GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 31, 2022

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

RE: License #: AS630300830
Investigation #: 2022A0991037
Nusbaum Home

Dear Ms. McKeown:

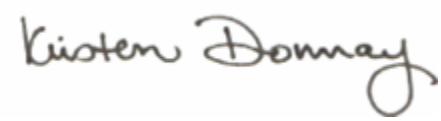
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630300830
Investigation #:	2022A0991037
Complaint Receipt Date:	08/16/2022
Investigation Initiation Date:	08/16/2022
Report Due Date:	10/15/2022
Licensee Name:	JARC
Licensee Address:	6735 Telegraph Rd Suite 100 Bloomfield Hills, MI 48301
Licensee Telephone #:	(248) 403-6013
Licensee Designee:	Sonia McKeown
Name of Facility:	Nusbaum Home
Facility Address:	29420 Minglewood Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-4616
Original Issuance Date:	08/10/2009
License Status:	REGULAR
Effective Date:	05/12/2022
Expiration Date:	05/11/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 08/14/22, Resident D's medication blister packs for her 4:00pm and 8:00pm medications were missing. Resident D did not receive the medications at the scheduled times.	Yes

III. METHODOLOGY

08/16/2022	Special Investigation Intake 2022A0991037
08/16/2022	Special Investigation Initiated - Letter Email to Office of Recipient Rights (ORR) worker, Alanna Honkanen
08/16/2022	Referral - Recipient Rights Sent to ORR worker, Alanna Honkanen
08/18/2022	Inspection Completed On-site Unannounced onsite inspection- interviewed home manager and district director
08/18/2022	Contact - Document Received Medication records
09/01/2022	Contact - Telephone call made Interviewed direct care worker, Wildeesha Hicks
09/01/2022	Contact - Telephone call made Left message for direct care worker, Myeshia Zambrana
09/19/2022	Contact - Telephone call made Left message for direct care worker, Myeshia Zambrana
10/06/2022	Contact - Telephone call made Interviewed direct care worker, Myseshia Zambrana
10/06/2022	Contact - Telephone call made Interviewed direct care worker, Racine Brooks
10/06/2022	Exit Conference Via telephone with licensee designee, Sonia McKeown

ALLEGATION:

On 08/14/22, Resident D's medication blister packs for her 4:00pm and 8:00pm medications were missing. Resident D did not receive the medications at the scheduled times.

INVESTIGATION:

On 08/16/22, I received a complaint indicating that a medication error occurred with Resident D's medications on 08/14/22. An incident report was received from Nusbaum Home dated 08/14/22. The incident report notes that direct care worker, Wildeesha Hicks, went to pass Resident D's medications at 4:00pm. The 4:00pm blister pack was found empty in the top drawer of the medication cart. The 8:00pm blister pack was missing and could not be located. Resident D did not receive her evening or bedtime medications, as it was unknown what time she received the medications. I initiated my investigation on 08/16/22 by contacting the Office of Recipient Rights (ORR) worker, Alanna Honkanen. On 08/18/22, I conducted an unannounced onsite inspection at Nusbaum Home.

On 08/18/22, I interviewed the home manager, Melissa Lukas. Ms. Lukas stated that she has worked in the home for one year. On 08/14/22, direct care worker, Wildeesha Hicks, contacted her when she could not locate Resident D's evening and bedtime medications. Ms. Lukas stated that the residents' medications are in blister packs. All of the medications are in one bubble for the time of day they are to be administered. Staff tear off the bubble and administer the medications for that date and time. When Ms. Hicks went to pass the 4:00pm medications on 08/14/22, the bubble for that date and time was missing from the pack. Ms. Hicks noticed that the 7:00pm bubble was also missing. Ms. Hicks located the empty 4:00pm bubble in the top drawer of the medication cart. The 7:00pm bubble could not be located. Ms. Lukas stated that she believed the medications were likely administered at some point during the day, but they were not given at the scheduled time. Resident D did not receive her 4:00pm dose of Latuda 20mg or the 7:00pm dose of Docusate 100mg and Levetiracetam 500mg as scheduled on 08/14/22. Resident D did receive her 4:00pm dose of Alprazolam (Xanax) 0.5mg and the 7:00pm dose of Alprazolam 1mg. Alprazolam is a controlled medication, so it is kept double locked in the medication cart and it is not in the blister pack with the other medications. Ms. Lukas stated that she contacted Resident D's primary care physician and psychiatrist regarding the medication error. They advised her to skip the dose and continue with the next scheduled dose. Resident D did not have any symptoms or negative side effects from missing the medications. Staff checked the medications for the other residents and no other medications were missing. Ms. Lukas stated that a medication refresher training is scheduled for all staff on 08/25/22.

On 08/18/22, I interviewed the district manager, Brandie Whelan. Ms. Whelan stated that she was aware of the medication error that occurred on 08/14/22. She stated that direct care worker, Myeshia Zambrana, passed medications that morning and did a

medication check at 12:00pm. Ms. Zambrana stated that the medications were all there when she did her checks. Staff administered the PRN medication Alprazolam 0.5mg to Resident D at 12:48pm, because they were having Resident D's birthday party at the home and Resident D was agitated and overwhelmed. Ms. Whelan stated that all of the medications would have been checked at that time. Later that day, when direct care worker Wildeesha Hicks went to pass the 4:00pm medications, she discovered that Resident D's 4:00pm and 7:00pm bubbles were missing. The empty 4:00pm blister pack was located in the top drawer of the medication cart. The empty 8:00pm blister pack was later located in the trash. Ms. Whelan stated that there were no issues with any of the other residents' medications. Resident D's doctor was contacted and stated to skip the dose and continue with the next scheduled dose. Resident D did not have any negative side effects. Ms. Whelan stated that none of the staff had an explanation as to what happened with the medications. The medication cart is always locked. Staff keep the key on their person during their shift. Ms. Whelan stated that a mandatory medication refresher training is scheduled for all staff on 08/25/22.

