GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 13, 2021

Justin Stein
Bickford of Shelby, LLC
Ste 301
13795 S. Mur-Len Rd
Olathe, KS 66062

RE: License #: AH500387432
Investigation #: 2022A0585007
Bickford of Shelby

Dear Mr. Stein:

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 (517) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500387432
Investigation #:	2022A0585007
Complaint Receipt Date:	10/26/2021
Investigation Initiation Date:	10/26/2021
Report Due Date:	12/25/2021
Licensee Name:	Bickford of Shelby, LLC
Licensee Address:	Ste 301 13795 S. Mur-Len Rd Olathe, KS 66062
Licensee Telephone #:	(913) 782-3200
Administrator:	Gretchin Mager
Authorized Representative:	Justin Stein
Name of Facility:	Bickford of Shelby
Facility Address:	48251 Schoenherr Road Shelby Township, MI 48316
Facility Telephone #:	(586) 685-5800
Original Issuance Date:	12/10/2018
License Status:	REGULAR
Effective Date:	06/10/2021
Expiration Date:	06/09/2022
Capacity:	74
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was given the wrong medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/26/2021	Special Investigation Intake 2022A0585007
10/26/2021	Special Investigation Initiated - Letter Emailed administrator for additional information.
10/26/2021	APS Referral Made a referral to Adult Protective Services (APS).
10/27/2021	Contact - Document Received Requested document received.
10/27/2021	Inspection Completed – BCAL Sub. Compliance.
12/13/2021	Exit conference. Conducted with authorized representative Justin Stein.

ALLEGATION:

Resident A was given the wrong medication.

INVESTIGATION:

On 10/21/21, the facility's administrator Gretchin Mager and RN coordinator Vickie Andrew submitted an incident report pertaining to Resident A that read on 9/27/21 at 4:30 pm that read, Med passer gave wrong medication to the wrong resident. Resident received wrong medication (Humalog) not ordered for her. Resident [A] had no signs or symptoms of adverse reactions. VS stable. No new orders. No injury. Notified authorized representative and healthcare provider on 9/27/21."

On 10/26/21, I made a referral to adult protective services (APS) centralized intake unit.

On 10/27/21, Ms. Andrews submitted additional documentation upon request including Resident A's service plan, Resident A's service plan, training documents for staff, Resident A's medication administration record (MAR) and medication error report.

Ms. Andrew email me, "*I also wanted to report I was able to add a feature to the Quick Mar related to NAME ALERT for residents with like names and added this education to the Med passer Meeting"*.

Resident A's progress note read:

> 9/27/21 - *Two units of Humalog given by med passer and not ordered. Resident is not a diabetic. Dr. Payne notified message, office phone and fax. Sandwich given + meal, tolerate well. Husband notified, stable. No new orders at this time. No injury noted.*
>
> *9/28/21 – Resident alert and ambulation.*
>
> *9/29/21 – No adverse reaction.*

A review of Resident A's MAR did not show that she was prescribed Humalog which is a mealtime insulin used to treat people with type 1 or type 2 diabetes for the control of high blood sugar and considered a fast-acting insulin that starts working faster and works for a shorter period than regular human insulin.

The in-service for staff read, that training consisted of six rights of medication, picture of Quick Mar, cart selection, room number, scan used for identification, name alert added, resident must swallow medication, three checks with bubble packs identification on removal/checking that is correct medication with MAR/scan/recheck the bubble pack.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.

ANALYSIS:	Resident A was given the wrong medication. Humalog is a fast-acting insulin. Although Resident A did not suffer any adverse reaction, she could have because of the severity of the drug. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION

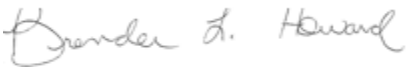
Email received from Ms. Andrews, stated that in reviewing files, she noted that a reportable was not sent to the State for Resident A for a medication error in which a medication was given to her that was not prescribed.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
For Reference: R 325.1901	**Definitions.**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	This medication error was not reported to the state within 48 hours. The facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/13/21, I conducted an exit conference with authorized representative Justin Stein by telephone.

IV. RECOMMENDATION

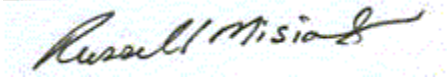
Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.



12/13/21

Brender Howard — Date
Licensing Staff

Approved By:



12/10/21

Russell B. Misiak — Date
Area Manager