RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

January 9, 2018

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

RE: License #: AS390252741
Investigation #: **2018A0578012**
10633 West J Avenue

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. 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,

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 #:	AS390252741
Investigation #:	2018A0578012
Complaint Receipt Date:	12/12/2017
Investigation Initiation Date:	12/12/2017
Report Due Date:	02/10/2018
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:	10633 West J Avenue
Facility Address:	10633 West J Avenue Kalamazoo, MI 49009
Facility Telephone #:	(269) 353-1809
Original Issuance Date:	10/31/2002
License Status:	REGULAR
Effective Date:	05/02/2017
Expiration Date:	05/01/2019
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff member Taylor Gustinis dispensed medications for Resident A, which were administered to Resident B by staff member Anna Seman.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/12/2017	Special Investigation Intake 2018A0578012
12/12/2017	Special Investigation Initiated - Telephone
12/12/2017	Document Review - *AFC Incident / Accident Report*
12/14/2017	On-site investigation completed – Interviewed staff member Taylor Gustinis and staff member Anna Seman.
12/14/2017	Contact – Telephone Interview – Completed with staff member Karmen Cryderman.
01/09/2017	Exit Conference- Completed with licensee Barry Bruns.

ALLEGATION:
Staff member Taylor Gustinis dispensed medications for Resident A, which were administered to Resident B by staff member Anna Seman.

INVESTIGATION:
On 12/12/2017, I received a verbal complaint from Complainant that Resident A received medications prescribed to for Resident B and was transported to Borgess Hospital for observation. Mr. Anzell reported staff did not follow the appropriate medication procedures established by the licensee.

I reviewed the *AFC Incident / Accident Report* completed by staff member Taylor Gustinis on 12/07/2017, which provided the following information:

> "At 8:50PM, staff [Taylor Gustinis] went to a resident's bedroom to pass her 8PM medication. As staff [Taylor Gustinis] was doing that, staff [Anna Seman] was buddy checking another residents medications. While staff [Taylor Gustinis] was passing the residents medications in her bedroom, staff [Anna Seman] passed [Resident A] the medications that she had checked. [Resident A] noticed that she could not swallow one of the medications that she was given and asked staff to

check and see what it was. Staff [Anna Seman] went into the medication room to check, as [Taylor Gustinis] was still downstairs, and noticed that it was not one of [Resident A]'s medications. When staff [Taylor Gustinis] came upstairs [Anna Seman] explained to her what happened and discovered that [Anna Seman] had passed [Resident A] another resident's medications. Staff [Taylor Gustinis] called house on-call at 9:14PM and explained the situation…"

"Admin on-call then advised staff the [Resident A] would need to go to the ER due to an unknown possible reactions to the medications. Staff notified house on-call and house on-call got ready to come in. At 9:38PM admin on-call called staff again and requested for [Resident A] to be transported to the hospital via ambulance and to call 911. At 9:40PM staff called 911, explaining what happened and the need for the ambulance. Staff talked to dispatch and was advised to watch for any change of color, lack of alertness, increased complaints or anything abnormal. Staff kept eyes on [Resident A] as they answered questions the dispatch had. At 10:00PM the ambulance arrived at the house and talked with [Resident A] to see how she was feeling. [Resident A] stated that she felt alright other than she was tired. The paramedics asked for a list of medications [Resident A] took which was Dicyclomine Cap 10mg (1), Docusate 500 Cap 100mg (1), Clozapine tab 25mg (2), Lorazepam tab 1mg (1), Quetiapine tab 300mg (1). At 10:08PM [Resident A] left in the ambulance and house on-call followed shortly after. Paramedics stated the only expected side effect was being extra tired and that the only medications they were worried about was the Quetiapine tab 300mg but [Resident A] is prescribed it with her 8PM medications so it should not have any unexpected reaction. Paramedics and staff decided to transport her for safety factors. At 10:08PM as [Resident A] was leaving, staff notified admin on-call. [Resident A]'s 8PM medications were disposed with witness. [Resident A] was transported to Borgess ER. [Resident A's] routine 8PM meds are Trileptal 150mg, Clotrimazole 1% cream, Benzotropine 0.5mg tab, and Seroquel 300mg tablet."

On 12/14/2017, I completed an investigation at the facility and interviewed staff member Anna Seman regarding the allegations. Ms. Seman agreed that she worked the day of 12/07/2017 with staff member Taylor Gustinis. Ms. Seman explained that the both of them usually split staff responsibilities and one of them would prepare the meal while the other staff prepared medications. Ms. Seman explained during this particular shift, she was preparing meals while Ms. Gustinis was preparing medications. Ms. Seman explained when one staff prepares medications, the other staff compares the empty blister packs to the medication administration record.

