GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 13, 2022

Christine Loria
Sterling Residence LLC
8097 Wildwood Trail
Mancelona, MI 49659

RE: License #: AS050395830
Investigation #: 2022A0009041
Sterling Residence

Dear Ms. Loria:

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 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 (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
701 S. Elmwood, Suite 11
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS050395830
Investigation #:	2022A0009041
Complaint Receipt Date:	08/22/2022
Investigation Initiation Date:	08/22/2022
Report Due Date:	09/21/2022
Licensee Name:	Sterling Residence LLC
Licensee Address:	8097 Wildwood Trail Mancelona, MI 49659
Licensee Telephone #:	(231) 409-6602
Administrator:	Christine Loria
Licensee Designee:	Christine Loria
Name of Facility:	Sterling Residence
Facility Address:	8097 Wildwood Trail Mancelona, MI 49659
Facility Telephone #:	(231) 409-6602
Original Issuance Date:	02/12/2019
License Status:	REGULAR
Effective Date:	02/13/2022
Expiration Date:	02/12/2024
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was given Resident B's medication by mistake.	Yes
The licensee designee told staff not to report the medication error and did not contact the appropriate health care professional.	Yes
Additional Finding	Yes

III. METHODOLOGY

08/22/2022	Special Investigation Intake 2022A0009041
08/22/2022	Special Investigation Initiated – Telephone call made to adult protective services worker Jacqueline Muzyl
08/26/2022	Inspection Completed On-site Interview conducted with licensee designee Christine Loria Face to face with Resident A
08/26/2022	Contact – Telephone call made to former direct care worker Nicole Coeur, left message
09/12/2022	Contact – Telephone call made to former direct care worker Nicole Coeur
09/13/2022	Contact – Telephone call made to adult protective services worker Jacqueline Muzyl, left message
09/13/2022	Contact – Telephone call made to licensee designee Christine Loria
09/13/2022	Exit Conference with licensee designee Christine Loria

ALLEGATION: Resident A was given Resident B's medication by mistake.

INVESTIGATION: I spoke with adult protective services worker Jaqueline Muzyl by phone on August 22, 2022. Ms. Muzyl stated that she had already been out to the facility and spoken to licensee designee Christine Loria about the complaint. Ms. Loria denied the allegation, saying that Resident A had gone to the hospital due to symptoms associated with Covid-19. They have dealt with several residents having Covid-19. Ms. Loria reportedly provided Ms. Muzyl with copies of the medication

administration logs for the facility. Ms. Muzyl stated that as far as she could see, Ms. Loria had administered almost all the residents' medication during the last several months. Ms. Loria explained that she lives next door and prefers to administer medication herself, however, some of her staff are trained to administer medication and do that on occasion. Ms. Muzyl stated that she would get back to me if she discovered anything that should be brought to my attention.

I conducted an unannounced site visit at the Sterling Resident adult foster care home on August 26, 2022. One direct care worker was on site who called Ms. Loria upon my arrival. Ms. Loria arrived on site shortly after being called, saying she had been next door. She explained that they had just gotten over a Covid-19 outbreak in the home and that she was dealing with staffing issues. I asked her about the administering of medication to the residents. Ms. Loria stated that she almost always is the one who gives the medications but that her own mother had recently been in the hospital so she did allow some of her trained staff to administer medication to the residents. Ms. Loria retrieved a compartmentalized pillbox that was organized by days of the week. She said that she distributed each resident's medication into the pillboxes to make it easier for her staff. I explained to Ms. Loria that she could not "pre-set" the medications in this fashion due to the fact that it often results in medication errors.

I asked Ms. Loria about a recent medication error regarding Resident A. She said that she had noticed that one of the compartments in a pillbox was empty when she came to check on things two days before. She said that she didn't know if the pills were missing or if she just didn't fill that compartment as she couldn't remember what day she ended on when filling the pillbox. I asked her if she figured out if there was missing medication or not. Ms. Loria replied that there was a lot going on and that she hadn't had time to figure it out right then. Ms. Loria stated that she didn't know about any medication error until an adult protective services (APS) worker showed up on August 22, 2022. The next day, her direct care staff Nicole Coeur did not show up to work. Ms. Loria went to check on her explaining that she rented an apartment to Ms. Coeur which is nearby. Ms. Coeur was home and explained she was quitting because she accidentally gave Resident A the wrong medication on August 13, 2022. It was Resident B's "P.M. dose". Resident A was given 100 mg of Trazodone, 10 mg of Aripiprazole, 25 mg of Metoprolol and 5 mg of Eliquis. I asked Ms. Loria when she first knew of the medication error. She said she did not know until Ms. Coeur told her on August 23, 2022. Ms. Loria said that she had been at the hospital with her mother on August 13 when the medication error happened. Ms. Coeur did not tell her about it but did tell the other staff. None of the other staff told her about it either. Ms. Loria denied that Ms. Coeur had called a doctor or an ambulance but said, "I would hope that she watched her like a hawk." Ms. Loria said that she called the Adult Protective Services worker as soon as she found out that it had happened. Ms. Coeur denied that Resident A had any health issues after the medication error. She said that Resident A had contracted Covid-19 and any health issues were related to that. Ms. Loria stated that each of her staff members know to call 911 if any of the residents have any health issues that need immediate attention.

