GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 13, 2021

Nancy Beach
Valley Residential Serv Inc.
P.O. Box 186
St Charles, MI 486550186

RE: License #:	AS060010188
Investigation #:	2021A0123039
	Orchard Bay AFC

Dear Ms. Beach:

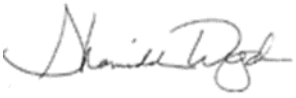
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (906) 226-4171.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS060010188
Investigation #:	2021A0123039
Complaint Receipt Date:	08/05/2021
Investigation Initiation Date:	08/09/2021
Report Due Date:	10/04/2021
Licensee Name:	Valley Residential Serv Inc.
Licensee Address:	300 S Saginaw St. Charles, MI 48655
Licensee Telephone #:	(989) 860-7904
Administrator:	Julie Kozlow
Licensee Designee:	Nancy Beach
Name of Facility:	Orchard Bay AFC
Facility Address:	400 Orchard Street Standish, MI 48658-1029
Facility Telephone #:	(989) 846-4666
Original Issuance Date:	12/26/1990
License Status:	REGULAR
Effective Date:	07/28/2021
Expiration Date:	07/27/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
Staff Amber Coriano failed to give Resident A his morning medications on 07/29/2921. As a result, Resident A experienced an increase in seizure activity and duration.	Yes

III. METHODOLOGY

08/05/2021	Special Investigation Intake 2021A0123039
08/09/2021	Special Investigation Initiated - Telephone I spoke with recipient rights via phone.
08/09/2021	Contact - Document Received Documentation received via email from Recipient Rights.
08/10/2021	Inspection Completed On-site I conducted an on-site with Recipient Rights Officer Kevin Motyka.
08/10/2021	APS Referral I received information regarding the APS referral from APS investigator Tina Thompson.
08/12/2021	Contact - Telephone call made I made a call to Guardian 1, Resident A's guardian. I left a message requesting a return call.
08/12/2021	Contact- Telephone call received I spoke with Guardian 1 via phone.
08/13/2021	Exit Conference I spoke with licensee designee Nancy Beach via phone.

ALLEGATION: Staff Amber Coriano failed to give Resident A his morning medications on 07/29/2921. As a result, Resident A experienced an increase in seizure activity and duration.

INVESTIGATION: On 08/09/2021, I made a call to Recipient Rights Office Kevin Motyka via phone. He stated that he received an incident report, and according to the nurse, Resident A had 30 second seizures, but on 07/29/2021, Resident A's seizures seemed harder than normal and were between a minute and a minute and 30 seconds long.

On 08/09/2021, I received a copy of the incident report and progress notes regarding Resident A via email from Mr. Motyka. The incident report dated for 07/29/2021 states the following:
Under the explain what happened/described injury (if any) section it states: *"Kelly was getting ready to pass [Resident A's] 8 pm meds and when she pulled out his med box she found a med cup full of his 8 am meds that were not given to [Resident A] at 8 am."*

Under the action taken by staff/treatment given section it states: *"Kelly called home manager and then the home nurse Penny. Penny instructed Kelly to hold all pills except for his Senna S, stool softener and Certavite antioxidant tab. Kelly passed [Resident A's] 8pm meds with two meds Penny instructed to pass. P.O. was written for the two meds she passed."*

Under the corrective measures taken to remedy and/or prevent recurrence section it states: "*7-30-21 Amber Coriano was med passer Kelly Kramp was med checker, Home manager spoke with Amber. We discussed how error occurred and will use internal corrective actions per policy. Resident monitored for ill effects and seizure activity. Checked professional order per hand written order- included from Penny Griffus R.N. This is considered med error = missed dose."*

The Bay Arenac Behavioral Health *Progress Note* documentation dated for 07/29/2021 states: *"ONCALL: Staff (Sabrina and Kelly) called to report 8am medications were found locked up tonight, popped from bubble pack, both initials written in the book as if they were taken by consumer. I advised staff to call morning med passer to verify if from today and Amber stated they were from today that she had popped and forgotten to pass them. 8am missed medications reviewed. I advised to pass the 8pm's along with the single dosing ones (Senna and Certavite) from this morning but to hold out the Keppra and Vimpat as he has them both due again now at 8PM. Compete IR in full detail. Staff did say that he had 2 seizures this afternoon that seemed longer and harder than his norm; 3:20pm for 2min and 6:40pm for 1 minute. Staff report his szr's are typically 20-30sec long. Advised to call me back with any activity out of the normal or any new concerns, as we may need to consider passing the two szr meds from earlier or contact physician on call (if he continues after the 8pm szr meds are given). No call back."*

On 08/10/2021, I conducted an on-site with Recipient Rights Officer Kevin Motyka at the facility. We spoke with administrator Julie Kozlow. She stated that staff Amber Coriano was taken off of med passing and has to go through med training again. She stated that Staff Coriano initialed the medication administration sheets as though she passed the 8:00 am medications on 07/29/2021, but the medications were not given to Resident A.

On 08/10/2021, during this on-site, on Mr. Motyka and I interviewed Staff Coriano and staff Kelly Kramp.

