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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 10, 2021

Rashalle Austin
Unity Group II, LLC
163 N. Fiske Road
Coldwater, MI 49036

RE: License #: AS120336139
Investigation #: 2021A0007006
Unity Group II

Dear Mrs. Austin:

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 (313) 456-0380.

Sincerely,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
301 E. Louis Glick Hwy
Jackson, MI 49201
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS120336139
Investigation #:	2021A0007006
Complaint Receipt Date:	01/12/2021
Investigation Initiation Date:	01/12/2021
Report Due Date:	03/13/2021
Licensee Name:	Unity Group II, LLC
Licensee Address:	163 N. Fiske Road Coldwater, MI 49036
Licensee Telephone #:	(517) 617-9591
Administrator:	Rashalle Austin
Licensee Designee:	Rashalle Austin
Name of Facility:	Unity Group II
Facility Address:	63 Wood Drive Coldwater, MI 49036
Facility Telephone #:	(517) 924-1486
Original Issuance Date:	08/30/2012
License **Status:**	REGULAR
Effective Date:	02/27/2021
Expiration Date:	02/26/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Allegations that Resident A did not receive his medications as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/12/2021	Special Investigation Intake- 2021A0007006
01/12/2021	Special Investigation Initiated - Letter
01/12/2021	APS Referral
01/25/2021	Contact - Telephone call made - Interview with Employee #2.
02/02/2021	Contact - Telephone call made - Case discussion with Mrs. Austin, Licensee Designee.
02/19/2021	Contact - Telephone call made - to Employee #1, no answer, unable to leave a message.
02/19/2021	Contact - Telephone call made - Interview with Employee #2.
02/19/2021	Exit Conference conducted with Mrs. Austin, Licensee Designee.
03/10/2021	Contact - Telephone call made to Mrs. Austin, to discuss the additional findings in the report.

ALLEGATIONS:

Allegations that Resident A did not receive his medications as prescribed.

INVESTIGATION:

Due to COVID-19, no onsite inspection was conducted. As a part of this investigation, I reviewed the following incident reports submitted by staff:

Employee #1 documented that on January 8, 2021, Resident A's medication (Flovent) was not in the medication cart. Therefore, staff passed Resident A's Albuterol in the place of his Flovent. The corrective measures included the manager contacting the previous facility and having Resident A's Flovent delivered to the home. Staff were reminded of the medication protocol. Resident A was monitored for health and safety. Verbal warnings were issued to staff.

On January 9, 2021, Employee #1 documented that Resident A's medication (Flovent) was not in the medication cart. Therefore, staff passed Resident A's Albuterol in the place of his Flovent. The corrective measures included the manager contacting the previous facility and having Resident A's Flovent delivered to the home. Staff were reminded of the medication protocol. Resident A was monitored for health and safety. Verbal warnings were issued to staff.

On this same day, another employee (Employee #2) authored an incident report, which included the same information.

On January 10, 2021, Employee #3 documented that they did not have the Flovent medication to pass at 8:00 a.m. The manager was contacted. The corrective measures included the manager contacting the previous facility and having Resident A's Flovent delivered to the home. Staff were reminded of the medication protocols. Resident A was monitored for health and safety. Verbal warnings were issued to staff.

On January 25, 2021, I interviewed Employee #3. He informed me that Resident A transferred from another facility (Unity Group III) within the corporation. Employee #3 informed me that Resident A is a heavy smoker and prescribed medications to help with his breathing. He is supposed to receive Flovent each day, and the Albuterol is prescribed as a PRN. Over the weekend, Resident A missed his prescribed medication Flovent, and was given the Albuterol instead. Employee #3 informed that there was an issue with the scanned medications and the barcodes not transferring to the new facility. Once the issue was discovered, the manager was informed of the problem and she reached out to Unity Group III staff and got the inhaler.

