GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 7, 2022

Tamesha Porter
Safe Haven Assisted Living Of Haslett LLC
5917 Edson St
Haslett, MI 48840

RE: License #: AL330404984
Investigation #: 2022A0790035
Safe Haven Assisted Living Of Haslett

Dear Ms. Porter:

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 (517) 284-9730.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL330404984 |
| | |
| **Investigation #:** | 2022A0790035 |
| | |
| **Complaint Receipt Date:** | 08/17/2022 |
| | |
| **Investigation Initiation Date:** | 08/18/2022 |
| | |
| **Report Due Date:** | 10/16/2022 |
| | |
| **Licensee Name:** | Safe Haven Assisted Living Of Haslett LLC |
| | |
| **Licensee Address:** | 5917 Edson St<br>Haslett, MI 48840 |
| | |
| **Licensee Telephone #:** | (517) 402-1802 |
| | |
| **Administrator:** | Tamesha Porter |
| | |
| **Licensee Designee:** | Tamesha Porter |
| | |
| **Name of Facility:** | Safe Haven Assisted Living Of Haslett |
| | |
| **Facility Address:** | 5917 Edson St<br>Haslett, MI 48840 |
| | |
| **Facility Telephone #:** | (517) 339-7278 |
| | |
| **Original Issuance Date:** | 09/29/2020 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 03/29/2021 |
| | |
| **Expiration Date:** | 03/28/2023 |
| | |
| **Capacity:** | 16 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was given another resident's crushed medications in error, which resulted in Resident A being admitted to Sparrow Hospital and placed on a ventilator. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 08/17/2022 | Special Investigation Intake<br>2022A0790035 |
| 08/18/2022 | Special Investigation Initiated - Face to Face- I interviewed direct care worker (DCW) Lori Evans who functions as the house manager and licensee designee Tamesha Porter.<br><br>I also interviewed facility's licensing consultant Jana Lipps. |
| 08/18/2022 | Inspection Completed On-site |
| 08/31/2022 | Contact - Telephone call made- I interviewed DCW Andrea Jones. |
| 08/31/2022 | Contact - Telephone call made- I interviewed Guardian A1. |
| 08/31/2022 | Exit Conference with licensee designee Tamesha Porter. |
| 08/31/2022 | Inspection Completed-BCAL Sub. Compliance |

**ALLEGATION:**

**Resident A was given another resident's crushed medications in error, which resulted in Resident A being admitted to Sparrow Hospital and placed on a ventilator.**

**INVESTIGATION:**

On 08/18/2022, I interviewed assigned Adult Foster Care Licensing Consultant Jana Lipps who stated she received an *AFC Licensing Division - Incident / Accident Report* indicating Resident A was given Resident B's medication by accident and Resident A is now in the hospital on a ventilator. She said she spoke to licensee designee Tamesha Porter and Ms. Porter indicated Resident B takes high doses of Lorazepam, Gabapentin, and Trazodone. Ms. Lipps said Ms. Porter indicated both Resident A and Resident B have a prescription for crushed medications. She said Ms. Porter indicated

they were told by their facility doctor to monitor Resident A for side effects. Ms. Lipps stated Ms. Porter stated they immediately contacted the facility doctor after Resident A was given Resident B's medication. She said Ms. Porter indicated she is keeping copious documentation of the events surrounding Resident A receiving Resident B's medication.

I reviewed the *AFC Licensing Division - Incident / Accident Report* and it said Resident A was given the wrong medication on 08/12/2022 at 7:30 p.m. Resident A was sent to the hospital on 08/13/2022 at 1:00 a.m. after monitoring per their facility doctor's orders indicated additional care was needed.

The *AFC Licensing Division - Incident / Accident Report* further indicated the doctor and Resident A's family were contacted when Resident A received the wrong medication. The doctor was given Resident A's vitals and he wrote an order to keep Resident A at the facility and continue to monitor her vitals. Resident A was sent to the hospital per doctor's order on 08/13/2022 at 1:00 a.m. for low blood pressure.

The *AFC Licensing Division - Incident / Accident Report* said to see written measures. The written measures were reviewed and indicated the direct care worker (DCW) responsible for giving Resident A the wrong medication was taken off medication passing and DCWs will continue to check on Resident A.

I conducted an unannounced onsite investigation on 08/18/2022. I interviewed DCW Lori Evans who functions as the house manager. Ms. Evans indicated DCW Andrea Jones was the DCW responsible for giving Resident A the wrong medication. She said Ms. Jones is still employed but has been taken off medication passing.

Ms. Evans indicated on 08/12/2022 Resident A was given Resident B's medication. She said she was unaware how Ms. Jones made this critical error. She said she does not fully understand what happened to cause the error, but Ms. Jones indicated she thought she was going to Resident A's bedroom but was supposed to go to Resident B's and give her the medication. Ms. Evans said she knows both Resident A and Resident B get their medications crushed. She stated DCWs only pass one resident's medication(s) at a time per their current procedure.

Ms. Evans stated they have been compiling a lot of paperwork to properly document the events surrounding this incident.

