GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 10, 2021

James Pilot
Bay Human Services, Inc.
P O Box 741
Standish, MI 48658

RE: License #: AM290248648
Investigation #: 2021A0577042
Krystal House

Dear Mr. Pilot:

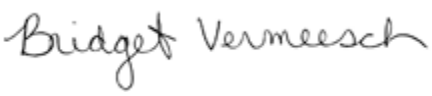
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (231) 922-5309.

Sincerely,



Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM290248648
Investigation #:	2021A0577042
Complaint Receipt Date:	08/02/2021
Investigation Initiation Date:	08/02/2021
Report Due Date:	10/01/2021
LicenseeName:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Tammy Unger
Licensee Designee:	James Pilot
Name of Facility:	Krystal House
Facility Address:	304 Crane Street Alma, MI 48801
Facility Telephone #:	(989) 463-6859
Original Issuance Date:	09/10/2004
License **Status:**	REGULAR
Effective Date:	05/26/2021
Expiration Date:	05/25/2023
Capacity:	8
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was administered another resident' s medications causing Resident A to be hospitalized.	Yes

III. METHODOLOGY

08/02/2021	Special Investigation Intake 2021A0577042
08/02/2021	Special Investigation Initiated – Telephone call to Sarah Cool, home manager.
08/02/2021	Contact - Document Received- Incident Report Received.
08/02/2021	APS Referral- Brooke Seaman, APS Gratiot Co, has an open investigation.
08/02/2021	Referral - Recipient Rights to Rachel McGregor.
08/02/2021	Contact - Document Received- Email from Tom Hilla, APS-Clinton County. Discharge and HNP from Mid-Michigan Medical Center Gratiot.
08/02/2021	Contact - Document Received- IR
08/02/2021	Inspection Completed On-site- Interview with staff.
08/04/2021	Inspection Completed-BCAL Sub. Compliance
08/13/2021	Exit Conference with licensee designee Joseph Pilot and administrator Tammy Unger.

ALLEGATION: Resident A was administered another resident's medications causing Resident A to be hospitalized.

INVESTIGATION:

On August 02, 2021 a complaint was received alleging Resident A was in the intensive care unit at Mid-Michigan Medical Center-Gratiot in serious condition after being given another resident's medications. The complaint reported that Resident A's blood

pressure was dropping which was making her condition serious. The complaint reported Resident A had been given the wrong medication on two other occasions as well with the first happening on October 2020 and the second on July 05, 2021.

On August 02, 2021 I received a call from home manager Sarah Cool who reported Resident A was currently in the hospital due to receiving Resident B's medications for the second time this month. The department was aware of the incident that occurred on July 05, 2021 due to receiving a phone call from Ms. Cool and receiving an *AFC Licensing Division-Incident/Accident Report (IR).* Per Ms. Cool and the IR received this incident occurred due to the facility being extremely short staffed, so direct care staff from other facilities owned by the licensee were filling in. Ms. Cool reported these direct care staff members were not as familiar with the residents and thought Resident A was Resident B and gave Resident A Resident B's medications. Ms. Cool reported the direct care staff member noticed the error immediately, contacted the on-call doctor, and direct care staff were advised to not administer any more medications, give fluids, and monitor Resident A's blood pressure. I completed a follow up phone call for the IR and incident on July 05, 2021 where Ms. Cool and I discussed not having unfamiliar direct care staff be the medication passer, just the medication observer, and only direct care staff who are familiar with the residents be the medication passer if and when possible.

On August 02, 2021 I spoke with Rachel McGregor, Office of Recipient Rights with Gratiot Integrated Health Network, who reported she interviewed direct care staff and supervision this morning and found Brittany Lane, direct care staff (DCS) was properly trained in medication administration but reported to Ms. McGregor she mixed up the residents and gave Resident A Resident B's medications.

On August 02, 2021 I spoke with Tom Hilla, Clinton County Adult Protective Service who provided me with a copy of Resident A's discharge notice from Mid-Michigan Medical Center-Gratiot Hospital. *Discharge Notice* documents stated the following: "[Resident A] was seen at the emergency department on July 31, 2021 for advertently being administered 75mg of Clozapine, 20mg of Lisinopril, 25mg Metoprolol and 40mg of Paxil. [Resident A] received her 10mg dose of Olanzapine on top of the 75mg of Clozapine. [Resident A] was otherwise doing well prior to the mix up. [Resident A] had no complaints in interview, denies headaches, dizziness, blurry vision, chest pain. Poison Control was contacted and recommended IV fluid boluses which were already given and then maintenance fluid and recommended a 24- hour observation maintaining a mean arterial pressure (MAP) of around 68. [Resident A] was accepted for admission and placed in the progressive care unit (PCU) for observation. Patient was discharged from hospital on August 02, 2021 with no active problems and follow up with primary care physician."

