GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 27, 2021

Kenneth Jordan
Samaritan Homes, Inc.
22610 Rosewood
Oak Park, MI 48237

RE: License #: AS820086487
Investigation #: 2021A0992032
Merriman Home

Dear Mr. Jordan:

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.

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 (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100, 3026 W. Grand Blvd, Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820086487
Investigation #:	2021A0992032
Complaint Receipt Date:	09/07/2021
Investigation Initiation Date:	09/08/2021
Report Due Date:	11/06/2021
Licensee Name:	Samaritan Homes, Inc.
Licensee Address:	22610 Rosewood Oak Park, MI 48237
Licensee Telephone #:	(248) 399-8115
Administrator:	Kenneth Jordan
Licensee Designee:	Kenneth Jordan
Name of Facility:	Merriman Home
Facility Address:	18901 Merriman Romulus, MI 48174
Facility Telephone #:	(734) 753-5638
Original Issuance Date:	08/15/1999
License Status:	REGULAR
Effective Date:	08/20/2020
Expiration Date:	08/19/2022
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was given too much medication on 9/7/2021 by staff Benjamin Parks. He was given his own medication as well as another resident's. Resident A was transported to the hospital.	Yes

III. METHODOLOGY

09/07/2021	Special Investigation Intake 2021A0992032
09/08/2021	Special Investigation Initiated - Telephone Stacey Washington, home manager/agency director
09/08/2021	Contact - Document Received Resident A's hospital discharge documents; Benjamin Parks training documents and employee disciplinary report and action form and incident reports.
09/15/2021	Inspection Completed On-site Ms. Washington; Benjamin Parks, direct care staff and Resident A
09/21/2021	Contact - Telephone call made Relative A, Resident A's former guardian
09/21/2021	Contact - Document Received Mr. Parks verification of training scheduled for 9/28/2021
09/21/2021	Exit Conference Kenneth Jordan, licensee designee

ALLEGATION: Resident A was given too much medication on 9/7/2021 by staff Benjamin Parks. He was given his own medication as well as another resident's. Resident A was transported to the hospital.

INVESTIGATION: On 09/08/2021, I received an email from Kara Robinson, licensing consultant notifying me of a call she received from Stacey Washington, home manager regarding the reported incident. Ms. Robinson provided Ms. Washington's contact information.

On 09/08/2021, I contacted Ms. Washington and interviewed her regarding the allegation. Ms. Washington explained that on 9/07/2021, Benjamin Parks, direct care staff was on shift and was in the process of administering medications when Resident A received his own medication and Resident B's medications. She said

apparently, Mr. Parks sat the medication down on the table and Resident A sat down at the table and took the medication. Ms. Washington said Mr. Parks immediately called 911 and contacted her to make her aware of the incident. She said Resident A was admitted into Beaumont Hospital Dearborn for observation and will possibly be discharged today. Ms. Washington said Mr. Parks is fully trained and has years of experience. She said she's uncertain how this occurred but as a result Mr. Parks was written up, demoted from medication coordinator to direct care staff, suspended from 9/07/2021 to 9/10/2021, provided in-service training and he is scheduled to take a basic medications refresher course through Community Living Services (CLS) on 9/28/2021. I asked if Resident A has a guardian and she said Relative A was his guardian, but the guardianship lapsed due to Covid-19. However, Ms. Washington said she notified Relative A. She also made me aware that Resident A is non-verbal. I requested a copy of the following documents, Resident A's discharge documents, Mr. Parks training and incident report. Ms. Washington said she will also provide a copy of Mr. Parks disciplinary action report and in-service training log.

On 09/08/2021, I received a copy of Resident A's hospital discharge documents, Benjamin Parks training documents and employee disciplinary report and action form. According to Resident A's discharge documents from Beaumont Hospital Dearborn, he was admitted due to accidental ingestion of substance. Resident A was discharged on 9/08/2021 and advised to follow-up with his primary care physician in a week. No additional discharge instructions were noted. As it pertains to Mr. Parks training documents, he was initially trained by CLS in 1990 including introduction to person centered planning, in-home assignment; rights test and documentation, nutrition, emergencies and infection control, cardiopulmonary resuscitation, health, medications class and medications return demo. Mr. Parks has continuously received continuing education training through Detroit Wayne Integrated Health Network (DWIHN) including annual and biennially training confirmed by review of his certificates of completion. I also received a copy of Mr. Parks disciplinary action report which confirmed the course of action taken as a result of the reported incident.

On 09/15/202, I completed an unannounced onsite inspection. Ms. Washington, Mr. Parks, direct care staff and Resident A was present. I observed Resident A and interviewed Mr. Parks regarding the allegation. Mr. Parks said he prepared morning medications by placing the medications in the med cups for Resident A and B and sat them on the dining room table according to where Resident's A and B typically sit. He said Resident B was in the shower, so he went to assist him with hygiene. I asked Mr. Parks where Resident A was when he sat the medication on the table, and he said on the couch. He said at some point Resident A sat at the dining table where Resident B typically sits and took his medication. I asked Mr. Parks, if he was on shift alone and he said no. He said Paige Gruza, direct care staff was on shift as well. He said she was in the kitchen preparing breakfast and washing dishes. Mr. Parks acknowledged that he didn't follow proper protocol and he was very apologetic; he said thankfully Resident A wasn't injured. Mr. Parks said as a result of

his wrongdoing he was suspended, demoted, received in-service training and he's scheduled for basic medication training with CLS.

While on-site, I reviewed the medication administration records (MARs) for Resident A and B. I also compared their prescribed medication to the MARs and no discrepancies were noted.

On 09/21/2021, I contacted Relative A, Resident A's former guardian and discussed the allegation. Relative A confirmed she was notified about the incident by Ms. Washington. She said Ms. Washington kept her abreast of Resident A's status. Relative A denied having any questions and/or concerns.

On 09/21/2021, I received a copy of Mr. Parks verification of training scheduled for 9/28/2021 with CLS.

On 09/21/2021, I contacted Kenneth Jordan, licensee designee and conducted an exit conference. Mr. Jordan said unfortunately the incident did occur and thankfully Resident A was not harmed. He said Mr. Parks was disciplined for his actions. I explained that I have had an opportunity to interview all involved parties and Ms. Washington provided all the documentation as requested. I proceeded to conduct an exit conference with Mr. Washington. I made him aware that based on the information obtained, I confirmed Mr. Parks is adequately trained based on his training certificates. However, he failed to take reasonable precautions to insure that prescription medication was not used by a person other than the resident for whom the medication was prescribed and as a result Resident A consumed Resident B's medication. I further informed Mr. Jordan that due to the violations identified, a written corrective action plan is required. Mr. Jordan said he understands and denied having any questions.

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:	During this investigation I interviewed Licensee Designee, Kenneth Jordan; Home Manager/Agency Director, Stacey Washington; and Direct Care Staff, Benjamin Parks and Resident A's former guardian, Relative A regarding the allegation. All of which confirmed the incident occurred. Resident A is non-verbal and as a result he was not interviewed but observed.

	Based on the investigative findings, there is sufficient evidence to support the allegation that Benjamin Parks failed to take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

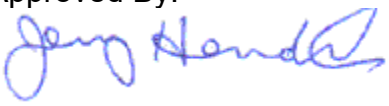
IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend the status of the license remain unchanged.

09/22/2021

Denasha Walker — Date
Licensing Consultant

Approved By:



09/27/2021

Jerry Hendrick — Date
Area Manager