GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 18, 2024

Meridee Watt
AH Holland Subtenant LLC
Ste 1600
1 Towne Sq
Southfield, MI 48076

RE: License #: AL700397730
Investigation #: 2024A0583057
AHSL Holland Beachside

Dear Ms. Watt:

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 (616) 356-0183.

Sincerely,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397730
Investigation #:	2024A0583057
Complaint Receipt Date:	09/25/2024
Investigation Initiation Date:	09/26/2024
Report Due Date:	10/25/2024
Licensee Name:	AH Holland Subtenant LLC
Licensee Address:	Ste 1600 1 Towne Sq Southfield, MI 48076
Licensee Telephone #:	(616) 283-9221
Administrator:	Christopher Trevathan
Licensee Designee:	Christopher Trevathan
Name of Facility:	AHSL Holland Beachside
Facility Address:	11821 James Street Holland, MI 49423
Facility Telephone #:	(616) 392-1007
Original Issuance Date:	03/21/2019
License Status:	REGULAR
Effective Date:	09/21/2023
Expiration Date:	09/20/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Facility staff did not administer Resident A's medications as prescribed.	Yes
Additional Findings.	Yes

III. METHODOLOGY

09/25/2024	Special Investigation Intake 2024A0583057
09/26/2024	Special Investigation Initiated - Telephone Faith Hospice RN Katie Brown
09/26/2024	Inspection Completed On-site Licensee Designee Meridee Watt
10/18/2024	Exit Conference Licensee Designee Meridee Watt

ALLEGATION: Facility staff did not administer Resident A's medications as prescribed.

INVESTIGATION: On 09/24/2024 complaint allegations were received from the BCAL online reporting system and assigned for my investigation on 09/27/2024. The allegations stated the following:

'Over the weekend multiple medication changes were made by hospice providers and written out for facility caregivers. Per facility caregivers Kay, Sara, Shay and others there was no nurse available to be able to make the medication changes in the facilities electronic medical record, leaving staff unable/unwilling to administer medications as ordered by a provider. This occurred throughout the weekend and into Monday.

Facility caregivers reported texting pictures of the medication orders from their personal phones to the assistant wellness director on the weekend to review orders for processing but again reporting the orders were not processed. These included discontinuation of her non-comfort medications in addition to morphine, haloperidol, and lorazepam for symptom management.'

On 09/26/2024 I interviewed Faith Hospice Nurse, Katie Brown, via telephone. Ms. Brown explained that Resident A resided at the facility until her death on 09/24/2024 and was actively dying over the weekend of 09/20/2024 until 09/23/2024. Ms. Brown stated that she was assigned as the "response team RN" for Resident A, from

09/21/2024 until 09/23/2024. Ms. Brown stated that from 09/21/2024 until 09/24/2024, Resident A presented as agitated and restless which necessitated modifications of Resident A's comfort care medications such as Lorazepam, Morphine, and Haloperidol. Ms. Brown stated that from 09/21/2024 until 09/22/2024, Ms. Brown visited the facility "multiple times" and provided facility staff with medical documentation to increase Resident A's comfort care medications and discontinue Resident A's regularly scheduled medications; however, facility staff did not follow the medication order changes. Ms. Brown stated that facility staff were provided with written documentation of dosage changes however facility staff stated that they did not have "anyone to update the orders" into the Electronic Medication Administration Record at the facility. Ms. Brown stated that she could not recall each medication dosage change as there were "many" adjustments that were made over that period.

On 09/26/2024 I completed an onsite investigation at the facility and privately interviewed licensee designee Meridee Watt. Ms. Watt stated that she was new to her position and did not have direct knowledge of this allegation. Ms. Watt stated that Resident A was admitted to the facility on 09/06/2024 and passed away at the facility with hospice services on 09/24/2024. Ms. Watt stated that Assistant Wellness Director Shay Duflo is assigned tasks related to medication records and administration and was acting as the facility's Wellness Director. Ms. Watt stated that she does not know how long it takes for medication dosage changes to be implemented or the process required to do so.

On 09/27/2024 I received and reviewed an email from licensee designee Meridee Watt. The email contained Resident A's Medication Administration Record dated 09/2024 and several Faith Hospice Supplementary Orders which were handwritten by Faith Hospice Registered Nurses.

