GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 26, 2024

Sandra and John Bishop
11705 Edgerton Rd
Cedar Springs, MI 49319

RE: License #: AF410094736
Investigation #: 2025A0357003
The Haven Of Rest

Dear Sandra and John Bishop:

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) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF410094736
Investigation #:	2025A0357003
Complaint Receipt Date:	10/29/2024
Investigation Initiation Date:	10/31/2024
Report Due Date:	12/28/2024
Licensee Name:	Sandra and John Bishop
Licensee Address:	11705 Edgerton Rd Cedar Springs, MI 49319
Licensee Telephone #:	(616) 866-7224
Name of Facility:	The Haven Of Rest
Facility Address:	11705 Edgerton Road Cedar Springs, MI 49319
Facility Telephone #:	(616) 918-6224
Original Issuance Date:	09/21/2001
License Status:	REGULAR
Effective Date:	07/24/2024
Expiration Date:	07/23/2026
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Sandra Bishop has not informed Resident A she needs to call the pharmacy for a refill of her medication and the pills have run out for two or three days.	No
Additional Findings	Yes

III. METHODOLOGY

10/29/2024	Special Investigation Intake 2025A0357003
10/31/2024	Special Investigation Initiated - Telephone
12/17/2024	Inspection Completed On-site unannounced inspection with Sandra Bishop and John Bishop.
12/17/2024	Contact - Document Received Reviewed Resident A's medication record, Health Care Appraisal and her assessment plan.
12/19/2024	Contact - Face to Face Interview with Resident A. Interview with Co-licensee John Bishop.
12/23/2024	Contact telephone call made to Co-licensee Sandra Bishop. Telephone interview with Resident A's Daughter.
12/26/2024	Telephone exit conference with Co-licensee, Sandra Bishop.

ALLEGATION: Sandra Bishop has not informed Resident A she needs to call the pharmacy for a refill of her medication and the pills have run out for two or three days.

INVESTIGATION: The complaint read that Ms. Bishop is supposed to inform Resident A's daughter or Resident A prior to her running out of medication because the doctor requires a monthly prescription request. Her doctor prescribes her 90 Norco meds to be taken 3x daily for pain management. According to the complaint, on Thursday October 24, Ms. Bishop was out of the medication. Resident A does not recall being given any Norco that day. Friday Oct 25th, Resident A reportedly called the pharmacy to check on when the medication would be sent. The pharmacy confirmed that the medication was signed and delivered to the home on 10/24/24. Resident A was given her 1st dose of Norco around 4pm that day after confirming the delivery with John Bishop. He showed her an empty pack with 2-4 pills from last

month's supply, (after being told they were gone). Resident A reportedly recalls being given 2 Norco on Sunday October 27. This is the day Resident A mentioned the concern to her daughter.

On 12/17/2024, I conducted a face-to-face interview with the co-licensees, Sandra and John Bishop. Ms. Bishop reported when Resident A was admitted she was told that only Resident A or Resident A's daughter can call her physician for the refills. Ms. Bishop explained that Resident A does not call the pharmacy for her medications, but she calls the prescribing physician. She said that she reminds Resident A to call her physician when she is down to 14 pills, but Resident A does not remember to call her physician. Ms. Bishop stated that she will ask Resident A if she has called, and Resident A will say she forgot and will make the call. She reported that she reminds her at least two times, and sometimes up to four times in a day.

I requested to see Resident A's medication. Her medication was contained on a large card supplied by LTC pharmacy. In large red letters at the top of the card was PRN (as needed). The medication was "Hydroco APAP Tab 5/325mg, take one table by mouth three times daily as needed for pain." Ms. Bishop reported that the medication has to have six hours between doses. She said she administered them at 8:00 AM, 2:00 PM and 8:00 PM. She stated that Resident A will leave the facility with her daughter and not tell her so she cannot have her medications packaged for her. Then when Resident A returns, times vary but usually close to or around 4:00 PM she wants her medications. Ms. Bishop explains to her that if she gives it to her then she cannot get it at the 8:00 PM time because it has not been six hours. Ms. Bishop reported that this has been a consistent problem. I asked to see the MAR (medication administration record) and Ms. Bishop acknowledged that she had not maintained the MAR since July of 2024. Therefore, I could not determine if the medication had been administered because her initials were not recorded on the MAR. Ms. Bishop said she never misses Resident A's Hydroco medication but she did not sign her initials on the MAR.

