GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 14, 2022

Scott Brown
Renaissance Community Homes Inc
P.O. Box 749
Adrian, MI 49221

RE: License #: AS470093665
Investigation #: 2022A0466009
Golf Club Road Home

Dear Mr. Brown:

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) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS470093665
Investigation #:	2022A0466009
Complaint Receipt Date:	11/18/2021
Investigation Initiation Date:	11/22/2021
Report Due Date:	01/17/2022
Licensee Name:	Renaissance Community Homes Inc
Licensee Address:	Suite C 1548 W. Maume St. Adrian, MI 49221
Licensee Telephone #:	(734) 439-0464
Administrator:	Scott Brown
Licensee Designee:	Scott Brown
Name of Facility:	Golf Club Road Home
Facility Address:	2367 Golf Club Road Howell, MI 48843
Facility Telephone #:	(517) 545-9921
Original Issuance Date:	09/01/2000
License Status:	REGULAR
Effective Date:	06/19/2020
Expiration Date:	06/18/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATIONS:

	Violation Established?
Resident A took Resident B's medication on 11/16/2021.	Yes
Resident B took Resident C's medication on 11/22/2021.	Yes

III. METHODOLOGY

11/18/2021	Special Investigation Intake- 2022A0466009.
11/19/2021	Contact - Document Sent to Elisabeth Simon, ORR.
11/19/2021	Contact - Document Received from Elisabeth Simon, ORR.
11/22/2021	Special Investigation Initiated - On Site.
11/23/2021	Contact - Document Received, fax from facility.
01/10/2022	Contact- Telephone call made to DCW Sarah Hacker, interviewed.
01/10/2022	Contact- Telephone call made to DCW Judy Quaderer, interviewed.
01/10/2021	Contact- Telephone call made to DCW Desirae Smith; phone was disconnected.
01/10/2021	Contact- Document sent to licensee designee Scott Brown.
01/10/2022	Contact- Documents Received.
01/10/2022	Contact- Telephone call made to DCW Michael Blandford documents requested.
01/11/2022	Contact- Telephone call made to DCW Desirae Smith, interviewed.
01/11/2022	Contact- Documents Received.
01/12/2022	Exit Conference with licensee designee Scott Brown, message left.

ALLEGATION: Resident A took Resident B's medication on 11/16/2021.

INVESTIGATION:
On 11/18/2021, I received an *Incident/Accident Report* (IR) authored by direct care worker (DCW) Sarah Hacker and signed off by DCW Michael Blandford on 11/16/2020 at 6:45pm that stated, "while getting 7pm meds, I prompted [Resident A] to get a water, she did, while I was getting her meds popped out, [Resident A] grabbed someone elses [sic] cup of meds and took them before I could stop her." In the "Action taken by staff" section of the report it stated, "called poison control, monitored [Resident A], called home manager and wrote IR." In the "Corrective Measures Taken" section of the report it stated "staff did good by calling poison control and monitoring [Resident A]. Home manager will re-train/go over medication toolbox with staff."

On 11/22/2021, I conducted an unannounced investigation and interviewed house manager DCW Blandford who reported that he did not have any information about Resident A taking Resident B's medication besides what was reported in the IR. DCW Blandford reported he was not on shift when the medication error occurred. DCW Blandford reported that DCW Hacker was not working at this time and therefore could not be interviewed. DCW Blandford reported that Resident A was not at the facility either as she was working and therefore could not be interviewed.

On 11/23/2021, I reviewed Resident A's medication administration (MAR) record which documented that on 11/16/2021 all of Resident A's medication had been administered and signed by DCW Hacker. On 11/16/2021 there was no note in MAR saying that any medication was not administered nor was there any note about a medication error.

On 1/10/2022, DCW Hacker reported that on 11/16/2021, she was responsible for medication administration and while she was in the medication cart putting medication away, Resident A came into the medication room and took medication that was in the cup on the counter. DCW Hacker reported that the medication in the cup was for Resident B, not Resident A. DCW Hacker reported that Resident A typically waits in the medication room until a cup of medication is given to her. DCW Hacker reported that she was not sure why on 11/16/2021, Resident A assumed the medication in the cup belonged to her and took it. DCW Hacker reported she contacted poison control and followed their directive to watch Resident A closely throughout the night. DCW Hacker reported she administered Resident A her medications as directed by poison control and signed for the medications she administered on the MAR. DCW Hacker reported that if poison control told her not to administer any medication there would be a note in MAR.

