RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

July 03, 2018

Scott Schrum
Residential Opportunities, Inc.
1100 South Rose Street
Kalamazoo, MI 49001

RE: License #: AS390314010
Investigation #: **2018A0462031**
Hill an Brook AFC

Dear Mr. Schrum:

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,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390314010
Investigation #:	2018A0462031
Complaint Receipt Date:	05/11/2018
Investigation Initiation Date:	05/11/2018
Report Due Date:	07/10/2018
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	David Stedman
Licensee Designee:	Scott Schrum
Name of Facility:	Hill an Brook AFC
Facility Address:	2702 Hill an Brook Dr. Portage, MI 49024
Facility Telephone #:	(269) 488-0977
Original Issuance Date:	10/17/2011
License Status:	REGULAR
Effective Date:	04/28/2018
Expiration Date:	04/27/2020
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care workers failed to administer Resident A his medication Keppra pursuant to label instructions.	Yes

III. METHODOLOGY

05/11/2018	Special Investigation Intake 2018A0462031
05/11/2018	Special Investigation Initiated – Telephone interview with RRO Suzie Suchyta.
05/14/2018	Contact - Telephone interview with ORR Lisa Smith.
05/30/2018	Unannounced investigation at the facility. Interview with administrator David Stedman and DCW Anna Sleeper.
06/29/2018	Documents requested and received.
06/29/2018	Referral made to Kalamazoo County APS.
06/29/2018	Exit conference with licensee designee Scott Schrum.

ALLEGATION:

Direct care workers failed to administer Resident A his medication Keppra pursuant to label instructions.

INVESTIGATION:

On 05/11/2018 I received a telephone call from Kalamazoo County recipient rights officer (RRO) Suzie Suchyta. Ms. Suchyta informed me that on 05/05/2018 direct care workers (DCW) at the facility failed to administer Resident A half of his evening dose of the anti-epileptic medication Keppra. As a result, on 05/06/2018 Resident A experienced a seizure and was hospitalized for two nights. Ms. Suchyta stated that Resident A was discharged from the hospital and had returned to the facility.

I reviewed an *AFC Incident/Accident Report* (IR) written and faxed to the department by administrator David Stedman on 05/07/2018. The IR indicated that at approximately 4:16 PM Resident A had a seizure which lasted five minutes. According to Resident A's seizure protocol DCWs rectally administered Resident A

the medication Diazepam. However, shortly after that Resident A experienced another seizure. The IR indicated that Resident A was transported to Borgess hospital and then later admitted. The IR indicated that an unidentified hospice agency was notified of the situation and DCWs would continue to follow Resident A's seizure protocol.

On 05/14/2018 I conducted a telephone interview with RRO Lisa Smith. Mrs. Smith confirmed the allegation that DCWs failed to administer Resident A half of a dose of his Keppra the evening of 05/05/2018. Mrs. Smith confirmed that on 05/06/2018 Resident A experienced two seizures and was admitted into the hospital. Mrs. Smith informed me that on the morning of 05/06/2018 Resident A had also refused all of his morning medications, which included his Keppra. Mrs. Smith stated that while it was confirmed that the facility made a medication error on the evening of 05/05/2018, because Resident A refused all of his medications on the morning of 05/06/2018, there was no way to determine whether the medication error on 05/05/2018 was the cause of Resident A's seizures.

On 05/30/2018 I conducted an unannounced investigation at the facility and attempted to interview Resident A who was unable to be interviewed. I interviewed administrator David Stedman who stated that Resident A had a diagnosis of Epilepsy and was to be administered two 500MG tablets of Keppra twice daily. I reviewed Resident A's *Health Care Appraisal*, as well as the labeling instructions on Resident A's bubble pack of Keppra, which confirmed this information. Mr. Stedman stated that on the evening of 05/05/2018 DCW Kiyondra Edmonds accidentally administered one tablet of Keppra to Resident A instead of two. However, because Ms. Edmonds documented on Resident A's May medication administration record (MAR) that Resident A had received his full dose of Keppra on the evening of 05/05/2018, this error was not discovered until a medication count was conducted on 05/06/2018. I reviewed documentation on Resident A's May MAR which confirmed this information. Mr. Stedman stated that before this medication error was discovered, Resident A refused to take all his medications on the morning of 05/06/2018, and at approximately 4:00 PM Resident A experienced two seizures, one of which lasted five minutes. Mr. Stedman further provided me with the same information that was documented on the IR submitted to the department on 05/07/2018.

