GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 14, 2021

Rochelle Reneker-Rothwell
Rose Hill Center Inc
5130 Rose Hill Blvd
Holly, MI 48442

RE: License #: AS630256367
Investigation #: 2022A0605003
Horton Home

Dear Ms. Reneker-Rothwell:

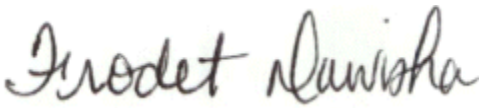
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630256367
Investigation #:	2022A0605003
Complaint Receipt Date:	10/19/2021
Investigation Initiation Date:	10/19/2021
Report Due Date:	12/18/2021
Licensee Name:	Rose Hill Center Inc
Licensee Address:	5130 Rose Hill Blvd Holly, MI 48442
Licensee Telephone #:	(248) 634-5530
Administrator/Licensee Designee:	Rochelle Reneker-Rothwell
Name of Facility:	Horton Home
Facility Address:	5130 Rose Hill Boulevard Holly, MI 48442
Facility Telephone #:	(248) 634-5530
Original Issuance Date:	01/09/2004
License Status:	REGULAR
Effective Date:	09/11/2020
Expiration Date:	09/10/2022
Capacity:	5
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Per incident report on 10/16/2021, direct care staff (DCS) Amy Fay mistakenly gave Resident A, Resident B's medications.	Yes

III. METHODOLOGY

10/19/2021	Special Investigation Intake 2022A0605003
10/19/2021	Special Investigation Initiated - On Site I conducted an unannounced on-site inspection. I interviewed Resident A and Resident B, the house coordinator Myra Porter, Clinical Director Shawn Bryson, Director of Staffing Pam Yokum, Director of Admissions and Program Kelli Waite, and registered nurse Elaine Green. I also reviewed Resident A's and Resident B's medications and medication logs and a simulated medication pass.
11/09/2021	Contact - Telephone call made I left a voice mail message for the house coordinator (HC) Te'Asia Dunk and direct care staff (DCS) Amy Fay requesting a return call to discuss the allegations.
11/11/2021	Contact - Telephone call received The HC Te'Asia Dunk returned my call.
11/16/2021	Contact - Telephone call made I attempted to call the HC Te'Asia Dunk and leave a message, but her mailbox was full. I texted Ms. Dunk requesting to return my call to discuss the allegations. I left another message for DCS Amy Fay to return my call.
11/17/2021	Contact - Telephone call received I interviewed the HC Te'Asia Dunk regarding the allegations.
11/18/2021	Contact - Telephone call received I interviewed DCS Amy Fay regarding the allegations.
12/02/2021	Contact - Telephone call made I interviewed DCS Renee Jorgenson regarding the allegations.

12/02/2021	Contact – Telephone call received Sondra Knisely with ORR stated she is substantiating her case.
12/06/2021	APS Adult Protective Services (APS) referral made.
12/06/2021	Exit Conference I left a message for licensee Rochelle Rothwell with my findings.

ALLEGATION:

Per incident report on 10/16/2021, direct care staff (DCS) Amy Fay mistakenly gave Resident A, Resident B's medications.

INVESTIGATION:

On 10/19/2021, intake #182665 was referred by Oakland County Office of Recipient Rights (ORR) regarding direct care staff (DCS) Amy Fay administered Resident B's medication in error to Resident A.

On 10/19/2021, I conducted an unannounced on-site investigation. I interviewed Resident A, Resident B, the house coordinator (HC) Myra Porter and the registered nurse (RN), Elaine Green regarding the allegations. The following individuals were present at Horton Home, the Clinical Director Shawn Bryson, the Director of Staffing Pam Yokum, and the Director of Admissions and Programs Kelli Waite. I reviewed Resident A's medications and medication logs and observed a simulated medication pass. I was provided with a copy of the incident report (IR) and a copy of Resident A's and Resident B's medication logs.

