STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

August 10, 2022

Michael Fields
Advanced Teaching Concepts Inc
P.O. Box 158
South Lyon, MI 48178

RE: License #: AS630015652
Investigation #: 2022A0991036
Rosemary Lane AIS/MR

Dear Mr. Fields:

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 #:	AS630015652
Investigation #:	2022A0991036
Complaint Receipt Date:	08/01/2022
Investigation Initiation Date:	08/01/2022
Report Due Date:	09/30/2022
Licensee Name:	Advanced Teaching Concepts Inc
Licensee Address:	60674 Russell Lane South Lyon, MI 48178
Licensee Telephone #:	(248) 486-5368
Licensee Designee:	Michael Fields
Name of Facility:	Rosemary Lane AIS/MR
Facility Address:	3075 Rosemary Lane Highland, MI 48357
Facility Telephone #:	(248) 887-3021
Original Issuance Date:	02/28/1994
License Status:	REGULAR
Effective Date:	12/20/2021
Expiration Date:	12/19/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff did not pass Resident A's 5:00pm medications on 07/19/22 and 07/25/22.	Yes

III. METHODOLOGY

08/01/2022	Special Investigation Intake 2022A0991036
08/01/2022	Special Investigation Initiated - Telephone Call to Office of Recipient Rights (ORR) worker, Katie Garcia
08/01/2022	Referral - Recipient Rights Referred to Katie Garcia, ORR worker
08/01/2022	Contact - Telephone call made To home manager, Denise Pattison
08/05/2022	Inspection Completed On-site Unannounced onsite inspection- interviewed staff and Resident A
08/05/2022	Contact - Document Received Medication logs, standing medical orders
08/08/2022	Exit Conference Via telephone with licensee designee, Mike Fields

ALLEGATION:

Staff did not pass Resident A's 5:00pm medications on 07/19/22 and 07/25/22.

INVESTIGATION:

On 08/01/22, I reviewed two incident reports indicating that staff at Rosemary Lane did not pass Resident A's 5:00pm medications on 07/19/22 and 07/25/22. I created a special investigation intake, which was assigned to me for investigation. On 08/01/22, I initiated my investigation by making a referral to the Office of Recipient Rights (ORR) and contacting the home manager.

On 08/01/22, I interviewed the home manager, Denise Pattison, via telephone. Ms. Pattison stated that on 07/19/22, direct care worker, Norma Barber, did not pass Resident A's 5:00pm dose of Tegretol and did not initial the medication administration record (MAR). Ms. Pattison also stated that on 07/25/22, direct care worker, Desiree Carpenter, did not pass Resident A's 5:00pm dose of Depakote. She stated that Resident A was recently in the hospital and the 5:00pm medications were added upon her discharge from the hospital. The rest of Resident A's medications are in pouches that are packaged by date and time of day. The 5:00pm medications were in separate bubble packs due to being recently added. Both staff were written up for the medication errors. Ms. Pattison stated that both staff are good workers, but they just made mistakes. Ms. Carpenter is a long-term staff person and is very good at her job. Ms. Pattison stated that Ms. Barber's daughter has been in the hospital, and she is "burning the candle at both ends." Ms. Pattison stated that they followed the doctor's standing medical orders for missed medications and did not pass the missed dose. Resident A did not have any negative effects from missing the medication.

On 08/05/22, I conducted an unannounced onsite inspection at the Rosemary Lane home. I interviewed direct care worker, Desiree Carpenter. Ms. Carpenter stated that she has worked at the home for four years. She stated that the information on the incident report indicating that she did not pass Resident A's medication on 07/25/22 was incorrect. She passed the medication and initialed the MAR, but she did not sign the bubble pack with the date that she passed the medication. I observed a pill remaining in the July bubble pack for the 5:00pm dose of Resident A's Divalproex (Depakote) 250mg Tab on the bubble numbered 25. Ms. Carpenter stated that staff had not been following the dates on the bubble pack correctly due to the medication starting on 07/08/22. The pill that remained in the bubble pack was from the incident when Norma Barber forgot to pass 5:00pm medications on 07/19/22. Another staff person saw the pill in the bubble numbered 25 and assumed the medication was missed on that date.

