GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 6, 2019

Kathleen Taylor
Consumer Services, Inc.
585 Jewett Rd.
Mason, MI 48854

RE: License #: AS780304830
Investigation #: 2020A0584002
Matthews Home

Dear Ms. Taylor:

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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9700.

Sincerely,

Candace L. Pilarski

Candace Pilarski, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-8967 enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS780304830
Investigation #:	2020A0584002
Complaint Receipt Date:	10/10/2019
Investigation Initiation Date:	10/11/2019
Report Due Date:	12/09/2019
Licensee Name:	Consumer Services, Inc.
Licensee Address:	585 Jewett Rd. Mason, MI 48854
Licensee Telephone #:	(517) 833-8100
Administrator:	Kathleen Taylor
Licensee Designee:	Kathleen Taylor
Name of Facility:	Matthews Home
Facility Address:	1016 Wood Ct. Owosso, MI 48867
Facility Telephone #:	(989) 723-3554
Original Issuance Date:	01/14/2010
License **Status:**	REGULAR
Effective Date:	08/06/2018
Expiration Date:	08/05/2020
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Samantha Rogers reported that she accidently gave Resident A another resident's medications. Resident was taken to the ER for evaluation.	Yes

III. METHODOLOGY

10/10/2019	Special Investigation Intake 2020A0584002
10/11/2019	Special Investigation Initiated - Letter Email to Andrea Andrykovich-Recipient Rights Director
10/11/2019	Contact - Document Received From APS intake-denied referral for investigation
10/11/2019	Contact - Telephone call received With Andrea Andrykovich
10/18/2019	Contact - Face to Face-With Resident A
10/18/2019	Contact - Face to Face-With Samantha Rogers, Direct care worker
10/18/2019	Contact - Face to Face-With Jared Ward, Home Manager
10/19/2019	Inspection Completed-BCAL Sub. Compliance Onsite
11/13/2019	Contact - Document Sent email sent to Kathleen Taylor, Licensee Designee
11/19/2019	Contact - Telephone call made Kathy Taylor, Consumer Services left message to call
11/19/2019	Exit Conference-With Kathy Taylor, Licensee designee

ALLEGATION:
Direct care staff member Samantha Rogers reported that she accidently gave Resident A another resident's medications. Resident was taken to the ER for evaluation.

INVESTIGATION:

On 10/18/2019, I interviewed Samantha Rogers, direct care worker at the Matthew's Home. Ms. Rogers was the worker on duty that reported the incorrect medication was given to a resident. Ms. Rogers said things were hectic that morning getting the residents that go to program ready for the day. Ms. Rogers stated she had "popped" Resident A's medications from the medication bubble card into a cup. Ms. Rogers said that Resident A was waiting for her medications while they were being popped into the cup, but then Resident A went back down the hallway to get a sweater. Ms. Rogers stated she then popped another resident's medications and placed them on the counter next to Resident A's medications. Ms. Rogers stated she saw Resident A approach the medication room and handed her a cup of medications. Ms. Rogers stated she grabbed the second cup of medications and gave to Resident A by mistake. Resident A had already swallowed the contents of the medication cup which contained the second resident's medications. Ms. Rogers stated she immediately notified management of her error and contacted poison control. Ms. Rogers then called EMS to evaluate Resident A. Ms. Rogers stated she has worked with the facility for a few years and knows she should not have prepared more than one resident's medications at a time. Ms. Rogers stated she understood and has been trained to not prepare more than one resident medication at a time. Ms. Rogers stated she did the two to save some time and admitted that she mixed them up even though that was not her intent.

On 10/18/2019, I observed and interviewed Resident A. Resident A is not able to completely understand or comprehend questions. Resident A appeared very healthy and was happy to have someone chat with her. Resident A did remember the incident of going to the ER. Resident A did not answer specific questions about the incident and was happy to show me pictures about Halloween pumpkins.

On 10/18/2019, I interviewed Jared Ward, the home manager for Matthew's Home. Jared Ward was aware of the incident. I asked Mr. Ward what the home policy is for passing medications. Mr. Ward stated that the home policy is to pass medications for each individual and not pass another individual's medications until the one already prepared has been taken and signed for. Mr. Ward stated that Samantha Rogers was aware of her error in not following the trained medication policy. Mr. Ward stated that Resident A did not require any special treatment at the hospital and was released back to the home. Mr. Ward stated that Resident A was sleepier than normal that day.

On 11/19/2019, I conducted an exit conference with Kathleen Taylor, Licensee Designee for Matthews Home.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on the interviews, staff Samantha Rogers understood and has been trained in medication administration, but she knowingly and admittedly did not follow her training. This resulted in Ms. Rogers mistakenly giving medications intended for another resident to Resident A resulting in Resident A being transported and evaluated at the emergency room. Ms. Rogers did not ensure a safe medication passing process by not following her training. The home manger, Jared Ward confirmed that the policy for passing medication is to give one resident medications at a time to prevent such errors.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of this license.

Candace L. Pilarski

_____12/6/2019_____
Candace Pilarski Date
Licensing Consultant

Approved By:

Dawn Timm 12/06/2019

_____
Dawn N. Timm Date
Area Manager