GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 1, 2021

Terrie Parker
Winter Wood Inc.
307 Broadway
Middleville, MI 49333

RE: License #: AM080007779
Investigation #: 2021A1029016
Middleville AFC

Dear Ms. Parker:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On August 2, 2021, you submitted an acceptable written corrective action plan. It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled.

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 (231) 922-5309.

Sincerely,
Jennifer Browning
Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM080007779
Investigation #:	2021A1029016
Complaint Receipt Date:	07/06/2021
Investigation Initiation Date:	07/08/2021
Report Due Date:	09/04/2021
Licensee Name:	Winter Wood Inc.
Licensee Address:	307 Broadway, Middleville, MI 49333
Licensee Telephone #:	(269) 795-3011
Administrator:	Terrie Parker
Licensee Designee:	Terrie Parker
Name of Facility:	Middleville AFC
Facility Address:	307 Broadway, Middleville, MI 49333
Facility Telephone #:	(269) 795-3011
Original Issuance Date:	12/08/1989
License **Status:**	REGULAR
Effective Date:	12/13/2019
Expiration Date:	12/12/2021
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

ALLEGATION(S)

	Violation Established?
Resident A received the wrong medication and was admitted to the hospital due to complications.	Yes
Additional Findings	Yes

II. METHODOLOGY

07/06/2021	Special Investigation Intake 2021A1029016
07/06/2021	Contact - Telephone call made to Leslie Herrguth, AFC licensing consultant
07/08/2021	Special Investigation Initiated - Face to Face with worker Shirley Molloy and Resident A at Middleville AFC home.
07/08/2021	Contact - Telephone call made to Spectrum Blodgett.
07/08/2021	Inspection Completed-BCAL Sub. Non-Compliance
07/09/2021	Contact - Telephone call made to complainant
07/14/2021	Contact - Telephone call made to Dr. Andrew Kepplinger
07/14/2021	Contact - Telephone call made to Relative A1, left a voice mail
07/14/2021	Contact - Telephone call made to Sebrina Burd at Pharmacy Care
08/02/2021	Contact – Face to face with Terrie and Denny Parker, Shirley Molloy, and Resident A.
08/02/2021	Exit conference with licensee designee, Terrie Parker.

ALLEGATION:

Resident A received the wrong medication and was admitted to the hospital due to complications.

INVESTIGATION:

On July 6, 2021, a complaint was received via a rejected adult protective services referral from centralized intake alleging Resident A received the wrong medications from a direct care staff member at Middleville AFC.

On July 8, 2021, I contacted Spectrum Health Blodgett. The operator stated that Resident A was discharged on July 6, 2021, from the hospital.

On July 8, 2021, I interviewed Resident A at Middleville AFC. Resident A stated that he was "too trusting with the staff" and they messed up his medication. He stated he took the wrong medication and ended up at Spectrum Health Blodgett. Resident A stated direct care staff member Shirley Molloy was passing medications and she had prepared two cups of medication. Resident A stated one cup was for him and the other cup was for Resident B. Resident A stated Ms. Molloy sat the two cups with medication down on the table, Resident A stated he grabbed the wrong one, and took the medication. Resident A stated that he was feeling so sick he had Ms. Molloy call an ambulance. Resident A stated he was in the hospital from July 4-6, 2021, due to side effects from the medications.

Resident A stated since this happened, Ms. Molloy now tapes their names to the table and places the cup with their medication in front of their name to make sure from now on no resident accidentally grabs the wrong medication cup. Resident A stated he has only lived in the home for fifteen days. He stated his doctor was Dr. Andrew Kepplinger in Zeeland, MI.

I interviewed direct care staff member, Shirley Molloy. When I arrived, Ms. Molloy was in the staff apartment with Resident A's medication administration records and medication bottles while she was on the phone trying to set up his prescriptions at a new pharmacy, Pharmacy Care in Middleville.

