GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 8, 2022

Kent VanderLoon
McBride Quality Care Services, Inc.
3070 Jen's Way
Mt. Pleasant, MI 48858

RE: License #: AS590012176
Investigation #: 2022A1029047
McBride Stanton AFC

Dear Mr. VanderLoon:

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS590012176
Investigation #:	2022A1029047
Complaint Receipt Date:	06/17/2022
Investigation Initiation Date:	06/17/2022
Report Due Date:	08/16/2022
Licensee Name:	McBride Quality Care Services, Inc.
Licensee Address:	3070 Jen's Way, Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 772-1261
Administrator:	Kent VanderLoon
Licensee Designee:	Kent VanderLoon
Name of Facility:	McBride Stanton AFC
Facility Address:	340 N Second, Stanton, MI 48888
Facility Telephone #:	(989) 831-4510
Original Issuance Date:	05/01/1990
License Status:	REGULAR
Effective Date:	01/21/2022
Expiration Date:	01/20/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

ALLEGATION(S)

	Violation Established?
Resident A was not administered his medication as prescribed.	Yes

II. METHODOLOGY

06/17/2022	Special Investigation Intake 2022A1029047
06/17/2022	Special Investigation Initiated – Letter to Angie Loiselle MCN Recipient Rights.
06/17/2022	Contact - Document Received from Angela Loiselle, Recipient Rights Officer
06/23/2022	Contact - Telephone call made to Cathie Griffis
06/24/2022	Contact - Face to Face with Brandi Cowling and Dawn Pennock at McBride Stanton AFC, reviewed employee record for Ms. Green and MAR documentation for Resident A.
07/26/2022	Contact - Telephone call made to direct care staff member / home manager, Brandi Cowling
07/26/2022	Contact - Telephone call made to direct care staff member, Christy Green
08/05/2022	Exit conference with licensee designee, Kent VanderLoon.

ALLEGATION:

Resident A was not administered his medication as prescribed.

INVESTIGATION:

On June 17, 2022, an *AFC Incident / Accident Report* was received from McBride Stanton AFC regarding Resident A not receiving his correct dosage of medication as prescribed. According to my review of the *AFC Incident / Accident Report,* direct care staff member Christy Green gave Resident A the wrong medications on June 15, 2022, which was witnessed by direct care staff member, Dawn Pennock. According to the *AFC Incident / Accident Report Resident A* received the wrong doses of Guanfacine and Buspirone.

On June 23, 2022, I interviewed administrator, Cathie Griffis who stated she was trying to obtain a medication cart that will require the direct care staff member to scan the medication before administering the medication with the hope to reduce medication errors. Ms. Griffis stated Ms. Green was on suspension due to the incident but will be back the following Monday. Ms. Griffis stated Ms. Green told her she was distracted and did not pay attention. Ms. Griffis stated there were no ill effects from Resident A not having the medication administered correctly. Ms. Griffis stated direct care staff members complete narcotic counts at shift changes. Ms. Griffis also contacted Montcalm Care Network to notify them of the error. Ms. Green will be retrained in medication administration as a result of this incident according to Ms. Griffis.

On June 24, 2022, I completed an unannounced onsite investigation at McBride Stanton AFC and interviewed direct care staff member whose current role is home manager, Brandi Cowling. Ms. Cowling stated the incident occurred on June 15, 2022 and gave me Resident A's medication administration records (MARs) to review. She stated Resident A was observed after receiving the wrong medication because she instructed direct care staff members to check his heart rate and oxygen readings every two hours to make sure there were no changes. I did not observe any documentation in the medication administration record regarding the error. She stated the medications were counted at 1:00 p.m. and Ms. Pennock witnessed the medications being passed at 1:00 p.m. and the 8:00 p.m. passes. After the medication count, that is when it was realized there were inaccurate counts of Guanfacine and Buspirone. According to Ms. Cowling, due to this incident Ms. Green will receive a coach and counsel, 5 day suspension, and she will not administer medications until she is retrained. Ms. Cowling stated Ms. Green does not have any other medication errors in her employee record, but she does have a documented witness error from April 4, 2022.

According to my review of Ms. Green's employee record, she completed medication administration training from Montcalm Care Network on July 1, 2021. In Ms. Green's employee record, there is also a "Coach and Counsel" in the file written by Ms. Cowling regarding this incident:

- "On June 15, 2022, you administered 1 Guanfacine tab ER at 1:00 p.m. when the written prescription order states to take one tablet at bedtime with food. At this time, you did not administer 1 Buspirone as the written prescription states, take one tablet three times per day."
- Ms. Green wrote under her comments, "2 meds were passed at 1:00 p.m. 5 meds at p.m. meds – an error was made – I can only do better."

