GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 13, 2020

Medilodge of Sterling Heights (504170)
C/O Jennifer Muszall, Administrator
14151 E 15 Mile Road
Sterling Heights, MI 48312
JMuszall@medilodgeofsterlingheights.com

COMPLAINT INVESTIGATION

Participants
Facility:
Jennifer Muszall, Administrator
Robert Garchow, Social Services
Janet Olafsson, Regional Director of Clinical

State Agency:
Barbara Zabitz, Health Care Surveyor

General Information
This survey was for the purpose of a re-investigation of Complaint intake #MI00109007.

On 1/7/2020 the department received the initial complaint, which was investigated under the authority of the Federal Code of Regulations on 1/22/2020. None of the allegations were substantiated and on 2/17/2020, the complainant requested a re-investigation. The re-investigation was conducted virtually by phone and email, under the authority of the Michigan Public Health Code, Act 368 of 1978, Article 17 Facilities and Agencies, Part 201 General Provisions (MCL 333.20101 through 333.20211); Part 17 Nursing Homes (MCL 333.21701 through 333.21799(e)); and/or the Michigan Administrative Rules for Health Facilities (R 325.45101 through R 325.45385), as applicable, initiated on 5/1/2020 and concluded on 5/6/2020.

The complainant was interviewed by phone on 4/30/2020.

One of three complaint allegations were substantiated; however, the facility was found to be in compliance with all applicable requirements.

Complainant Allegations
It was alleged by the complainant that:

1. The resident is receiving medications that are giving him bad side effects.

2. The "stand-by" guardian is not being notified with medical changes regarding the resident.

3. The facility is not honoring medication orders prescribed by an outside specialist.

Bureau Investigation Findings

1. The complainant stated that the resident was prescribed an anti-psychotic medication Risperdal (risperidone) and she was afraid that this medication would cause the resident to display or worsen symptoms of tardive dyskinesia.

   According to the facility administrator, it was the facility's practice to monitor medications known to have the potential to cause tardive dyskinesia by using Abnormal Involuntary Movement Scale (AIMS) testing every six months when a resident was prescribed those medications.

   According to the medication orders, the resident was prescribed risperidone in May 2019. Risperidone is a medication known to have the potential to cause abnormal involuntary movements (tardive dyskinesia). On file, the facility had AIMS testing recorded 5/14/2019, 8/6/2019, 11/8/2019, and 2/8/2020. None of the AIMS testing indicated that the resident displayed involuntary movements associated with tardive dyskinesia.

   There was no evidence that the resident was experiencing adverse side effects from his prescribed medication and the complaint is not substantiated.

2. The complainant stated that she had been the resident's legal guardian for many years, but during the summer of 2018, she had lost guardian status in a court hearing and had been relegated to "stand-by" guardian. The complainant stated that she was aware that meant that she would regain guardianship if the current legal guardian died; but acknowledged that was meaningless since in the resident's case, the legal guardian was now a guardianship company.

   Facility social service progress notes dated 9/20/2018 read, "writer notified that the Arc of Macomb County will take over guardianship for (name of resident) per court hearing today…(name of resident)'s sister (name) was terminated as active guardian and will no longer be making medical decisions…"

Although this allegation is substantiated, there is no non-compliance with any rule or statute. After the guardianship status was terminated, the facility was no longer obligated to notify the complainant of medical changes.

3. The complainant stated that during the time that she was the resident's legal guardian, she had him seen by an outside neurologist, who prescribed medications for him, but that the facility refused to administer these medications, claiming "this facility is not licensed to dispense medicines from outside Doctors. These (a)r(e) the words of (facility name)'s own attorney."

   Review of the resident's medical file revealed a consultation form dated 7/31/2018 from the outside neurologist, indicating a recommendation for the medication Nuplazid, an anti-psychotic medication used for schizophrenia, with an 8-week follow-up appointment. Review of medication administration records from August 2018 until January 2019 revealed that this medication was administered to the resident on a daily basis as ordered until the end of January 2019, when the order was changed to a "once every 48 hour" schedule. This schedule was maintained until the resident was hospitalized in April 2019.

   The allegation is not substantiated as the evidence indicates that the facility administered the medication ordered by the outside neurologist.

Complaint Summary

At the completion of the survey, it was determined that the facility is in compliance with Michigan Public Health Code, Act 368 of 1978, Article 17 Facilities and Agencies, Part 201 General Provisions (MCL 333.20101 through 333.20211); Part 17 Nursing Homes (MCL 333.21701 through 333.21799(e)); and/or the Michigan Administrative Rules for Health Facilities (R 325.45101 through R 325.45385), as applicable.

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