GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 24, 2021

Amanda Hart
Crisis Center Inc - DBA Listening Ear
PO Box 800
Mt Pleasant, MI 48804-0800

RE: License #: AS050071211
Investigation #: 2021A0009034
North Limits

Dear Ms. Hart:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the 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 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 (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS050071211 |
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| **Investigation #:** | 2021A0009034 |
| | |
| **Complaint Receipt Date:** | 07/29/2021 |
| | |
| **Investigation Initiation Date:** | 07/29/2021 |
| | |
| **Report Due Date:** | 08/28/2021 |
| | |
| **Licensee Name:** | Crisis Center Inc - DBA Listening Ear |
| | |
| **Licensee Address:** | 107 East Illinois<br>Mt Pleasant, MI 48858 |
| | |
| **Licensee Telephone #:** | (989) 773-6904 |
| | |
| **Administrator:** | Sherry Kidd |
| | |
| **Licensee Designee:** | Amanda Hart |
| | |
| **Name of Facility:** | North Limits |
| | |
| **Facility Address:** | 1179 North Limits<br>Mancelona, MI 49659 |
| | |
| **Facility Telephone #:** | (231) 587-8688 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/24/2019 |
| | |
| **Expiration Date:** | 08/23/2021 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was given Resident B's medication. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 07/29/2021 | Contact – Document received, Incident/Accident Report (BCAL-4607) |
| 07/29/2021 | Special Investigation Intake<br>2021A0009034 |
| 07/29/2021 | Special Investigation Initiated – Telephone call made to administrator Ms. Sherry Kidd |
| 08/02/2021 | Inspection Completed On-site<br>Interview with home manager Ms. Kippon Beck<br>Face to face with Resident A |
| 08/02/2021 | Contact – Document (email with attachments) received |
| 08/10/2021 | APS Referral |
| 08/18/2021 | Contact – Telephone call made to administrator Ms. Sherry Kidd |
| 08/18/2021 | Contact – Telephone call made to direct care worker Ms. Ashley Blakeman |
| 08/18/2021 | Contact – Telephone call made to licensee designee Ms. Amanda Hart |
| 08/23/2021 | Exit conference with licensee designee Ms. Amanada Hart |

**ALLEGATION: Resident A was given Resident B's medication.**

**INVESTIGATION:** On July 29, 2021, I received an Incident/Accident Report (BCAL-4607) from administrator Ms. Sherry Kidd. It indicated that on July 28, 2021, Resident A was given 500 mg of Oscal and 15 mg of Buspar belonging to another resident in the home.

I spoke with administrator Ms. Sherry Kidd by phone on July 29, 2021. She stated that the night before, direct care worker Ms. Ashley Blakeman accidentally gave

Resident A another resident's medication. Ms. Blakeman reportedly realized her error immediately and called the agency's on-call supervisor. She was directed to call poison control as well as Resident A's primary physician. Ms. Blakeman was instructed by the on-call physician to observe Resident A for any side effects and check his blood pressure and other vitals every two hours. This was reportedly done and there were no observable, adverse effects. Ms. Kidd went on to explain that the staff, Ms. Blakeman, was supposed to have a second direct care staff on duty to observe the passing of the medication. The second staff person, Mr. Miguel Alvarado, is new but has been trained on passing medication. It was Ms. Kidd's understanding that Mr. Miguel observed the medication pass but also did not notice the error. Ms. Kidd stated that both staff know the names of the residents and should have caught the error before it happened.

I conducted an unannounced site inspection at the North Limits AFC (adult foster care) home on August 2, 2021. I wore personal protection equipment to protect myself and others. Home manager Ms. Kippon Beck was present at the time of my inspection. Ms. Beck stated that she was on-call the night before and Ms. Blakeman had called her and reported that she had accidentally gave the wrong medication to Resident A. Ms. Beck stated that she asked about Resident A's condition and Ms. Blakeman reported that he seemed fine. She told Ms. Blakeman to call poison control and Resident A's primary physician's on-call number and follow their instructions. This included monitoring him closely throughout the night and taking his vitals which did happen. Ms. Beck stated there did not seem to be any ill effects from the medication error. I observed Resident A while on site and he seemed to be fine at that time. I asked for records involving the incident and Ms. Beck stated that she would provide those to me electronically later that day.

