GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 12, 2024

Caitlin Hartman
Fleischman Residence
6710 West Maple Road
West Bloomfield, MI 48322

RE: License #: AH630236785
Investigation #: 2024A1035066
Fleischman Residence

Dear Caitlin Hartman:

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,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630236785
Investigation #:	2024A1035066
Complaint Receipt Date:	07/25/2024
Investigation Initiation Date:	07/25/2024
Report Due Date:	09/24/2024
Licensee Name:	Jewish Home and Aging Services
Licensee Address:	6710 W Maple Rd. West Bloomfield, MI 48322
Licensee Telephone #:	(248) 661-2999
Administrator:	Caitlin Hartman
Authorized Representative:	Caitlin Hartman
Name of Facility:	Fleischman Residence
Facility Address:	6710 West Maple Road West Bloomfield, MI 48322
Facility Telephone #:	(248) 661-2999
Original Issuance Date:	09/01/1999
License **Status:**	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	116
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents are not being rounded on. Service Plan not followed.	Yes
Medications are not being administered as ordered. Medication orders are not being processed.	No
Additional Findings	No

III. METHODOLOGY

07/25/2024	Special Investigation Intake 2024A1035066
07/25/2024	Special Investigation Initiated - Letter
08/27/2024	Contact - Face to Face
09/16/2024	Contact - Phone interview with AR, Family A, SP2, & SP3
12/10/2024	Inspection Complete BCAL Sub-Compliance
12/12/2024	Exit Conference

ALLEGATION:

Residents are not being rounded on. Service Plan not followed.

INVESTIGATION:

On September 25, 2024, the department forwarded from Adult Protective Services (APS) which read:

"The patients are not being rounded on. About two weeks a Resident A passed away. It is unknown why she passed away, but she had a DNR in place. She was just found unresponsive. The staff did not round on her for five hours. She was found at 8:50am, and the last time someone saw her was at 3:50am. There was a service plan for memory care where she was supposed to be rounded every 30 minutes. A patient had a fall, and when the med tech was asked if the patient fell. The med tech said no, but other employees confirmed the patient did fall. The patient had a recent fracture from already falling. This past Friday, a patient Resident B fell. The patient's private caregiver reported it to the floor nurse. The nurse indicated they would go see the patient. The nurse never saw the patient.

On Monday this was brought to the attention of the director of nursing. It was then brought to administration's attention because there was no incident report. The administration wanted the director to do an incident report even through the director was not there and didn't see it. The patient's family was notified on Monday, but they should have been notified immediately."

APS did not open an investigation pertaining to the allegations.

While onsite I interviewed Catlin Hartman Authorized Representative/ Administrator who states no concerns were voiced to her related to Resident A expiring. Resident A was observed nonresponsive, 911 services were called, administration, family, and physician were notified.

While onsite, I interviewed staff person (SP)1 who states she's been newly appointed to her position. SP1 states residents are often kept in the common area and dining areas during day shift to keep a closer eye on them. Each resident has a service plan which states safety round requirements.

On September 16, 2024, SP2 states rounds are documented in Point Click Care (PCC) as ordered. Caregivers are expected to follow service plan directives related to safety rounds. SP2 states she was off the day of the occurrence noted above.

On September 16, 2024, a phone interview was conducted SP3 who states she heard a staff member scream, she responded to the room and observed Resident A nonresponsive. SP3 call the nurse supervisor on the first floor and notified her of the findings. Nurse responded to room and directed SP3 to take vital signs as she contacts 911. 911 responded noting Resident A without pulse and respiration. DNR directives were in place.

On September 16, 2024, a phone interview was conducted with Family A who states the nurses were nice, but she did not care for the experience she had with administration. Family A voiced concerns related to the phone called received stating Resident A was "unresponsive" not realizing Resident A had expired. Resident A had multiple falls within the short stay at the facility Family A states "I think they could have done a better job and prevented some of the falls and notifying me of my mother's death."

