GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 7, 2024

Appolonia Okonkwo
Lakeside Manor Inc
8790 Arlington
White Lake, MI 48386

RE: License #: AL630086778
Investigation #: 2025A0611005
Lakeside Manor Inc

Dear Mrs. Okonkwo:

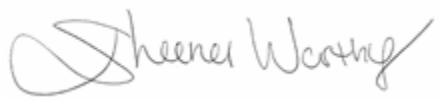
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630086778
Investigation #:	2025A0611005
Complaint Receipt Date:	10/21/2024
Investigation Initiation Date:	10/22/2024
Report Due Date:	12/20/2024
Licensee Name:	Lakeside Manor Inc
Licensee Address:	8790 Arlington White Lake, MI 48386
Licensee Telephone #:	(248) 666-9010
Administrator:	Appolonia Okonkwo
Licensee Designee:	Appolonia Okonkwo
Name of Facility:	Lakeside Manor Inc
Facility Address:	8790 Arlington White Lake, MI 48386
Facility Telephone #:	(248) 666-9010
Original Issuance Date:	11/13/2000
License Status:	REGULAR
Effective Date:	07/07/2023
Expiration Date:	07/06/2025
Capacity:	20
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident R has missed multiple appointments with the VA.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/21/2024	Special Investigation Intake 2025A0611005
10/21/2024	APS Referral The assigned Adult Protective Services (APS) worker is Lisa Black.
10/22/2024	Special Investigation Initiated - Telephone I received a telephone call from the Adult Protective Services worker Lisa Black. Ms. Black stated she has completed an onsite and she is in the process of completing paperwork in order to receive information from the VA office.
10/29/2024	Inspection Completed On-site I completed an unannounced onsite. I interviewed Resident R, staff member Noelle Heller, and Resident A. I received copies of Resident R MAR and his record of physician contacts.
10/29/2024	Contact - Telephone call made I made a telephone call to the home manager Nancy Huntington. The allegations were discussed.
10/30/2024	Contact - Telephone call made I made a telephone call to the Adult Protective Services worker Lisa Black. An update was provided.
10/30/2024	Contact - Telephone call made I made a telephone call to the reporting source. I left a voice message requesting a call back.
10/30/2024	Contact - Telephone call made I made a telephone call to Resident R's guardian. The allegations were discussed.

10/30/2024	Contact - Telephone call made I attempted to contact staff member Jana Charbonneau however; there was no answer nor was there an option to leave a message.
11/04/2024	Contact - Document Received I received documentation regarding Resident R's appointments at the VA from the Adult Protective Services worker, Lisa Black. Ms. Black stated she will be substantiated.
11/06/2024	Exit Conference I completed an exit conference with the licensee designee Appolonia Okonkwo via telephone.

ALLEGATION:

Resident R has missed multiple appointments with the VA.

INVESTIGATION:

On 10/21/24, a complaint was received and assigned for investigation alleging that Resident R has schizoaffective disorder and is unable to make healthy decisions for himself. Resident R has missed multiple appointments with the VA in Ann Arbor that was scheduled by the AFC home. They are scheduling appointments where the house manager is off of work which causes the resident to not have access to video appointments. The guardian stated he doesn't attend appointments with Resident R because that is the AFC group home job.

On 10/29/24, I completed an unannounced onsite. I interviewed Resident R, staff member Noelle Heller, and Resident A. I received copies of Resident R MAR and his record of physician contacts.

On 10/29/24, I interviewed Resident R. Regarding the allegations, Resident R stated he has lived at the AFC group home for five years. Resident R stated living at the AFC group home is terrible because there are a lot of older residents in the home and he is not allowed to do what he wants to do. Resident R admitted that he likes to smoke and drink but he is not permitted to do so at the AFC group home. Resident R described the staff as snobbish and they make him ask for permission in order to do things. Resident R confirmed that he is given three meals a day and the staff administer his medications. Resident R initially stated Ms. Nancy gave him the wrong medication which caused him to have a migraine and hallucinate. Resident R stated this incident occurred in the beginning of January 2024. Resident R then stated that he was prescribed the medication that Ms. Nancy gave him but the medication was too strong and changes were made to his prescribed medications.

