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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 15, 2021

Linda Rice
United Country Care, Inc.
535 Gilletts Lake Road
Jackson, MI 49201

RE: License #: AS380357952
Investigation #: 2021A0007014
Rice Manor II

Dear Ms. Rice:

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.

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
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosures

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

I. IDENTIFYING INFORMATION

License #:	AS380357952
Investigation #:	2021A0007014
Complaint Receipt Date:	05/17/2021
Investigation Initiation Date:	05/18/2021
Report Due Date:	07/16/2021
Licensee Name:	United Country Care, Inc.
Licensee Address:	535 Gilletts Lake Road Jackson, MI 49201
Licensee Telephone #:	(517) 531-3005
Administrator:	Linda Rice
Licensee Designee:	Linda Rice
Name of Facility:	Rice Manor II
Facility Address:	PO Box 84 345 S. Union Street Parma, MI 49269
Facility Telephone #:	(517) 531-3005
Original Issuance Date:	06/17/2015
License Status:	REGULAR
Effective Date:	12/17/2019
Expiration Date:	12/16/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On May 17, 2021, Ms. Riggs, Direct Care Staff, gave Resident A the wrong medications.	Yes

III. METHODOLOGY

05/17/2021	Special Investigation Intake- 2021A0007014
05/17/2021	Contact - Telephone call received - Case discussion with Ms. Tabor, Administrative Staff.
05/18/2021	Special Investigation Initiated - On Site - Face to face contact with Ms. Riggs, Direct Care Staff, Resident A, and other residents.
05/18/2021	Contact - Telephone call received from Ms. Tabor, Administrative Staff.
05/18/2021	Contact - Document Received - I received a copy of the Incident Report, medication logs, and training records for Ms. Riggs.
07/09/2021	Contact - Telephone call made to the facility, no answer.
07/09/2021	Contact - Telephone call made - Interview with Ms. Riggs.
07/12/2021	Exit Conference conducted with Ms. Rice, Licensee Designee.
07/12/2021	APS Referral

ALLEGATIONS:

On May 17, 2021, Ms. Riggs, Direct Care Staff, gave Resident A the wrong medications.

INVESTIGATION:

On May 17, 2021, I spoke with Ms. Tabor, Administrative Staff. It was noted that Resident A was given Resident B's medications that morning, and they were taking Resident A to the hospital. Resident A's blood pressure was fine, and staff were monitoring him.

On May 18, 2021, I conducted an unannounced on-site investigation and made face to face contact with Ms. Riggs, Direct Care Staff, Resident A, and other residents.

I interviewed Resident A, and he informed me that yesterday was "miserable." Resident A stated that he had a lousy day, yesterday, but today was better. Resident A informed me that she (Ms. Riggs) had given him the wrong medications; according to Resident A, it was a little green pill. Resident A stated that the medication wore off around 4:00 p.m. and that he is all better today. Resident A had positive things to say about the home and stated, "I think it's nice here."

I briefly spoke with Ms. Riggs, she was aware of her mistake, and appeared to be sorry for what happened. She was busy at the time of the on-site inspection; therefore, I informed her that I would follow-up with her, at a later date, to interview her.

On this same date, I spoke with Ms. Tabor, Administrative Staff. I inquired if Ms. Riggs had been retrained to pass medications. Ms. Tabor informed me that she did have a conversation with her about the 6 Rights and reminded her of the medication administration process; however, since the incident occurred yesterday, they have not had the opportunity to formally retrain her. Ms. Tabor informed me that they were short staffed, but Ms. Riggs would be retrained that week. Ms. Tabor agreed to send the medication training records for Ms. Riggs, along with the medication logs for Resident A and Resident B. Once Ms. Riggs was retrained, that documentation would be forwarded as well.

As a part of this investigation, I reviewed the medication logs for Resident A and Resident B, and the incident report, authored by Ms. Riggs. She documented that on May 17, 2021, during the 8:00 a.m. medication pass, Resident A received another residents medication. Resident A was monitored, his vitals were checked, and he was sent to the emergency room to be assessed.

I also reviewed the training records, which documented that Ms. Riggs had been trained to pass medications.

On July 9, 2021, I interviewed Ms. Riggs. She informed me that during the medication pass, she gave the wrong medications; Resident A received all of Resident B's medications. I asked how this occurred and she stated that she had the medications for both residents out at the same time. Ms. Riggs informed me that she no longer passes medications this way, and she does not allow more than one

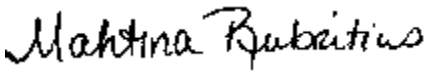
resident, at a time, in the medication room. Ms. Riggs reported that she was retrained, and she was monitored passing medications (3 medication passes). Ms. Riggs was very cooperative during the interview and reported to be available if I had any additional questions.

On July 12, 2021, I conducted the exit conference with Ms. Rice, Licensee Designee. I informed her of the conclusion of the investigation and my recommendations. Ms. Rice agreed to submit a written corrective action plan to address the established violation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered during this investigation and provided above, it is concluded that there is a preponderance of the evidence to support the allegations that Resident A did not receive his medications as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it is recommended that the status of the license remains unchanged.



7/12/2021

Mahtina Rubritius — Date
Licensing Consultant

Approved By:

7/15/2021

Ardra Hunter — Date
Area Manager