GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 15, 2024

Michael Eby
The Cortland Memory Care & Rediscovery
3736 Vista Springs Ave.
Grand Rapids, MI 49525

RE: License #: AH410400149
Investigation #: 2024A1010073
The Cortland Memory Care & Rediscovery

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

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
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 #:	AH410400149
Investigation #:	2024A1010073
Complaint Receipt Date:	08/05/2024
Investigation Initiation Date:	08/06/2024
Report Due Date:	10/04/2024
Licensee Name:	AHR Northview Grand Rapids MI TRS Sub, LLC
Licensee Address:	18191 Von Karman Ave. Irvine, CA 92612
Licensee Telephone #:	(616) 364-4690
Authorized Representative/ Administrator:	Mike Eby
Name of Facility:	The Cortland Memory Care & Rediscovery
Facility Address:	3736 Vista Springs Ave. Grand Rapids, MI 49525
Facility Telephone #:	(616) 364-4690
Original Issuance Date:	03/04/2020
License Status:	REGULAR
Effective Date:	09/04/2023
Expiration Date:	09/03/2024
Capacity:	56
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive approximately ten doses of his prescribed Metformin medication to treat his diabetes.	No
Resident A is diabetic, and a diabetic diet is not being implemented by staff.	No
Additional Finding	Yes

III. METHODOLOGY

08/05/2024	Special Investigation Intake 2024A1010073
08/06/2024	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
08/06/2024	APS Referral APS referral emailed to Centralized Intake
08/15/2024	Inspection Completed On-site
08/15/2024	Contact - Document Received Received resident MARs and service plan
10/15/2024	Exit Conference

ALLEGATION:

Resident A did not receive approximately ten doses of his prescribed Metformin medication to treat his diabetes.

INVESTIGATION:

On 8/5/24, The Bureau received the allegations from the online complaint system. The complaint read, “[Resident A] was not provided approximately ten dosage of his Metformin medication for his diabetes since the beginning of June. [Resident A] was not provided these necessary medications on the following date: June 2, 2024, 4 p.m. dosage, June 3, 2024, 8 a.m. and 4 p.m. dosage, June 4, 2024, 8 a.m. and 4 p.m. dosage, June 11, 2024 4 p.m. dosage, July 21, 2024, 4 p.m. dosage, July 22, 2024 8 a.m. and 4 p.m. dosage, and July 23, 2024 8 a.m. dosage.”

The complaint also read Resident A's responsible person confirmed with the pharmacy that "a prescription/30 days supply of Metformin was sent to Vista Springs on the following dates: June 3, 2024, June 28, 2024, and July 23,2024. When speaking with [Staff Person 1 (SP1)] on August 1, 2024, [SP1] indicated that the facility could not find [Resident A's] prescriptions for Metformin. [SP1] explained she personally reached out to Synchrony Pharmacy and confirmed that the medications were sent and received at the facility. [SP1] stated that she has searched the facility, looked in the medication cart and still has not been able to find 27 pills of the Metformin. [SP1] informed the family that the current medication process at Vista Springs is not being followed. [SP1] explained that the facilities [sic] process is when Synchrony Pharmacy delivers medications, they are supposed to drop off the medications to the Vista Springs and the Memory Care & Rediscovery building, but indicated they are only dropping them off at Vista Springs. [SP1] stated the med-tech is supposed to sign when receiving the delivery and then secures the medications in the medication cart, but once again indicated this is not happening. Due to this neglect, [Resident A] has missed 10 doses of his necessary medications."

On 8/6/24, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 8/15/24, I interviewed SP1 by telephone while I was at the facility. SP1 reported the facility recently switched to Synchrony Pharmacy. SP1 reported there were several incidents in which Synchrony Pharmacy delivered resident medications to the incorrect building on the facility's premises. SP1 explained there are also Adult Foster Care (AFC) facilities located on the facility's premises where some resident medications were delivered. SP1 said this happened to some of Resident A's medications.

SP1 explained SP2 discovered Resident A had Metformin that was missing during one of her medication cart audits. SP1 was unable to recall how many Metformin medication "cards" were missing for Resident A. SP1 said the facility paid the pharmacy for the missing Metformin medication to be re-delivered to the facility. SP1 reported the incident in which Synchrony Pharmacy delivered Resident A's Metformin to the incorrect building on the facility's premises occurred in June and July 2024.

SP1 stated when Synchrony Pharmacy delivers resident medications, they are supposed to be separated in two different totes, one for the facility, and a separate one for the AFC facility that is currently occupied. SP1 reported in June and July 2024, Synchrony Pharmacy was not separating the resident medications by facility, and they were all combined in one tote. SP1 explained Synchrony Pharmacy staff are also supposed to obtain a signature from the medication technician (med tech) on at the time of the delivery. SP1 stated Synchrony Pharmacy staff were not following this process and left resident medications without obtaining a signature from the med tech. SP1 said as a result, it was difficult to locate Resident A's Metformin medication.

SP1 reported because of Resident A's missed Metformin doses in June and July 2024 due to Synchrony Pharmacy not following the proper delivery procedure, she has had discussions with Synchrony Pharmacy staff to resolve the issue. SP1 stated since Synchrony Pharmacy staff have been following the proper delivery procedure, including separating the facility's resident medications from AFC resident medications and having the med tech on shift sign for the medications, there have not been any issues regarding Resident A's medications.

