GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2022

Sonia McKeown
JARC
Suite 100
6735 Telegraph Rd
Bloomfield Hills, MI 48301

RE: License #: AS630012708
Investigation #: 2023A0611002
Laker

Dear Ms. McKeown:

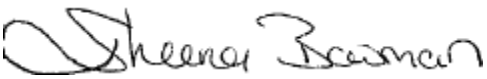
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012708
Investigation #:	2023A0611002
Complaint Receipt Date:	10/12/2022
Investigation Initiation Date:	10/13/2022
Report Due Date:	12/11/2022
Licensee Name:	JARC
Licensee Address:	Suite 100 6735 Telegraph Rd Bloomfield Hills, MI 48301
Licensee Telephone #:	(248) 403-6013
Administrator:	Sonia McKeown
Licensee Designee:	Sonia McKeown
Name of Facility:	Laker
Facility Address:	6078 Ledgeway West Bloomfield, MI 48322
Facility Telephone #:	(248) 626-2667
Original Issuance Date:	03/11/1991
License Status:	REGULAR
Effective Date:	11/15/2022
Expiration Date:	11/14/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident S did not receive his morning medication.	Yes

III. METHODOLOGY

10/12/2022	Special Investigation Intake 2023A0611002
10/13/2022	Special Investigation Initiated - On Site I completed an announced onsite. I received a copy of the September MAR's for Resident S and Resident K.
10/21/2022	Contact - Telephone call made I made a telephone call to staff member Sandra Baldwin. The allegations were discussed.
10/21/2022	Contact - Telephone call made I made a telephone call to the home manager, Dasha Betts. The allegations were discussed.
10/21/2022	Contact - Telephone call made I made a telephone call to staff member Curtis Jones. The allegations were discussed.
10/21/2022	Contact - Telephone call made I left a voice message for the District Manager, Antwanette Cureton requesting a call back.
10/21/2022	Exit Conference I completed an exit conference with the licensee designee, Sonia McKeown via telephone.
10/24/2022	Contact - Face to Face On 10/24/22, I completed an announced onsite. I interviewed Resident K and Resident S.

ALLEGATION:

Resident S did not receive his morning medication.

INVESTIGATION:

On 09/29/22, I received an incident report regarding the abovementioned allegations. The incident report is dated 09/28/22. As a result, an intake was created. The incident report was completed by the home manager, Dasha Betts. The staff members involved are Sandra Baldwin and Curtis Jones.

On 10/13/22, I completed an announced onsite regarding the renewal of the AFC group home. I received a copy of Resident S and Resident K's MAR's for the month of September 2022 from the District Manager Antwanette Cureton.

On 10/21/22, I made a telephone call to staff member Sandra Baldwin. Ms. Baldwin works the afternoon shift. Regarding the allegations, Ms. Baldwin stated while she was administering 4pm medications, she noticed that Resident K's 8:00pm Gabapentin 100mg for 09/28/22 was missing. Ms. Baldwin informed the home manager Dasha Betts. Ms. Betts contacted the pharmacy and had the missing pill delivered to the AFC group home. Ms. Baldwin confirmed that Resident K was administered his Gabapentin at 8:00pm.

Ms. Baldwin stated Resident S is prescribed Phenobarbital 30mg three times a day (7:00am, 4:00pm, 8:00pm). Ms. Baldwin noticed that Resident S 7:00am Phenobarbital 30mg for 09/28/22 was not administered as the pill was still in the bubble packet. Ms. Baldwin stated she administered Resident S Phenobarbital 30mg at 4:00pm and 8:00pm. Ms. Baldwin stated the midnight shift was responsible for administering Resident S morning medications. Ms. Baldwin informed Ms. Betts regarding Resident S 7:00am Phenobarbital. Ms. Betts completed an incident report and contacted Ms. Cureton.

On 10/21/22, I made a telephone call to the home manager, Dasha Betts. Regarding the allegations, Ms. Betts confirmed that the incident took place on 09/28/22. Ms. Betts stated when Ms. Baldwin informed her that Resident K's 8:00pm Gabapentin was missing, she looked for the medication and then called Nurse Laurence Rueben. Ms. Betts was advised by Nurse Laurence to contact staff member, Curtis Jones to find out what happened when he administered the morning medications. Nurse Laurence contacted the pharmacy and had another Gabapentin delivered to the AFC group home. Ms. Betts stated the medication was delivered within the next hour and Resident K received his medication on time.