Ms. Molloy stated Resident A grabbed the wrong medication cup after she had set out the medication cups for Resident A and Resident B. Resident B did not take Resident A's medication because he noticed that the medication pills in the cup were not the same as what he typically takes. Ms. Molloy stated the medications Resident A accidentally took were Benztropine 1 mg, Haldol ½ tablet, Quetiapine tablet 300 mg, and Vitamin D3 1000 units.

Ms. Molloy stated that this has not happened before in the home. She is the only direct care staff member who passes medication. She doubled checked his medications before putting them in the cup because Resident A was a new resident to the home. However, Ms. Molloy stated she did not know initially that the wrong medications were given because she sat the medication cups down rather than pass the medication directly to Resident A or Resident B or watch either Resident A or Resident B take their medication. Ms. Molloy stated she then turned her back so she did not see which medication cup each resident grabbed after she placed the medication cups down on the table.

I reviewed Resident A's medications along with the July 2021 medication administration record (MAR) and found there were several medications that were prescribed to Resident A and listed on the MAR but were not available to Resident A at Middleville AFC as there was no physical medication bottle or packet in the AFC. The following medications were listed on Resident A's July 2021 MAR but were not available in the AFC to be passed as prescribed to Resident A:

- Apixaban 5 mg tablet – Take 10 mg daily
- Baclofen 10 mg tablet – Take 10 mg 3 times daily
- Metoprolol 25 mg – Take 1 tablet 2 times daily
- Pantoprazole 40 mg – Take 1 tablet 2 times daily
- Rosuvastatin 10 mg – Take 1 tablet daily
- Ondansetron 4 mg or Promethazine 12.5 mg – These are both stomach medications and he did not have them at the facility. Ms. Molloy stated that Dr. Kepplinger was reviewing them.

The medications listed on Resident A's July 2021 MAR as having been administered as prescribed were the following:

Amlodipine Besylate 5 mg – Take 10 mg daily
Furosemide / Lasix 20 mg – Take 20 mg daily
Gabapentin 400 mg – Take 400 mg 4 times daily
Lantus Solostar – 100 unit / ml pen injector – inject 60 units under the skin nightly
Lisinopril 20 mg – Take 20 mg daily
Hydrocodone 5-325 mg – Take 1 every 6 hours as needed
Albuterol inhaler as needed – Take 2 puffs by inhalation every 4 hours as needed or wheezing or shortness of breath.
Tylenol PRN

While reviewing the medications for Resident A, I noted there were two different Hydrocodone packages with different instructions. Both of these medications had different instructions than what was recorded on the medication administration record. The Hydrocodone / APAP Tab 5/325 mg sent from Hastings Nursing and Rehabilitation from June 15, 2021, had instructions to give 1 tablet by mouth every six hours around the clock (use caution with APAP total daily dose greater than 3,000 mg). The refill from Walgreens from January 6, 2021, had instructions for Hydrocodone to take one to two tablets by mouth three times daily as needed for severe break through pain.

Ms. Molloy stated since Resident A moved in, she has been working with Pharmacy Care and Walgreens in order to receive all medications with a current physician's order for Resident A.

On July 9, 2021, I interviewed Complainant who stated Resident A was given the wrong medication on two different occasions by two different direct care staff members at Middleville AFC. Complainant reported that the first direct care staff member who gave Resident A the wrong medications was Mr. Parker. Complainant alleged Mr. Parker told Resident A to "lay down and sleep it off." Complainant stated Resident A did not go into the hospital or receive any type of medical intervention for this medication error. Complainant did not know what type of medication was given to Resident A in error or when this incident occurred. Complainant reported Resident A did not have any known adverse health effects from this incident.