On August 2, 2021, I received emails with attachments from Ms. Beck. These included documentation that Resident A's vitals were monitored on the evening of July 28 and morning of July 29, 2021. It indicated that his vitals were taken every two hours between 11 p.m. and 5 a.m. Another document indicated that bed checks were made every 30 minutes from 9 p.m. through 7 a.m. that evening and morning. I also received documentation and certification of "Medication Orientation" for Ms. Ashley Blakeman and Mr. Miguel Alvarado. From the records provided, it looked as though Ms. Blakeman had been trained in January and March of 2021 and Mr. Alvarado was trained in June of 2021. Ms. Beck also provided me with medication administration records for both Resident A and Resident B which appeared up to date at that time.

I reviewed the corrective action plan dated June 7, 2021, from Special Investigation #2021A0009021. This investigation involved a previous incident, on April 13, 2021, in which another resident received a different resident's medication. The North Limits AFC home was cited at that time for not taking reasonable precautions to ensure that prescription medication was not used by a person other than the resident for whom the medication was prescribed. The corrective action plan from that investigation dated June 7, 2021, indicated that, "2-person medication passing

implemented in the home. This requires a second staff to verify all medications and procedures before, during and after medication passing."

I spoke with administrator Ms. Sherry Kidd by phone on August 18, 2021. We reviewed the previous corrective action plan. Ms. Kidd agreed that although they had instituted the "2-person medication passing" it had not prevented the latest medication error. She reported that she had instituted a much more specific 2-person medication system which ensured that the second person was verifying the medication and that the correct person was receiving that medication. Ms. Kidd sent me an email on August 18, 2021 with an attachment. The attachment contained a specific "Medication Pass Protocol for North Limits" which outlined the additional steps she had put in place since the most recent medication error. Ms. Kidd reported that Ms. Blakeman was working at the facility later that day but that Mr. Alvarado was no longer employed by the agency.

I spoke with direct care worker Ms. Ashley Blakeman by phone on August 18, 2021. She acknowledged that she had accidentally given Resident A another resident's medication. She said that she had set up Resident B's medication, but that Resident A was "next in the book" so she erroneously gave him Resident B's medication. I asked her about Mr. Alvarado supervising the administration of the medication. Ms. Blakeman stated that Mr. Alvarado did not supervise the administration of the medication that night because he was new and she did not believe he had been trained to pass medication yet. She said that she didn't believe that he would have known "how to check them". Otherwise, she said, two staff have checked medication when medication has been passed.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | (6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed. |
| **ANALYSIS:** | It was confirmed through this investigation that reasonable precautions were not taken to ensure that prescription medication was not used by a person other than the resident for whom the medication was prescribed. On July 28, 2021, Resident A received Resident B's medication. This included 500 mg of Oscal and 15 mg of Buspar.<br><br>Previously, on April 13, 2021, a resident in the facility had also received another resident's medication. The facility was cited following that incident and a corrective action plan was received on June 7, 2021. The corrective action plan stated that "2-person medication passing" would be implemented in the home. The direct care worker involved reported that this did not |

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|---|---|
| | happen on July 28, 2021, when the latest medication error occurred.<br><br>It should be noted that on both occasions of a medication error occurring, both staff involved immediately reported their mistake. In both instances, staff called their on-call supervisor and then medical professionals to establish how best to deal with the error. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br>Previous LSR Dated May 05, 2021<br>Previous Corrective Action Plan Dated June 07, 2021 |

An exit conference was conducted by phone on August 23, 2021, with licensee designee Ms. Amanda Hart. I told her of the findings of my investigation and gave her the opportunity to ask questions.

## IV. RECOMMENDATION

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

08/23/2021

Adam Robarge — Date
Licensing Consultant

Approved By:

08/24/2021

Jerry Hendrick — Date
Area Manager