According to the medication administration record for Resident A, he is prescribed Guanfacine 2 mg at bedtime (7:30 p.m.) with food. He is prescribed Buspirone 7.5 mg three times daily. According to the medication administration record, Resident A receives five total pills at the 7:30 p.m. medication pass. The MAR shows all medication given as prescribed on June 15, 2022.

On July 24, 2022, I interviewed direct care staff member Dawn Pennock. She stated she realized the medication administration error when shift change started for second shift. She stated she is familiar with the medications enough to notice when something is off. Ms. Pennock stated after counting, she realized the Buspirone and Guanfacine count was wrong. Ms. Pennock told her Ms. Green grabbed the wrong packet. After this Ms. Pennock stated she called Ms. Cowling to report the error to her and called the Montcalm Care Network twenty four hour nurse line. They did not have a nurse available so she called the Sheridan Hospital on call number. Ms. Pennock stated she spoke with a nurse named, Trina who reported Resident A would be fine. Ms. Pennock stated they did check Resident A's blood pressure through the night to ensure his safety and he did not have any side effects from receiving the wrong dosage.

On July 26, 2022, I contacted Ms. Cowling. Ms. Cowling stated Ms. Green has not been able to pass medications since that time and will be taking medication class again on July 29, 2022. Ms. Cowling stated Ms. Green did not seem to take it very seriously but she kept saying, "well there was the right number of medications." Ms. Cowling stated Ms. Green kept saying there were the right number of medications in the cup but did not seem to recognize if they were not the right pills. Once Ms. Green completes the first training, she will receive a certificate showing she completed the in-person portion of the class. However, the manager still needs to verify Ms. Green is comfortable passing medications by observing at least three medication passes. After this time, she will receive another certificate which will show completion of the full medication administration training.

On July 26, 2022, I interviewed direct care staff member, Christy Green. Ms. Green stated she was working on June 15, 2022. Ms. Green stated she took over medications at 1:00 pm and administered Resident A's medications. However, when the evening medication count at 8:00 p.m. was completed the numbers were off for medications. Ms. Green stated Resident A's Guanfacine medication count was off by 1 pill at the evening medication count. Ms. Green stated she has been there for over a year and she was used to what the medications look like. Ms. Green stated when Resident A was given his evening medications, they were the "correct number." According to Ms. Green if Resident A received an extra pill in the evening, he would have received seven pills instead of six pills. At 1:00 p.m. he would have gotten 3 pills instead of 2 pills. At 1:00 pm, Ms. Green stated she remember administering two pills two Resident A. According to the MAR, this would have been the Buspirone and the Propranolol 10 mg.

Ms. Green stated at 7:00 p.m. he is supposed to be given six medications and she remembers there were six medications, but she does not know if they are the correct six pills or not. However, when I reviewed the MAR, I was able to verify Resident A receives five pills in the evening: Buspirone, Trazodone, Propranolol, Lamotrigine, and Guanfacine.

Ms. Green stated she started her workday at 1:00 pm there was no error when the medication count was completed in the afternoon. Ms. Green denied giving Resident A an extra medication or a wrong medication that day but the "med sheets don't lie." Ms.

Green stated she worked with Helena Haling and Ms. Pennock that day. Direct care staff member Ms. Haling passed the morning medications according to Ms. Green and then Ms. Green took over medication administration at 1:00 p.m. Ms. Green stated her record is not “exactly the best” because she has been written up before but never for a medication error. She will be taking a medication administration class again next week. She stated she has had one other medication error within the last year. She stated she does not know how the medication error occurred during this incident and denied there was ever a time that she was distracted. When it was realized, she called Ms. Cowling to call to report the error. Ms. Cowling advised her to check vitals for Resident A. Resident A did not need to go to the hospital after the incident and did not have any side effects after this incident.

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 {333.1101 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:	Resident A was not administered his medication as prescribed on June 15, 2022 when direct care staff member, Ms. Green administered one Guanfacine tab ER at 1:00 p.m. when the written prescription order states to take one tablet at bedtime with food. Ms. Green also failed to administer one Buspirone as the written prescription states to take one tablet three times per day. After the incident, the Montcalm Care Network and the Sheridan Hospital were notified of the medication administration error. Ms. Cowling instructed the direct care staff members to do one hour checks on Resident A and to check his pulse to monitor for any health changes as a result of the medication error. Resident A did not require medical treatment from the incident and Ms. Green was required to retake medication administration training on July 29, 2022, at Montcalm Care Network.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

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

_____8/5/2022_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

08/08/2022

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Dawn N. Timm
Area Manager

Date