I asked Ms. Bishop about the October dates that were in the complaint. On October 24th, 2024, it alleged that Resident A did not recall being given any Norco on that day. Ms. Bishop explained that she had been asking Resident A numerous times to telephone her physician for a refill on her Hydroco because she was almost out of this medication. Ms. Bishop showed me the delivery slip from the pharmacy which listed the Hydroco having been delivered on 10/24/2024. There was no time recorded for the delivery, but Ms. Bishop remembered it being around 3:55 pm. She said she immediately administered the Hydroco at 4:00 PM to Resident A. Ms. Bishop said she cannot administer Resident A's medications if she does not have it and she had no control over getting Resident A's medications. She went on to say that she had explained to Resident A at the time of the 4:00 PM administration on 10/24/204, that she could not administer her 8:00 PM Hydroco because it was not six hours between doses. Ms. Bishop stated that she made a verbal agreement with Resident A that she would stay up until 10:00PM to administrator the Hydroco at that

time and she reported Resident A agreed. Ms. Bishop stated that at 10:00PM she knocked on Resident A's bedroom door many times, but Resident A did not respond so she assumed that she was sleeping soundly. Therefore, she was unable to administer the Hydroco medication to Resident A. The complaint read that Resident A had called the pharmacy to confirm that her medication had been delivered to the home on 10/24/2024. The complaint went on to say that Resident A had confirmed the delivery with Mr. Bishop and he had showed the empty pack of with 2-3 pills from last month's supply (after being told they were gone). I asked Mr. Bishop about this, and he stated that he had confirmed with Resident A that her medications had been delivered to them on 10/24/2024, but he said he showed her another resident's medications card by mistake. He verbally confirmed that Resident A had run out of her Hydroco and her pharmacy labeled container was empty until it was delivered on 10/24/2024.

The complaint stated that on 10/28/2024, Ms. Bishop told Resident A there was a new law in Michigan about Narcotics and that the pharmacy only sent out two sleeves (typically three) of her Norco. Resident A only recalls being given two Norco that day. I asked Ms. Bishop about this, and she explained that she was on her computer, and she had read that there was a shortage of Kemo and a shortage of Norco in Michigan at that time. She reported that she had spoken to Resident A about this, but she believed that Resident A had misunderstood what she had been talking about. On 10/28/2024, the complaint read that Resident A had called the pharmacy to clarify the new law and they told her there was no new law and that they had delivered 90 pills on 10/24/2024. The complaint went on to say that Resident A questioned Ms. Bishop after calling the pharmacy, and Ms. Bishop told Resident A she found the missing sleeve that was misplaced. Ms. Bishop stated that Resident A's third pharmacy card containing her Hydorco was not missing, and she has no idea what Resident A was talking about. Ms. Bishop denied that she had misplaced Resident A's Hydorco third card of her medication.

The complaint read on 10/27/2024, Resident A reported to her family that on this day at bedtime she had to request her nighttime dose of Hydroco because, it was missing from her medication cup. I asked Ms. Bishop about this, and she reported that she had put the Hydorco in Resident A's cup but she just missed it, so she asked Resident A to look again in the medication cup and she found it.

On 12/17/2024, I reviewed Resident A's assessment plan and there was no mention of the arrangement of Ms. Bishop letting Resident A know when she was down to 14 pills and to ask her to call her physician for the renewal for the next month. Ms. Bishop said it was just a verbal agreement when she was admitted to the home, because they told Ms. Bishop only Resident A or her daughter could call in the renewal of the prescription. I reviewed Resident A's Health Care Appraisal and one of her diagnosis was "Cognitive Impairment." The name of the physician prescribing the Hydotco was Dr. Laponsa. Ms. Bishop stated that Dr. Scham was Resident A's family doctor.