I interviewed licensee designee Tamesha Porter. She reiterated the incident occurred on 08/12/2022 and that Resident A was inadvertently given Resident B's medication at approximately 7:30 p.m. Ms. Porter said DCW Andrea Jones was passing the medication when she accidentally made this serious medication error. Ms. Porter said she interviewed Ms. Jones and Ms. Jones could not articulate how she made the error. Ms. Porter said Ms. Jones explained it was an accident and she does not know how or why she gave Resident A the wrong medication.

Ms. Porter said Ms. Jones immediately contacted house manager/DCW Lori Evans, informing her of the medication error. She said Ms. Evans contacted her (Ms. Porter) and then contacted their facility doctor. Ms. Porter said she immediately came to the facility when she heard what had happened and promptly contacted Resident A's family.

Ms. Porter stated the facility doctor said if Resident A were in significant danger, she would already be experiencing significant symptoms. The doctor gave the orders to have Resident A remain at the facility and to check her vital signs every four hours. Ms. Porter said she was not comfortable with only checking Resident A's vital signs every four hours, so she implemented 30-minute checks. She said DCWs were checking on Resident A every 30-minutes and monitoring her vital signs.

Ms. Porter said at bedtime Resident A was drinking a lot of water and her vital signs appeared normal. She said the doctor sent over a second order to check on Resident A and monitor her vital signs every hour throughout the night. Ms. Porter said the doctor indicated it was okay for Resident A to sleep. She said the doctor stated Resident A was going to sleep. Ms. Porter said the doctor explained it was part of the natural progression of the medications working through Resident A's system.

Ms. Porter stated DCWs continued to check on Resident A and monitor her vital signs every 30-minutes. Ms. Porter said around 1:00 a.m. on 08/13/2022, Resident A's blood pressure began dropping and fell to 74/47. She stated they called 911 and Resident A's family. Ms. Porter stated Resident A was taken to the hospital by Emergency Medical Services.

Ms. Porter stated she went to the hospital and met Resident A's family there. She said when she arrived Resident A was talking and responsive but soon after "crashed", was intubated, and transferred to the intensive care unit (ICU). Ms. Porter said a couple of days later Resident A had the tube removed, was transferred out of ICU, and doing well. She stated Resident A subsequently contracted hospital pneumonia and is currently not doing well. This was as of 08/18/2022.

Ms. Porter stated Resident A's family members wanted Resident A brought back to Safe Haven Assisted Living of Haslett as soon as medically possible. Ms. Porter stated the plan is to bring Resident A back to Safe Haven on hospice. She said Resident A's prognosis is currently not good and doctors have said she will most likely pass away soon.

Ms. Porter said Resident A's daughter is a doctor and has stated she knows medication errors happen in healthcare settings. Ms. Porter stated Resident A's daughter has indicated she trusts Ms. Porter and the DCWs working at the facility and has stated this was an unfortunate accident. Ms. Porter stated Resident A's family members have asked her not to fire Ms. Jones.

Ms. Porter stated Ms. Jones has been a stellar DCW. She said Ms. Jones is a hard worker, is caring and compassionate toward the residents, and she believes in her.

Ms. Porter said Ms. Jones cannot provide an explanation for what happened other than it was a mistake. Ms. Porter said it is their practice to pass one resident's medications at a time. She said Ms. Jones meant to pass the crushed medications to Resident B, but her brain told her to pass them to Resident A instead. Ms. Porter said it was hard for her to come up with a Corrective Action Plan for Ms. Jones because of the medication error being the result of an accident, so she felt the best course of action was to write her up and immediately take her off medication passing.

Ms. Porter stated their current Electronic Medication Administration Record System (E-MAR System) is practically foolproof, but she plans to add additional safeguards to ensure no more medication errors happen at any of her facilities. She said the E-MAR System helps ensure medication is administered reliably.

Ms. Porter demonstrated how their E-MAR System works. She showed me how you click on a specific resident and a picture of the resident appears with a list of the medications he/she is prescribed. Ms. Porter demonstrated how you must scan a bar code on each of the resident's blister packs and/or bottles of medication one at a time, and then scan a bar code with a picture of the medication listed in the E-MAR System to ensure you have the correct medications for the resident you wish to administer medications to. She showed me what the E-MAR System does if you are not scanning the correct medications for the resident you are attempting to administer medications to. A flashing red light appears on the screen and an alarm goes off if it is not the correct medication(s) for the resident.

Ms. Porter said she plans to add the following steps to their current procedure when DCWs are administering medications. She said she is going to require two DCWs to pass medications so there will be two individuals reviewing the medications and ensuring they are administering the correct medication(s) to the correct resident. Ms. Porter stated she is going to add a second sign off in their E-MAR System so both DCWs will be required to insert their electronic signature before recording a medication pass.

Ms. Porter said she has also purchased bracelets for each resident and is going to require DCWs to read, and one DCW to say out loud, the resident's name listed on the bracelet before administering their medications. Ms. Porter said she is also planning to find out if she can insert or attach a bar code to the bracelets, and if so, she will have DCWs scan the resident in their E-MAR System and then scan the resident's bracelet to ensure they are about to administer the medications to the correct resident. Ms. Porter said she is planning to add these safeguards as soon as possible and will include them when preparing and implementing her Corrective Action Plan (CAP).

