, and Resident B. Review of resident records initiated. Reconciliation of all resident medications completed.
05/21/2024	Contact - Telephone call made Interview with licensee designee, Jeanette Glasscoe, via telephone.
05/21/2024	Inspection Completed-BCAL Sub. Compliance
05/21/2024	Exit Conference- Conducted via telephone with licensee designee, Jeanette Glasscoe.

ALLEGATION: Direct care staff cannot produce a *Medication Administration Record* for Resident A for the month of April 2024.

INVESTIGATION:

On 5/6/24 I received an online complaint regarding the Loving Care & Comfort MJB LLC, adult foster care facility (the facility). The complaint alleged direct care staff were unable to produce a *Medication Administration Record* (MAR) for Resident A for the month of April 2024. On 5/7/24 I interviewed Complainant via telephone. Complainant reported Resident A was hospitalized on 4/23/24 and his Community Mental Health care team attempted to obtain his MAR for the month of April 2024 for his hospital records and were told by direct care staff at the facility that they did not have a MAR for the month of April 2024. The direct care staff reported that they had previously sent the MAR with Resident A for another hospitalization that occurred in April 2024 and the MAR was never returned to the facility when Resident A was discharge back to the facility. Complainant reported that registered nurse, Dalila Herronen, with Clinton-Eaton-Ingham Community Mental Health (CEI-CMH), Older Adult Services (OAS), had additional information to provide.

On 5/7/24 I interviewed Ms. Herronen via telephone. Ms. Herronen reported that Resident A has been struggling with mental health instability for the past three months. She reported Resident A has been in and out of the hospital due to these issues. Ms. Herronen reported that on 4/23/24 CEI-CMH staff were called to the facility to assist with Resident A as he was exhibiting aggressive behavior and required hospitalization. She reported Resident A's case manager, Nichole Busch, and another mental health worker (name unknown) arrived at the facility to assist the direct care staff with Resident A. Ms. Herronen reported that Ms. Busch was attempting to obtain the current MAR for the month of April 2024 for the hospital admission records for Resident A and Ms. Busch was told that the direct care staff had previously sent the MAR to the hospital with Resident A on 4/3/24 and never received it back when he was discharged back to the facility. The direct care staff reported that they had not initiated a new MAR for the month of April 2024 for Resident A and just went forward administering his medications and not documenting the dates and times of administration. Ms. Herronen reported that due to not having a MAR for the month of April 2024, they could not determine whether Resident A had been receiving his antipsychotic medication, Clozaril, as ordered. She reported that there were suspicions this medication was not being administered as the hospital staff started Resident A on this medication and he had a reaction while in the hospital where he experienced difficulty walking and had a fall after the medication was administered. Ms. Herronen reported that the Clozaril dosage Resident A was on needs to be titrated so that his body can adjust to the medication slowly. Ms. Herronen reported that the symptoms Resident A experienced after having this medication administered at the hospital indicated that his body may not have been receiving the correct dosage, or any of the medication while at the facility. Ms. Herronen reported that not having been administered the correct dosage of Clozaril could explain why Resident A experienced a psychotic episode which

required a psychiatric hospitalization for Resident A on 4/23/24. Ms. Herronen reported that a registered nurse (name unknown) at the hospital reported that she had spoken to licensee designee, Jeanette Glasscoe, who indicated that Resident A had been refusing his medications at the facility for the past four days. Ms. Herronen reported that she spoke with Ms. Glasscoe on 5/1/24 and Ms. Glasscoe reported that she had never stated to the hospital that Resident A had been refusing his medications. Ms. Herronen reported that Ms. Glasscoe stated to her that she was aware that Resident A's MAR had not been returned to the facility on 4/4/24 from his previous hospital admission. Ms. Herronen reported on 4/26/24 she had a conversation with direct care staff, Dories Harris, and asked for a copy of the March or April MARs for Resident A. Ms. Herronen reported that Ms. Harris was unable to provide copies of either MAR requested on this date. Ms. Herronen reported that she also spoke with the Executive Care Pharmacy, who provide medications to Resident A at the facility, on 4/23/24. She reported that she requested a new MAR for Resident A for the month of April 2024 and this was provided to her by the pharmacy staff.

