GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 2, 2022

Fatima Mayo
813 S. Bond St
Saginaw, MI 48601

RE: License #: AS730409293
Investigation #: 2022A0871033
A Place Called Home 2

Dear Ms. Mayo:

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.
matter.

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 (989) 732-8062.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730409293
Investigation #:	2022A0871033
Complaint Receipt Date:	04/22/2022
Investigation Initiation Date:	04/27/2022
Report Due Date:	06/21/2022
Licensee Name:	Fatima Mayo
Licensee Address:	813 S. Bond St Saginaw, MI 48601
Licensee Telephone #:	(989) 482-8989
Administrator:	Fatima Mayo
Licensee Designee:	
Name of Facility:	A Place Called Home 2
Facility Address:	2810 Hampshire Saginaw, MI 48601
Facility Telephone #:	(989) 482-8989
Original Issuance Date:	09/22/2021
License Status:	REGULAR
Effective Date:	03/22/2022
Expiration Date:	03/21/2024
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was out of his medication Clozaril. The pharmacy filled a 28-day Clozaril bottle on 04/01/2022 and Case Manager Ashley Thornton delivered it to the facility. Complainant 1 spoke with Staff Daisy Sherman at the AFC home yesterday (04/21/22) and she stated they only had a few pills from the pharmacy, not the 28-day supply that was delivered. Ms. Sherman could not provide a Medication Administration Record for Resident A to indicate where the medication was going.	Yes

Was a referral made to APS regarding this alleged neglect to Resident A?

III. METHODOLOGY

04/22/2022	Special Investigation Intake 2022A0871033
04/26/2022	Contact - Telephone call made Telephone call to Complainant 1
04/27/2022	Special Investigation Initiated - On Site Interviewed Staff Daisy Sherman and Resident A
06/01/2022	Contact - Telephone call made Telephone call to Pharmacy Tech Precious Williams
06/02/2022	Contact - Telephone call made Telephone call to Licensee Fatima Mayo
06/02/222	APS Referral Through Central Intake to Saginaw County MDHHS
06/02/2022	Exit Conference Telephone exit conference with Licensee Fatima Mayo
06/02/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A was out of his medication Clozaril. The pharmacy filled a 28-day Clozaril bottle on 04/01/2022 and Case Manager Ashley Thornton delivered it to the facility. Complainant 1 spoke with Staff Daisy Sherman and the AFC home yesterday (04/21/22) and she stated they only had a few pills from the pharmacy, not the 28-day supply that was delivered. Ms. Sherman could not provide a Medication Administration Record for Resident A to indicate where the medication was going.

INVESTIGATION:

On April 26, 2022, I telephoned Complainant 1. Complainant 1 indicated Resident A was placed at A Place Called Home II on April 1, 2022. Ms. Johnston said on April 20, 2022, she received a call from Case Manager Ashley Thornton and indicated she went to the home on April 20, 2022, and Resident A was out of Clozaril.

On April 26, 2022, I interviewed Case Manager Ashley Thornton via telephone. Ms. Thornton indicated she picked up Resident A's Clozaril 28-day supply from the pharmacy and took it to the facility on April 1, 2022. Ms. Thornton said she went to the facility on April 20, 2022 and was told Resident A was out of his Clozaril. Ms. Thornton was told by Ms. Sherman that only a 10-11-day supply was sent to the facility on April 1, 2022. Ms. Thornton indicated she asked Staff Daisy Sherman to see Resident A's *Medication Administration Record* and Ms. Sherman told her she did not have it and she was recording it on a piece of paper.

On April 27, 2022, I conducted an unannounced onsite investigation and interviewed Staff Daisy Sherman. Ms. Sherman indicated that on April 1, 2022, Resident A moved in with his medications, and they were in bubble packs. Ms. Sherman said Resident A "did not have the Clozaril with him." Ms. Sherman indicated only a 10-day supply of Clozaril was sent with him and they ran out on either the 11th or 12th of April. Ms. Sherman said it was noticed that Resident A was not getting his Clozaril when the nurse came out to the facility and an emergency order was filled. Ms. Sherman said Resident A's *Medication Administration Record* "was not in her computer and she was keeping track on a piece of paper." Ms. Sherman said she does not know what happened to Resident A's Clozaril.

On April 27, 2022, I observed Resident A's *Medication Administration Record.* Resident A's record indicates the Clozaril, along with the other medications that he is prescribed, were not initialed as given since April 1-19th. The *Medication Administration Record* indicates his medication was given and initialed as given starting on April 20, 2022.

On April 27, 2022, I interviewed Resident A. He stated he is doing good and getting his medications. Resident A appeared to be clean and no bruising or injuries were noted.

On June 1, 2022, I telephoned Pharmacy Tech Precious Williams with Genova Pharmacy. Ms. Williams said that on April 1, 2022, a 28-day supply of Clozaril was picked up by Case Manager Ashley Thornton to take to the facility. Ms. Williams indicated that a 28-day supply of Clozaril is always given to Resident A on the first of the month.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	A Place Called Home II was given a 28-day supply of Clozaril on April 1, 2022, to give to Resident A. According to the *Medication Administration Record,* he did not receive Clozaril or any of his other prescribed medications, until April 20, 2022. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:** **(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:	Staff Daisy Sherman said she was recording Resident A's medications on a piece of paper because he was not in the computer. Resident A's *Medication Administration Record* was not initialed as given for the month of April until April 20, 2022. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Case Manager Ashley Thornton took a 28-day supply of Clozaril to the facility on April 1, 2022, for Resident A. Staff Daisy Sherman said only a 10–11-day supply of Resident A's Clozaril was sent to the facility. Pharmacy Tech Precious Williams confirmed a 28-day supply was sent to the facility on April 1, 2022. It is unknown what happened to the 28-day supply of Clozaril that ran out on either April 10th or 11th. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On June 2, 2022, I conducted a telephone exit conference with Licensee Fatima Mayo. I advised License Mayo there were several rule violations cited in this complaint regarding Resident A's medications.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care small group home remain unchanged (capacity 1-4).

Kathryn Huber 06/02/2022

Kathryn A. Huber Date
Licensing Consultant

Approved By:

Mary Holton 06/02/2022

Mary E Holton Date

Area Manager