RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

December 9, 2018

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

RE: License #: AM390084283
Investigation #: **2019A0579008**
824 W. Kalamazoo

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,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM390084283
Investigation #:	2019A0579008
Complaint Receipt Date:	10/26/2018
Investigation Initiation Date:	10/26/2018
Report Due Date:	11/25/2018
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:	824 W. Kalamazoo
Facility Address:	824 W Kalamazoo Kalamazoo, MI 49007
Facility Telephone #:	(269) 373-8815
Original Issuance Date:	12/15/1998
License **Status:**	REGULAR
Effective Date:	06/19/2017
Expiration Date:	06/18/2019
Capacity:	12
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff pre-set medication which resulted in Resident A receiving Resident B's medication and having to go to the hospital.	Yes

III. METHODOLOGY

10/26/2018	Special Investigation Intake 2019A0579008
10/26/2018	Special Investigation Initiated - Letter Allegations referred to Recipient Rights.
10/29/2018	Contact- Face to Face Unannounced on-site interviews completed with Resident A and Resident B.
11/21/2018	Contact- Telephone call made Telephone interview completed with staff, Ms. Chelsea Gholston.
11/21/2018	Exit Conference

ALLEGATION: Staff pre-set medication which resulted in Resident A receiving Resident B's medication and having to go to the hospital.

INVESTIGATION: On 10/26/2018, I received this complaint through the BCHS on-line complaint system. The complaint alleged staff pre-set medication which resulted in Resident A receiving Resident B's medication and having to go to the hospital.

On 10/26/2018, I reviewed the *Incident/Accident Report* forms for Resident A and Resident B which both documented that direct care staff member, Chelsea Gholston, "pre-popped pills" which resulted in Resident A receiving Resident B's medication. Resident A was taken to Bronson Emergency Room for monitoring.

On 10/26/2018, I exchanged emails with Recipient Rights Officer, Ms. Lisa Smith, who stated Recipient Rights also received the *Incident/Accident Report* regarding the incident. She stated since corrective measures were put in place and the resident did not have a significant medical incident following the error, Recipient Rights opted to not investigate this incident.

On 10/29/2018, I completed unannounced on-site interviews at the facility individually with Resident A and Resident B. Resident A stated "Staff Chelsea"

made a mistake and gave him another resident's medication. He stated he was taken to the hospital after taking the wrong medication. He stated the medication made him feel "strange", "kind of odd", "like [he] was high", and "groggy." He stated "it took a week for [him] to get back to normal." He denied any concern with his medication prior to or since that incident.

Resident B denied there being any incident involving his medication. He denied receiving a medication not prescribed to him. He denied receiving the wrong dose of medication or not receiving medication. He denied having to go to the hospital due to an incident with his medication. Resident B stated he has felt "good" and denied any concerns with his medication or health.

On 11/21/2018, I completed a telephone interview with staff, Ms. Chelsea Gholston, who stated Resident A and Resident B are the two residents in the home who take blood sugar medication, so they were easily confused. She stated she was rushing during her shift and "pre-popped" the medication. She stated after passing the medication to Resident A, she realized it was the wrong medication. She stated on the day of the incident, Resident A was already emotional over a female resident but after taking the medication, he began rubbing his head. She stated he was taken to the hospital, observed, and then returned to the home. She stated she was spoken to and will no longer "pre-pop" the medication.

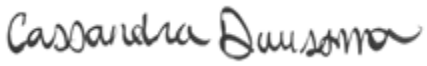
On 11/21/2018, I completed an exit conference with licensee designee, Mr. Bruns, who did not dispute my findings or recommendation.

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:	Ms. Gholston acknowledged she took resident medication, for multiple residents, from the original pharmacy-suppled container and put it in cups prior to passing the medication to each resident. This led to Resident A receiving Resident B's medication and having to be observed in the hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.



11/21/2018

Cassandra Duursma Date
Licensing Consultant

Approved By:

12/09/2018

Dawn N. Timm Date
Area Manager