On 5/20/24 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff, China Roberts. Ms. Roberts reported that she has worked at the facility since about December 2023. She reported that the facility currently cares for five residents. She reported that Resident A is hospitalized and has been hospitalized for multiple weeks. She reported she does not have knowledge of when Resident A is set to be discharged back to the facility. Ms. Roberts reported having no knowledge of where Resident A's April 2024 MAR was located at the time of this investigation. She reported that she is uncertain whether she administered medication to Resident A in the month of April. Ms. Roberts reported direct care staff, Mandy Griffin, was managing all resident medications and verifying resident medications match the MARs each month, but she has not been working in multiple weeks due to a motor vehicle accident. Ms. Roberts reported she is not sure who is managing this task now while Ms. Griffin is on a medical leave of absence. Ms. Roberts reported she is unsure where the MARs from previous months are kept and was able to show me MARs for the month of April for four of the five residents being cared for. Ms. Roberts was not able to locate Resident A's MAR. She was also able to show me the MARs for the month of May 2024 on this date. There was a MAR for the month of May 2024 available for Resident A. This MAR had notations indicating that Resident A had not been in the facility any of the days of this month and had not been administered medications on any of these dates due to hospitalization.

On 5/20/24 I interviewed Resident B during the on-site investigation. Resident B reported that the direct care staff administer her medications each day and she feels confident that she is receiving all of her prescribed medications. She had no concerns about the facility or direct care staff at the time of this interview.

During the on-site investigation on 5/20/24 I reviewed the following documents:

- MARs for Resident B, C, D, & E for the month of April 2024. The MAR for Resident A was not available on-site.
- MARs for Resident A, B, C, D, & E for the month of May 2024.
- I also completed a complete medication reconciliation for all five residents. I did not find any medications that were not listed on the current May 2024 MARs. I also did not find any missing medications during this inspection.

On 5/21/24 I interviewed Ms. Glasscoe, via telephone. Ms. Glasscoe reported that Ms. Griffin was a live-in caregiver at the facility up until her recent motor vehicle accident near the end of March 2024. She did not have the exact date of this accident but knew that it occurred near the end of March 2024. Ms. Glasscoe reported that Resident A experienced a behavioral disturbance at the facility on 4/23/24 and the direct care staff, Ms. Harris, could not calm Resident A. She reported that Resident A was threatening Ms. Harris and the other residents, so they decided to contact the police. The local police arrived and reported that since Resident A is his own decision maker and does not have a guardian, they could not force him to go with them to the hospital for an evaluation. Ms. Glasscoe reported that at that time she made contact with Ms. Busch to receive assistance from CEI-CMH staff about how to handle Resident A's behaviors on this date. Ms. Glasscoe reported that Ms. Busch and another CEI-CMH staff arrived at the facility and assisted the police in getting Resident A to go to the local emergency department for evaluation. Ms. Glasscoe reported that Resident A is still hospitalized related to this incident and is expected to be discharged back to the facility on 5/22/24. Ms. Glasscoe reported that the CEI-CMH staff were asking for Resident A's MAR for the month of April 2024, on 4/23/24, to take to the hospital for review. Ms. Glasscoe reported that Ms. Harris was unable to locate the MAR and they still do not have the MAR in their possession. Ms. Glasscoe reported that the April 2024 MAR for Resident A has not been found to this date and there is not documentation of administered medications for Resident A for the month of April 2024.

APPLICABLE RULE	
R 400.14312	**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.
ANALYSIS:	Based upon interviews with the Complainant, Ms. Herronen, Ms. Roberts, & Ms. Glasscoe, as well as review of the resident MARs during the on-site investigation on 5/20/24, it can be determined that direct care staff did not have a MAR for Resident A for the month of April 2024 and have no evidence that the medications administered to Resident A during the month of April 2024, were actually administered due to a lack of documentation available for review. Therefore, a violation has been established at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on 5/20/24 I reviewed the resident records for Residents A, B, C, D, & E. I observed that the *Health Care Appraisals* for Resident A, B, C, & D were all dated 10/3/22.

On 5/21/24 I interviewed Ms. Glasscoe. I spoke with Ms. Glasscoe about the Health Care Appraisal forms reviewed for Residents A, B, C, & D being dated 10/3/22. Ms. Glasscoe reported that these are the current *Health Care Appraisals* on file for these residents. She reported that they have the same medical provider who makes monthly visits to the home. She reported she has not had the provider complete updated *Health Care Appraisals* for these residents but will do so going forward.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.

ANALYSIS:	Based on the findings of the on-site investigation and the interview with Ms. Glasscoe, it can be determined that Ms. Glasscoe failed to have the medical provider for Residents A, B, C, & D, update their *Health Care Appraisal* forms annually as required. Therefore, a violation has been established at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

5/22/24

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Jana Lipps Date
Licensing Consultant

Approved By:

06/03/2024

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Dawn N. Timm Date
Area Manager