GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 14, 2022

Deana Fisher
St. Louis Center for Exceptional Children & Adults
16195 Old US-12
Chelsea, MI 48118

RE: License #: AS810409206
Investigation #: 2022A0122022
Knights of Columbus House

Dear Ms. Fisher:

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) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS810409206
Investigation #:	2022A0122022
Complaint Receipt Date:	03/28/2022
Investigation Initiation Date:	03/28/2022
Report Due Date:	05/27/2022
Licensee Name:	St. Louis Center for Exceptional Children & Adults
Licensee Address:	16195 Old US-12 Chelsea, MI 48118
Licensee Telephone #:	(734) 475-8430
Administrator:	Deana Fisher
Licensee Designee:	Deana Fisher
Name of Facility:	Knights of Columbus House
Facility Address:	1659 Hayes Rd Chelsea, MI 48118
Facility Telephone #:	(734) 475-8430
Original Issuance Date:	08/11/2021
License Status:	TEMPORARY
Effective Date:	08/11/2021
Expiration Date:	02/10/2022
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A is not receiving his seizure medication as prescribed.	Yes
Staff are not following medication error protocols.	No

III. METHODOLOGY

03/28/2022	Special Investigation Intake 2022A0122022 APS Referral Denied
03/28/2022	Special Investigation Initiated - Telephone Completed interview with Complainant 1.
03/30/2022	Inspection Completed On-site Completed interviews with Deana Fisher, Licensee Designee, and Emily Wild, LPN. Received requested documents. Reviewed resident medications and medication administration records.
03/30/2022	Exit Conference Discussed findings with Deana Fisher, Licensee Designee.

ALLEGATION: Resident A is not receiving his seizure medication as prescribed.

INVESTIGATION: On 03/28/2022, I completed an interview with Complainant 1. Complainant 1 reported that she is no longer employed by St. Louis Center for Exceptional Children and Adults but used to be a direct care staff member until she decided to terminate her employment. While performing her duties Complainant 1 stated she observed that Resident A had not been receiving his seizure medication as prescribed. Complainant 1 stated she observed that fellow staff members would sign off as if they had administered Resident A's medication, however, the actual medication would be found in its original pharmacy packaging not given.

On 03/30/2021, I completed an interview with Deana Fisher, Licensee Designee. Ms. Fisher acknowledged that there have been issues with staff following medication administration procedures and an all-staff medication training had been completed to refresh them of the proper medication administration protocol. At my request, Ms.

Fisher submitted medication error sheets to give a description of the types of issues staff have been experiencing.

On 03/30/2021, I reviewed Medication Error Forms for Resident A dated 01/03/2022, 01/28/2022, 02/02/2022, 02/17/2022, 02/24/2022, 02/26/2022, and 03/03/2022. On these dates Resident A's seizure medication were not passed to Resident A even though staff had signed off on the medication administration record verifying that the medication had been passed, the actual medication was found in its original pharmacy packaging later. During an internal investigation it was found that Resident A's seizure medication is in a 2nd pharmacy package in the same container as his 1st package, however, staff failed to pull from the 2nd package. These incidents were reported to the nursing staff and nursing staff gave direction regarding appropriate next steps for each resident that missed their medication.

On 03/30/2022, I reviewed Meeting Sign-In Sheets with "Medication Administration Training" as the topic with the dates of 03/21/2022, 03/22/2022, 03/23/2022, 03/24/2022, 03/25/2022, and 03/28/2022 verifying that staff attended the training.

On 03/30/2022, I completed an exit conference with Deana Fisher, Licensee Designee. My findings were discussed with her, and Ms. Fisher responded by stating that she would submit a corrective action plan to address the rule violations.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	On 03/28/2022, Complainant 1 reported that Resident A is not receiving his seizure medication as prescribed. On 03/30/2022, I reviewed Medication Error Forms for Resident A dated 01/03/2022, 01/28/2022, 02/02/2022, 02/17/2022, 02/24/2022, 02/26/2022, and 03/03/2022. On these dates Resident A's seizure medications were not passed even though staff had signed off on the medication administration record verifying that the medication had been passed, the actual medication was found in its original pharmacy packaging later Based upon my investigation I find that Resident A is not receiving his seizure medication as prescribed as the Medication Error Forms reviewed showed that staff members had signed off on the medication administration records verifying that the medications had been administered however the actual medication was found in its original pharmacy packing later.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff are not following medication error protocols.

INVESTIGATION: On 03/28/2022, Complainant 1 reported that medication errors are not reported.

On 03/30/2022, Deana Fisher reported staff medication errors had been observed and to address this issue an all-staff medication training had been completed to refresh them of the proper medication administration protocol. At my request, Ms. Fisher submitted medication error sheets to give a description of the types of issues staff have been experiencing.

On 03/30/2022, I reviewed Medication Error Forms for Resident A dated 01/03/2022, 01/28/2022, 02/02/2022, 02/17/2022, 02/24/2022, 02/26/2022, and 03/03/2022. The forms document resident names, list of the medication, the type of error, the reporting of the error to the nursing staff, and what instruction was given.

On 03/30/2022, I completed an interview with Emily Wild, LPN on staff. Nurse Wild reported that nursing staff employed by St. Louis Center for Exceptional Children and Adults had been informed of Resident A's missed seizure medication, however, the physician that prescribed the medication had not been informed, therefore, no direction from the prescribing physician had been received.

On 03/30/2022, I completed an exit conference with Deana Fisher, Licensee Designee. Ms. Fisher agreed with my findings of this investigation and a corrective action plan to address the rule violation would be submitted.

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: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	On 03/28/2022, Complainant 1 reported that medication errors are not being reported. On 03/30/2022, I reviewed Medication Error Forms for Resident A dated 01/03/2022, 01/28/2022, 02/02/2022, 02/17/2022, 02/24/2022, 02/26/2022, and 03/03/2022. The forms document that the nursing staff of St. Louis Center for Exceptional Children and Adults had been informed of the medication errors. Based upon my investigation I find no evidence to support that medication errors are not being reported.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend no change in the status of the license.

Vanita C. Bouldin — Date: 04/14/2022
Licensing Consultant

Approved By:

Ardra Hunter — Date: 04/14/2022
Area Manager