SP1 said Resident A did not suffer any adverse side effects from missing some doses of his prescribed Metformin in June and July 2024. SP1 reported Resident A did not need or receive any medical treatment as a result of missing some doses of his prescribed Metformin.

On 8/15/24, I interviewed SP2 at the facility. SP2's statements were consistent with SP1. SP2 reported she completes weekly audits of the med carts in the facility. SP2 stated her weekly audits are implemented as a way of catching whether any resident medications are not present or not being administered as prescribed.

SP2 provided me with a copy of Resident A's June 2024 medication administration record (MAR) for my review. The June 2024 MAR read, "METFORMIN TAB 1000MG TAKE 1 TABLET BY MOUTH TWICE DAILY." The MAR read Resident A was not administered this medication on 6/2/24, 6/3/24, 6/4/24, and 6/11/24. SP2 provided me with a copy of Resident A's July 2024 MAR for my review. The July MAR read Resident A did not get his prescribed Metformin on 7/21/24, 7/22/24, and 7/23/24.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.

ANALYSIS:	The interviews with SP1 and SP2, along with review of Resident A's June and July 2024 MARs, revealed Resident A missed some doses of his prescribed Metformin. SP1 and SP2 reported the facility had switched its pharmacy provider to Synchrony Pharmacy. SP1 and SP2 stated as a result, Synchrony pharmacy did not follow the facility's resident medication delivery procedure. SP1 reported she had discussions with Synchrony Pharmacy staff regarding the facility's resident medication delivery procedure and they have since been compliant. SP1 stated there have been no issues with Resident A's prescribed medications since. The corrective actions already taken appear to have addressed the situation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is diabetic, and a diabetic diet is not being implemented by staff.

INVESTIGATION:

On 8/5/24, the complaint read, "[Resident A] is diagnosed with Type II Diabetes. [Resident A] has had an extremely high increase in his glucose levels. The facility is not adhering to a specialty diet. The facility continues to serve [Resident A] cookies, cakes, pies, which have increased his blood sugar levels in a range between 300-400. With [Resident A] not being provided his necessary diabetes medication and the facility not adhering to a specialty diet they are putting him at risk of DKA and potential complications that can arise with uncontrolled hyperglycemia. It has been discussed with the facility several times that [Resident A] cannot have some of the food items they are serving him (canned fruit in surgy [sic] syrup, sherbet, ice cream, cookies, pie, ect.)."

On 8/15/24, I interviewed culinary director Kerry Emelander at the facility. Ms. Emelander reported Resident A does not have a physician order for a special or therapeutic diet. Ms. Emelander stated because Resident A is diagnosed with Type II Diabetes, his dessert options include various fruits. Ms. Emelander explained Resident A and the other residents in the facility who are diagnosed with Type II Diabetes get low sugar dessert alternatives.

Ms. Emelander stated there is a white board posted in the kitchen where the residents diagnosed with Diabetes are listed. I observed this white board in the kitchen. I observed Resident A's name was listed under the "Diabetic" column. Resident A was designated as being served only water and not juice during meals. I observed the resident dining room seating chart where it was documented Resident

A is to be served water and “sugar free” desserts, such as sugar free Jello and applesauce.

Ms. Emelander reported there have been incidents in the past in which staff forgot to substitute Resident A’s dessert at mealtimes. Ms. Emelander reported when she is notified of these incidents, she provides re-education to staff. Ms. Emelander stated dessert items and various sugary snacks, such as cookies, are not left out in the dining room.

Ms. Emelander provided me with a copy of this week’s menu for my review. I observed the menu outlined various food items for breakfast, lunch, and dinner. There was a statement at the bottom of the weekly menu that read, “The meal items shown are those served on a Regular Diet. If you physician has ordered for you a Therapeutic or Texture Altered Diet, you may be served a different menu item, a different portion of the menu item or the item may be eliminated entirely in order to comply with your current diet order.”

On 8/15/24, I observed there were no dessert items or sugary snacks out or within each of residents in the facility’s dining room or in common areas.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(4) Medical nutrition therapy, as prescribed by a licensed health care professional and which may include therapeutic diets or special diets, supplemental nourishments or fluids to meet the resident's nutritional and hydration needs, shall be provided in accordance with the resident's service plan unless waived in writing by a resident or a resident's authorized representative.
ANALYSIS:	The interview with Ms. Emelander revealed Resident A is not on a physician ordered special or therapeutic diet. I observed a posting in the facility’s kitchen that identified the residents diagnosed with Diabetes, including Resident A, who receive low sugar and sugar free dessert alternatives, such as sugar free Jello and sugar free applesauce. This information is also provided in the resident seating chart document for kitchen staff. Resident A is also identified as a resident who can only be served water at mealtimes. There is insufficient evidence to suggest the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 8/15/24, I observed there was no explanation documented within Resident A's June and July 2024 MAR regarding why his prescribed medication was not administered on 6/2/24, 6/3/24, 6/4/24, 6/11/24, 7/21/24, 7/22/24, and 7/23/24.

APPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(iv) The time when the prescribed medication is to be administered and when the medication was administered.**
ANALYSIS:	Review of Resident A's June and July 2024 MARs revealed there was no documentation or explanation given as to why his prescribed Metformin was not administered on 6/2/24, 6/3/24, 6/4/24, 6/11/24, 7/21/24, 7/22/24, and 7/23/24. As a result, the facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/25/2024

Lauren Wohlfert Date
Licensing Staff

Approved By:

10/15/2024

_____

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