GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 10, 2022

Sonia McKeown
JARC
Suite 100
6735 Telegraph Rd
Bloomfield Hills, MI 48301

RE: License #: AS630012708
Investigation #: 2022A0611025
Laker

Dear Ms. McKeown:

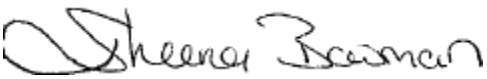
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS630012708
Investigation #:	2022A0611025
Complaint Receipt Date:	04/26/2022
Investigation Initiation Date:	04/26/2022
Report Due Date:	06/25/2022
Licensee Name:	JARC
Licensee Address:	Suite 100 6735 Telegraph Rd Bloomfield Hills, MI 48301
Licensee Telephone #:	(248) 403-6013
Administrator:	Sonia McKeown
Licensee Designee:	Sonia McKeown
Name of Facility:	Laker
Facility Address:	6078 Ledgeway West Bloomfield, MI 48322
Facility Telephone #:	(248) 626-2667
Original Issuance Date:	03/11/1991
License Status:	REGULAR
Effective Date:	11/15/2020
Expiration Date:	11/14/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident J was not administered his Eliquis medication at 8:00 pm.	Yes

III. METHODOLOGY

04/26/2022	Special Investigation Intake 2022A0611025
05/03/2022	Inspection Completed On-site I completed an unannounced onsite. I interviewed the home manager, Latrice Hartley and staff member, Sandra Baldwin. I observed Resident J's bubble packets and electronic medication administration record.
05/04/2022	Contact - Telephone call made I made a telephone call to staff member, Opeyemi Adewumi. The allegations were discussed.
05/04/2022	Exit Conference I completed an exit conference with the licensee designee, Sonia McKeown via telephone.

ALLEGATION:

Resident J was not administered his Eliquis medication at 8:00 pm.

INVESTIGATION:

On 04/22/22, I received an incident report regarding the aforementioned allegations. On 04/26/22, I received another incident report regarding Staff member, Opeyemi Adewumi inadvertently administering Resident J the wrong quantity of Eliquis 5 mg.

On 05/03/22, I completed an unannounced onsite. I interviewed the home manager, Latrice Hartley and staff member, Sandra Baldwin. I observed Resident J's bubble packets and electronic medication administration record.

On 05/03/22, I interviewed the home manager, Latrice Hartley, Regarding the allegations, Ms. Hartley stated Resident J was prescribed two pills of Eliquis 5 mg once in the morning and once in the evening starting on 04/19/22. Ms. Hartley stated the pharmacy provided this medication in bubble packets. I observed the bubble packets

and the medication was provided on dates marked for the 30th through the 23rd for the morning bubble packet. The medication for the afternoon bubble packet was provided on dates marked for the 30th through 22nd. Ms. Hartley's description of what transpired was confusing as she could not provide concise details regarding which exact date and shift Resident J ran out of his Eliquis. Ms. Hartley said on 04/22/22, the pharmacy was contacted regarding Resident J not having any more Eliquis pills. Ms. Hartley stated the pharmacy provided more of the medication on the same day.

Ms. Hartley stated Resident J's prescription for Eliquis changed from two pills twice a day to one pill twice a day. Ms. Hartley stated the bubble packets reflected the change as there was a singe pill in each bubble packet. On 04/26/22, staff member, Opeyemi Adewumi administered two pills of Eliquis to Resident J in the morning. Ms. Hartley stated Mr. Adewumi punched out two separate pills for two separate days on the morning bubble packet. Ms. Hartley stated that Mr. Adewumi made this mistake because he misread the instructions on the electronic medication administration record.

On 05/03/22, I interviewed staff member, Sandra Baldwin. Regarding the allegations, Ms. Baldwin stated on 04/21/22, she was administering 8:00 pm medications. Ms. Baldwin discovered that Resident J's Eliquis evening bubble packet had no more pills left. Ms. Baldwin stated she contacted the nurse but she received no response. Resident J did not receive his Eliquis at 8:00 pm on 04/21/22.

On 05/04/22, I interviewed staff member, Opeyemi Adewumi. Regarding the allegations, Mr. Adewumi stated on 04/26/22, Resident J's instructions for his Eliquis changed from two doses twice a day to a single dose twice a day. Mr. Adewumi stated the bubble packet had one pill for each day however; the way he read the medication record he thought he was supposed to administer two pills of Eliquis. Mr. Adewumi stated he punched out two separate pills from the morning bubble packet and administered them to Resident J.

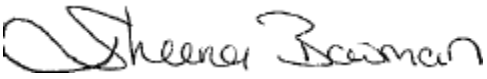
On 05/04/22, I completed an exit conference with the licensee designee, Sonia McKeown. Ms. McKeown was informed that the allegations will be substantiated and a corrective action plan will be required.

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

ANALYSIS:	Staff member, Sandra Baldwin confirmed that she did not administer Resident J his Eliquis 5 mg at 8:00 pm on 04/21/22 because there were no pills left. Staff member, Opeyemi Adewumi confirmed that on 04/26/22, he administered Resident J two pills of Eliquis 5 mg when Resident J was only prescribed one pill of Eliquis.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

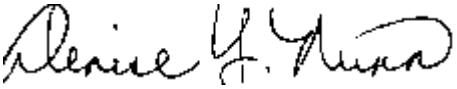
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



05/04/22

Sheena Bowman — Date
Licensing Consultant

Approved By:



05/10/2022

Denise Y. Nunn — Date
Area Manager