I attempted to interview Ms. Bryson, Ms. Yokum and Ms. Waite but they did not have specific details as to how the medication error occurred. Ms. Yokum provided me with a copy of the IR. The IR was written by DCS Amy Fay on 10/16/2021 at 7:35AM; "mistakenly passed the wrong medication to Resident A. Resident A was given Resident B's medications; **Clonidine 0.2MG Tab, Famotidine 20MG, Lithium Carb Cap 600MG, Oxcarbazepine Tab 300MG, and Risperidone Tab 0.5MG Tab.** Ms. Bryson stated that DCS Amy Fay has been with Rose Hill Center for about six months. Ms. Fay completed medication training. I was provided with copies of Resident A's and Resident B's October 2021, medication logs for my review.

I interviewed the RN regarding the allegations. Ms. Green stated she was contacted by the third shift HC Te'Asia Dunk on 10/16/2021, stating that DCS Ms. Fay accidentally gave Resident A, Resident B's medications. The RN directed third shift HC to tell Ms. Fay to hold off on administering Resident A's medication until the psychiatrist was contacted. Resident A and Resident B have the same psychiatrist. The RN contacted the psychiatrist Dr. Zakhar and went through both Resident A's and Resident B's

medications. Due to both residents' having similar medications, the psychiatrist advised to hold Resident A's medications until 10/17/2021. The RN stated she spoke with Ms. Fay regarding the medication error and Ms. Fay stated she "double checked the meds," but the error still occurred. The RN stated it was unclear how the medication error happened because they have a two-person check during each medication administration.

I interviewed the HC Myra Porter regarding the allegations. The HC was off on 10/16/2021 and did not return to work until today, 10/19/2021. She stated she does not know what happened other than reading the IR that DCS Ms. Fay wrote. The HC conducted a simulated medication pass. The HC pulls the residents' medication log on the computer. The residents' picture is on the left of the screen and the medications that need to be passed are in the middle of the screen. There are no pictures of the actual pills next to each medication, just the medication label. The HC stated the DCS goes through each residents' medications for the specific time, pops each pill out of the blister pack, places the pill in a small white paper cup and then sets the cup with the pills on a tray in front of the residents' name. I observed the tray sitting next to the laptop. The tray has Resident B's name first, then Resident A, and then the rest of the other residents. The HC stated then the double checking is completed by the DCS leaving their shift. For example, DCS working the midnight shift would double check the morning shifts medications prior to the midnight shift leaving. The occurs during each shift change. Then the DCS calls the resident to the medication room, resident gives their first and last name, then DCS gets the cup from the tray in front of that residents' name, hands the cup to the resident and the resident "tells staff each pill and staff verifies that medication on the medication log on the computer screen." The HC stated this is the medication process throughout Rose Hill Center. The HC does not know how the medication error occurred as she has not spoken with Ms. Fay.

I interviewed Resident A regarding the allegations. On 10/16/2021, Resident A stated it was early in the morning when DCS Amy Fay called her down to take her medications. Resident A went into the medication room where Ms. Fay was standing. Resident A stated, "she (Amy Fay) gave me the pills. I was sleepy and my vision was blurred. I just took the pills and swallowed them. She (Amy Fay) said, oh no, I gave you the wrong pills. I was ok. I just drank lots of water and I was ok. I didn't get sick." Resident A stated all the medication cups are on the tray and that staff grab a cup in front of the residents' name and staff then hand the cup to the resident and tell the resident to take their medications. Resident A stated Ms. Fay did not ask Resident A to name her pills. She stated, "Amy just gave me the cup and I took my pills." Resident A stated she never had to tell staff what pills she was taking, "until last night," when she had to identify her pills in the cup. Resident A stated she believes she knows her pills but sometimes when she's sleeping usually in the morning, she just takes her pills and wants to return to bed as residents can sleep in on the weekends.