Resident R stated he used to be in the military. Resident R stated he is supposed to go to the VA every three weeks. He hasn't been to the VA in a while. Resident R thinks his last appointment at the VA was at the end of September. Resident R stated his next appointment at the VA is on 11/6/24. Resident R visits the VA to get a shot to help keep him calm. Resident R is transported to the VA by a staff member. Resident R stated he has scheduled video appointments once a month.

On 10/29/24, I interviewed staff member Noelle Heller. Regarding the allegations, Ms. Heller confirmed that Resident R receives a monthly injection (Invega Sustenna) at the VA. Ms. Heller stated there was a change this week for Resident R to receive his injection every three weeks. This change was made as Resident R's medication was wearing off which caused him to be aggressive and non-compliant. Ms. Heller stated Resident R punched her last month. Resident R has a history of being physically aggressive towards other residents as well. Resident R was admitted into Havenwyck hospital for assaulting Ms. Heller. Resident R was at Havenwyck from 09/23/24 to 10/10/24.

Ms. Heller stated the staff transport Resident R to his VA appointments. Ms. Heller is not aware of Resident R missing any of his appointments at the VA. Ms. Heller stated either she or the home manager Nancy Huntington schedule Resident R appointments at the VA. Ms. Heller stated the staff document when Resident R is taken to the VA. Resident R also participates in video appointments. Resident R had two video appointments yesterday regarding medication adjustments. Ms. Heller does not know how often video appointments are scheduled for Resident R. Resident R uses a staff cell phone or the computer at the AFC group home to attend his video appointments.

Ms. Heller stated when residents leave the AFC group home that are required to get permission from staff and to sign out. Resident R is not allowed to leave the AFC group home without staff supervision. However, Resident R does leave the AFC group home without staff supervision and without staff permission. Ms. Heller stated the home does not follow policy regarding absent without notice because Resident R usually returns to the AFC group home within a half hour after walking to the corner store. Ms. Heller stated there was an instance a few years ago when Resident R was absent from the home for a few hours and staff found him and he was intoxicated. Ms. Heller could not say how often Resident R leaves the AFC group home without staff being aware but, it does happen. Ms. Heller admitted that staff cannot watch the residents at all times because that is impossible. Ms. Heller stated there are two staff members present during waking hours and one staff member during the midnight shift. It was explained to Ms. Heller that staff are required to provide 24-hour supervision.

On 10/29/24, I interviewed Resident A. Resident A has lived at the AFC group home for forty years. Resident A stated he is ready to move out of the AFC group home. Resident A wants to live with his brother in Detroit. Resident A stated he does not like the staff members because they are too bossy and they tell him what to do. Resident A stated the staff administer his medications every day. Resident A denied the staff ever

forgetting to administer his medications. If Resident A needs to see a doctor the staff will transport him. Resident A stated four staff members work at the AFC group home every day. The staff members keep an eye on all the residents in the home. Resident A stated the new resident leaves the home without signing out and without permission. Resident A does not know the name of the new resident but he was not talking about Resident R. Resident A stated no other resident leaves the home without permission.

On 10/29/24, I reviewed the resident record of physician contacts for Resident R and his MAR for the month of October. According to the physician contacts, Resident R was transported to the Ann Arbor VA for his monthly injection on the following dates:

- 06/04/24,
- 07/02/24
- 07/30/24
- 08/28/24

Resident R was also transported to the Ann Arbor VA on 06/07/24 for lab work. Resident R was discharged from Harbor Oaks on 10/10/24 and it is documented that he received a Risperidone injection while at the hospital. Resident R had two video appointments scheduled for 10/24/24, and one on 10/28/24.