On July 14, 2021, I contacted Resident A's primary doctor, Dr. Andrew Kepplinger but was redirected to speak with Katelyn Streur from Dr. Kepplinger's office. Ms. Streur will send the progress notes from the last appointment. She said their office sent medication refills to Pharmacy Care Inc. of Middleville. Resident A had an appointment on July 13, 2021. She will send the current medication list. Ms. Streuer was asked what the instructions were for the Hydrocodone. Dr. Kepplinger did not prescribe narcotics however, on the current list it's prescribed as 1-2 tablets orally as needed. Resident A will need to have an appointment with a pain clinic to get more narcotic medication.

Ms. Streur sent documentation and progress notes from Resident A's follow up appointment with Dr. Andrew Kepplinger. According to the documentation, "He was assessed for accidental drug ingestion, initial encounter and hospital discharge follow up." The clinical notes include "Patient has supply of Norco until he is seen by Dr. Kane-Smart, will not prescribe any of these controlled substances." She was able to review the hospital discharge summary from Spectrum Health Blodgett which included documentation that patient was apparently having an episode of A. fib with RVR and was kept for a few days. Metoprolol was continued and Eliquis was added for stroke.

On July 14, 2021, I spoke with Sebrina Burd at Pharmacy Care in Middleville. She does have nine medications that were filled on July 8, 2021. They were signed and picked up the same day by Shirley Molloy. The same prescriber, Dr. Kepplinger, is on all the medications. Ms. Burd was unsure why the facility did not have the medications since his move in date.

On July 23, 2021, I contacted Relative A1 who stated she knew Resident A received the wrong medications in early July 2021. Relative A1 stated she asked Resident A if he looked at the medication before he took them to make sure and verify it was his pills. Relative A1 was under the impression that he had all his medications when he arrived at the AFC from the rehabilitation center. Relative A1 stated she assumed they were correct since they came right from the rehabilitation center. Relative A1 takes him to appointments but she does not handle his medications.

On July 29, 2021, I made a telephone call to Resident A at Middleville AFC. He said that the medications were straightened out. He has all the medications that he was supposed to have since he moved in. Resident A did confirm this is the second time the medications were wrong. The first time the medications were mixed up, the direct care staff member put them down and the guy across from him took his medication cup and he took the other residents' medications on accident. He said that it was Mr. Parker that gave him the medications wrong the first time. He was told to "lay down and sleep it off." He did not go to the hospital does not remember feeling as sick as the second time he received the wrong medications.

On July 29, 2021, I interviewed licensee designee, Terrie Parker. She stated direct care staff member, Shirley Molloy gave the wrong medication to Resident A. Ms. Molloy told her that she set the medications up on the table and Resident A took Resident B's medication. Ms. Parker stated she told Ms. Molloy not to do that anymore. Ms. Parker stated she did not give Ms. Molloy any formal discipline or write up.

Ms. Parker denied that the wrong medication has been passed before. She denied knowing that there was another incident regarding Resident A receiving the wrong medication. Ms. Parker was informed after the incident that Resident A was informed by Mr. Parker to "lay down and sleep it off." She stated something seriously could have gone wrong by any resident getting the wrong medication.

Ms. Parker confirmed that Ms. Molloy has been trained to give medications and she knows how to do it. She does not know why she did not do it correctly. Ms. Parker stated she will plan on retraining her for medications.

Ms. Parker stated she was not aware Resident A was not receiving all of his prescribed medications and could not provide an explanation why Resident A's medications were not at Middleville AFC. Ms. Parker stated she did not have a list from the doctor's office what Resident A was prescribed.

On August 2, 2021, contact was made with licensee designee, Terrie Parker, Denny Parker, direct care staff member, Shirley Molloy, and Resident A.

Mr. Parker was interviewed regarding the medications for Resident A. He stated that he did not know why the medications were wrong and denied following up with a doctor to find out what he was supposed to be taking. Mr. Parker stated he set medications down close to another resident's medications and Resident A grabbed the wrong cup of medications and took those medications. Mr. Parker stated he is supposed to mark the medications and watch them take them but could not remember if he did that. Mr. Parker denied telling Resident A to "sleep it off." He stated he has been doing this a long time and he knows how to give medications but he must have been "too comfortable."