I observed a handwritten Supplementary Order dated 09/21/2024 that lacked a time stamp. The document discontinued Resident A's "Benzonate, Colace, Benadryl, Protonix, Torsemide, Zoloft, Trazadone, Tylenol", increased Resident A's "25 MG patch" to 50 MG, and ordered Resident A's Morphine Sulfate 10 MG be administered "every six hours scheduled and every hour as needed".

I observed a handwritten Supplementary Order dated 09/21/2024 time 0022 (12:22 AM) ordering Resident A's "Lorazepam 1 MG give 1 tablet every 4 hours scheduled".

I observed a handwritten Supplementary Order dated 09/21/2024 time 1600 (4PM) ordering Resident A's Haloperidol 2 MG/ML give 2 ML be administered every six hours scheduled, Lorazepam 1 MG tablet be administered every six hours scheduled, Morphine 20MG/ML give .5 ML be administered every six hours scheduled, Haloperidol 2MG/ML give .5 be administered PRN, Lorazepam 1 MG give 1 tablet be administered PRN, and Morphine 20MG/ML be administered as needed. The document ordered that scheduled medications must administered at 6:00 AM, 12:00 PM, 6:00 PM, and 12:00 AM.

I observed a handwritten Supplementary Order dated 09/22/2024 3:15 PM which ordered that Resident A's Haloperidol 2 MG/ML 4 MG be administered every four hours, Lorazepam 1 MG tablet be administered every four hours, and Morphine 20MG/ML give .5 ML be administered every four hours. The document ordered that the scheduled medications must be administered at midnight, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. I observed this document discontinued Resident A's "scheduled Morphine, Lorazepam, Haldol orders" and maintained "current as needed orders".

I observed that Resident A's Medication Administration Record does not reflect an order requiring Resident A's Lorazepam 1 MG must be administered every four hours scheduled at midnight, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. I observed that Resident A's Medication Administration Record indicates that on 09/22/2024 Resident A received Lorazepam 1 MG tablet at 8:00 AM, 5:00 PM, 9:50 PM, and 11:58 AM.

I observed that Resident A's Medication Administration does not reflect an order requiring that Resident A's Morphine 20MG/ML .5 ML must be dispensed every four hours scheduled and administered at midnight, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. I observed that Resident A's Medication Administration Record indicates that on 09/22/2024 Resident A received this medication at 9:50 PM and 11:58 AM.

I observed that Resident A's Medication Administration Record does not reflect an order requiring that Resident A's Haloperidol 2 MG/ML dispense 4 MG must be administered every four hours scheduled at midnight, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. I observed that Resident A's Medication Administration Record indicates that on 09/22/2024 Resident A received 2MG/ML oral at 10:02 PM.

On 10/03/2024 I interviewed Amanda Oliver, Faith Hospice Clinical Director, via telephone. Ms. Oliver stated that Faith Hospice staff provided comfort care to Resident A prior to her passing. Ms. Oliver stated that Faith Hospice staff provided a response team of nurses and a social worker to support Resident A and facility staff with her care. Ms. Oliver stated that according to their medical documentation, facility staff did not administer Resident A's medication according to the changes as prescribed prior to her death. Ms. Oliver stated that facility staff were educated and provided written documentation for multiple dosage changes of Resident A's comfort care medications however, Faith Hospice staff documented that facility staff did not execute these changes in a timely manner. Ms. Oliver stated that Faith Hospice staff delivered additional comfort care medications to the facility to have enough of the medications on hand for immediate dosage increases.

On 10/03/2024 I received an email from Amanda Olliver, Faith Hospice Clinical Director, which contained Resident A's medical documentation. I observed the following "Patient Care Orders" from this documentation:

Patient Care Order 09/21/202 1:18 AM: Katie Brown RN ordered administration of Lorazepam 1 MG oral tablet every 4 hours for anxiety and discontinuation of Lorazepam 1 MG two times daily.

Patient Care Order 09/21/2024 11:50 AM: Kimberly Bouchard RN ordered administration of Fentanyl 50 MG transdermal film every 72 hours, Morphine .25 milliliters oral concentrate every six hours, Morphine 10 milligrams every six hours for pain, and discontinue Diphenhydramine 25 MG two times daily, discontinue Benzonate 200 MG, discontinue Colace 100 MG, discontinue Diphenhydramine 25 MG, discontinue Pantoprozole 40 MG, discontinue Prochlorperzine 10 MG, discontinue Propranolol 10 MG, discontinue Torsemide 20 Mg, and discontinue Zoloft 50 MG,.