On September 16, 2024, a phone interview was conducted with Caitlin AR who states camera footage does not capture Resident A door; therefore, confirmation of rounds being completed or not cannot be confirmed. Caitlin states former D.O.N. had sent email communication that she completed education related to rounding with midnight staff. Education sign in sheet was not located. Catlin states separation with former D.O.N. was not in good standing. Caitlin reports she has a ticket into PCC to obtain Point of Care (POC) charting.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Through record review and interview, Resident A was admitted on 6/27/2024 and expired on 7/7/2024. Resident A had multiple fall occurrences in which service plan was updated to limit or prevent further falls. Incident reports and notification to the physician, management team and family were conducted in accordance with facility policy and procedure. Point of Care (POC) charting provided, POC charting indicates Safety Checks every 30 minutes PRN. Safety Check order does not reflect Service Plan guidance, last safety check documented was at 21:45 PM on 07/06/2024. Additional POC charting noted post expiration of Resident A. Based on information noted above this violation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medications are not being administered as ordered. Medication orders are not being processed.

INVESTIGATION:

On September 25, 2024, the department forwarded from Adult Protective Services (APS) which read:

> *"There are many medication errors occurring at the facility. Staff are documenting that patients are getting medication when they are really not receiving them. Medication is being discontinued, but patients are still getting the medication that are supposed to be discontinued. It is unknown if the patients have had any reactions to these issues or had any hospitalizations. There is only one midnight med tech, who is through an agency. There is also a delay in care for the patients. On Friday, a doctor did rounds and wrote orders for some patients. On Monday, nothing had been done about the doctor's orders. There were four nurses on Friday, Saturday, and Sunday. There was no reason the orders shouldn't have been done.*

On August 27, 2024, an onsite investigation was conducted. While onsite, I interviewed Caitlin Hartman Authorized Representative (AR)/ Administrator who states all med passers are trained with competency check off prior to administering medications. Director of Nursing or Nurses manage new orders utilizing the dashboard. No concerns related to medication administration has been brought to her attention.

While onsite, I interviewed Staff Person (SP)1 who states she was trained on medication administration with a competency check off. SP1 explained medication administration, narcotic counts, and what to do in the event a resident declines a medication. Medication Administration Record (MAR) and Narcotic book aligned with proper medication administration according to MAR being shown. Narcotic book count aligned with statements made.

On September 16, 2024, a phone interview was conducted with SP2 who states she was newly appointed to her position at the beginning of August and can only attest for practices at this time. Medication orders are placed by physicians and the Director of Nursing (D.O.N.) is responsible for confirming medication order and checking that the order is correct when received form pharmacy. In the event the Director of Nursing is unavailable to complete this task, floor nurses can complete task to ensure there is not a delay in care. If a doctor writes orders afterhours on Friday, the nurse scheduled over the weekend will verify order and have it sent to pharmacy. The D.O.N. is responsible for checking the dashboard over the weekend to ensure all orders are processed.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional. **(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.** **(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions:** **(a) Be trained in the proper handling and administration of medication.** **(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 administered the medication, which shall be entered at the time the medication is given. (vi) A resident's refusal to accept prescribed medication or procedures. **(c) Record the reason for each administration of medication that is prescribed on an as-needed basis.** **(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as-needed basis. The review process shall include the resident's prescribing licensed health care professional, the resident's authorized representative, if any, and the agency responsible for the resident's placement, if any.** **(e) Adjust or modify a resident's prescription medication with instructions from a prescribing licensed health care professional who has knowledge of the medical needs of the resident. A home shall record, in writing, any instructions regarding a resident's prescription medication.** **(f) Contact the appropriate licensed health care professional if a resident repeatedly refuses prescribed medication or treatment. The home shall follow and record the instructions given.** **(g) Upon discovery, contact the resident's licensed health care professional if a medication error occurs. A medication error occurs when a medication has not been given as prescribed.** **(4) If a resident requires medication while out of the home, then the home shall assure that the resident, or the person who assumes responsibility for the resident, has all of the appropriate information, medication, and instructions.** **(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.** **(6) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a licensed health care professional or a pharmacist.**
ANALYSIS:	Through record review and staff interview, Residents C, D, and E received medications as ordered. “Med passer” was able to articulate proper medication administration, Narcotic book and MAR aligned with her statements. Based on information obtained this allegation has not been substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

09/16/2024

Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

12/10/2024

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