RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

March 16, 2018

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

RE: License #: AS390087990
Investigation #: **2018A0578025**
5359 North 8th St 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 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.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390087990
Investigation #:	2018A0578025
Complaint Receipt Date:	02/21/2018
Investigation Initiation Date:	02/22/2018
Report Due Date:	04/22/2018
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:	5359 North 8th St AFC
Facility Address:	5359 North 8th St Kalamazoo, MI 49009
Facility Telephone #:	(269) 353-8869
Original Issuance Date:	09/13/1999
License **Status:**	REGULAR
Effective Date:	04/07/2016
Expiration Date:	04/06/2018
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff member Melanie Vargas became distracted when passing medications and gave the wrong medications to Resident A, resulting in Resident A being taken to ER.	Yes

III. METHODOLOGY

02/21/2018	Special Investigation Intake 2018A0578025
02/22/2018	Special Investigation Initiated - Telephone KCMHSASORR
02/22/2018	APS Referral Completed
02/23/2018	Inspection Completed On-site- Interview with Resident A.
03/01/2018	Contact-Phone Interview With staff member Melanie Vargas
03/08/2018	Exit Conference With licensee Barry Bruns

ALLEGATION:
Staff member Melanie Vargas became distracted when passing medications and gave the wrong medications to Resident A, resulting in Resident A being taken to ER.

INVESTIGATION:
On 02/21/2018, I received this complaint through the BCAL on-line complaint system. Complainant alleged that while passing medications, staff member Melanie Vargas set up more than one set of resident medications. Complainant alleged Resident A came to Ms. Vargas and requested her medications that were already set up to be administered. Complainant alleged Ms. Vargas gave the wrong cup of medications to Resident A. Resident A allegedly received the following medications in error: Fenofibrate cap 135mg, Tegretol XR 200mg, Ativan 1mg, Cogentin 1mg, Lexapro 15mg, Lithium Carb tab 300mg, Risperdal 1mg, and Topamax tab 100mg. Because of this error, Resident A was taken to the ER on 2/16/18.

On 02/21/2018, I reviewed the details of the allegations with Kalamazoo Community Mental Health and Substance Abuse Services Recipient Rights Officer Michele Schiebel. Ms. Schiebel reported she was aware of the allegations and the medications consumed by Resident A and added that a risk of harm consultation was completed that indicated Resident A could have experienced bodily injury due

to falling or not being familiar with the medications. Ms. Schiebel reported she was substantiating a violation of Resident A's rights.

On 02/21/2018, I reviewed the *AFC Incident/Accident Report* related to the allegations. Completed on 02/16/2018 by staff member Melanie Vargas, the report includes the following information:

> "Staff MV (Melanie Vargas) reported to JS at approx. 8:40am that [Resident A] was given the wrong medications during morning med pass on 02/16/2018. MV (Melanie Vargas) passed [Resident A] [Resident B]'s medications. MV (Melanie Vargas) explained both cups of medications were sitting on the med table. MV (Melanie Vargas) reported she attempted to pass [Resident B] his medications when he suddenly needed to use the restroom. [Resident A] approached the med room and staff MV (Melanie Vargas) accidentally grabbed [Resident B]'s container of medications and handed it to [Resident A]. Staff JS immediately reported the situation to home manager KC (Karmen Cryderman) at 8:42am. KC instructed staff to transport [Resident A] to Bronson E.R. immediately. Staff MV (Melanie Vargas) transported [Resident A] to the emergency room at 8:47am."

On 03/01/2018, I interviewed staff member Melanie Vargas by phone regarding the allegations. Ms. Vargas agreed that she worked during the day on 02/16/2018 and commented that several residents were awake while she was preparing medications in the morning. Ms. Vargas explained how she had prepared medications for Resident A when they had to quickly go to the bathroom. Ms. Vargas explained while Resident A was in the bathroom she began preparing medications for Resident B. Ms. Vargas explained that she had left the medication cup for Resident A on the shelf of the door to the medication room, which resulted in Resident B grabbing the wrong cup and consuming the wrong medications. Ms. Vargas reported she could see the medications through the bottom of the clear cup and immediately recognized the medications did not belong to Resident B. Ms. Vargas stated she reported the event to her supervisor and the home manager and Resident A was transported to the hospital.

On 02/23/2018, I completed an unannounced on-site investigation at the facility and interviewed Resident A. Resident A agreed that she recently went to the hospital related to taking the wrong medications. Resident A explained the event occurred in the morning but could not recall details of the event. Resident A denied that she had ever received the wrong medications before.

While at the home, I reviewed the details of the event with staff member Jennifer Scofield. Ms. Scofield provided a list of the following medications that were ingested by Resident A in error:

Fenofibrate cap 135mg
Tegretol-XR 200mg
Ativan 1mg

Cogentin 1mg
Lexapro 15mg
Lithium Carb tab 300mg
Risperdal 1mg
Topamax tab 100mg.

I reviewed Resident A's discharge summary provided by Sherrie Bencik, MD, at Bronson Hospital on 02/16/2018. Dr. Bencik stated the following in her findings:

> "Patient asymptomatic. I reviewed the medications that she accidentally took and am not concerned with a one-time dose."

Resident A was discharged from Bronson Hospital with no special instructions.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the interview with staff member Melanie Vargas, and the *AFC Incident/Accident Report* completed on the same day of the event, medications were left unsecured in a container other than the original supplied by the pharmacy, on a shelf near the kitchen area of the home. This allowed Resident A access to another resident's medications and resulted in Resident A consuming the wrong medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

ANALYSIS:	Ms. Vargas acknowledged that she did not take reasonable precautions to ensure the medications provided to Resident A were prescribed to her, instead leaving medications in an unlabeled container on a counter. Consequently, prescribed medications were consumed by Resident A that were not intended for further causing Resident A to need medical evaluation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

03/15/2018

Eli DeLeon Date
Licensing Consultant

Approved By:

03/16/2018

Dawn N. Timm Date
Area Manager