Patient Care Order 09/21/2024 5:01 PM: Katie Brown RN ordered administration of .25 milliliters Morphine every six hours, discontinue Imodium 2 MG, discontinue Trazadone 100 MG, Trazadone 50 MG, and discontinue Tylenol 500 MG

Patient Care Order 09/21/2024 5:08 PM: Katie Brown RN ordered administration of 2 milliliters Haloperidol oral concentrate every six hours, 1 MG oral tablet Lorazepam every six hours, and discontinue 1 MG Lorazepam tablet every four hours.

Patient Care Order 09/22/2024 3:37 PM: Katie Brown RN ordered administration of 2 milliliters Haloperidol every four hours, 1 MG tablet Lorazepam every four hours, 10 milligrams Morphine oral concentrate every four hours, discontinue 2 MG oral concentrate Haloperidol every six hours, discontinue Lorazepam 1 MG tablet every six hours, and discontinue Morphine 10 milligrams every six hours.

On 10/04/2024 I interviewed staff Stephanie Kirks via telephone. Ms. Kirks stated that she worked at the facility on 09/21/2024 and 09/22/2024 and administered Resident A's medications. Ms. Kirks stated that she no longer works for the facility. Ms. Kirks stated that on 09/21/2024 and 09/22/2024 Faith Hospice staff "kept changing (Resident A's) medications" which included discontinuing her regularly scheduled medications and increasing Resident A's "Morphine, Lorazepam, and Haloperidol". Ms. Kirks stated that Faith Hospice staff were "constantly changing" Resident A's medication dosages and writing the orders in "military time". Ms. Kirks stated that due to Faith Hospice's staff changing Resident A's dosages, the facility's pharmacy could not change the medications in the electronic Medication Administration Record. Ms. Kirks stated that she "kept calling" the facility's Wellness Director Shay Duflo on 09/21/2024 and 09/22/2024 and informed Ms. Duflo that Resident A's medication dosage changes were not being updated into the Electronic Medication Administration Record. Ms. Kirks stated that Ms. Duflo encouraged Ms. Kirks to pass Resident A's medications based on the paper order left at the facility by Faith Hospice Staff. Ms. Kirks stated that she passed Resident A's medications based on the written orders left at the facility and not based upon the Electronic Medication Administration Record. Ms. Kirks stated that she could not recall the times or names of each medication she passed on 09/21/2024 and 09/22/2024, and

there was no place to document the medication passes because Resident A's electronic Medication Administration Record was not updated.

On 10/07/2024 I interviewed assistant wellness director Shay Duflo via telephone. Ms. Duflo stated that she was on call from 09/20/2024 until 09/23/2024. Ms. Duflo stated that she received a telephone call from staff Stephanie Kirks who reported that numerous medications changes were ordered by Faith Hospice Staff for Resident A. Ms. Duflo stated that Ms. Kirks and Faith Hospice staff attempted to fax medication order changes to their pharmacy the weekend of 09/20/2024 however the pharmacy's fax was malfunctioning. Ms. Duflo stated that because the facility's pharmacy did not receive the medication order changes, numerous medication changes were not updated into Resident A's Electronic Medication Administration Record. Ms. Duflo stated that she informed Ms. Kirks to administer Resident A's medications based on the written orders that were left by Faith Hospice staff at the facility. Ms. Duflo stated that on Monday 09/23/2024 she worked at the facility and updated the Electronic Medication Administration Record to reflect the most up-to-date medication changes. Ms. Duflo stated that she reviewed the written orders drafted by Faith Hospice Staff and agreed that facility staff did not follow the orders as written from 09/20/2024 until 09/23/2024.