During the onsite inspection, I reviewed Resident D's August 2022 medication administration record (MAR). The MAR shows that Resident D did not receive the 4:00pm dose of Latuda 20mg on 08/14/22. It notes that the medication was not administered, and the manager was notified. It also shows that resident D did not receive the 7:00pm dose of Docusate 100mg or Levetiracetam 500mg. It notes that the medication was not administered at the scheduled time. The notes were entered by direct care worker, Wildeesha Hicks. I observed that the medication cart was locked during my onsite inspection. The home utilizes an electronic medication administration system. The bubble packs are scanned into the computer before staff administer medications. I reviewed the medications for Resident D, as well as the other residents in the home. No other discrepancies were noted.

On 09/01/22, I interviewed direct care worker, Wildeesha Hicks, via telephone. Ms. Hicks stated that she was responsible for passing evening medications on 08/14/22. When she went to pass the medications at 4:00pm, she noticed that Resident D's evening (4:00pm) and bedtime (7:00pm) blister packs were missing. She checked around the medication cart and checked the other residents' medications. She located the 4:00pm blister pack in the top drawer of the medication cart. It was torn open, and the medications were not there. She was not able to locate the 7:00pm blister pack. Ms. Hicks stated that she was not sure what happened with the medications. She stated that there must have been a medication error on the previous shift and staff probably passed the medication at the wrong time. Ms. Hicks stated that she contacted the home manager regarding the medication error. She did not give Resident D any medications at 4:00pm or 7:00pm that day, as it was unknown if or when she received the medications. Ms. Hicks stated that Resident D did not have any negative side effects. Ms. Hicks stated that the medication cart was locked when she went to pass medications. Myeshia Zambrana was the medication passer on the previous shift. Ms. Hicks stated that Ms. Zambrana had a problem with her reporting the medication error. Ms. Zambrana told her that there have been medication errors in the past and staff did not report it. They just did "what they saw fit." Ms. Hicks stated that after this incident

happened, the home put a medication check system in place where they do a medication check with the other staff on shift. Prior to this incident, there was no formal medication check system in place.

On 10/06/22, I interviewed direct care worker, Myeshia Zambrana, via telephone. Ms. Zambrana stated that she has worked at Nusbaum Home for a little over one year. She stated that she passed 7:00am medications on 08/14/22. When she passed the 7:00am medications, all of Resident D's medications were there. The medications are all on the same blister pack with the morning, evening, and bedtime bubbles in a row for each day. Staff tear off the bubble for the date and time that they are passing medications. Ms. Zambrana stated that she would have noticed if the evening and bedtime medications were missing when she was passing medications. The other staff on shift, Racine Brooks, also checked the medications and did not notice any issues. They always do a medication check before the end of the shift. Ms. Zambrana did not know what happened to the medications. Ms. Zambrana stated that the medication cart is always locked. They were having a birthday party for Resident D that day. She did not observe anybody going into the medication cart. She stated that she thought staff on the next shift might have passed the medications to the wrong resident and then tried to cover up the error by putting the empty blister in the medication cart and blaming it on the previous shift. Ms. Zambrana stated that if there is a medication error, she contacts the on-call number and calls the manager. There has never been a time when she did not follow protocol for reporting a medication error.

On 10/06/22, I interviewed direct care worker, Racine Brooks, via telephone. Ms. Brooks stated that has worked in the home for approximately one year. She recalled a time when there was a medication error with Resident D's medications. She stated that she always checks all of the medications when she comes on shift to make sure everything is there. She noticed that Resident D's bedtime bubble pack was missing for the next day. She stated that she thought the medications were given at the wrong time, but she was not sure what happened. She reported this issue to the on-call manager. Ms. Brooks stated that she could not recall what day this happened. She always reports any medication errors or any issues with the residents to on-call during her shift. She stated that she keeps the medication cart locked at all times during her shift.

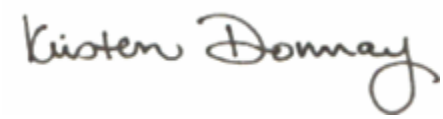
On 10/06/22, I conducted an exit conference via telephone with the licensee designee, Sonia McKeown. Ms. McKeown stated that a medication training was conducted with all staff at Nusbaum Home. She stated that they completed an internal investigation as well, but staff could not explain what happened with the medications. Ms. McKeown stated that she would submit a corrective action plan to address the rule violation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident D did not receive her medications pursuant to label instructions on 08/14/22. Direct care worker, Wildeesha Hicks, discovered Resident D's 4:00pm and 7:00pm blister packs were missing on 08/14/22. It is unknown if or when the medications were administered. Resident D did not receive her 4:00pm dose of Latuda 20mg or the 7:00pm dose of Docusate 100mg and Levetiracetam 500mg as scheduled on 08/14/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

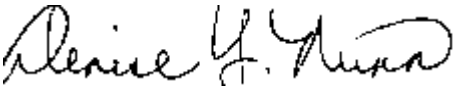


10/06/2022

_____

Kristen Donnay Date
Licensing Consultant

Approved By:



10/31/2022

_____

Denise Y. Nunn Date
Area Manager