On 10/29/24, I made a telephone call to the home manager Nancy Huntington. Regarding the allegations, Ms. Huntington stated Resident R is usually transported to the VA to receive his injections by Ms. Heller. Ms. Huntington stated she is not aware of Resident R missing any appointments at the VA unless he was hospitalized. Ms. Huntington stated Resident R was recently discharged from Harbor Oaks. Ms. Huntington stated during this last hospitalization Resident R was not admitted into Havenwyck therefore; Ms. Heller was mistaken when she said Resident R was taken to Havenwyck. Resident R did not receive his Invega injection at the VA in October due to his hospitalization at Harbor Oaks. While Resident R was hospitalized, he received a Risperidone injection. Since Resident R was discharged from the hospital, his prescription for his Invega injection was changed from getting it every four weeks to every three weeks.

Ms. Huntington stated Resident R receives his injection at the VA by the clinical pharmacist Lindsey Murphy. A video appointment is scheduled for Resident R every three months as a follow-up between Resident R's injections. The video appointments are conducted through a link from the VA that is only sent to Ms. Huntington's email. Resident R attends the video appointments by using Ms. Huntington's cell phone. Ms. Huntington stated she can't say Resident R has never missed a video appointment when she was not at work however; she would do whatever she can to prevent that from happening. Ms. Huntington also stated if she is not at work when Resident R has a scheduled video appointment, she will call a staff member to re-schedule or she will re-schedule when she returns to work.

Ms. Huntington stated she is not going to say definitively that Resident R has never missed an appointment at the VA. However, Resident R may have missed one

appointment in the three years he has lived at the AFC group home. When asked why she thinks someone would say that Resident R has missed several appointments, Ms. Huntington stated she is not going to say on record why someone would say Resident R is not attending his appointments.

Ms. Huntington stated I did not receive the third page of the physician contacts while I was at the AFC group home. Ms. Huntington stated her note dated for 10/28/24 regarding Resident R's video appointment was unfinished. Ms. Huntington stated she just finished writing the note. Ms. Huntington provided a copy of three pages of the physician contacts via text message. However, two of the pages were the same which is the same page I already had a copy of. These two pages were dated from 10/10 to 10/28. The note dated 10/28, Ms. Huntington added that Resident R's Invega injection was changed to every three weeks and; Jackie will call to schedule an appointment. The other page was dated 10/10 to 10/23. On 10/21, there is a note that states Cyanocobalamin was delivered via mail without a prescription or notification. The other notes on this page was regarding Resident R's discharge medications, and inquiries on whether or not Resident R will resume getting Invega injections versus a Risperidone injection.

Ms. Huntington stated Resident R does have a history of leaving the AFC group home without permission. Ms. Huntington stated every year on Resident R's birthday he leaves the home without permission and he seeks out alcohol or drugs. The police have picked up Resident R and returned him to the AFC group home and sometimes he has come back on his own intoxicated. Ms. Huntington stated she has had to call the police either two or three times. Ms. Huntington stated when these instances occurred, Resident R is usually hospitalized and when he is discharged, he is apologetic. Ms. Huntington stated after Resident R assaulted Ms. Heller in September, she created a behavior contract stating Resident R will receive a 24-hour discharge notice if he breaks the house rules again. Resident R's guardian agreed to the contract over the phone but he has not signed it yet.

On 10/30/24, I made a telephone call to the Adult Protective Services worker Lisa Black. Ms. Black stated she made a request to receive records from the VA and she is waiting to receive the records regarding Resident R's injection appointments and video appointments.

On 10/30/24, I made a telephone call to Resident R guardian. The guardian stated he is aware of the complaint as he was contacted by the Adult Protective Services worker. The guardian stated it is his understanding that the timeframe for when it was alleged that Resident R missed his VA appointments occurred while he was hospitalized at the end of September until 10/10/24. The guardian stated Resident R has extreme behavior problems and the VA is responsible for meeting all of his health care needs and living arrangements. The guardian does not know why this complaint would rise to the level of contacting Adult Protective Services because the VA should have been fully aware that Resident R was hospitalized which is why he missed his appointment.

