GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 8, 2022

Arteria Young
Infinity Care LLC
P.O. Box 40658
Redford, MI 48240

RE: License #: AS820384496
Investigation #: 2022A0992035
Cypress

Dear Ms. Young:

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 (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820384496
Investigation #:	2022A0992035
Complaint Receipt Date:	07/27/2022
Investigation Initiation Date:	07/29/2022
Report Due Date:	09/25/2022
Licensee Name:	Infinity Care LLC
Licensee Address:	14175 Garfield Redford, MI 48239
Licensee Telephone #:	(313) 516-7947
Administrator:	Arteria Young
Licensee Designee:	Arteria Young
Name of Facility:	Cypress
Facility Address:	35875 Cypress Romulus, MI 48174
Facility Telephone #:	(313) 516-7947
Original Issuance Date:	07/05/2017
License Status:	REGULAR
Effective Date:	07/05/2022
Expiration Date:	07/04/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident was given wrong amount of insulin by direct care staff Theresa Sampson.	Yes

III. METHODOLOGY

07/27/2022	Special Investigation Intake 2022A0992035
07/29/2022	Special Investigation Initiated - On Site Abony Austin, home manager and Resident A.
08/02/2022	Contact - Telephone call made Arteria Young, licensee designee
08/31/2022	APS Referral
08/31/2022	Contact - Telephone call made Theresa Sampson, former Cypress direct care staff
08/31/2022	Contact - Telephone call made Relative A, Resident A's guardian; number no longer in service
08/31/2022	Exit Conference Ms. Young

ALLEGATION: Resident was given wrong amount of insulin by direct care staff Theresa Sampson.

INVESTIGATION: On 07/29/2022, I completed an unannounced onsite inspection. Abony Austin, home manager and Resident A were present; I interviewed Ms. Austin regarding the allegations. She said on the day in question, she was scheduled to work but had an emergency and called in; she said Arteria Young, licensee designee covered her shift. Ms. Austin said Ms. Young worked along with Theresa Sampson, direct care staff. She said Ms. Young contacted her at some point that day and asked about Resident A's blood sugar level because she works with him regularly and is more familiar with his normal levels and behaviors. Ms. Austin said Ms. Young made her aware her that Resident A's blood sugar had been low throughout the day.

Ms. Austin said sometimes his levels are all over the place, so she suggested certain snacks that typically help to increase his blood sugar level. She said she was later informed that his levels remained low, and he was hospitalized. Ms. Austin said she has worked with Resident A long enough to know when something is not right. She said she reviewed Resident A's medication administration records (MARs) to confirm his blood sugar levels were taken, which it was by Ms. Sampson. Ms. Austin said she asked Ms. Sampson about Resident A's blood sugar level when she administered his insulin, as well as how much insulin he received, and she said 100 units. Ms. Austin said she could not believe she administered 100 units. She said knew something was not right because when his blood sugar level is low, it typically goes up after eating. She said from her understanding Resident A had breakfast, snacks including ice cream and his sugar level remained low, which is unusual. Ms. Austin provided me with a copy of Resident A's insulin sliding scale. According to the sliding scale, if Resident A's blood sugar level is between 80-150, he is supposed to receive 6 units of insulin and if it is greater than 400, he is supposed to receive 12 units. The insulin sliding scale did not reflect 100 units at all. Ms. Austin said as a result, Ms. Sampson was written-up, taken off schedule and received in-serviced on medication administration. However, she said Ms. Sampson resigned. Ms. Austin said some changes have been implemented. She said they used to just initial when the medication is administered but now as it pertains to insulin, they actually write the amount of insulin that was given.

In addition, to Resident A's sliding insulin scale, Ms. Austin provided me with a copy of the incident report, Resident A's discharge documents, his follow-up consultation, and Ms. Sampson employee file. Ms. Sampson's date of hire was 01/21/2022. According to her training transcript she completed basic medication training through Community Living Services August 2016.

I attempted to interview Resident A regarding the allegations. Resident A said he received too much insulin. I asked Resident A if he is familiar with his medical condition including his blood sugar levels and the amount of insulin he is supposed to receive according to the level and he did not respond. Resident A has limited communication skills and displayed difficulty understanding. He appeared to be clean and adequately dressed. Resident A said he feels fine.

