RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

December 21, 2018

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

RE: License #: AM390084283
Investigation #: **2019A0579010**
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 #:	2019A0579010
Complaint Receipt Date:	10/31/2018
Investigation Initiation Date:	10/31/2018
Report Due Date:	12/30/2018
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?
On 10/26/18, staff Bialo Aladun gave Resident B 9mg instead of his prescribed 3mg of Warfarin.	Yes

III. METHODOLOGY

10/31/2018	Special Investigation Intake 2019A0579010
10/31/2018	Special Investigation Initiated - Letter Emails exchanged with Complainant.
10/31/2018	Documentation received Reviewed Resident B's interview from 10/29/2018.
11/022018	Documentation received *Incident/Accident Report* received.
11/19/2018	Documentation received Received staff, Bialo Aladun 's, contact information.
11/21/2018	Telephone call made Telephone interview completed with staff, Mr. Aladun.
11/21/2018	Exit Conference

ALLEGATION: On 10/26/18, staff Bialo Aladun gave Resident B 9mg instead of his prescribed 3mg of Warfarin.

INVESTIGATION: On 10/31/2018, I received this complaint through the BCHS online complaint system. The complaint alleged that on 10/26/18 direct care staff member Bialo Aladun gave Resident B 9mg of Warfarin instead of his prescribed 3mg of Warfarin. This dose of blood thinner put Resident B at risk of internal or other bleeding due to the additional dosage.

On 10/31/2018, I exchanged emails with Complainant who confirmed the allegations as reported and stated an *Incident/Accident Report* was completed for the incident as well.

On 10/31/2018, I reviewed my documentation from an interview with Resident B that was completed on 10/29/2018. This interview with Resident B was completed after this alleged incident which was documented as having occurred on 10/26/2018. During that interview, I discussed Resident B's medication with him. On 10/29/2018, Resident B denied there being any incident involving his medication. He denied receiving a medication not prescribed to him, denied receiving the wrong dose of medication or not receiving medication, and also 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 11/02/2018, I received the *Incident/Accident Report* (IR)for the incident which stated on 10/26/2018, direct care staff member Mr. Bialo Aladun accidentally passed 9 MG of Warfarin to Resident B. The IR noted that following the medication error, Mr. Aladun contacted Resident B's doctor and was then advised to contact the triage nurse. The nurse advised direct care staff members to hold Resident B's Warfarin for one day and return to his normal passing schedule on 10/28/2018. The IR noted Poison Control was also contacted and advised direct care staff members to ensure that Resident B did not bump his head and to notify Resident B's doctor of the error should this medication error change any upcoming blood testing or medication appointments Resident B has scheduled.

Included with the *Incident/Accident Report* was Resident B's *Medication Administration Record (MAR)* which noted Resident B is prescribed Warfarin 6 MG one tablet on Tuesday, Thursday, Saturday, and Sunday and Warfarin 6 MG halved tablet on Monday, Wednesday, Friday. On 10/26/2018, which was a Friday, Resident B was due to receive the halved tablet or 3 MG but Mr. Aladun passed a halved tablet and whole tablet resulting in Resident B receiving 9 MG.

On 11/21/2018, I completed a telephone interview with Mr. Aladun who stated he typically works first shift and is familiar with Resident B's morning medication. He stated on 10/26/2018, he worked both first and second shift and had to pass Resident B's evening medication. He stated in passing the evening medication, he accidentally passed the wrong dosage due to Resident B receiving varying dosages on different days. He denied Resident B displaying any side effects and reported Resident B's doctor's office advised to just hold Resident B's next medication pass

for that medication. He stated he was retrained in medication and he was observed passing medication in response to him making this error.

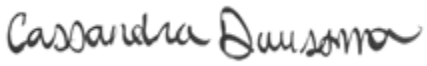
Special Investigation #2019A0579008, dated 10/26/2018, established violation of Rule 400.14312 (1) after a staff member removed medication from the original pharmacy containers, preset the medication in labeled medication cups, and then proceeded to pass to the wrong resident. This resident had to be observed at the hospital due to the types of medication passed to the resident. A corrective action plan was pending at the time of this report.

On 11/21/2018, I completed an Exit Conference with licensee designee, Mr. Bruns, who did not dispute my findings or recommendations.

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:	Staff, Mr. Aladun, reported he was not familiar with Resident B's evening medications and due to Resident B' Warfarin having varying dosages on different days, he accidentally gave Resident B an incorrect dosage. This resulted in Resident B taking 9 MG which is not the dosage that was not prescribed to Resident B.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR # 2019A0579008 DATED 10/26/2018 AND CAP- Pending]**

IV. RECOMMENDATION

Upon receipt of an acceptable plan of corrective action, it is recommended the status of the license remain the same.



11/21/2018

Cassandra Duursma — Date
Licensing Consultant

Approved By:

12/21/2018

Dawn N. Timm — Date
Area Manager