STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

May 19, 2017

Cindy Whaley
Liberty Living Inc.
P O Box 1273
Bay City, MI 48706

RE: License #:	AS090256087
Investigation #:	2017A0123026
	Jefferson North

Dear Mrs. Whaley:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 (810) 787-7031.

Sincerely,

Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090256087
Investigation #:	2017A0123026
Complaint Receipt Date:	04/10/2017
Investigation Initiation Date:	04/14/2017
Report Due Date:	06/09/2017
Licensee Name:	Liberty Living Inc.
Licensee Address:	P O Box 1273 Bay City, MI 48706
Licensee Telephone #:	(989) 892-0247
Administrator:	Cindy Whaley
Licensee Designee:	Cindy Whaley
Name of Facility:	Jefferson North
Facility Address:	1611 S. Jefferson Bay City, MI 48708
Facility Telephone #:	(989) 892-4361
Original Issuance Date:	06/19/2003
License Status:	REGULAR
Effective Date:	12/18/2015
Expiration Date:	12/17/2017
Capacity:	6
Program Type:	MENTALLY ILL DEVELOPMENTALLY DISABLED PHYSICALLY HANDICAPPED

II. ALLEGATION(S)

	Violation Established?
Staff administered insulin to Resident A, even though Resident A's blood sugar level was dangerously low.	Yes

III. METHODOLOGY

04/10/2017	Special Investigation Intake 2017A0123026
04/14/2017	Special Investigation Initiated - On Site I interviewed Resident A at Jefferson North.
04/18/2017	Contact - Face to Face I interviewed staff at Jefferson North.
04/18/2017	APS Referral I received APS referral information from APS worker Julie Anderson.
05/15/2017	Exit Conference I conducted an exit conference via phone with Cindy Whaley.
05/15/2017	Inspection Completed BCAL- Sub. Compliance

ALLEGATION:

Staff administered insulin to Resident A, even though Resident A's blood sugar level was dangerously low.

INVESTIGATION:

On 04/14/2017, I conducted an unannounced visit to Jefferson North. I interviewed Resident A. Resident A stated that staff Paradice Russell did not feed them. She stated that with her being diabetic she has to have three square meals a day. Resident A stated that her blood sugar dropped to 43 on Saturday April 8, 2017 because they (the residents) were not fed. Resident A stated that they did not receive lunch because they were going to have an early dinner at 3:00 pm. Resident A stated that she has resided at Jefferson North for three months. She stated that she likes Jefferson North better than her previous placement. Resident A stated that she did not ask Staff Russell to fix her any food. Resident A stated that she is prescribed Humalog, Lantus, and Metformin for her diabetes. Resident A stated that

she administers her own insulin medication, and that staff does not administer the medication to her. She stated that for her insulin, she uses a pen with a dial on it to measure the insulin. Resident A stated that when her sugar dropped low, she felt light headed "and everything else." Resident A stated that she also takes heart pills. She stated that she is diagnosed with diabetes and congestive heart failure. She stated that staff administers her other medication to her. She stated that her blood sugar went from 43 to 349 that day. She stated that her sugar level jumped after she ate dinner, and that she felt fine after dinner. She stated that she did not get to the point of needing medical attention. She stated that Staff Russell thought that they would be going out to eat earlier than 3:00 pm, so she did not fix lunch. Resident A stated that this incident has only happened this one time. She stated that Staff Russell is a weekend worker. She reported that they arrived back to the home around 5:00 pm, and that she checked her blood sugar at 3:00 pm prior to leaving for dinner. She stated that they arrived to the restaurant around 3:30 pm. She stated that she was fine once she ate, that her blood sugar leveled out, and that she had no other issues after this. Resident A stated that she is her own guardian. Resident A stated that she checks her own blood sugar levels. Resident A stated that she has spoken to the recipient rights advisor. Resident A stated that the APS worker is Julie Anderson, and that she has also payee.

On 04/18/2017, I interviewed direct care worker Diane Hecht at Jefferson North. She stated that she has worked as a direct care worker for nine years. Staff Hecht stated that she started her shift at 7:00 pm on April 8, 2017, and worked until 8:00 am the following day. Staff Hecht stated that during her shift on April 8, 2017 Resident A approached her and stated that her sugar was low. She stated Resident A told her they went to Ponderosa and that Resident A had dessert as well. She stated that Resident A was sitting on the couch and was looking kind of shaky. Staff Hecht stated that she called the home nurse, Penny Griffus. She stated that Ms. Griffus was worried. She stated that blood sugar medication is on a sliding scale, but Resident A is not on a sliding scale, as Resident A's doctor's orders state specifically how many units Resident A is to administer. Staff Hecht stated that Resident A's blood sugar was checked at 7:30 pm and it was over 300. She stated that Resident A administered her insulin shot herself, and ate a snack. Staff Hecht stated that she documented the administration on the medication log sheet. Staff Hecht stated that Resident A's blood sugar has been normal. She stated that the only thing she did wrong during her shift was not calling the home manager first. Staff Hecht stated that earlier that day Resident A did not have her shot or eat lunch. Staff Hecht stated that she was informed that Resident A's blood sugar was at 43 around 3:30 pm earlier that day. Staff Hecht stated that she called the home manager, Rachel Collins, after she called Ms. Griffus. Staff Hecht stated that she did not know why Resident A skipped her lunch, and stated that Resident A probably didn't think to eat because they were going to have a big dinner at Ponderosa. She stated that after Resident A's 7:30 pm insulin injection, Resident A was fine, and slept good.