During this investigation, I compared the current prescribed medication list from Dr. Kepplinger to the medications available at Middleville AFC for Resident A. All prescribed medications were now at the facility and all were given as prescribed according to the medication administration record. I also reviewed Resident C's medications and all medications that he was prescribed were available at the facility and administered correctly according to the medication administration record.

Ms. Parker submitted a corrective action plan and signed a statement accepting the provisional license issuance. Included in the corrective action plan is that the direct care staff members will pass medications correctly, retrain the staff to pass medication correctly, watch to make sure they take the medication, and pass one resident's medication at a time. They will also make sure they have one pharmacy for each resident's medication and have an updated medication list from the doctor to confirm the prescribed medications are at the facility. Ms. Parker also agreed that she will report all incidents to the licensing department within 48 hours.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A's medication was not given pursuant to label instructions after Resident A received the wrong prescription medications from two different direct care staff members at Middleville AFC on two separate occasions. After the first incident, Resident A was not provided with any medical intervention rather he was told by direct care staff member Denny Parker to "sleep it off." The second incident led to Resident A experiencing serious side effects requiring Resident A to be hospitalized at Spectrum Blodgett for two days after he received Resident B's prescribed medication. While reviewing Resident A's July 2021 MAR, I also determined there were also several medications prescribed to Resident A that were not being administered to Resident A due to the medications not being available at Middleville AFC. Licensee designee Terrie Parker did not have an updated list of prescribed medications from Resident A's physician and therefore was not able to give Resident A all his prescribed medications pursuant to the label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A was in the hospital from July 4-6, 2021, due to staff member, Shirley Molloy, giving him wrong medications. After a review of Resident A's record and the AFC facility record, I determined that licensee designee Terrie Parker did not send an *AFC Licensing Division – Incident / Accident Report (BCHS-4607)* to the department within 48 hours of the incident. On July 6, 2021, AFC Licensing Consultant, Leslie Herrguth confirmed she did not receive an *AFC Licensing Division – Incident / Accident Report (BCHS-4607)* regarding Resident A receiving the wrong medication and his hospitalization.

On July 8, 2021, I interviewed Ms. Molloy who would typically send the incident reports. She stated that she did not send an incident report to their licensing consultant, Leslie Herrguth because she could not find the form. On July 29, 2021, I spoke with licensee designee, Terrie Parker. She stated she did not have an incident report sent and she was not sure if one was done. Ms. Parker talked to Ms. Molloy after the incident and she told her where the forms were.

On August 2, 2021, I contacted licensee designee, Terrie Parker at Middleville AFC. She provided a completed *AFC Licensing Division – Incident / Accident Report (BCHS-4607)* signed by Shirley Molloy but stated she did not know where to send the form. Ms. Parker was able to locate the business card of the currently assigned AFC Licensing Consultant Leslie Herrguth which contains Ms. Herrguth's telephone and fax number. Since this incident, Ms. Parker stated that she made a packet of licensing forms and put them on the desk so they would be easily accessible for further incidents.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.**

ANALYSIS:	Resident A was hospitalized from July 4-6, 2021, as a result of not receiving the right medication. Licensee designee, Terrie Parker, did not make a reasonable attempt to contact the adult foster care division within 48 hours. She did not send an *AFC Licensing Division – Incident / Accident Report (BCHS 4607)* to the department within 48 hours of the incident. The direct care staff member, Shirley Molloy completed a form but indicated she did not know where to send the form.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

An approved corrective action plan has been received. I recommend modification of the license to a provisional.

Jennifer Browning _____8/30/2021_____

Jennifer Browning
Licensing Consultant
Date

Approved By:

Dawn Timm 09/01/2021

_____

Dawn N. Timm
Area Manager
Date