GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 23, 2022

Leisa Oliver
Group Living Facility Inc
G5095 Van Slyke Rd
Flint, MI 48507

RE: License #: AL250006953
Investigation #: 2022A0582032
Group Living Facility Inc

Dear Ms. Oliver:

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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

Derrick Britton, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-9721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250006953
Investigation #:	2022A0582032
Complaint Receipt Date:	04/01/2022
Investigation Initiation Date:	04/05/2022
Report Due Date:	05/31/2022
Licensee Name:	Group Living Facility Inc
Licensee Address:	G5095 Van Slyke Rd Flint, MI 48507
Licensee Telephone #:	(810) 767-5858
Administrator:	Jamie Saturnino
Licensee Designee:	Leisa Oliver
Name of Facility:	Group Living Facility Inc
Facility Address:	G5095 Van Slyke Road Flint, MI 48507
Facility Telephone #:	(810) 234-9461
Original Issuance Date:	03/15/1976
License Status:	REGULAR
Effective Date:	11/21/2020
Expiration Date:	11/20/2022
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION

	Violation Established?
On 03/26/2022, Guardian A picked up Resident A for a weekend visit and was informed that his supply of seizure medication (Valproic Acid) had run out a few days earlier.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/01/2022	Special Investigation Intake 2022A0582032
04/05/2022	Special Investigation Initiated - Telephone With Complainant
04/06/2022	Inspection Completed On-site
04/06/2022	Contact - Face to Face With Jamie Saturnino, Administrator
04/06/2022	Contact - Face to Face With Direct Care Worker Edith Hadley
04/06/2022	Contact - Face to Face With Direct Care Worker Shatoya Allen
05/20/2022	Contact - Telephone call made With Guardian A
05/23/2022	Inspection Completed-BCAL Sub. Compliance
05/23/2022	Exit Conference With Leisa Oliver, Licensee Designee
05/23/2022	Corrective Action Plan Requested and Due on 06/08/2022

ALLEGATION:

On 03/26/2022, Guardian A picked up Resident A for a weekend visit and was informed that his supply of seizure medication (Valproic Acid) had run out.

INVESTIGATION:

I received this complaint on 04/01/2022 and contacted Complainant on 04/05/2022. Complainant stated that Guardian A picks up Resident A from the facility on weekends. Complainant stated that when Guardian A arrived on 03/26/2022, a staff member told her that she hopes she had this particular medication (Valproic Acid) at her house, because they were all out at the facility. Complainant stated that the facility staff contacted the pharmacy regarding a refill of the medication but were told that they were ordering too soon. Complainant stated that if the home staff had informed the pharmacy that the medication was completely out, the pharmacy would have provided the medication. Complainant stated that the pharmacy was not made aware that Resident A was completely out of medications, so they would be receiving the medication at the regularly scheduled time. Complainant stated that Guardian A went to the pharmacy and was able to get the medications.

On 04/06/2022, I conducted an unannounced, onsite inspection at the facility. I interviewed Jamie Saturnino, Administrator. Ms. Saturnino stated that the medication is a liquid medication that they ran out of, and she is unsure how they ran out. Ms. Saturnino stated that the pharmacy informed them that they would be delivering the medication on 03/24/2022, but the medication was not delivered. Ms. Saturnino stated that there was no follow-up from their end to check on the status of delivering the medication. Ms. Saturnino stated that Guardian A arrived to pick up Resident A, and “blew a gasket” because the facility was out of the medication.

On 04/06/2022, I interviewed Direct Care Worker Edith Hadley. Ms. Hadley stated that Guardian A picks up Resident A every other Saturday. Ms. Hadley stated that she typically prepares medication to give to Guardian A when Resident A leaves for the weekends. Ms. Hadley stated that she went to get Resident A’s medication (Valproic Acid) and did not have the medication to give to Guardian A. Guardian A stated she called the pharmacist afterwards, and by that time Guardian A had gone to the pharmacy and picked up the medication. Ms. Hadley stated that it was assumed that whoever initially called the pharmacy did not make it clear that they were completely out of the medication, and Resident A’s insurance would not cover the cost until it was time. Ms. Hadley stated that the pharmacy should have been made aware that they were completely out of the medication, not just trying to fill a new script.

On 04/06/2022, I interviewed DCW Shatoya Allen, who stated that on the morning of 3/22/2022, she became aware the Resident A’s medication for Valproic Acid was getting low. Ms. Allen stated that they contacted the pharmacy but was told that it was too soon to refill the medication. Ms. Allen stated that they were told that the

medication could be refilled on 03/24/2022. Ms. Allen stated that she did not know exactly when the medication ran out.

I reviewed Resident A's *Medication Administration Log*, which documented that he is prescribed Valproic Acid 10 ML by mouth three times a day at 8AM, 2PM, and 8PM. I reviewed a staff log for Resident A, which documented on 03/22/2022, Resident A's Valproic Acid was "called in" and would not be ready until the 3/24/2022.

On 05/20/2022, I interviewed Guardian A. Guardian A stated that on Saturday morning at 9am on 03/26/2022, she arrived at the facility to pick up Resident A for the weekend. Guardian A stated that Direct Care Worker Edith Hadley came to her and stated, "I hope you have some of that red medicine; we have been all out since Thursday." Guardian A stated that she to Ms. Hadley that "you cannot be out." Ms. Hadley stated that someone called the pharmacy, and the prescription could not be filled before Saturday because the insurance would not cover it. Guardian A stated that Ms. Hadley told her that the pharmacy was supposed to bring the medication before that day. Guardian A stated that she told Ms. Hadley that she would go to the pharmacy herself when it opened. Guardian A stated that the pharmacist was surprised that the facility was out of the medication, as their records indicated that they should have three more weeks of the medication. Guardian A stated that since the medication is liquid, a staff person could have spilled it, but that would have been a lot to spill. Guardian A stated that her interactions with management regarding this issue were difficult, and she had not heard back on a remedy to ensure that this would not happen again.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Based on interviews with Complainant, Ms. Saturnino, Ms. Hadley, Ms. Allen, and Guardian A, there is sufficient evidence to confirm that Resident A did not have his prescribed medication (Valproic Acid) to provide Guardian A while Resident A was out of the home for a visit. Guardian A had to go to the pharmacy and pick up the medication herself.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 04/06/2022, I conducted an unannounced, onsite inspection at the facility. I reviewed Resident A's *Medication Administration Record* for March 2022, which documented that Resident A was administered Valproic Acid on 03/26/2022 by "E.H." at 8AM. I interviewed DCW Edith Hadley, who stated that she initialed that she passed the medication even though they were out of the medication. Ms. Hadley had no reason why she initialed as if she passed the medication without having the medication.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4)(b) Complete an individual medication log that contains all of the following information: **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Based on a review of Resident A's *Medication Administration Record* (MAR) and interview with DCW Edith Hadley, Ms. Hadley admitted to initialing the MAR on the morning of 03/26/2022, even though there was no medication (Valproic Acid) to administer.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/23/2022, I conducted an Exit Conference with Leisa Oliver, Licensee Designee. I informed Ms. Oliver of the findings of the investigation and the expectation of a corrective action plan.

IV. RECOMMENDATION

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

05/23/2022

Derrick Britton — Date
Licensing Consultant

Approved By:

05/23/2022

Mary E Holton — Date
Area Manager