On 08/02/2022, I contacted Ms. Young and interviewed her regarding the allegations. She explained that on the in question, she was covering Ms. Austin's day shift and Ms. Sampson's midnight shift was coming to an end. She said she told Ms. Sampson to make sure she passes medication before leaving, in which Ms. Sampson agreed. Ms. Young said Ms. Sampson left and it was time for the residents to eat breakfast, so she took Resident A's blood sugar level, and it was low. She said typically after he eats it will go up, so she prepared breakfast. Ms. Young said Resident A ate and it went up, but she checked it before lunch, and it was back down. She said she prepared lunch and gave him a pop. Ms. Young said she checked his blood sugar level every two hours, and it was up and down. She said at some point that day she called Ms. Austin because she works with him regularly and

is more familiar with his normal levels and behaviors. She said Ms. Austin said his blood sugar levels sometimes fluctuate and suggested giving him a snack. Ms. Young said she continued to monitor Resident A and she did not notice any abnormal behaviors. She said typically if his blood sugar level is too high, he will pace the floor, act silly and he try to steal something. She said it if is too low, he will exhibit behaviors including yelling and acting out; she said he was not doing none of the above. She said Kenyatta Ufomba, direct care staff came in and she planned to take the residents out on an outing. She said she made Ms. Ufomba aware that Resident A's blood sugar level was low and told her to make sure she keeps an eye on him and take check his levels every hour. Ms. Young said after they returned to the house for dinner, Ms. Ufomba made her aware that his blood sugar level was still low. Ms. Young said at this point she instructed Ms. Ufomba to call 911. She said the emergency medical services (EMS) arrived and they administered a shot to increase his blood sugar level and it did not work, so Resident A was transported to the hospital. Ms. Young said she called Ms. Sampson and asked about Resident A's blood sugar level when she administered his insulin, as well as how much insulin he received, and she said 100 units. Ms. Young said Ms. Sampson was reprimanded, written-up and in-serviced. She said soon after, Ms. Sampson resigned.

On 08/31/2022, I contacted Ms. Sampson and interviewed her regarding the allegations. Ms. Sampson said Ms. Austin was supposed to come in and relieve her but she had an emergency and called in; she said Ms. Young covered Ms. Austin's shift. She said Ms. Young told her to make sure she passes medication before leave. She said also told her to make sure she read Resident A's new prescription in the book before administering his insulin; she said he got a new prescription the day before. Ms. Sampson said from what she read; Resident A was supposed to receive 100 units of insulin; she said she read it several times to make sure. Ms. Sampson said apparently, she misread the prescription. She said the overall script was 100 units and Resident A was supposed to receive 28 units of insulin. Ms. Sampson said she take full responsibility for what happened. She said she received medication administration in-service. She said she has been working in this field for years and never had any medication errors. However, she said throughout all her medication training, she has never been trained on insulin. Ms. Sampson said due to other reasons, she resigned and is no longer employed at the Cypress home.

On 08/31/2022, I contacted Ms. Young regarding Resident A's guardian. Ms. Young explained that Resident A does not have a guardian. She said his previous guardian is deceased and his cousin is interested in obtaining guardianship, but the process is pending a court hearing. I proceeded to conduct an exit conference with Ms. Young. I explained that based on the investigative findings, there is evidence that Ms. Sampson did not administer Resident A's medication pursuant to label instructions. I further explained that the allegation is substantiated and requires submission of a corrective action plan (CAP). Ms. Young said she understand and agreed to submit a CAP. She denied having any questions.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	During this investigation I interviewed Arteria Young, licensee designee; Abony Austin, home manager; Theresa Sampson, former Cypress direct care staff regarding the allegations. All of which confirmed Resident A was given wrong amount of insulin by direct care staff Theresa Sampson. Based on the investigative findings, there is sufficient evidence to support the allegation. The allegation is substantiated
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend the status of the license remain unchanged.

09/01/2022

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Denasha Walker Date
Licensing Consultant

Approved By:

09/08/2022

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Ardra Hunter Date
Area Manager