On 10/07/2024 I interviewed staff Carina Jackson. Ms. Jackson stated that Resident A had been prescribed 150 MG of Trazadone administered once daily at bedtime in one 100 MG tablet and one 50 MG tablet. Ms. Jackson stated that on 09/23/2024 at 8:00 PM Ms. Jackson administered Resident A with one 50 MG of Trazadone. Ms. Jackson stated that she could not recall the rational for administering one 50 MG tablet. Ms. Jackson stated that she documented in Resident A's Medication Administration Record that on 09/23/2024 at 8:00 PM, Ms. Jackson administered the total 150 MG trazadone dose, despite only administering one tablet of 50 MG. Ms. Jackson stated that the previous "staff did not" inform Ms. Jackson that Resident A's Trazadone had been discontinued effective 09/21/2024.

On 10/08/2024 I interviewed staff Julie Marks via telephone. Ms. Marks confirmed that she had worked at the facility on the afternoon of 09/23/2024 and administered Resident A's medications. Ms. Marks stated that on 09/23/2024 at 5:00 PM she administered Diphenhydramine 25 MG and MAPAP (Tylenol) 1000 MG because the Electronic Medication Administration Record prompted her to do so, and she was unaware that the medicines had been discontinued by Faith Hospice Staff.

On 10/18/2024 I completed an Exit Conference with licensee designee Meridee Watt via telephone. Ms. Watt stated that she had "nothing to add" to the report findings and would send the report to the facility's "compliance team". Ms. Watt stated that she would "accept the findings" and "did not feel comfortable making any statements at this time". Ms. Watt stated that she would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	A handwritten Supplementary Order dated 09/22/2024 3:15 PM ordered that Resident A's Haloperidol 2 MG/ML 4 MG, Lorazepam 1 MG tablet, and Morphine 20 MG/ML give .5 ML each must be administered every four hours. The document ordered that the scheduled medications must be administered at midnight, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. Resident A's Medication Administration Record does not reflect an order requiring Resident A's Lorazepam 1 MG must be administered every four hours scheduled at midnight, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. Resident A's Medication Administration Record indicates that on 09/22/2024 Resident A received Lorazepam 1 MG tablet at 8:00 AM, 5:00 PM, 9:50 PM, and 11:58 AM. Resident A's Medication Administration does not reflect an order requiring that Resident A's Morphine 20MG/ML .5 ML must be dispensed every four hours scheduled and administered at midnight, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. Resident A's Medication Administration Record indicates that on 09/22/2024 Resident A received said medication at 9:50 PM and 11:58 AM. Staff Julie Marks stated that on 09/23/2024 at 5:00 PM she administered Diphenhydramine (Benadryl) 25 MG and MAPAP (Tylenol) 1000. Assistant Wellness Director Shay Duflo stated that she reviewed the written orders drafted by Faith Hospice Staff and agreed that facility staff did not follow the orders as written from 09/20/2024 until 09/23/2024

	A preponderance of evidence was established to substantiate a violation of the applicable rule. On 09/22/2024 at 3:15 PM, Resident A's Haloperidol 2 MG/ML 4 MG, Lorazepam 1 MG, and Morphine 20 MG/ML give .5 ML were ordered to be administered every four hours at midnight, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. Resident A's Medication Administration Record indicates that on 09/22/2024 Resident A did not receive her scheduled doses of Haloperidol, Lorazepam, and Morphine at 4:00 PM and 8:00 PM. On 09/23/2024, staff Julie Marks administered Diphenhydramine (Benadryl) 25 MG and MAPAP (Tylenol) 1000 MG although said medications had been discontinued on 09/21/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: Facility staff failed to accurately document the administration of Resident A's medications.

INVESTIGATION: On 09/27/2024 I received and reviewed an email from licensee designee Meridee Watt. The email contained Resident A's Medication Administration Record dated 09/2024. Resident A's Medication Administration indicated that staff Shay Duflo administered Resident A's Diphenhydramine 25 MG on 09/23/2024 at 8:00 AM, MAPAP (Acetaminophen) 500 MG at 8:00 AM, Pantoprazole 40 MG at 8:00 AM, Preservision Soft gel at 8:00 AM, Sertraline 50 MG at 8:00 AM, Lorazepam 1 MG, and Torsemide 1 MG at 8:00 AM.