Ms. Loria acknowledged that Resident A's doctor was not contacted about the medication error. She said that she would do that yet that day and also contact Resident A's guardian about it.

I spoke with former direct care worker Nicole Coeur by phone on September 12, 2022. She confirmed that she accidentally gave Resident A another resident's medication on August 13, 2022.

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:	It was confirmed through this investigation that on August 13, 2022, Resident A received Resident B's medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The licensee designee told staff not to report the medication error and did not contact the appropriate health care professional.

Licensee designee Christine Loria acknowledged that Resident A received Resident B's medication on August 13, 2022. I asked Ms. Loria if this medication error was reported to the appropriate health care professional and she said that the direct care worker who reportedly made the error, Nicole Coeur, did not report the error to the appropriate health care professional. Ms. Loria stated that she did not find out about the error until August 23, 2022, and still had not reported the error to the appropriate health care professional as of August 26, 2022.

I spoke with former direct care worker Nicole Coeur by phone on September 12, 2022. She said that she had accidentally given Resident A another resident's medication on August 13, 2022. She said that she realized immediately what she had done and called licensee designee Christine Loria. She told Ms. Loria that she thought that they should call an ambulance but Ms. Loria told her not to call an ambulance. Ms. Loria told her to keep an eye on Resident A and check her vitals every hour. Ms. Coeur went on to say that Resident A said that she felt "weird" and stayed in bed for the rest of the night. Her vitals were fine for the rest of that evening. Ms. Coeur said that she did feel that Resident A "declined" in the days following the medication error. Ms. Coeur said that she noticed that Resident A was not as active, needed help standing and had trouble eating. After five days, Ms. Coeur said that she told Ms. Loria about her belief that Resident A had declined since the time of the medication error. Ms. Loria did call an ambulance for Resident A at that time but did not tell them about the medication error. She only told them

about the symptoms Resident A was exhibiting. Ms. Coeur stated that after the APS worker showed up at the house, Ms. Loria contacted her (Ms. Couer) and asked her to lie about the medication error. Ms. Coeur said that was when she quit her employment at the facility. I asked Ms. Coeur why she believed Ms. Loria wanted her to lie about the medication error. She said that it was because Ms. Loria did not want her residents exposed to Covid-19 at the hospital and she did not want them or herself to be forced to take a Covid-19 vaccination.

I spoke with licensee designee Christine Loria by phone on September 13, 2022. She maintained that Ms. Coeur had not told her about the medication error until August 23, 2022. I asked her why Ms. Coeur would lie about that. She said she thought it was because Ms. Coeur did not want to get a "write-up" for the medication error. Ms. Loria stated that she did not believe that Resident A had any complications from the medication error. She said that it was Resident A having Covid-19 and a reaction she had to the anti-viral they had given her that caused her some issues. She said that this was all documented by the health professionals involved. Ms. Loria stated that she would not hesitate to call an ambulance if she ever thought that a resident needed any assistance whatsoever. There is a record of Emergency Medical Services (EMS) being out to the home on several occasions.

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 the following provision: (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.
ANALYSIS:	It was confirmed through this investigation that Resident A received Resident B's medication on August 13, 2022. The direct care worker who made the error did not report the error to the appropriate health care professional. She said that she immediately notified the licensee designee about it but was told not to call an ambulance. The direct care worker who made the error said that an ambulance was called for Resident A five days later but that the emergency personnel were not told of the medication error. The licensee designee stated she did not find out about the error until August 23, 2022 but had still had not reported the error to the appropriate health care professional as of August 26, 2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On August 26, 2022, Ms. Loria showed me that she regularly took the residents' medication out of the original pharmacy-supplied container and placed them in compartmentalized pillboxes corresponding to the day of the week.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	It was confirmed through this investigation that the licensee designee regularly took the residents' medication out of the original pharmacy-supplied container and placed them in compartmentalized pillboxes corresponding to the day of the week.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee designee Christine Loria by phone on September 13, 2022. I told her of the findings of my investigation and gave her the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

09/13/2022

Adam Robarge Date
Licensing Consultant

Approved By:

09/13/2022

Jerry Hendrick Date
Area Manager