GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 6, 2022

Stephanie Riley
Valley Residential Serv Inc.
P O Box 186
St Charles, MI 486550186

RE: License #: AS230068521
Investigation #: 2022A0466057
Mulliken Afc Home

Dear Ms. Riley:

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) 284-9727.

Sincerely,

Julie Elkins, 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 #:	AS230068521
Investigation #:	2022A0466057
Complaint Receipt Date:	08/17/2022
Investigation Initiation Date:	08/17/2022
Report Due Date:	10/16/2022
Licensee Name:	Valley Residential Serv Inc.
Licensee Address:	300 S Saginaw St. Charles, MI 48655
Licensee Telephone #:	(231) 580-5204
Administrator:	Denise Foren
Licensee Designee:	Stephanie Riley
Name of Facility:	Mulliken Afc Home
Facility Address:	9120 E Eaton Hwy Mulliken, MI 48861
Facility Telephone #:	(517) 649-2377
Original Issuance Date:	11/01/1995
License Status:	REGULAR
Effective Date:	07/26/2021
Expiration Date:	07/25/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION:

	Violation Established?
Resident A was not being administered his prescribed Omeprazole medication 6/1/2022 through 8/10/2022.	Yes

III. METHODOLOGY

08/17/2022	Special Investigation Intake-2022A0466057.
08/17/2022	Special Investigation Initiated – Telephone call to licensing consultant Jana Lipps.
08/31/2022	Inspection Completed On-site- No one home.
09/08/2022	Inspection Completed On-site.
10/05/2022	Contact - Telephone call made administrator Denise Foren interviewed.
10/06/2022	Exit Conference with Stephanie Riley.

ALLEGATION: Resident A was not being administered his prescribed Omeprazole medication 6/1/2022 through 8/10/2022.

INVESTIGATION:
On 08/17/2022, Complainant reported Resident A's Omeprazole medication dose was changed on 6/1/22, but facility direct care staff members did not administer correct dose until an internal chart audit caught the error on 8/10/22.

On 08/17/2022, I reviewed an *Adult Foster Care (AFC) Incident/Accident Report* dated 8/16/2022 and signed by administrator Denise Foren. In the "Explain what happened" section of the report stated, "During VRSI internal audit, CQI medication checking, it was noted that during month of June through August 10, 2022, [Resident A] did not receive his second dose of Omeprazole DR 20mg capsule at 7pm. As of June 1st, the prescription stated to give this medication twice a day. The change wasn't noted and he was getting one daily." In the "Action taken by staff" section of the report it stated, "Physician had not notified home of change/med and order delivered on June 29th. Corrected the error immediately and informed medication administrator. Home to notify pharmacy, physician and CEI." In the "Corrective measures" section of the report it stated, "During written counseling, the manager, assistant manager, and medication administrators/medication checkers to review medication policy concerning 5 rights and will in-service again at next scheduled staff meeting."

On 08/31/2022, I conducted an unannounced investigation and I reviewed Resident A's record which contained a medication administration record (MAR) for June, July and August 2022 which documented that Resident A was prescribed "Omeprazole DR 20mg capsule, take 1 capsule by mouth twice daily." Resident A's MAR for June, July and until August 10, 2022, document that Resident A was only being administered the medication once daily.

On 10/05/2022, I interviewed administrator Denise Foren who reported that she, area manager Robin Pardee and assistant manager Keith Rohrbacher conducted a continuous quality improvement (CQI) audit at the facility on 8/10/2022. Administrator Foren reported that is when they reviewed Resident A's June, July and August 2022 MARs and noticed that as of 06/01/2022, Resident A's Omeprazole was increased. Administrator Foren reported according to the MARs, Resident A was prescribed "Omeprazole DR 20mg capsule, take 1 capsule by mouth twice daily." Administrator Foren reported that Resident A was being administered Omeprazole once daily from 6/01/2022 through 08/10/2022. Administrator Foren reported that according to the MARs and comparing the MAR to the Omeprazole available for Resident A, Resident A had not been being administered his second dose of Omeprazole from 06/01/2022-08/10/2022. Administrator Foren reported that on 06/01/2022, Resident A was seen by a physician and that a direct care worker (DCW) had accompanied Resident A to this appointment. Administrator Foren reported that the physician did not notify the DCW that Resident A's Omeprazole was being increased. Administrator Foren reported that it appears that the physician sent a prescription to the pharmacy as the MARs for Resident A did document the increase, however that was also missed by facility direct care staff members.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A was not administered his prescribed Omeprazole medication from 6/1/2022 through 8/10/2022 as prescribed. Resident A was prescribed "Omeprazole DR 20mg capsule, take 1 capsule by mouth twice daily." Resident A was being administered Omeprazole once daily from 6/01/2022 through 08/10/2022 therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.

10/06/2022

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Julie Elkins Date
Licensing Consultant

Approved By:

10/06/2022

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Dawn N. Timm Date
Area Manager