On 12/19/2024, I conducted a face-to-face interview with Resident A in her bedroom. Resident A reported that she had been out of her Hydorco pills for the weekend of October 19-20/2024. She stated that her pills were delivered to the home on 10/24/2024. She said she received one dose at 4:00pm on 10/24/2024 because she can only have them six hours apart and her 8:00pm dose would be too close. I asked her about Ms. Bishop staying up to give her the medication at 10:00PM but she did not remember that. She was certain that Ms. Bishop had told her that she had only received two of her sleeves of medications but then Ms. Bishop told her she found the third sheeve. I asked her how she renews her prescription for her medication Hydroco and she reported that she has to call her physician each month. I asked her for the name of her physician, and she provide the name of Dr. Schram. (Her physician noted on her medication card as Dr. Laponsa). I asked her if Ms. Bishop had told her when her pills were getting low and she said yes, when she is down to 14 pills. I asked her about calling her physician and she said, “I just forgot to call.” I asked if that has happened before, and she acknowledged that she has forgotten to call her physician for the renewal each month several times. I asked if that was the reason she ran out of pills and she said yes. I asked her about receiving her Hydrodo on 10/24/2024 and she said she did not receive her pill until 4:00PM. She went on to explain that on 10/27/2024, her Norco was missing from her medication cup and she had to ask Ms. Bishop for it. She said she now looks at every one of her medications that are in her medication cups to make sure they are all there. She also explained that she has lower back pain, and the Norco helps with that pain. I asked her if she knew what PRN stood for and she immediately stated, “As needed.” I asked if she knew that her medication Hydroco was prescribed as a PRN. She asked me: “Does that mean I have to ask for it?” I said usually. She said she would now ask Ms. Bishop for her pain medications for three times per day. I asked her if she likes living in this home and she stated: “I love it here,” She also stated that she loves Ms. Bishop.

On 12/23/2024, I telephoned Resident A’s daughter. She did acknowledge that occasionally Resident A has problems with her memory but stated: “She is not a liar.” She went on to report that at Resident A’s admission to the home they had discussed with Ms. Bishop that either herself or Resident A can call for a refill on her Norco. She reported that the physician who prescribes the Norco is in Ann Arbor, and they do a “virtual visit.” She also stated that she has asked Resident A to find a doctor closer to home, but she is unwilling to change. She reported that just recently Ms. Bishop has asked her to keep track of when the prescription is to be called for Resident A’s new month and Resident A’s daughter stated she now has the renewal date on her phone, and she will make the call for the renewal prescription of behalf of Resident A.

On 12/ 26/2024 I conducted a telephone exit with the Co-licensee, Sanda Bishop and she agreed with my findings.

APPLICABLE RULE	
R 400.1418	**Resident medications.**

	(2) Medication shall be given pursuant to label instructions.
ANALYSIS:	It was alleged that Sandra Bishop has not informed Resident A when she needs to call the pharmacy for a refill of her medication and therefore, she has run out. Resident A acknowledged that she has forgotten to call her physician for a renewal of her Hydroco even after Ms. Bishop has reminded her several times. She confirmed that she has to call her physician herself for her renewal medications. As a result, her medications were not delivered to the home until 10/24/2024. Ms. Bishop confirmed she has asked Resident A to call her physician up to four times to renew her prescription for her Hydroco. She confirmed her medication Hydroco was not delivered the home until 10/24/2024, which she administered at 4:00 PM on 10/24/24. Resident A's daughter confirmed that Resident A has been forgetful in calling her physician for her Hudroco. During this investigation evidence was found that Resident A was responsible for calling her physician to renewal her Hudroco and she forgot to call. Therefore, the Licensee's did not have the medication to administer until 10/24/2024 when the pharmacy delivered them to the home. there was no violation found to the rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: On 12/17/2024 Sandra Bishop acknowledged that she had not completed Resident A's MAR since July 2024. She acknowledged that she had administered Resident A's medications but did not put her initials on the MAR at the time of the administration.

On 12/26/2024, I conducted a telephone exit conference with Co-licensee, Sandra Bishop. She agreed with my findings.

APPLICABLE RULE	
R 400.1418	**Resident medications.**

	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: **(a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.**
ANALYSIS:	Sandra Bishop acknowledged that she had not completed Resident A's MAR (Medication Administration Record) with her initials at the time she administered her medications to her.
	VIOLATION ESTABLISHED

IV. RECOMMENDATION:

I recommend the Licensee's provide an acceptable plan of correction.

Arlene B. Smith 12/26/2024

Arlene Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 12/26/2024

Jerry Hendrick Date
Area Manager