GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 5, 2021

Geri Turner
Quality Living, Inc.
PO Box 9
Holly, MI 48442

RE: License #: AS630015369
Investigation #: 2022A0611003
Hidden Lane Home

Dear Ms. Turner:

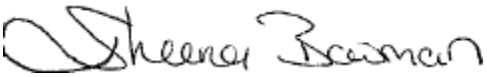
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630015369
Investigation #:	2022A0611003
Complaint Receipt Date:	10/22/2021
Investigation Initiation Date:	10/26/2021
Report Due Date:	12/21/2021
Licensee Name:	Quality Living, Inc.
Licensee Address:	10947 Erindale Ct. Holly, MI 48442
Licensee Telephone #:	(248) 634-3140
Administrator:	Geri Turner
Licensee Designee:	Geri Turner
Name of Facility:	Hidden Lane Home
Facility Address:	5710 Hidden Lane White Lake, MI 48383
Facility Telephone #:	(248) 887-9863
Original Issuance Date:	10/25/1994
License Status:	REGULAR
Effective Date:	07/11/2020
Expiration Date:	07/10/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Per incident report, on 10/20/21, direct care worker Debra Allen gave Resident M a second dose of her morning medications.	Yes

III. METHODOLOGY

10/22/2021	Special Investigation Intake 2022A0611003
10/26/2021	Special Investigation Initiated - Letter I reviewed the incident report regarding the allegations.
11/02/2021	Inspection Completed On-site I completed an unannounced onsite. I interviewed the home manager, Heather Parks regarding the allegations. I observed Resident M. I received a copy of Resident M's MAR, medical records, and a copy Staff member, Debra Allen medication training certificate.
11/03/2021	Contact - Telephone call made I made a telephone call to the home manager, Heather Parks. Ms. Parks provided additional information regarding Resident M's MAR.
11/03/2021	Contact - Telephone call made I left a voice message for staff member, Debra Allen requesting a call back.
11/03/2021	Contact - Telephone call received I received a telephone call from staff member, Debra Allen. The allegations were discussed.
11/04/2021	Exit Conference I completed an exit conference with the licensee designee, Geri Turner.

ALLEGATION:

Per incident report, on 10/20/21, direct care worker Debra Allen gave Resident M a second dose of her morning medications.

INVESTIGATION:

On 10/22/21, I received the abovementioned intake along with an incident report regarding the allegations. The incident report is dated for 10/20/21. According to the incident report, staff member, Debra Allen gave Resident M a second dose of her morning medications.

On 11/02/21, I completed an unannounced onsite. I interviewed the home manager, Heather Parks. I observed Resident M. I received copies of Resident M's MAR and medical records, and a copy of staff member, Debra Allen medication training certificate.

On 11/02/21, I interviewed the home manager, Heather Parks. Regarding the allegations, Ms. Parks stated on 10/20/21, she was assigned to administer the medications to all of the residents. Ms. Parks started to administer medications around 8:00 am. Staff member, Debra Allen was also working during the morning shift. While Ms. Allen was getting Resident M ready to take a shower, Ms. Parks gave Resident M her medications in front of Ms. Allen. Ms. Parks stated when she was getting ready to administer medications to another resident, she realized that the dixie cup she left out was missing. Ms. Parks then checked the medication book and saw that Ms. Allen gave Resident M her morning medications a second time and Ms. Allen initialed the MAR on 10/21/21. Resident M received a second dose of Divalproex, Fluoxetine, Levetiraceta, Loratadine, Omega-3, Amlodipine, Baclofen, Calcium, Certavite, SOD Chloride, and Vitamin D3. Ms. Parks stated Ms. Allen could not provide a reason to why she would administer Resident M's medications when she knew Resident M already received her medications. Ms. Parks instructed Ms. Allen to transport Resident M to the hospital. Resident M was observed at the hospital for six hours and then she was sent back to the AFC group home.

Ms. Parks stated Ms. Allen is still working at the AFC group home however; she is not allowed to administer medications until she completes medication training again. Ms. Allen has worked at the AFC group home for about two and a half years. I received a copy of Ms. Allen initial medication training certificate. Ms. Allen completed the MORC medication training on 09/23/19.

On 11/02/21, I observed Resident M sitting at the kitchen table. Resident M waved at me while I greeted her but she did not speak as she is non-verbal. I received a copy of Resident M's MAR for the month of October. According to the MAR, the number 12 is initialed on 10/20/21 and 10/21/21. The number 12 is the code that is used by Ms. Parks when she administers medications. According to Resident M's medical records,

Resident M was taken to McLaren Clarkston hospital on 10/20/21 for accidental drug ingestion.

On 11/03/21, I made a telephone call to the home manager, Heather Parks. Regarding the allegations, Ms. Parks stated when Ms. Allen administered Resident M a second dose of her medications, she initialed the bubble packet but not the MAR. Ms. Parks stated in order to administer Resident M's morning medication the next day for 10/21/21, she gave Resident M her morning medication from an earlier date on the bubble packet. Ms. Parks stated the AFC group home receives their bubble packets two weeks into a month as they still have medications leftover from the previous month. Resident M was not administered her afternoon/evening medications on 10/20/21 per doctors' orders as she had already received a second dose that morning. The following afternoon/evening medications were not administered to Resident M on 10/20/21: Divalproex, Levetiraceta, Amlodipine, Baclofen, SOD Chloride, and Vitamin D3.

On 11/03/21, I received a return phone call from staff member, Debra Allen. Regarding the allegations, Ms. Allen stated when she was in the bathroom giving Resident M a shower, she was not paying attention when Ms. Parks came into the bathroom to administer Resident M her medications. Ms. Allen stated when Ms. Parks entered the bathroom, she was bent over washing Resident M's feet. Ms. Allen then walked out of the bathroom because it wasn't enough room for all three of them to be in the shower. Ms. Allen stated she did not look directly at Ms. Parks which is why she did not see her give Resident M her medications. Ms. Allen stated after she gave Resident M a shower, she took her into the kitchen and gave her a second dose of her morning medications inadvertently. Ms. Allen informed Ms. Parks that she administered Resident M's medications and; that is when Ms. Parks told her she had already given Resident M her medication. Ms. Parks instructed Ms. Allen to call poison control and to transport Resident M to the emergency room. Ms. Allen is remorseful for her actions and she recognizes the severity of her mistake. Ms. Allen expressed how much she loves and cares for Resident M. Ms. Allen stated she was written up and she is in the process of re-taking a medication training.

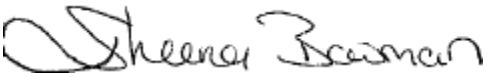
On 11/04/21, I completed an exit conference with the licensee designee, Geri Turner. Ms. Turner was informed that the allegations will be substantiated and a corrective action plan will be required.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on my investigation and findings, on 10/20/21, Ms. Allen administered a second dose of Resident M's morning medications shortly after Ms. Parks had already given Resident M her morning medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes with the license.

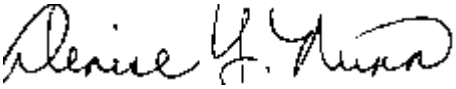


11/04/21

Sheena Bowman
Licensing Consultant

Date

Approved By:



11/05/2021

Denise Y. Nunn
Area Manager

Date