On 1/10/2022, I interviewed DCW Quaderer who reported she worked with DCW Hacker on 11/16/2021 and DCW Hacker was responsible for medication administration. DCW Quaderer reported she observed Resident A grab medication off of the counter. DCW Quaderer reported she was not aware that the medication

Resident A grabbed was not prescribed for Resident A until DCW Hacker said something. DCW Quaderer reported Resident A grabbed Resident B's medication and ingested it before DCW Hacker realized what had happened. DCW Quaderer reported Resident A did not wait for the medication to be handed to her by DCW Hacker. DCW Quaderer reported DCW Hacker contacted poison control for direction.

On 01/11/2021, DCW Blandford reported DCW Hacker had been trained in medication administration. DCW Blandford provided a *Certificate of Completion* dated 10/16/2021 that documented that DCW Hacker has completed Pharmacology Class.

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:	DCW Hacker, DCW Quaderer and DCW Blandford all reported that on 11/16/2021, Resident A took medication that she was not prescribed. DCW Hacker, DCW Quaderer and DCW Blandford reported that the medication in the cup that Resident A ingested was Resident B's prescribed medication therefore a violation has been established as reasonable precautions were not taken to ensure that Resident A did not get medication that she was not prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B took Resident C's medication on 11/22/2021.

INVESTIGATION:
On 11/23/2021, Complainant reported Resident B was administered Resident C's medications.

On 11/23/2021, office of recipient rights (ORR) officer Elisabeth Simon reported Resident B was administered Resident C's medications.

On 11/23/2021, I received an IR authored by DCW Desirae Smith and signed off by DCW Blandford that stated on 11/22/2021 at 7:00pm, "staff was having [Resident C] come to the table to take medication and Resident B came out and while staff was marking Resident C's medication in the computer and took most of Resident C's medications. Medication that Resident B took were Keppra 750 mg, mucus relief 600mg, Vimpat 200mg and 50mg, Seroquel 100mg, vitamin D3, 25mg and Clozapine, 10 mg." In the "action taken by staff" section of the report it states "Staff called poison control let them know the meds [Resident B] took. Poison control said

to hold [Resident B's] Seroquel 300 mg and Remon 30 mg. Poison control said only medication that might affect [Resident B] would be Clozapine because its stronger. She may be a fall risk. To monitor her close so she doesn't fall." In the "corrective measures" section of the report it stated "Staff will re-do medication toolbox ASAP. Staff will start to pass [Resident B's] medication first. Continue training/go over medication training.

On 1/10/2022, I interviewed DCW Quaderer who reported that she worked on 11/22/2021 with DCW Desirae Smith and DCW Smith was responsible for medication administration. DCW Quaderer reported DCW Smith had all of the residents' medications in labeled cups on the counter. DCW Quaderer reported DCW Smith handed Resident B, Resident C's medication. DCW Quaderer reported DCW Smith contacted poison control for direction.

On 01/10/2022, I reviewed Resident B's MAR record which documented that on 11/22/2021 all of Resident B's medication had been administered and signed by DCW Smith with the exception of Clonazepam, 1mg tab which was left blank on the MAR. On 11/22/2021 there was no note in MAR saying that that a medication error occurred.

On 01/11/2022, I interviewed DCW Desirae Smith who reported that although she typically administers medications in the medication room there was a cabinet being installed and since there was not enough room to administer medication, she put the medications in cups marked with the residents' name on them on the kitchen counter. DCW Smith reported that she called Resident B while she popped Resident C's medication and Resident B took the medication from the counter and ingested it. DCW Smith reported that typically Resident B waits for the medication to be handed to her, she typically does not just pick up a cup of medication and take it. DCW Smith reported that Resident C had two cups of medication and Resident B only took one of the cups. DCW Smith reported that Resident B and Resident C take some of the same medications just different dosage amounts. DCW Smith reported that she signed for all of Resident B's medications because even if she did not administer them because she disposed of them per the direction of poison control and because poison control told her not to administer them. DCW Smith recalled poison control telling her not to administer Resident B's Clonazepam as that medication was also prescribed to Resident C as she did want Resident B to get a double dose of that medication.

On 01/11/2021, DCW Blandford reported that DCW Smith had been trained in medication administration. DCW Blandford provided a *Certificate of Completion* dated 05/15/2021 that documented that DCW Smith has completed Pharmacology Class.

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:	DCW Quaderer, DCW Smith and DCW Blandford all reported that on 11/22/2021, Resident B took medication that she was not prescribed. DCW Quaderer, DCW Smith and DCW Blandford all reported that Resident B took Resident C's prescribed medication therefore a violation has been established as reasonable precautions were not taken to ensure that Resident B did not get medication that was not prescribed for her.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/13/2021, an exit conference was conducted with licensee designee Scott Brown who understood the findings of the investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in the status of the license.

01/13/2022

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Julie Elkins Date
Licensing Consultant

Approved By:

01/14/2022

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Dawn N. Timm Date
Area Manager