Ms. Porter said she is going to do her best to ensure a medication error never occurs again in any of her facilities, but if it does, she plans to immediately send the resident to the emergency room. She said she plans to add this protocol to their policies and procedural manual. Ms. Porter said both the doctor and Resident A's family did not feel Resident A needed immediate medical attention but in retrospect it may have been

beneficial and potentially lifesaving to have immediately sent her to the emergency room.

I interviewed DCW Andrea Jones via phone on 08/31/2022. Ms. Jones explained to me what happened prior to her giving Resident A another resident's medications on 08/12/2022. She said she crushed Resident B's medications and then went to the kitchen to get apple sauce to mix up the crushed medications in. Ms. Jones indicated they have another resident at the facility who is loud and demanding and she interrupted what Ms. Jones was doing by asking her something while she was entering and exiting the kitchen. Ms. Jones said the resident is hard to understand, so she listened intently to ensure she understood what the resident was saying so she could respond appropriately. Ms. Jones said this interaction distracted her and played a part in giving the crushed medications to the wrong resident.

Ms. Jones stated after responding to the resident, Resident A popped in her mind. She said she took the crushed medications in applesauce to Resident A's room and proceeded to administer the medications to Resident A. She said she then returned to the facility's medication room to finish the process in QuickMAR and realized she gave the crushed medications to the Resident A but should have given them to Resident B. Ms. Jones said she immediately contacted home manager/DCW Lori Evans and informed her of the medication error. She said Ms. Evans immediately contacted licensee designee Tamesha Porter and the facility doctor.

Ms. Jones stated Resident A is back at the facility and is doing well. She said Resident A is sitting up in her wheelchair and eating on her own.

I interviewed Guardian A1 via telephone on 08/31/2022. Guardian A1 said she used to be a medical examiner and the medication error involving Resident A was not intentional nor the result of incompetence. She said the medication error was an accident and unfortunate mistake. Guardian A1 said medication errors occur in medical facilities of all types and are most often accidental like the incident involving Resident A. Guardian A1 said Resident A has been at the facility for several years and has received exceptional care. She said Resident A is always clean and well-manicured. Guardian A1 stated Resident A is happy and content when visiting the facility.

Guardian A1 stated Resident A is doing much better after returning from the hospital. She said Resident A is sitting up in her wheelchair, talking, and eating on her own. She said Resident A appears to have made a full recovery.

I reviewed Resident A's *Resident Records.* Resident A's *Assessment Plan for AFC Residents* indicated DCWs are responsible for administering Resident A's medication. I reviewed a doctor's order from Careline Physician Services for Resident A which indicated the following, "Services Ordered: Hospital Bed; Wheelchair for mobility assistance; crush all allowable medications; Use thick-it per package directions for honey consistency." I reviewed the facility's E-MAR System under Resident A's name and it said to "Crush all medications" at the top of the screen.

Resident A was still inpatient at Sparrow Hospital when I conducted the unannounced on-site investigation, so I was not able to interview her regarding this incident.

I reviewed Resident B's *Resident Records.* Resident B's *Assessment Plan for AFC Residents* indicated DCWs are responsible for administering Resident B's medication. I reviewed a doctor's order from Dr. Angela Yurk indicating the following: "Crush all pts meds before giving". I reviewed the facility's E-MAR System under Resident B's name and it said to "Crush all medications" at the top of the screen. I saw Resident B when at the facility and noticed she was wearing her new name bracelet.

I held an exit conference with licensee designee Tamesha Porter via phone on 08/31/2022. Ms. Porter was informed of the established violations and requested to complete a Corrective Action Plan. She indicated she plans to comply with the request to complete a Corrective Action Plan and would do so in the required time frame.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.** |
| **ANALYSIS:** | Based on information gathered during this special investigation through review of documentation and interviews with DCW Lori Evans who functions as the house manager, licensee designee Tamesha Porter, DCW Andrea Jones, and Guardian A1 there is evidence indicating medication was not given, taken, or applied pursuant to label instructions as Resident A was administered Resident B's medications, which led to Resident A being admitted to Sparrow Hospital and placed on a ventilator. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15312** | **Resident medications.** |
| | **(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.** |

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|---|---|
| **ANALYSIS:** | Based on information gathered during this special investigation through review of documentation and interviews with DCW Lori Evans who functions as the house manager, licensee designee Tamesha Porter, DCW Andrea Jones, and Guardian A1 there is evidence indicating the licensee failed to take reasonable precautions to ensure that prescription medication was not used by a person other than the resident for whom the medication was prescribed. Resident A was administered Resident B's medications, which led to Resident A being admitted to Sparrow Hospital and placed on a ventilator. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

09/01/2022

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Rodney Gill Date
Licensing Consultant

Approved By:

09/07/2022

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Dawn N. Timm Date
Area Manager