Ms. Betts stated Mr. Jones informed her that he administered all of the morning medications despite the fact that Resident S 7:00am Phenobarbital was still in the bubble packet. Ms. Betts stated she thinks Mr. Jones administered Resident K's 8:00pm

Gabapentin to Resident S instead of administering Resident S his 7:00am Phenobarbital; which explains why the 7:00am Phenobarbital was still in the bubble packet. Ms. Betts stated Gabapentin and Phenobarbital are narcotics and are kept together in a separate lock box. Ms. Betts stated the staff are not following the 5 rights as they do not look at the MAR before they start punching the medications out of the bubble packet.

Ms. Betts stated she wrote Mr. Jones up and he is required to complete another medication training. Ms. Betts stated Mr. Jones is scheduled to have surgery next week and his medication class will be scheduled upon his return on 10/31/22. Mr. Jones has worked at the AFC group home for three years.

On 10/21/22, I made a telephone call to staff member Curtis Jones. Regarding the allegations, Mr. Jones stated he worked the midnight shift on 09/27/22. Mr. Jones was responsible for passing the morning medications on 09/28/22. Mr. Jones stated he thought he administered all of the residents morning medications including Resident S 7:00am Phenobarbital. Mr. Jones stated he was made aware that Resident S did not receive his 7:00am Phenobarbital when Ms. Betts contacted him around 5:00pm on 09/28/22. Mr. Jones denied forgetting to administer medications prior to this incident. Mr. Jones could not explain why Resident K's 8:00pm Gabapentin was missing however; he was certain that he did not administer Resident K's Gabapentin to Resident S. Mr. Jones stated he is required to complete another medication training.

On 10/21/22, I reviewed Resident S and Resident K's MAR for the month of September 2022. According to Resident S MAR, he is prescribed Phenobarbital 30mg at 7:00am, 4:00pm, and 8:00pm. On 09/28/22, the initials "CJ" is documented on the MAR in the box for Phenobarbital at 7:00am. The initials "SB" is documented on the MAR on 09/28/22 for the 4:00pm and 8:00pm dose.

According to the MAR for Resident K, he is prescribed Gabapentin 100mg at 6:00am and 8:00pm. The initials "CJ" is documented on the MAR for the 6:00am dose and the initials "SB" is documented on the MAR for the 8:00pm dose.

On 10/24/22, I completed an announced onsite. I interviewed Resident K and Resident S.

On 10/24/22, I interviewed Resident K. Regarding the allegations, Resident K stated he has lived in the AFC group home for a while. Resident K stated he likes living at the AFC group home. Resident K stated staff administers his medications in the morning, at 4:00pm, and at 8:00pm every day. Resident K denied any instances where staff did not administer his medications when they were supposed to. Resident K does not know if a staff member has ever given him another residents medication.

On 10/24/22, I interviewed Resident S. Regarding the allegations, Resident S stated he has lived in the AFC group home since 2013. The staff administer Resident S medications in the morning, at 4:00pm, and at 8:00pm. Resident S stated the staff

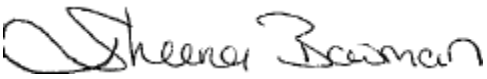
ensure that he receives his medications every day. Resident S stated there has never been a time where staff did not administer his medications when they were supposed to. Resident S does not know if a staff member ever gave him the wrong medication or another residents medication.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident S is prescribed Phenobarbital 30 mg three times a day. On 09/28/22 during the afternoon shift, Ms. Baldwin observed that Resident S 7:00am dose of Phenobarbital was not administered as the pill was still in the bubble packet. Mr. Jones was responsible for administering Resident S 7:00am dose of Phenobarbital. Mr. Jones thought he administered all of the resident's morning medications. However, he was later made aware that he didn't.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	On 09/28/22, Ms. Baldwin observed Resident K's Gabapentin 8:00pm dose was missing. Mr. Jones could not explain why Resident K's Gabapentin was missing and; he was certain he did not administer Resident K's Gabapentin to Resident S. However, it is likely that Mr. Jones inadvertently administered Resident K's Gabapentin to Resident S instead of administering Resident S his Phenobarbital; which would explain why Resident S 7:00am dose of Phenobarbital was still in the bubble packet and Resident K's 8:00pm Gabapentin was missing.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

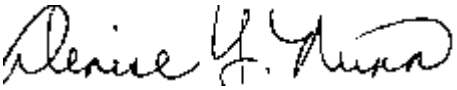
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



10/24/22

Sheena Bowman — Date
Licensing Consultant

Approved By:



10/25/2022

Denise Y. Nunn — Date
Area Manager