GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 14, 2021

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

RE: License #: AS230068521
Investigation #: 2021A1029020
Mulliken AFC Home

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 was required. On September 8, 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.

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
Browningj1@michigan.gov
(989) 444-9614

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS230068521
Investigation #:	2021A1029020
Complaint Receipt Date:	07/27/2021
Investigation Initiation Date:	07/28/2021
Report Due Date:	09/25/2021
Licensee Name:	Valley Residential Serv Inc.
Licensee Address:	300 S Saginaw, St. Charles, MI 48655
Licensee Telephone #:	(989) 860-7904
Administrator:	Nancy Beach
Licensee Designee:	Nancy Beach
Name of Facility:	Mulliken AFC Home
Facility Address:	9120 E Eaton Hwy, Mulliken, MI 48861
Facility Telephone #:	(517) 649-2377
Original Issuance Date:	11/01/1995
License **Status:**	REGULAR
Effective Date:	07/26/2021
Expiration Date:	07/25/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

ALLEGATION(S)

	Violation Established?
On July 21, 2021, direct care staff member, Mary Pline passed medications that were prescribed to Resident A to Resident B in error.	Yes

II. METHODOLOGY

07/27/2021	Special Investigation Intake 2021A1029020
07/28/2021	Special Investigation Initiated – Telephone from Denise Foren Home manager
07/28/2021	Recipient Rights referral made to Greg Fox, Recipient Rights officer
07/28/2021	Contact - Face to Face attempted but no one was home at Mulliken AFC
08/04/2021	Contact - Face to Face with Mary Pline and Denise Foren
09/01/2021	Contact - Document Sent - Email sent to Nancy Beach
09/01/2021	Contact - Telephone call made to Nancy Beach, left a voicemail.
09/01/2021	Exit Conference with Nancy Beach

ALLEGATION:

On July 21, 2021, direct care staff member, Mary Pline passed medications that were prescribed to Resident A to Resident B in error.

INVESTIGATION:

On July 27, 2021, an *AFC Licensing Division - Incident / Accident Report* was received documenting that Resident A received medication that was not prescribed to him. The report showed an incident date of July 21, 2021, with the following incident description: “Staff accidently gave wrong meds to resident and noticed right away. Called residents primary doctor and gave them a list of the meds given to {Resident B} and asked what kind of action should be taken. Primary Doctor said to hold off on {Resident B’s} medications for the whole day. The corrective measure: Try not to get distracted. Keep in mind the 5 R’s. Mary Pline will be counseled and retrained.”

On July 28, 2021 a referral was made to Community Mental Health Recipient Rights officer, Greg Fox. Mr. Fox advised that he followed up with the concerns but a recipient rights investigation will not be opened for a medication error.

On July 28, 2021, I attempted to contact Ms. Pline at Mulliken AFC Home however there was no one present at the home and a business card was left in the door.

On July 28, 2021, I interviewed Denise Foren. She is employed as a direct care staff member and her role is a home manager. She confirmed that direct care staff member, Mary Pline passed Resident B the wrong medications. Ms. Foren stated that Resident B was passed the following medications that were prescribed to Resident A:

- Fluoxetine 20 mg
- Loratadine 10 mg
- Olanzapine 5 mg
- Pantoprazole 40 mg
- Lamotrigine 150 mg
- Niacin 100 mg X 2
- Stool softener
- Vitamin D3 1000

Ms. Foren stated that Ms. Pline told her she was distracted while passing the medications. Ms. Foren reported Ms. Pline stated that when she went to get the ear drops for another resident, she missed the five rights of medications. She stated that Ms. Pline noticed right away and responded appropriately by contacting Resident B's doctor and pharmacy. A similar incident of Ms. Pline passing the wrong medication occurred on May 21, 2019. Ms. Pline was given a written counseling for the incident. Ms. Foren stated that Resident B is non-verbal and autistic and would not be able to discuss the incident however when she observed him the following day, he did not seem ill nor did he have any adverse side effects from the medication.

On August 4, 2021, I interviewed direct care staff member, Mary Pline at Mulliken AFC Home. Ms. Pline stated she was getting the medications ready and one of the other residents woke up. Ms. Pline stated she was thinking of the ear drops she would need to pass to another resident and became distracted. She missed the five rights of medications and passed Resident A's prescribed medications to Resident B. Immediately she noticed the error and called Resident B's doctor at Birch Clinic who reported that he would be fine but to hold Resident B's medications for that day. Ms. Pline also contacted the pharmacy to inform them the medication count would be off for Resident A due to the error.

I was able to observe a simulated medication pass by Ms. Pline and she was able to recall all steps needed to safely pass resident medications. She stated after this incident Ms. Foren and assistant manager Keith Rohrbacker watched her pass medications five times. I also reviewed the medications along with the July 2021

medication administration records (MAR) for Resident A and Resident B and all prescribed medications were given as prescribed according to the medication administration record with the exception of this incident.

While at the home, I reviewed the documentation on the *Medication Error Review Form* and *Medication Administration Error Counseling Form – health and safety infraction* that was completed by Ms. Foren on July 22, 2021. The form stated the following: "There is documentation the error was reviewed with other staff members so it can be avoided in the future, Ms. Pline should follow the five rights in passing, and have the consumer come to her to pass the medications. There is documentation Ms. Pline will have someone watch her next five times of scheduled medication administration. This document was also signed by Ms. Pline and Ms. Foren on July 22, 2021. Ms. Pline also had her next five medication administrations on July 22, 26, 28, 29, and 31, 2021 observed to make sure she followed the correct steps."

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident B's medication was not given as prescribed pursuant to the label instructions. On July 21, 2021, direct care staff member, Mary Pline passed medications that were prescribed to Resident A to Resident B in error. The medications that were prescribed and given in error to Resident B were Fluoxetine 20 mg, Loratadine 10 mg, Olanzapine 5 mg, Pantoprazole 40 mg, Lamotrigine 150 mg, Niacin 100 mg X 2, Stool softener, and Vitamin D3 1000. Ms. Pline noticed the error immediately and took steps to rectify the incident by contacting Resident B's physician and pharmacy for instruction. She completed an incident report and was given a written counseling regarding the issue. Ms. Pline also had her next five medication administrations on July 22, 26, 28, 29, and 31, 2021 observed to make sure she followed the correct steps.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

An acceptable corrective action plan has been received; I recommend no change in the license status.

_____ _____9/10/2021_____

Jennifer Browning — Date
Licensing Consultant

Approved By:

09/14/2021

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Dawn N. Timm — Date
Area Manager