I reviewed Resident A's physician's orders for medication and the documentation on Resident A's May MAR, which indicated that Resident A was prescribed the following scheduled medications to treat seizures:

- Keppra 500MG, two tablets twice daily
- Dilantin 100MG, two tbs twice daily
- Onfi 10MG, 1.5 tablets daily
- Onfi 10MG, one tablet at bedtime
- Valproic Acid, 20ML twice daily
- Vimpat, 200MG tablet twice daily

According to documentation on Resident A's May MAR, the facility scheduled the following times for these medications to be administered to Resident A:

- Keppra 500MG, two tablets at 10:00 AM and 8:00 PM
- Dilantin 100MG, two tbs at 10:00 AM and 8:00 PM
- Onfi 10MG, 1.5 tablets at 10:00 AM
- Onfi 10MG, one tablet at 8:00 PM
- Valproic Acid, 20ML at 10:00 AM and 8:00 PM
- Vimpat, 200MG tablet at 10:00 AM and 8:00 PM

I reviewed a document provided to me by Mr. Stedman titled *Residential Opportunities, Inc. Protocols for Medication Errors* that was signed by Resident A's physician on 03/26/2018. According to the instructions on this document, DCWs were to do the following if Resident A was not administered a medication within a ½-hour window of the scheduled time:

- Keppra: Give up to four hours late. After that time lapse omit missed dosage, resume medication at next scheduled dosage.

- Dilantin: Give up to four hours late. After that time lapse omit missed dosage, resume medication at next scheduled dosage.

- Onfi: Give up to four hours late. After that time lapse omit missed dosage, resume medication at next scheduled dosage.

- Valproic Acid (Depakote): Give up to two hours late. After that time lapse omit missed dosage, resume medication at next scheduled dosage.

- Vimpat: Give up to four hours late. After that time lapse omit missed dosage, resume medication at next scheduled dosage.

Mr. Stedman provided me with an additional copy of an IR written by both him and DCW Anna Sleeper on 05/06/2018 and 05/07/2018. This IR was filed in Resident A's record located in the facility. According to documentation on this IR, on 05/06/2018 Resident A refused his morning medications. Documentation indicated that Ms. Sleeper encouraged Resident A to take his medication and then later followed the instructions indicated for missed medication on Resident A's *Residential Opportunities, Inc. Protocols for Medication Errors* form. Documentation on the IR indicated that Ms. Sleeper notified Resident A's primary care physician of Resident A's refusal to take his morning medications.

I interviewed Ms. Sleeper who confirmed that while counting Resident A's medications on 05/06/2018 she discovered the medication error made by Ms. Edmonds the evening of 05/05/2018. Ms. Sleeper also confirmed that she discovered the error following Resident A's refusal to take his morning medications.

Ms. Sleeper further provided me with the same information indicated on the IR submitted to the department on 05/07/2018, as well as provided me with the same information indicated on the additional IR filed in Resident A's record.

I requested confirmation of Ms. Edmonds training in the area of medication administration. Facility staff member Caitlin Bradac, whose title is human resources assistant, provided me with documentation verifying that on 02/16/2018 Ms. Edmonds was trained in medication administration.

According to a Licensing Study Report (LSR), dated 04/26/2016, the facility was in violation of rule 400.14312(2) when it was established that several of the residents' "as needed" (PRN) medications did not indicate the reason for administration. On 05/11/2016 licensee designee Scott Schrum submitted an acceptable corrective action plan (CAP) indicating that prescribing physicians would be contacted and asked to rewrite orders for PRN medications to include specific conditions under which PRN medications should be administered.

According to Special Investigation Report (SIR) #2017A0462041, dated 07/25/2017, the facility was in violation of rule 400.14312(2) when it was established that due to an ongoing DCW shortage at the facility, a resident was not administered her medication Lamictal on 05/28/2017. On 08/03/2017 Mr. Schrum submitted an acceptable CAP indicating that relief DCWs asked to work at the facility would be further trained on the nuances of administering medication at the facility to ensure that DCWs were competent and comfortable with their responsibilities.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On the evening of 05/05/2018 DCW Kiyondra Edmonds accidentally administered Resident A one 500MG tablet of Keppra instead of two as prescribed. On the morning of 05/06/2017 Resident A refused to take his morning medications, including several medications prescribed to treat his seizures. There is no way to determine whether the medication error on 05/05/2018 was the cause of Resident A's seizures and hospitalization on 05/06/2018. It has been established that on the evening of 05/05/2018 Resident A was not administered his medication Keppra pursuant to label instructions.

CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [REFERENCE LSR dated 04/26/2016 and CAP dated 05/11/2016. REFERENCE SIR#2017A0462041 dated 07/25/2017 and CAP dated 08/03/2017.**

On 06/29/2018 I conducted an exit conference with Mr. Schrum and shared with him the findings of this investigation.

IV. RECOMMENDATION

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

07/02/2018

Michele Streeter Date
Licensing Consultant

Approved By:

07/03/2018

Dawn N. Timm Date
Area Manager