I interviewed Resident B regarding the allegations. Resident B stated on 10/16/2021, she was asleep when Resident A was given the wrong medications. Resident B heard about what happened after she woke up. Resident B was told by Resident A that "Amy

gave me your (Resident B) medications." Resident B stated, "I got my pills, and they were right." Resident B stated when staff call her for her medications, she sometimes is given her pills inside of the medication room and sometimes she gets her pills outside of the medication room. There is a chair and a side table right outside the medication room. Resident B stated, "sometimes I sit on the chair and staff set the cup of pills on the table and say, take your meds." Resident B stated staff have never asked her to identify each pill in the cup, but that residents are supposed to say their medications out loud, but sometimes Resident B is too tired especially in the morning. Resident B stated, "Amy is a great staff. She's caring and nice. I don't want her to be fired."

I recommended to Ms. Bryson, Ms. Yokum, the RN, and the HC to review their current medication process as the current medication administration that staff was trained to follow, is not being followed. I suggested having DCS pop Resident A's medications first, calling Resident A to take their medications before moving to Resident B, Resident C and so forth hopefully prevent any further medication errors.

On 11/17/2021, I interviewed third shift HC Te'Asia Dunk regarding the allegations. HC stated she received a telephone call on 10/16/2021 from DCS Amy Fay stating she gave Resident A, Resident B's medications. The RN was present; therefore, the RN contacted the psychiatrist, and discussed both residents' medications. HC stated because both Resident A and Resident B take similar medications, Resident A did not have any adverse reactions. HC stated this was an isolated incident. HC explained the process that DCS were trained in how to administer medication. HC stated that the DCS set up each of the residents' medications by popping the medications from the residents' blister packs. Each resident has a small cup that DCS place the pills after being popped into the cup. All DCS follow the five rights when they are popping the blister packs. HC stated, then the second DCS who is ending their shift does the second checking of each pill in each of the residents' cups by reviewing the pills with the medication logs. Then the resident is called into the room, the resident then identifies their pills after DCS ask residents to and then after identifying the pills, then the resident takes their medication. DCS Ms. Fay told the HC that, "she (Amy Fay) grabbed the wrong med cup that was labeled Resident B, handed it to Resident A and then realized what she did." HC stated this was an isolated incident and that DCS Ms. Fay has completed medication training. The HC stated since this incident, Rose Hill Center is looking to change the medication administration process.

On 11/18/2021, I interviewed DCS Amy Fay regarding the allegations. Ms. Fay stated she has been with Rose Hill Center for about six months. She completed medication training. Ms. Fay stated on 10/16/2021, she set up all the residents' medications following the same process she was trained. Pop everyone's pills first by following the five rights, place each cup in front of the residents' names, the DCS who is ending their shift will double check the medications, and then she calls each resident on-by-one into the medication room, hands them the medication cup and watches the resident take their pills. Ms. Fay stated on this day, "I accidentally grabbed Resident B's cup and gave it to Resident A and then I turned around to look at the tray and saw Resident A's cup still sitting in front of Resident A's name. By the time I turned around after I realized I

grabbed the wrong cup, Resident A had already taken the pills." Ms. Fay stated she usually asks the residents to identify their medications, but Ms. Fay did not have time to as Ms. Fay stated, "Resident A grabbed them so fast, I didn't have a chance to ask her if these were her pills." Ms. Fay stated this was an isolated incident. She called the HC and the RN who immediately contacted the psychiatrist. Ms. Fay stated that both Resident A's and Resident B's medications are similar, Resident A did not have an adverse reaction. Ms. Fay stated since this medication error, Rose Hill Center is looking into changing this process to ensure medication errors do not reoccur.