On 08/05/22, I interviewed direct care worker, Norma Barber. Ms. Barber stated that she has worked in the home for four years. She stated that on 07/19/22, she forgot to pass both of Resident A's 5:00pm medications, Carbamazepine 200mg (Tegretol) and Divalproex 250mg (Depakote). She realized that she forgot to pass the 5:00pm medications around 7:30pm when she began preparing to pass 8:00pm medications. She contacted the home manager, Denise Pattison, who advised her to skip the dose per Resident A's standing medical orders for missed medications. Ms. Barber stated that there was a misunderstanding that medication errors occurred on two different days. Both medications were not passed on 07/19/22 when she made an error. The dates on the bubble packs did not correspond to the correct dates when medications were passed due to the medication being prescribed later in the month. Ms. Barber stated that Resident A's 5:00pm medications were added after Resident A was discharged from the hospital in July. The rest of Resident A's medications are packaged together in pouches, but the 5:00pm medications were in separate bubble packs. The home manager posted a note on the medication cabinet stating that Resident A had new medications added after she was discharged from the hospital. Ms. Barber stated that she just forgot to pass Resident A's 5:00pm medications on 07/19/22. She was

working with a new staff person who was not fully trained, so she was responsible for cooking dinner and passing medications that day. Usually, Ms. Barber works shifts with Ms. Carpenter. Ms. Carpenter passes medications while Ms. Barber cooks dinner. Ms. Barber stated that she was written up for the medication error and the home manager reviewed medication passing procedures with her following the incident.

On 08/05/22, I interviewed Resident A. Resident A stated that she has lived in the home for a few months. She always gets her medications. She has diabetes and issues with her sodium levels. She had been feeling dizzy and was in the hospital for a while. She is feeling much better now, and her medications are helping. She stated that staff in the home are great. The home manager is wonderful, and she likes living in the home.

During the onsite inspection, I observed the bubble packs from July 2022. There was one pill remaining in the bubble pack for the 5:00pm dose of Resident A's Divalproex (Depakote) 250mg Tab on the bubble numbered 25. There was one pill remaining in the bubble pack for the 5:00pm dose of Carbamazepine 200mg (Tegretol) in the bubble numbered 19. I reviewed a copy of Resident A's July 2022 medication administration record (MAR). There was a note on the back of the MAR from the home manager indicating that on 07/19/22 Norma informed her that she forgot to give Resident A her 5:00pm medications (Carbamazepine and Depakote). The standing missed medication orders state to omit the next dose. I reviewed the standing medical orders for missed medications for Divalproex 250mg Tab and Carbamazepine 200mg. The orders for both medications state that staff should omit the missed dose and resume medication at the next scheduled dose. I reviewed a copy of the medication buddy check log, which shows that on 07/19/22 a second staff person did not complete a check of the medications. Ms. Barber indicated that the buddy check system was not completed on that day, because the staff she was working with was not medication trained.

On 08/08/22, I conducted an exit conference via telephone with the licensee designee, Mike Fields. Mr. Fields stated that he has a staff meeting scheduled at Rosemary Lane on 08/16/2022 and would conduct a medication refresher training with all staff. He stated that he would submit a corrective action plan to address the violation.

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 her medications as prescribed. On 07/19/22, direct care worker, Norma Barber, made a medication error and did not pass Resident A's 5:00pm dose of Divalproex 250mg Tab and Carbamazepine 200mg. During the onsite, I observed that the pills remained in the July 2022 bubble packs, and there was a

	note on the back of the July 2022 medication log indicating that Ms. Barber contacted the home manager and stated that she forgot to pass the 5:00pm 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.

08/08/2022

Kristen Donnay — Date
Licensing Consultant

Approved By:

08/10/2022

Denise Y. Nunn — Date
Area Manager