RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

December 12, 2017

Barry Bruns
HomeLife Inc, PMB #360
5420A Beckley Rd., Battle Creek, MI 49015

RE: License #: AM030353416
Investigation #: 2018A0350008
691 W. Bridge Street AFC

Dear Mr. Bruns:

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) 356-0183.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030353416
Investigation #:	2018A0350008
Complaint Receipt Date:	12/11/2017
Investigation Initiation Date:	12/11/2017
Report Due Date:	01/10/2018
Licensee Name:	HomeLife Inc
Licensee Address:	3 Heritage Oak Lane Battle Creek, MI 49015
Licensee Telephone #:	(269) 660-0854
Administrator:	Barry Bruns
Licensee Designee:	Barry Bruns
Name of Facility:	691 W. Bridge Street AFC
Facility Address:	691 W. Bridge Street Plainwell, MI 49080
Facility Telephone #:	(269) 225-1021
Original Issuance Date:	02/04/2014
License Status:	REGULAR
Effective Date:	08/11/2016
Expiration Date:	08/10/2018
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was to receive three Clindamycin pills three times a day for 10 days; however some staff were not passing all three pills at each pass, resulting in there being 40 leftover.	Yes

III. METHODOLOGY

12/11/2017	Special Investigation Intake 2018A0350008
12/11/2017	Special Investigation Initiated - Telephone I spoke with Jennifer Zoulek, Home Manager
12/11/2017	Contact - Telephone call made I spoke with Michelle Schiebel, Recipient Rights Officer
12/12/2017	Exit Conference Held with Barry Bruns, Licensee Designee

ALLEGATION: Resident A was to receive three Clindamycin pills three times a day for 10 days; however some staff were not passing all three pills at each pass, resulting in there being 40 leftover.

INVESTIGATION: On 12/11/2017, I called and spoke with Jennifer Zoulek, the Home Manager. I informed Ms. Zoulek that a complaint was made that Resident A had not been getting his full dose of Clindamycin, and she stated that she knew about this complaint and that she just finished speaking with Michelle Schiebel, Recipient Rights Officer, about it. I asked Ms. Zoulek what she had found out, and she replied that some of her staff members who passed medications since December 4th (2017) neglected to give Resident A his full dose of Clindamycin, which is three pills, three times a day. She said that these pills came in a bottle, and that she checked to see if the Medication Administration Record (MAR) matched the prescription, and said that it did. Ms. Zoulek informed me that she has not yet determined which staff members did not provide Resident A with his full dose of Clindamycin, and will counsel each staff member who passed medications during the run of this medication. She also stated that she will talk about medication administration at the next staff meeting on December 18th.

On 12/11/2017, I called and spoke with Michelle Schiebel, Recipient Rights Officer. Ms. Schiebel stated that the staff members who passed medications denied that they did not pass Resident A's Clindamycin correctly. Ms. Schiebel told me she learned that Resident A was prescribed Clindamycin for cellulitis and the dosage was three pills, three times a day for ten days. However, it wasn't discovered until

the 10th day that the correct dosage was not been being, resulting in 40 pills that had not been given. Ms. Schiebel told me that she verified that the transcription in the MAR for Resident A's Clindamycin was correct, and that the bottle, the MAR, and the prescription all matched. Ms. Schiebel spoke with a doctor and inquired about the risk of harm regarding this medication error and was informed that it could have resulted in the spread of cellulitis to other parts of Resident A's body.

On 12/12/2017, I called and held an exit conference with Barry Bruns, the Licensee Designee for this home. I informed Mr. Bruns that I was citing a violation of this rule because Resident A had not been given his proper dosage of Clindamycin for several days, as evidenced in there being 40 extra pills on the last day of the ten days for which it was prescribed to be taken. Mr. Bruns replied that he expected this finding and reported that it was being handled internally.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A was not given his full dosage of Clindamycin during the ten-day run of this medication. At the end of the run, there were 40 pills leftover.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that upon receipt of an acceptable corrective action plan, that the status of this home's license remain unchanged, and that this special investigation be closed.

December 12, 2017

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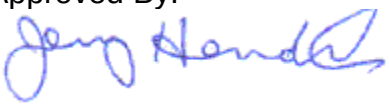
Ian Tschirhart Date
Licensing Consultant

Approved By:



December 12, 2017

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Jerry Hendrick Date
Area Manager