Staff Coriano reported the following: She has been working at the facility for about a year and works first shift from 7:00 am to 3:00 pm. On 07/29/2021, it was a busy morning. She popped the medications from the bubble packs, and went to give Resident A his meds, and got distracted. She missed all of the 8:00 am medications. She put the medication in a cup, went to go get Resident A some yogurt or something, then got distracted. She found out about her error later that night when second shift did med checks. Second shift text and informed her of the error. The medication was left in the med cup in the med room. The med room is locked when staff is not in the room, and the meds are passed in the med room. Staff Kramp said she checked the med pass behind Staff Coriano, by looking through the med book to check Staff Coriano's initials, and the bubble packs to see that they were packed. The cup of medication was left in Resident A's medication bucket, and she does not know how Staff Kramp missed them. She heard that Resident A had a couple of seizures that night, but he did not have any seizures during her shift that day (on 07/29/2021). Resident A did not go to the hospital. Second shift staff contacted Bay Arenac Behavioral Health nurse Penny Griffus. At this time, she (Staff Coriano) can only do med checks. She has been signed up for a Zoom med training on September 8th. She received a written write-up, and this is the first medication error she has made.

Staff Kramp reported the following: She works at the facility on first shift between 7:00 am and 3:00 pm and has worked at the facility for three years. Resident A did not have his seizure medication passed to him. It was a normal morning, and she and Staff Coriano were passing meds and feeding residents. She asked Staff Coriano if she was done with med passing, and she was not. When Staff Coriano was done, she (Staff Kramp) checked the bubble packs against the med sheets. Staff Coriano's first and second initials were noted on the sheets, and all of the pills were popped. She did not see a med cup in the box but was told it was behind Resident A's nose spray box which she never pulls because he does not use the nose spray. She was informed the following Monday (08/02/2021) about what happened due to being gone for the weekend. Resident A had no seizure activity during the first shift on 07/29/2021. She received a write up. This is the first medication error she has experienced to this extent.

On 08/10/2021, I made a face-to-face with Resident A. Resident A could not be interviewed due to lack of verbal skills. He appeared to be clean and appropriately dressed. He was observed standing at the dining room table.

During this on-site, I observed Resident A's medication which was placed in a large plastic bin. Resident A's medication was observed to be in bubble packs. His nose spray box was situated to the left of the bubble packs.

A copy of Resident A's *Health Care Appraisal* was reviewed. It is dated for 10/27/2020. It notes that Resident A is diagnosed with seizures and is non-verbal autistic.

A document that lists Resident A's seizure activity was reviewed. It notes that Resident A had four seizures between 07/29/2021 and 07/30/2021. On 07/29/2021, he had seizures at 3:20 pm for one minute, 6:40 pm for 50 seconds, 8:50 pm for a minute and 30 seconds, and on 07/30/2021 at 9:03 am for 56 seconds.

A copy of Resident A's *Assessment Plan for AFC Residents* dated for 12/08/2020 was reviewed. Resident A's assessment plan indicates that "*staff will give him the medicine prescribed by his doctors.*"

A copy of Resident A's *Medication Chart* for July 2021 was reviewed. On 07/29/2021, Staff Coriano's signature is noted for all 8:00 am medications on 07/29/2021. There are 13 medications listed for 8:00 am. The Valley Residential Services, Inc. *Medication Check List* was reviewed, and appears to be signed by both Staff Coriano in the medication passer column, and Staff Kramp in the medication checker column for 07/29/2021.

A copy of a *Staff Meeting/In-Service* document dated for 07/28/2021 was reviewed and shows that home manager/administrator Julie Kozlow reviewed medications with staff during this meeting. Staff Kramp and Staff Coriano signed the documentation that they were present for this review.

On 08/10/2021, I spoke with APS investigator Tina Thompson via phone. She reported that she received allegations regarding Resident A not being administered his medications. I informed her that I and Mr. Motyka had just conducted interviews at the home.

On 08/12/2021, I received a return call from Guardian 1 via phone. Guardian 1 stated that he was unaware of the incident. He stated that Resident A has seizures regularly, but he did not know about the medication error. He stated that Resident A has resided in the home for about 30 years.

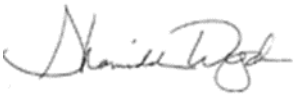
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Staff Coriano was interviewed and reported that she failed to pass Resident A's 8:00 am medications to him on 07/29/2021. Staff Kramp reported that she was the first shift med checker and checked medications for Resident A after the 8:00 am medication pass and did not see that the medications were still in Resident A's medication box. An incident report dated for 07/29/2021 details that second shift staff found the medications that were not passed and contacted both the home manager and nurse Penny Griffus regarding the medication error.

	Resident A had an increase in seizure activity as documented by staff, after the medication error. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 08/13/2021, I conducted an exit conference via phone with licensee designee Nancy Beach. I informed her of the findings and conclusion.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home (capacity 6).



08/13/2021

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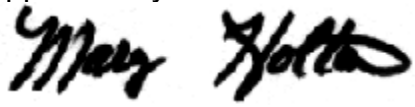
Shamidah Wyden Date
Licensing Consultant

Approved By:



08/13/2021

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Mary E Holton Date
Area Manager