On 10/04/2024 I interviewed assistant wellness director Shay Duflo via telephone. Ms. Duflo stated that on 09/23/2024 she documented in Resident A's Medication Administration Record that she administered one tablet of Diphenhydramine 25 MG, two tablets of MAPAP 500 MG, one tablet of 1 MG Lorazepam, one tablet of Pantoprazole 40 MG (Protonix), one capsule of Preservation, one tablet of 50 MG Sertraline, and three tablets of 20 MG Torsemide, when in fact she did not administer those medications. Ms. Duflo stated that staff Stephanie Kirks worked at the facility on 09/23/2024 at 8:00 AM and Ms. Kirks administered the medications but could not access Resident A's Electronic Medication Administration Record to document the administration. Ms. Duflo stated that she documented in Resident A's Electronic Medication Administration Record that she administered the medications when she did not. Ms. Duflo stated that she placed a note in Resident A's Electronic Medication Administration Record which stated "medication given per med tech" to document that Ms. Duflo did not in fact, administer the medications.

On 10/07/2024 I interviewed staff Stephanie Kirks via telephone. Ms. Kirks stated that she worked at the facility the morning of 09/23/2024. Ms. Kirks stated that she "popped" Resident A's routine morning medications, which included one tablet of Diphenhydramine 25 MG, two tablets of MAPAP (Tylenol) 500 MG, one tablet of

Pantoprazole 40 MG (Protonix), one capsule of Preservation, one tablet of 50 MG Sertraline, one tablet of 1 MG Lorazepam, and three tablets of 20 MG Torsemide, and placed them into a cup but never administered the medications. Ms. Kirks stated that Resident A's "daughter" informed Ms. Kirks that Resident A's routine medications had been discontinued by Faith Hospice staff and therefore Ms. Kirks disposed of the medications before administrating any. Ms. Kirks stated that on the morning of 09/23/2024 she had not been informed by facility staff or observed any documentation from Faith Hospice staff discontinuing the medications before "popping" the medications out of their packaging. Ms. Kirks stated that she telephoned Faith Hospice staff and verified that the medications had been discontinued. Ms. Kirks stated that after her shift ended in the afternoon on 09/23/2024, she telephoned Assistant Wellness Director Shay Duflo and informed Ms. Duflo that the medications had been discontinued and were never administered. Ms. Kirks informed Ms. Duflo that Resident A's Electronic Medication Record required updating to reflect the most recent dosage changes including the discontinuation of Resident A's routinely scheduled medications.

On 10/18/2024 I completed an Exit Conference with licensee designee Meridee Watt via telephone. Ms. Watt stated that she had "nothing to add" to the report findings and would send the report to the facility's "compliance team". Ms. Watt stated that she would "accept the findings" and "did not feel comfortable making any statements at this time". Ms. Watt stated that she would submit an acceptable Corrective Action Plan.

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.**
ANALYSIS:	Resident A's Medication Administration indicated that staff Shay Duflo administered Resident A's Diphenhydramine 25 MG on 09/23/2024 at 8:00 AM, MAPAP (Tylenol) 500 MG at 8:00 AM, Pantoprazole 40 MG at 8:00 AM, Preservision Soft gel at 8:00

	AM, Sertraline 50 MG at 8:00 AM, Lorazepam 1 MG at 8:00 AM, and Torsemide 20 MG at 8:00 AM. Assistant wellness director Shay Duflo stated that she documented in Resident A's Medication Administration Record that she administered one tablet of Diphenhydramine 25 MG, two tablets of MAPAP 500 MG (Tylenol), one tablet of Pantoprazole 40 MG (Protonix), one capsule of Preservation, one tablet of 50 MG Sertraline, 1 tablet of 1 MG Lorazepam, and three tablets of 20 MG Torsemide, when in fact she did not administer those medications. A preponderance of evidence was established to substantiate a violation of the applicable rule. Assistant wellness director Shay Duflo documented that on 09/23/2024 at 8:00 AM, she administered Resident A's Diphenhydramine 25 MG, MAPAP (Tylenol) 500 MG, Pantoprazole 40 MG, Lorazepam 1 MG, Preservision Soft gel, Sertraline 50 MG, and Torsemide 20 MG. Ms. Duflo stated that she did not administer said medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

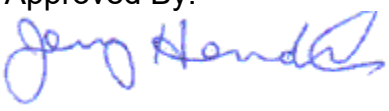
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend that the license remain unchanged.

10/18/2024

Toya Zylstra — Date
Licensing Consultant

Approved By:



10/18/2024

Jerry Hendrick — Date
Area Manager