On 11/04/24, I received documentation regarding Resident R's appointments at the VA from the Adult Protective Services worker, Lisa Black. Ms. Black stated her case will be substantiated. According to the documentation, I reviewed a progress note dated 08/14/24 and written by Veronica Presnall stating Resident R was not present for his video appointment. Ms. Presnall contacted Resident R via telephone and also spoke to Ms. Huntington regarding concerns about the VA inability to connect to video appointments due to staff unavailability during scheduled appointments resulting in missed appointments. Ms. Huntington appeared to be receptive. It was also documented that if missed appointments continue Resident R's guardian will be contacted.

The second progress note dated 07/11/24 written by Veronica Presnall stated a psychiatry appointment was scheduled but Resident R was a no-show, as Resident R was not reached by telephone. Ms. Heller stated management is not working today to assist with providing access to video to connect meeting. The VA was unable to provide the link to Ms. Heller due to HIPPA.

The third progress note dated 05/16/24 written by Christopher Thomas stated a psychiatry appointment was scheduled but Resident R was a no-show, as Resident R was not reached by telephone.

The fourth progress note dated 05/13/24 written by Veronica Presnall stated a psychiatry appointment was scheduled but Resident R was a no-show, as Resident R was not reached by telephone.

The fifth progress note dated 03/06/24, written by Veronica Presnall stated a psychiatry appointment was scheduled but Resident R was a no-show, as Resident R was not reached by telephone. A caregiver stated the individual who manages the video appointment is not available.

The sixth progress note dated 02/02/24, written by Veronica Presnall stated psychiatry appointment was scheduled but Resident R was a no-show, as Resident R was not reached by telephone. Staff stated this appointment was not listed on the calendar.

APPLICABLE RULE	
R 400.15310	**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: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions**

	and recommendations shall be recorded in the resident's record.
ANALYSIS:	Based on the information gathered, there is sufficient evidence to support this allegation. Documentation from the VA was reviewed and confirmed that Resident R was a no-show for six (8/14/24, 7/11/24, 5/16/24, 5/13/24, 3/6/24, 2/2/24) psychiatry video appointments. The link for the psychiatry video appointments was provided to the home manager, Ms. Huntington. However, according to the documentation from the VA, there were two instances where Resident R was a no-show to his video appointment because Ms. Huntington was not at work and/or available.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

According to Resident R's MAR for the month of October, I observed initials that appear to be "NH" documented on 10/09/24 for Resident R's Amlodipine Besylate 5mg at 8:00am. As mentioned above, Resident R was hospitalized from 09/23/24 to 10/10/24. With regards to Resident R's Atorvastatin 80mg, Folic Acid 1mg, Metformin 500mg, and Olanzapine 2.5, there were several missing staff initials from 10/10/24 through 10/21/24. In between the timeframe of 10/10/24 through 10/21/24, there were some staff initials with a circle around the initial. Resident R's Invega injection was crossed out on the MAR along with the time and all of the staff initials which were from 10/1/24 through 10/08/24. Resident R's Naltrexone 50mg and Olanzapine 2.5 was also crossed out on the MAR and the times when they were prescribed to be administered. Regarding Resident R's Atorvastatin 80mg, Invega injection, Metformin 500mg, Naltrexone 50mg, and Olanzapine 2.5, it was documented on the MAR that there was no order to continue these medications. It was also documented that Naltrexone 50mg and Olanzapine 2.5 was discontinued "per VA on 10/28/24" via telephone.

Ms. Huntington stated that before she spoke to Nurse Jackie at the VA on or about 10/22/24, she administered Resident R's Amlodipine when he returned home and; he continued to get it every day. Ms. Huntington stated Resident R usually refuses to take his Metformin therefore she did not attempt to administer it to him. Resident R did not start getting all of his medications on his MAR until 10/21/24. Ms. Huntington explained that when a staff circles their initials that means the medication was not administered. Ms. Huntington confirmed that some staff left the MAR blank between the dates of 10/10/24 through 10/20/24 and some staff documented their initials with a circle around it.