Ms. Seman explained it was Resident A's very first day in the facility. Ms. Seman explained she had just returned from taking several residents to the movies and had received approval to pass medications late but wanted to complete them before the approval was necessary. Ms. Seman stated Ms. Gustinis had prepared medications for Resident A and Resident B in the medication room and had left the room to prompt Resident B to take her medications. Ms. Seman stated while Ms. Gustinis

had left the medication room, Ms. Seman began to compare the empty blister packs to the medications administration records when she became aware that Resident A was present and asking for her medications. Ms. Seman stated this startled her and she grabbed a cup of medications that was in the corner of the counter and provided those to Resident A. Ms. Seman stated Resident A took the medications and went to sit at the kitchen table when she dropped one of her medications on the ground. Ms. Seman stated Resident A did not recognize this medication and requested that staff identify it. Ms. Seman stated she went back to the medication room and obtained the medication sheet for Resident A to compare the medication to her list of medications but could not identify the medication. Upon further review, Ms. Seman realized none of the medications she provided to Resident A matched what was prescribed to Resident A. Ms. Seman could not identify the exact time but stated it was sometime after 9PM. Ms. Seman reported Ms. Gustinis called staff member Karmen Cryderman who informed her to call 911. Ms. Seman reported emergency services arrived right away and Resident A was taken to the hospital for observation. Ms. Seman denied that she recorded her initials on Resident A's medication record at the time the medications were given, stating she was just trying to help and was caught off guard when Resident A asked for her medications.

I also interviewed staff member Taylor Gustinis regarding the allegations. Ms. Gustinis agreed that she worked the day of 12/07/2017 with staff member Anna Seman. Ms. Gustinis reported that she was the staff responsible for medications while Ms. Seman prepared meals. Ms. Gustinis stated she usually prepares medications for one resident at a time, but the outing was late and she was trying to get everyone their medications in time once they returned, so she had prepared the medications and placed them in a medication cup on the counter in the medication room. Ms. Gustinis stated she had gone to a resident bedroom to prompt them for their medication while Ms. Seman checked previously administered medications. Ms. Gustinis stated this was when Resident A asked Ms. Seman for her medications. Ms. Gustinis stated Ms. Seman grabbed the medications she had just checked instead of the medications prepared for Resident A.

Ms. Gustinis stated Resident A had returned a pill to Ms. Seman, stating it was too large and she didn't recognize it. Ms. Gustinis stated she then asked Ms. Seman what was going on and she recognized the medication as lithium carbonate, which was not a medication prescribed to Resident A. Ms. Gustinis stated Ms. Seman asked Resident B if she had taken her medications since she is prescribed lithium carbonate and she denied taking them. Ms. Gustinis stated this was when they realized Resident A was provided the wrong medications. Ms. Gustinis stated the called the house on-call as well as the administrative on-call, which was Karmen Cryderman. Ms. Gustinis stated she was instructed to take Resident A to the hospital, but she was then informed by the administrative on-call to contact emergency services.

I also interviewed staff member Karmen Cryderman regarding the allegations. Ms. Cryderman agreed she was the administrative on-call on 12/07/2017 and was

contacted by Ms. Gustinis regarding the incident. Ms. Cryderman reported she was informed Resident A received all of Resident B's medications with the exception of Resident B's lithium carbonate. Ms. Cryderman identified Ms. Seman as the staff responsible and instructed staff to identify Resident A's drug allergies and none were identified. Ms. Cryderman stated she instructed staff to call the house on-call and transport Resident A to the hospital. Ms. Cryderman stated she began to search for side effects of the medications when she decided to call the staff back and instruct them to call 911 and observe Resident A until emergency services arrived. Ms. Cryderman reported staff initially called her at 9:27PM.

I reviewed the *Patient Discharge Instructions* related to the treatment of Resident A at Borgess Medical Center. The report indicates Resident A was treated on 12/08/2017 by attending physician Umayr Azimi, MD. Resident A's diagnoses during this visit were "poisoning by unspecified drugs, medicaments and biological substances, accidental (unintentional), and altered mental status, unspecified". Resident A was advised to follow up with behavioral health and psychiatry and her primary care provider. Discharge information for Resident A identified a regular diet with no restrictions and activity as tolerated.

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. Seman acknowledged that she did not take reasonable precautions to ensure the medications provided to Resident A were prescribed to her, instead providing medications that were pre-dispensed, which Ms. Seman did not prepare or identify previous to their administration to Resident A. Consequently, prescribed medications were to passed to a resident they were not intended for further causing Resident A to need medical evaluation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

Ms. Gustinis stated she usually prepares medications for one resident at a time, but the outing was late and she was trying to get everyone their medications in time once they returned, so she had prepared all of the resident medications and placed them in a medication cup on the counter in the medication room.

Ms. Seman stated she noticed another medication cup in the medication area that matched the medications on Resident A's medication sheets and noticed Resident

A's initials inscribed on the side of the cup with permanent marker. Ms. Seman stated this was when she realized the error occurred. Ms. Seman denied that medications are typically prepared in advance and stored in cups with resident initials on the side.

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 S333.1101 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:	During their interviews, Ms. Seman and Ms. Gustinis acknowledged medications were unsecured and available in the medication room without being contained in the original pharmacy-supplied container labeled for the specific resident before they were administered to Resident A. Ms. Seman and Ms. Gustinis both acknowledged this was done in order to complete medications on time.
CONCLUSION:	**VIOLATION ESTABLISHED**

I also interviewed staff member Aaron Anzell regarding the allegations. Mr. Anzell was able to provide medication administration records for Resident A. Mr. Anzell confirmed that evening medications for Resident A on 12/07/2017 did not have the initials of the staff that passed the medications at the time of administration, and instead had a "O" code, meaning "Other", referring to a nurse's note that explained the event. Mr. Anzell acknowledged that Resident A had since been discharged and returned to the facility.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:**

	(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Based on a review of the medication administration record, Ms. Seman administered medications to Resident A without completing the individual medication log at the time the medication was given.
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.

12/26/2017

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Eli DeLeon Date
Licensing Consultant

Approved By:

01/09/2018

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Dawn N. Timm Date
Area Manager