GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 30, 2022

Renee Ostrom
Residential Alternatives Inc
P.O. Box 709
Highland, MI 48357-0709

RE: License #: AS630080974
Investigation #: 2022A0991031
Beacham CLF

Dear Ms. Ostrom:

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,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630080974
Investigation #:	2022A0991031
Complaint Receipt Date:	06/22/2022
Investigation Initiation Date:	06/22/2022
Report Due Date:	08/21/2022
Licensee Name:	Residential Alternatives Inc
Licensee Address:	14087 Placid Dr Holly, MI 48442
Licensee Telephone #:	(248) 369-8936
Licensee Designee:	Renee Ostrom
Name of Facility:	Beacham CLF
Facility Address:	3278 Beacham Waterford, MI 48329
Facility Telephone #:	(248) 335-3280
Original Issuance Date:	08/04/1998
License Status:	REGULAR
Effective Date:	03/05/2021
Expiration Date:	03/04/2023
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 06/16/22, Resident A did not receive his 8:00am medications.	Yes

III. METHODOLOGY

06/22/2022	Special Investigation Intake 2022A0991031
06/22/2022	Special Investigation Initiated - Telephone Call to Dawn Krull, Office of Recipient Rights (ORR) worker
06/22/2022	Referral - Recipient Rights Received from Office of Recipient Rights (ORR)
06/24/2022	Inspection Completed On-site Interviewed home manager
06/24/2022	Contact - Document Received Incident report, medication records, in-service form
06/29/2022	Contact - Telephone call made To direct care worker- Elaine Reyes- number not in service
06/30/2022	Exit Conference Via telephone with licensee designee, Renee Ostrom

ALLEGATION:

On 06/16/22, Resident A did not receive his 8:00am medications.

INVESTIGATION:

On 06/22/22, I received a complaint from the Office of Recipient Rights (ORR) alleging that Resident A did not receive his 8:00am medications on 06/16/22. I initiated my investigation on 06/22/22 by contacting the assigned ORR worker, Dawn Krull.

On 06/24/22, I conducted an unannounced onsite inspection at Beacham CLF. I interviewed the home manager, Rachel Griffin. Ms. Griffin stated that she has worked at the home for one year and has been the home manager for the past three months. On 06/16/22 around 10:00pm, she received a phone call from direct care worker, Amanda Makaroff. Ms. Makaroff informed her that she was checking medications at the beginning of her shift and noticed that Resident A's 8:00am medications had not been passed that morning. Ms. Griffin stated that she called the pharmacy and the on-call number for Resident A's primary care physician. The doctor told her not to pass the missed medications and to continue with the scheduled dose the following morning. Resident A did not have any symptoms or negative side effects as a result of the missed medications. Ms. Griffin stated that Elaine Reyes was the scheduled medication passer for 8:00am on 06/16/22. Ms. Reyes initialed the medication administration record (MAR) for the 8:00am medications, but she did not pass the medications. The pills were still in the bubble pack that evening. The medications that were not passed at 8:00am were: Carbamazepine 200mg, Docusate Sodium 100mg, Metformin Hcl 1000mg, Risperidone 3mg, and Vitamin D3 25mcg. Resident A is prescribed Repaglinide 2mg tab, which he takes daily with meals. This medication was passed with his breakfast on 06/16/22.

Ms. Griffin stated that an incident report was completed following the medication error and an in-service was held with staff to review medication passing procedures. The medication passer is supposed to double check to make sure all medications were administered when they are done passing medications. The other staff on shift is also supposed to check the medications. Ms. Griffin initialed the medication log on 06/16/22 indicating that she completed the second person medication check for the AM and PM shifts on 06/16/22. Ms. Griffin stated that she came in and did transport that day. She counted the narcotics, but she did not check the other medications.

During the onsite inspection, I reviewed the medication bubble packs and MARs. I noted that Resident A's 8:00am medications on 06/16/22 were still in the bubble packs. Resident A's June 2022 MAR was initialed by Elaine Reyes for all of the 8:00am medications on 06/16/22. I reviewed a copy of the incident report dated 06/16/22, which contained the same information that was reported by the home manager. The incident report notes that the on-call physician, pharmacy, and guardian were contacted. I reviewed a copy of the in-service form, which staff signed to acknowledge that they received training on 06/20/22. The training covered proper medication passing procedures, including the eight rights of medication passing and completing medication checks after administering medications.

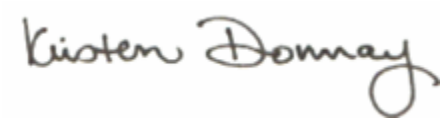
On 06/30/22, I conducted an exit conference via telephone with the licensee designee, Renee Ostrom. Ms. Ostrom indicated that she would submit a corrective action plan to address the violations.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A did not receive his 8:00am medications on 06/16/22. Direct care worker, Amanda Makaroff, noticed that the medications were still in the bubble pack when conducting a medication check at 10:00pm. The medications that were not passed at 8:00am were: Carbamazepine 200mg, Docusate Sodium 100mg, Metformin Hcl 1000mg, Risperidone 3mg, and Vitamin D3 25mcg.
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: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Based on the information gathered in my investigation, there is sufficient information to conclude that direct care worker, Elaine Reyes, initialed Resident A's medication administration record on 06/16/22, but she did not pass the 8:00am medications. The 8:00am medications remained in the bubble pack. The home manager also initialed the medication log indicating that she completed a check of the medications for the AM and PM shifts, but she did not check all of the 8:00am medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

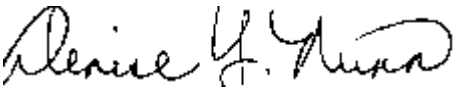
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



06/30/2022

Kristen Donnay Date
Licensing Consultant

Approved By:



06/30/2022

Denise Y. Nunn Date
Area Manager