Ms. Huntington explained that she crossed out Resident R's Invega injection on his MAR because the staff made an error by initialing the MAR as if the Invega injection was being administered every day. Ms. Huntington admitted that staff made another error by initialing the MAR for Resident R's Amlodipine on 10/9/24 when he was still in the hospital. Ms. Huntington stated the initial documented on 10/9/24 for the Amlodipine was NH but she was not the one who initialed the MAR. Ms. Huntington stated she crossed out Resident R's Naltrexone and Olanzapine on his MAR because she did not want staff to administer these medications. Ms. Huntington is not sure when she crossed out these medications but it may had been on 10/14/24.

Ms. Huntington stated on 10/22/24, a medication by the name of Cyanocobalamin was delivered to the AFC group home without a prescription order. Ms. Huntington stated she was not notified by the VA that this medication was being prescribed to Resident R. Ms. Huntington stated it is not uncommon for the VA to deliver medications without an order. Ms. Huntington admitted that she did not verify with a doctor from the VA if Resident R is prescribed to take this medication.

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.** **(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.**

ANALYSIS:	Based on my investigation and the information gathered, there is sufficient evidence to support this allegation. The home manager, Ms. Huntington admitted to crossing out medications on Resident R's MAR as well as the time to be administered, and the staff initials. Ms. Huntington also admitted that staff made another error by initialing the MAR for Resident R's Amlodipine on 10/9/24 as if the medication was administered when he was still in the hospital. Ms. Huntington also confirmed that she did not verify with a doctor from the VA if Resident R is prescribed to take Cyanocobalamin after it was delivered to the AFC group home on 10/22/24 without a prescription. I observed Cyanocobalamin written by hand on Resident R's MAR. However, there were no label instructions provided on the MAR regarding this medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 10/29/24, Ms. Huntington stated when Resident R was discharged from Harbor Oaks, the only medications he was prescribed per the discharge record was Mirtazapine 7.5mg, Risperidone 3mg, and Oxcarbazepine 300mg. Ms. Huntington provided a copy of this discharge record via text and this information was verified. Resident R was already prescribed Risperidone and Oxcarbazepine before his hospitalization but, Mirtazapine was a new medication. Ms. Huntington stated she did not receive an order to continue Resident R's other medications that he was prescribed prior to his hospitalization. Ms. Huntington attempted to speak to someone from Harbor Oaks but never received a call back. Ms. Huntington stated she spoke to Nurse Jackie Hill from the VA on or about 10/22/24 and she advised her to resume administering Resident R's medications that he was prescribed before he was hospitalized. Ms. Huntington admitted that she did not put Nurse Jackie's instructions in writing nor did Nurse Jackie provide an order listing the medications Resident R is permitted to take.

On 11/06/24, I completed an exit conference with the licensee designee Appolonia Okonkwo via telephone. Ms. Okonkwo was informed that the allegations will be substantiated and a corrective action plan will be required.

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: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a**

	pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.
ANALYSIS:	Resident R was discharged from the hospital on 10/10/24. The discharge record only listed Mirtazapine 7.5mg, Risperidone 3mg, and Oxcarbazepine 300mg as the medications prescribed to Resident R. Resident R was already prescribed Risperidone and Oxcarbazepine before his hospitalization but, Mirtazapine was a new medication. As a result, Resident R was not being administered the remaining of his medications listed on his MAR prior to his hospitalization. Ms. Huntington spoke to Nurse Jackie Hill from the VA on or about 10/22/24 and she advised her to resume administering Resident R's medications that he was prescribed before he was hospitalized. Ms. Huntington admitted that she did not put Nurse Jackie's instructions in writing nor did Nurse Jackie provide an order listing the medications Resident R is permitted to take.
CONCLUSION:	**VIOLATION ESTABLISHED**

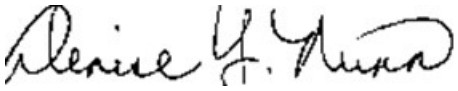
IV. RECOMMENDATION

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

11/06/24

Sheena Worthy
Licensing Consultant
Date

Approved By:



11/07/2024

Denise Y. Nunn
Area Manager
Date