GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 29, 2022

Phillip Mastrofrancesco
Mastrofrancesco AFC Inc
Suite #5
23933 Allen Road
Woodhaven, MI 48183

RE: License #: AS820013572
Investigation #: 2022A0116044
Mastrofrancesco AFC

Dear Mr. Mastrofrancesco:

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,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820013572
Investigation #:	2022A0116044
Complaint Receipt Date:	09/08/2022
Investigation Initiation Date:	09/08/2022
Report Due Date:	11/07/2022
Licensee Name:	Mastrofrancesco AFC Inc
Licensee Address:	Suite #5 23933 Allen Road Woodhaven, MI 48183
Licensee Telephone #:	(734) 671-3654
Administrator:	Phillip Mastrofrancesco
Licensee Designee:	Phillip Mastrofrancesco
Name of Facility:	Mastrofrancesco AFC
Facility Address:	13944 Stratford Riverview, MI 48192
Facility Telephone #:	(734) 281-7548
Original Issuance Date:	02/15/1982
License **Status:**	REGULAR
Effective Date:	03/21/2021
Expiration Date:	03/20/2023
Capacity:	6

Program Type:	MENTALLY ILL

II. ALLEGATION

	Violation Established?
Incident report received documented that on 08/26/22, Resident A was given her am medications and 10 additional medications belonging to Resident B. Resident A was taken to the emergency room and required prolonged cardiac monitoring.	No

III. METHODOLOGY

09/08/2022	Special Investigation Intake 2022A0116044
09/08/2022	Special Investigation Initiated - Telephone Received a telephone call from Kimberly Sanderlin, Administrative Manager with Mastrofrancesco, Inc. regarding allegations.
09/08/2022	Contact - Telephone call made Interviewed interim home manager, Angelia Mireles.
09/12/2022	APS Referral Made by ORR.
09/12/2022	Referral - Recipient Rights Referral made to ORR by staff, Ms. Mireles.
09/20/2022	Inspection Completed On-site Spoke with Ms. Mireles, visually observed Resident A, and reviewed four months of medication administration records.
09/21/2022	Contact - Telephone call made Interviewed Amy Torony, Guardian Case Manager, for Resident A, with Faith Connections.
09/21/2022	Contact - Telephone call made Interviewed staff, Connie Pinson.
09/21/2022	Inspection Completed-BCAL Sub. Compliance
09/26/2022	Exit Conference With licensee designee, Phillip Mastrofrancesco.

ALLEGATION:

Incident report received documented that on 08/26/22, Resident A was given her am medications and 10 additional medications belonging to Resident B. Resident A was taken to the emergency room and required prolonged cardiac monitoring.

INVESTIGATION:

On 09/08/22, Telephone call from Kimberly Sanderlin, Administrative Manager with Mastrofrancesco. Ms. Sanderlin reported that she wanted to make sure that I had received the incident report regarding staff Connie Pinson administering Resident B's medication to Resident A. I informed her that I had received the incident report and that an investigation had been opened. Ms. Sanderlin reported that Resident A was hospitalized for observation for a few days, however, was back home and doing well. Ms. Sanderlin reported that Adult Protective Services was at the home on 09/07/22 and they are investigating the matter also. Ms. Sanderlin further reported that Ms. Pinson has been written up and can not pass medication again until she completes medication training and until she successfully completes 10 med passes while being supervised by the interim home manager, Angelia Mireles, or lead staff Cynthia Woods.

On 09/08/22, I interviewed interim home manager Angelia Mireles. Ms. Mireles reported that she was not at home when the medication error occurred but reported she was notified upon her return by Ms. Pinson. Ms. Mireles reported that after speaking with Ms. Pinson regarding the matter, it is her belief that Ms. Pinson had pre-popped the medication for Resident A and B and then forgot that she had already given Resident A her medication. Ms. Mireles reported that Ms. Pinson told her that she had called for both Resident A and B to come downstairs to take their medication. Resident A came down and Ms. Pinson administered her medication, and she returned upstairs. Ms. Mireles reported that Ms. Pinson had called for Resident B again to come back downstairs, but Resident A came back down instead of Resident B and she mistakenly gave Resident A Resident B's medication.

Ms. Mireles reported that Ms. Pinson's hours have been reduced, she will have to complete medication training again, she was written up and before she can pass medication independently, she will be supervised 10 times by her or staff Cynthia Woods. Ms. Mireles reported that Resident A is home and is doing well. Ms. Mireles reported that she will be making a referral to ORR and sending them a copy of the incident report today.