On 12/02/2021, I interviewed Renee Jorgenson who was the person who double checked DCS Amy Fay's medications on 10/16/2021. Ms. Jorgenson stated her title is hospitality but that she also DCS and was the DCS working the afternoon shift on 10/15/2021 from 4PM-12AM. Ms. Jorgenson stated on 10/16/2021, Ms. Fay arrived at her shift at 12AM and began setting up the morning's medications. Ms. Fay called Ms. Jorgenson to the medication room to double-check the medications which were already popped out of the blisters, placed into the small cups, and put on the tray in front of each residents' name. Ms. Jorgenson stated she followed the five rights of medication administration, and all the medications were correctly placed in each cup and correctly placed in front of each of the residents' names. Ms. Jorgenson stated whenever she double checks the pills, she pulls up the residents' medication which has the picture of the pill and confirms it's the correct pill in the cup in front of the correct resident. Ms. Jorgenson stated she was not present when Ms. Fay gave Resident B's medications to Resident A; however, Ms. Jorgenson asked Ms. Fay what happened. Ms. Fay told Ms. Jorgenson that Resident B was called down take her medications, so Ms. Fay set Resident B's medication cup on the counter. Instead of Resident B coming down, Resident A came down, went into the medication room and Ms. Fay picked up the cup of pills, handed them to Resident A and Resident A swallowed the pills. When Ms. Fay realized she had the wrong resident in the medication room, it was too late as Resident A had already taken the pills. Ms. Jorgenson stated the second person check is completed during shift change; therefore, the midnight shift sets up the 8AM morning medications at 12AM before the afternoon shift leaves; then the morning shift sets up their afternoon medications before the morning shift leaves and so forth. Ms. Jorgenson stated this has been the same process since she has been with Rose Hill Center. She stated there have been several medication errors with this process including Ms. Jorgenson passing medication to the wrong resident. She stated this occurred when she first started working for Rose Hill Center, but it was not at Horton Home. She too grabbed the wrong cup and gave it to the wrong resident. Ms. Jorgenson stated she believes management is now changing this process to prevent any future medication errors.

On 12/02/2021, I received a telephone call from ORR stating she was substantiating her case regarding DCS Amy Fay administering the wrong medication to Resident A.

On 12/06/2021, I attempted to conduct the exit conference with licensee designee Rochelle Rothwell via telephone but left a message with my findings.

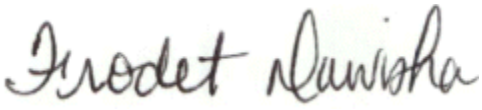
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Based on my investigation and review of Resident A's medication logs, **Atenolol Tab 50MG, Docusate 100MG Cap, Famotidine Tab 20MG, Levetiracetam Tab 500MG, Lithium Carb Tab 450MG ER, Multivitamin Tab, Vitamin D3 Tab 1000 Unit**, were not administered per the direction of Resident A's psychiatrist on 10/06/2021 at 7:30AM, but DCS Amy Fay initialed the medication logs.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based on my investigation and information gathered, reasonable precautions were not taken to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed. On 10/16/2021, DCS Amy Fay administered Resident B's medications **Clonidine 0.2MG Tab, Famotidine 20MG, Lithium Carb Cap 600MG, Oxcarbazepine Tab 300MG, and Risperidone Tab 0.5MG Tab** in error to Resident A. Horton Home's process for medication administration allow for medication errors. According to all the individuals I interviewed, all medications for each resident are popped out of the blister packs, then placed in the small white paper cups and then placed in front of that residents' name on the tray. DCS Amy Fay stated she followed the five rights of medication passing, however, on 10/16/2021, Ms. Fay grabbed the wrong medication cup, set it on the counter and Resident A took the

	medications. Ms. Fay stated seconds later she realized she grabbed the wrong cup and when she turned around, Resident A had already taken the medication. Ms. Fay completed medication training, and this was an isolated incident. Ms. Fay immediately contacted third shift HC, who contacted the RN who was in contact with Resident A's and Resident B's psychiatrist. Due to Resident A and Resident B being on similar medications, Resident A did not have an adverse reaction to Resident B's medications. The psychiatrist advised the RN to hold and not administer Resident A's medications on 10/16/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

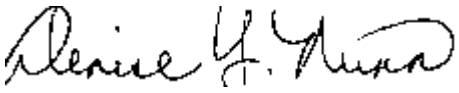
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



12/14/2021

Frodet Dawisha — Date
Licensing Consultant

Approved By:



12/14/2021

Denise Y. Nunn — Date
Area Manager