On August 02, 2021, I received a copy of an *AFC Licensing Division-Incident/Accident Report* completed on August 1, 2021 by Brittany Layne. The *AFC Licensing Division-Incident/Accident Report* documented the incident occurred on July 31, 2021 as "staff reported [Resident A] received the wrong meds at 8pm, her doctor was contacted and

advised to check BP every half hour, push fluids and hold her meds ending in “lol”, if BP drops below 90 take to ER, BP fell below 90, [Resident A] was taken to the ER around 10pm. [Resident A] was seen at the ER immediately upon arrival, blood test, EKG, IV with fluids, admitted into the hospital at 5am due to BP remaining unstable. Home manager will ensure all medication policies are being followed by both medication passer and observed. Consumers will go to the medication room for meds to be administered, of consumer refuses to go to the medication room both the passer and observer will go to the consumer for medications to be administered.”

On August 02, 2021 I completed an unannounced onsite investigation and interviewed Resident A who reported she just got back from the hospital because she was given the wrong medication. Resident A reported she is doing fine and is happy. I interviewed Brittany Layne, Direct Care Staff (DCS) who reported on July 31, 2021 she was the medication passer and Hailey Bard was the medication observer. Ms. Layne reported herself and Ms. Bard were in the medication room preparing Resident B’s medications and started talking about a situation with Resident A. Ms. Layne reported she got done popping Resident B’s pills out of the bubble pack into a cup, walked out into the living room and saw Resident A sitting in her wheelchair and gave her the cup of medication. Ms. Layne reported she went back into the medication room, grabbed a new cup and the next resident’s medication basket, read the name to Ms. Bard and realized at that point she administered Resident B’s medications to Resident A. Ms. Layne reported she contacted Dr. Ernest, Resident A’s primary care physician immediately and was advised to administer Resident A’s medications except for the medications ending in “lol” and her Paxil. Ms. Layne reported Dr. Ernest advised staff to check Resident A’s vitals every two hours and if Resident A becomes drowsy or the top number of Resident A’s blood pressure drops below 90 then Resident A should be taken to taken to the hospital. Ms. Layne reported she checked Resident A’s blood pressure every 30 minutes, gave her water to drink and around 9:30 pm Resident A became dizzy, blood pressure dropped to 85 and Resident A was taken to the hospital and admitted for observation. Ms. Layne reported she has been trained in medication administration a few different times due to working at different houses and feels comfortable passing medications. Ms. Layne stated, “we started talking about [Resident A] while passing [Resident B’s] medications and I still had that conversation in my head when I walked out of the medication room and saw [Resident A,] I just gave her the cup of medication.” Ms. Layne reported per policy, the medication observer is supposed to follow the medication passer and watch the medications be administered and this did not happen. Ms. Layne stated, “we both messed up.”

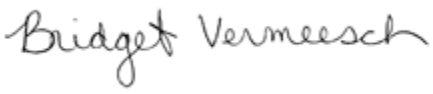
On August 03, 2021 I interviewed home manager Sarah Cool who reported direct care staff member Brittany Layne was hired back to the facility in May of 2020 and in June of 2020 received medication administration class at the library, observed other medication passers for five passes and then did five medication passes herself with management prior to being approved to be a medication passer. Ms. Cool reported the medication administration procedure for the facility is as follows: there is a medication passer and medication observer, the medication passer grabs the basket of medications for a resident, reads the name to the observer, the observer flips to the medication

administration record (MAR) for that resident, the medication passer reads the name on the MAR to ensure is matches the name and picture on the basket, the medication passer pulls out the first bubble pack, matches the label to the MAR, pops the pill into the cup, passes the bubble pack to the medication observer, they check the label and the MAR and count the medications, the medication passer puts in their first initial in the box, and goes to the next medication and does this process until all medications are in the cup that need to be administered at that time. Ms. Cool reported then the resident is supposed to come to the medication room by themselves and be administered their medication, but this process was not followed by previous home manager and Ms. Cool is starting to restart this process. Ms. Cool reported if the resident refuses to come to the medication room to take their medication, then both the medication passer and observer are to go to the resident and administer the medications. Ms. Cool reported once the medications are administered the medication passer returns to the medication room and signs their second initial and moves on to the next resident's medications. Ms. Cool, HM reported Ms. Layne and Ms. Bard will have a formal write up in their personal files and all staff will be retrained in medication administration, plus facility policy and procedures regarding medication administration.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	On July 31, 2021 direct care staff Brittany Layne administered Resident B's medications to Resident A. Ms. Layne reported she was talking with Hailey Bard, DCS and medication observer about an incident pertaining to Resident A while preparing Resident B's medications, walked into the living room and saw Resident A and gave her Resident B's medications. Ms. Layne and Ms. Cool, home manager explained the facilities procedure also includes the medication observer following the medication passer and watching the medications be administered and this did not occur. The facility has policies and procedures in place to prevent medication errors however these were not followed. It has been found the direct care staff Ms. Layne and Ms. Bard did not take reasonable precautions to ensure that prescription medication was not used by a person other than the resident for whom the medication was prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended the current status of the license remains unchanged.



9/10/2021

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

09/10/2021

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Dawn N. Timm Date
Area Manager