On 09/20/22, I conducted a scheduled onsite at the facility and spoke with Ms. Mireles, visually observed Resident A and reviewed four months of medication administration records (MARs). Ms. Mireles reported that Resident A continues to do

well and is back to her normal self. Ms. Mireles reported that Ms. Pinson is still not passing medication independently.

I visually observed Resident A. I attempted to interview her but was unsuccessful as Resident A speaks minimal English. Resident A was nicely dressed and neatly groomed. I also reviewed four months of MARS for all of the residents. No concerns noted.

Ms. Mireles reported that APS has been out to the home and reported that she has spoken with the Recipient Rights investigator, however, could not recall his name.

On 09/21/22, I interviewed Amy Torony, Guardian case manager with Faith Connections. Ms. Torony reported that she was aware of the medication error and reported it was concerning to her. Ms. Torony reported that Resident A is taking chemotherapy to treat her breast cancer, and then to be administered someone else's medications coupled with her own, could have been disastrous. Ms. Torony reported that she is glad that Resident A is doing well and hopes there are no long-term effects from the error. Ms. Torony reported that prior to this incident she had no concerns regarding the care being provided in the home. She reported that the home manager that was there ran the home like a well-oiled machine. Ms. Torony reported that manager is out due to some health issues and unlikely to return. Ms. Torony reported her desire for another manager to be put in place to, "tighten things up." Ms. Torony reported that Ms. Mireles has been very helpful and believes if she is the interim home manger, she should be compensated for the extra work she is doing.

On 09/21/22, I interviewed staff Connie Pinson and she reported that on 08/26/22, she was passing medication and reported that she made a mistake. Ms. Pinson admitted that she had pre-popped Resident A's and B's medications into a clear medication cup. She reported that she had called for both residents to come downstairs to take their medication. Ms. Pinson reported that Resident A came down first and so she administered her medications, and she went back upstairs. Ms. Pinson reported that she called several more times for Resident B to come down, but some time passed, and she still had not come down. Ms. Pinson reported getting busy doing something else and then reported Resident A came back down to her and that's when she accidentally gave her Resident B's medication. The 10 medications were Lisinopril 5mg, Omeprazole 20mg, Sertraline Hcl 50 mg, Vitamin D3 5000, Metformin HCL 500mg, Benztropine Mes 1mg, Docusate Sodium 100mg, Metoprol Tar 25mg, Ferrous 325mg, Haldol 5mg. Ms. Pinson reported when Resident B came downstairs she realized her error. She reported that she notified Ms. Mireles and immediately transported Resident A to the hospital. Ms. Pinson reported Resident A was admitted on 08/26/22 and was discharged on 08/30/22.

Ms. Pinson reported Resident A is doing good and that she is extremely sorry for her error. I informed Ms. Pinson of the rules regarding medication administration as well as the requirement to always follow the 5 rights of medication. Ms. Pinson reported

her understanding of the rules and reported that she is fully trained and knows better. Ms. Pinson reported that she was written up, will have to complete medication training again, and will be supervised while completing at least 10 med passes. Ms. Pinson reported that she will never pre-pop medication again as she does not want to put residents in danger, nor does she want to lose her job.

On 09/26/22, I conducted the exit conference with licensee designee, Phillip Mastrofrancesco and informed him of the findings of the investigation. Mr. Mastrofrancesco reported an understanding of the rule violation and reported he would submit an acceptable corrective action plan.

Mr. Mastrofrancesco reported that initially he was going to terminate Ms. Pinson but she begged for her job and so he decided to write her up for improper medication procedures, have her re-take medication training and not allow her to pass medication until she completes 10 correct medication passes while being supervised. Mr. Mastrofrancesco reported that he is glad that Resident A is doing well and did not suffer any aftereffects from the error. Mr. Mastrofrancesco also reported his desire to name a new home manager soon. He reported that Ms. Mireles stepped up to help and has done a good job.

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:	Ms. Pinson pre-popped Resident A's and B's medications and by doing so failed to administer the medications as prescribed by their respective physicians. Ms. Pinson administered Resident A's medications to her and shortly thereafter administered Resident B's medications to Resident A. Due to the medications being prepared prior to administration Ms. Pinson was unaware of what medications belonged to what resident. This violation is established as Ms. Pinson failed to give the medication as prescribed and did not keep the medication in the original pharmacy supplied container at the time of administration as required by these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/28/22

Pandrea Robinson — Date
Licensing Consultant

Approved By:

09/29/22

Ardra Hunter — Date
Area Manager