On 04/18/2017, I interviewed direct care worker Paradice Russell at Jefferson North. She stated that she has been a direct care worker for about one month. Staff Russell

stated that Resident A is supervised when checking her blood sugar. She stated that the residents told her that they were going to Ponderosa. She stated that staff did not inform her of this, and that she did not know if it was for lunch or dinner. She stated that Resident A's blood sugar was at 69 prior to lunch time, and at 3:00 pm it was under 50. She stated that she offered Resident A a sandwich and Resident A declined stating that she would wait to eat at Ponderosa. Staff Randall stated that there is a posting on the medication cabinet on display in the home that states you should call the nurse if sugar levels are under 40. She stated that Resident A's care plan states that if it is under 50 to call the nurse. She stated that Resident A's plan is located in her personal book. Staff Russell stated that Resident A is the only resident that checks her blood sugar, so she was confused, because Resident A is the only one in the home with diabetes. She stated that at one point, she called the home nurse, Penny Griffus, and that she handed the phone to Staff Hecht because Ms. Griffus wanted to speak with Staff Hecht about the matter. She stated that after dinner, Resident A's blood sugar was high, either in the 200's or 300's. Staff Russell stated that Staff Hecht monitored this blood sugar check after her shift was over. Staff Russell stated that she did not notice Resident A showing any signs of being ill. She stated that Resident A was up walking around talking. She stated that when they got to Ponderosa, Resident A ate. She stated that Resident A administers her insulin, and staff supervises it. Staff Russell stated that Resident A took her insulin before she went to Ponderosa. She stated that Resident A is supposed to take the insulin before she eats. Staff Russell stated that the book states Resident A is to not take her insulin if she doesn't eat. Staff Russell stated that she now knows not to allow Resident A to have her insulin if she refused to eat, and that Resident A has to eat first. She stated that Resident A had a buffet meal at Ponderosa, and ice cream and cake for dessert. She said that Resident A stated that she was going to eat a little more to get her blood sugar up. Staff Russell said that Resident A stated that she was okay and refused to eat. Staff Russell stated that she is a new worker, that Resident A knows her sugar well, and that she feels Resident A should have informed her of what to do.

On 04/18/2017, I interviewed home manager Rachel Collins at Jefferson North. She said that Resident A stated that she was waiting to eat at Ponderosa. She stated that Resident A is particular about her blood sugar levels and she tries to cut back if she knows she'll be eating extra. Staff Collins stated that Resident A did have milk and something else when her sugar was low prior to going to Ponderosa. Staff Collins stated that she received a call from Ms. Griffus. She stated that she was informed that Resident A's blood sugar went up to 364 and that Ms. Griffus gave the okay for Resident A to have a snack and take her Lantus that night. Staff Collins stated that Resident A keeps candy, and will eat it when her sugar is low. She stated that Ms. Griffus has discussed with Resident A about her blood sugar. Staff Collins stated that she thinks there was confusion, and this was Staff Russell's first day working a shift on her own. Staff Collins stated that staff is supposed to monitor Resident A when she administers her medication. She stated that Staff Russell should have called Ms. Griffus prior to the trip to Ponderosa. Staff Collins stated that the nursing care plan for Resident A states that if her blood sugar is under 50 to call the nurse. She stated that

Ms. Griffus was called when Staff Hecht came in to work. Staff Collins stated that she first heard about this incident when Ms. Griffus called her about it. She stated that Ms. Griffus authored the incident report.

Resident A’s health care appraisal indicates that she is diagnosed with CAD, DM, HTN, depression, OA, and obesity. It also indicates that Resident A is on a diabetic diet. Her assessment plan states that she has a nutritional plan which consists of an 1800 calorie, carbohydrate counted diet. She needs occasional assistance with bathing and personal hygiene. Her assessment plan also indicates that staff will administer medication per physician’s orders.

Per Resident A’s nursing care plan, it states that staff will assist her in checking and recording blood sugar per physician order. Abnormal readings are to be reported to the RN and physician. In bold it states, “Staff to be aware of blood sugar levels to hold insulin per Physician.” The instructions for if Resident A’s blood sugar is below 50 is to have her eat a peanut butter and jelly sandwich and a glass of milk, and to call the nurse (if she is able to swallow).

Resident A’s medication administration sheets were reviewed. On April 8, 2017, Metformin was administered at 8:00 am by Staff Russell and 8:00 pm by Staff Hecht. Lantus was administered at 8:00 pm (30 units at bed time) by Staff Hecht. Humalog was administered at 8:00 am (4 units in the morning), 12:00 pm (4 units at lunch), and 5:00 pm by Staff Russell (6 units at dinner). There is a note dated for 4/27 that states “if under 70 hold Humalog per Lynn Begres (home nurse).”

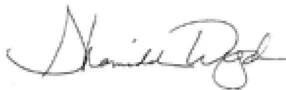
An incident report authored by nurse Penny Griffus, dated on 04/08/2017 was reviewed. The incident report states that on 04/08/2017, insulin was administered three times on this day, to Resident A, while blood sugars were low. Staff did not notify the nurse of the dangerous levels. It further states that Ms. Griffus spoke with Staff Collins about the danger of insulin administration with low blood sugar already, in addition to the danger of staff’s lack of knowledge/response.

On 05/15/2017, an exit conference was completed with licensee designee Cindy Whaley. The allegations and findings were discussed.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	There is a preponderance of evidence to establish a rule violation as Staff Paradice Russell did not follow Resident A's care plan as documented in her nursing care plan and resident assessment plan. The plans states to follow the physician's orders in regards to medication administration and notifying the nurse and physician when Resident A's sugar levels are below 50.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend continuation of the current status of the license of this AFC adult small group home (capacity 6 or less.)



05/19/2017

Shamidah Wyden　　　　　　　　　　Date
Licensing Consultant

Approved By:

5/19/2017

Mary E Holton　　　　　　　　　　Date
Area Manager