GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 16, 2020

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

RE: License #: AS390279690
Investigation #: 2020A0581020
Litchfield

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390279690
Investigation #:	2020A0581020
Complaint Receipt Date:	02/05/2020
Investigation Initiation Date:	02/05/2020
Report Due Date:	04/05/2020
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	Anthony Tipken
Licensee Designee:	Scott Schrum
Name of Facility:	Litchfield
Facility Address:	6072 Litchfield Kalamazoo, MI 49009
Facility Telephone #:	(269) 343-9728
Original Issuance Date:	12/08/2005
License Status:	REGULAR
Effective Date:	06/23/2018
Expiration Date:	06/22/2020
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was given the wrong dosage of medication after her prescription changed. She experienced side effects and required medical attention.	Yes

III. METHODOLOGY

02/05/2020	Special Investigation Intake 2020A0581020
02/05/2020	Referral - Recipient Rights Kalamazoo Recipient Rights is investigating the complaint.
02/05/2020	Contact - Document Received Received Incident Report from RRO.
02/05/2020	Special Investigation Initiated - Telephone Interview with RRO, Lisa Smith
02/11/2020	Contact - Face to Face Interview with direct care staff at ROI's main office.
03/02/2020	Inspection Completed-BCAL Sub. Compliance
03/03/2020	Exit conference with licensee designee, Scott Schrum.

ALLEGATION:

Resident A was given the wrong dosage of medication after her prescription changed. She experienced side effects and required medical attention.

INVESTIGATION:

On 02/05/2020, I received this complaint from Kalamazoo's Recipient Right's Officer, (RRO), Lisa Smith. Ms. Smith stated she had received an incident report (IR) from the facility on 01/31/2020 stating Resident A's medication, Doxepine, was increased from 20 mg to 40 mg after a doctor's appointment. The IR stated Resident A became groggy and fell after she took the new dosage of the medication. The complaint alleged the pharmacy delivered 400 mg of Doxepine, which staff then administered to Resident A, despite the doctor's order of 40 mg.

On 02/11/2020, Ms. Smith and I, along with ROI's program director, Tara Cyrocki, interviewed the facility's Administrator and Home Manager, Anthony Tipken and direct care staff, Giana Lambert-Coleman and Seth Hatfield.

Mr. Tipken stated Resident A's original prescription for Doxepin, a sleeping aid medication, was for two 10 mg pills or a total of 20 mg at bedtime. He stated after Resident A attended a doctor appointment on 01/27/2020, her physician changed the prescription to four 10 mg pill or a total of 40 mg of Doxepin at bedtime. Mr. Tipken stated the pharmacy delivered Resident A's new prescription on 01/28/2020; however, the pharmacy delivered 100 mg pills of Doxepin instead of the 10 mg pills.

Mr. Tipken stated since the facility had leftover 10 mg pills, staff were able to increase Resident A's dosage in the interim before receiving the additional pills on 01/28/2020. He stated the delivery on 01/28/2020 had occurred during 3rd shift so Resident A did not receive the incorrect dosage of medication until bedtime on 01/29/2020. He stated on 01/29/2020, direct care staff, Seth Hatfield, administered four 100 mg Doxepin pills to Resident A. He stated it was during 3rd shift that Resident A began to display the side effects of the excessive Doxepin dosage and subsequently went to the ER. Mr. Tipken stated the ER provided a new order changing Resident A's Doxepin to two 10 mg pills at bedtime.

I reviewed Resident A's Medication Administration Record (MAR), which confirmed the original prescription and instructions for the Doxepin. The new instructions for the increased dosage resulting from Resident A's doctor appointment was handwritten on the MAR stating Resident A should be administered four tabs of 10 mg Doxepin at bedtime.

I reviewed the facility's "Report of Consultation" or physician contact confirming Resident A's Doxepin dosage was increased on 01/27/2020 to "10 mg 4 capsules at bedtime".

I also reviewed the facility's pharmacy delivery slip from 01/28/2020 confirming the pharmacy delivered the incorrect dosage of Doxepin on 3rd shift.

Direct care staff, Giana Lambert-Coleman, stated she worked 3rd shift at the facility starting on 01/28/2020 through 01/29/2020. She stated Resident A had received her bedtime medications because the MAR had been signed acknowledging they had been administered. She stated during the overnight shift, Resident A became to "cry" and at one point, "fell out of bed", which did not appear to be normal behavior for Resident A; however, it wasn't long before Resident A eventually calmed down and went to bed. She stated she monitored and checked on Resident A every two hours throughout the night to ensure she was ok. She stated it was in the morning when Resident A woke up stating she was feeling dizzy and uneasy so she took her to the ER.

Ms. Lambert-Coleman stated she now knew when signing for medications that she is to check the medication labels with the MAR before placing the medications in the medication drawers.

Direct care staff, Seth Hatfield, confirmed he was the staff who administered the wrong dosage of Doxepin to Resident A at bedtime around 8 pm on 01/29/2020. He stated on 01/29/2020 he had worked from 2 pm until 10 pm. He stated he "overlooked the extra 0" on the medication label and "passed too quickly". He acknowledged knowing Resident A had a change in her 8 pm medication; however, he was in a "rhythm and flow" and made an error.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	Resident A received an increase in her Doxepin medication on 01/27/2020 from two 10 mg pills to four 10 mg pills as ordered by her physician; however, on 01/28/2020 the facility's pharmacy made an error by delivering 100 mg pills of Doxepin instead of 10 mg pills. This error was not caught by the facility and subsequently, direct care staff, Seth Hatfield administered four 100 mg pills for a total of 400 mg of Doxepin to Resident A. Though Mr. Hatfield was aware of the change in Resident A's medication, he failed to follow the instructions and recommendations of Resident A's physician, which was documented on Resident A's Medication Administration Record and on the facility's physician contact sheet, Report of Consultation, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/03/2020, I conducted an exit conference with licensee designee, Scott Schrum, allowing him an opportunity to ask questions or make comments relating to my findings; however, he did not have any.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

03/03/2020

Cathy Cushman Date
Licensing Consultant

Approved By:

03/16/2020

Dawn N. Timm Date
Area Manager