Employee #3 reported that there were no negative effects from Resident A not receiving the Flovent. The staff involved, Employee #1 and Employee #2, were retrained on medication administration and given verbal warnings. During that interview, I requested that the medication logs be sent to me along with the contact information for Employee #1 and Employee #2.

On February 2, 2021, I spoke with Mrs. Austin, Licensee Designee. We discussed the situation and Mrs. Austin reported that Resident A had relocated to and from the different facilities (Unity Group II & Unity Group III). They have a barcode system, in which they scan the medications for the specific facilities. They thought the medications had been switched to Unity Group II but there was an issue with that situation. According to Mrs. Austin, Resident A did not have any adverse effects due

to this medication error. The staff involved were required to be retrained. Mrs. Austin agreed to send me the contact information for Employee #1 and Employee #2, along with the medication logs for Resident A. During this phone call, we also discussed other incident reports received.

On February 19, 2021, I attempted to contact and interview Employee #1, without success.

On February 19, 2021, I interviewed Employee #2. She informed me that Resident A had just moved into the home and she was clicking through the prescribed medications but the Flovent was not there. There were no side effects from Resident A being given the Albuterol and not receiving the Flovent. According to Employee #2 they got the medications transferred from the other home. The staff were retrained after the incident occurred.

On February 19, 2021, I conducted the exit conference with Mrs. Austin, Licensee Designee. I informed her of the conclusion of the investigation, and I would be requesting a written corrective action plan to address the established violation.

I reviewed the January 2021 medication logs for Resident A. He is prescribed Flovent HFA AER 110 MCG, twice daily at 8:00 a.m. and 8:00 p.m. Beginning on January 8 at 8:00 p.m., staff initialed that the medication (Flovent) was passed. Staff also initialed that the medication was passed on January 9th and 10th.

Resident A is also prescribed Albuterol AER HFA, which is to be administered every six hours, as needed, for shortness of breath or wheezing. There were no initials on the log for January 8th. Employee #2 initialed the log on January 9th. On January 10th and 11th, it was noted that Resident A received the PRN “3X.”

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Resident A transferred from another facility. His prescribed medication, Flovent, was not transferred to the new home at the time of placement. Resident A was given Albuterol, a PRN medication, in the place of the Flovent. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A did not receive his medication, Flovent, as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed the January 2021 medication logs for Resident A. He is prescribed Flovent HFA AER 110 MCG, twice daily at 8:00 a.m. and 8:00 p.m. Beginning on January 8 at 8:00 p.m., staff initialed that the medication (Flovent) was passed. Staff also initialed that the medication was passed on January 9th and 10th at 8:00 a.m. and 8:00 p.m.

Resident A is also prescribed Albuterol AER HFA, which is to be administered every six hours, as needed, for shortness of breath or wheezing. There were no initials on the log for January 8th. Employee #2 initialed the log on January 9th. On January 10th and 11th, it was noted that Resident A received the PRN "3X."

The staff documented on the medication logs that Resident A received the Flovent on January 8, 9, and 10th. However, they submitted incident reports documenting that the Albuterol was given in the place of the Flovent.

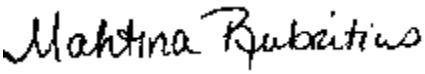
On March 10, 2021, I spoke with Mrs. Austin and informed her of the additional findings. We discussed the information documented in the medication logs. She questioned if staff had documented the information in the exceptions' category. I informed her that as related to the Flovent, they had not addressed the matter. She agreed to address this violation in the written corrective action plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

	(b) Complete an individual medication log that contains all of the following information: **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Based on the written incident reports, interviews, and information included above, the staff did not properly document and initial the medication log when the medication was administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



03/10/2021

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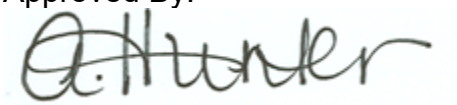
Mahtina Rubritius Date
Licensing Consultant

Approved By:



03/10/2021

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Ardra Hunter Date
Area Manager