GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 26, 2022

Timothy Carmichael
Crisis Center Inc - DBA Listening Ear
PO Box 800
Mt Pleasant, MI 48804-0800

RE: License #: AS050071211
Investigation #: 2023A0009001
North Limits

Dear Mr. Carmichael:

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 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 (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS050071211
Investigation #:	2023A0009001
Complaint Receipt Date:	10/07/2022
Investigation Initiation Date:	10/07/2022
Report Due Date:	11/06/2022
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	Sherry Kidd
Licensee Designee:	Timothy Carmichael, Designee
Name of Facility:	North Limits
Facility Address:	1179 North Limits Mancelona, MI 49659
Facility Telephone #:	(231) 587-8688
Original Issuance Date:	05/16/1996
License Status:	REGULAR
Effective Date:	08/24/2021
Expiration Date:	08/23/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
The medication room door was left open and unlocked. Resident A's medication was left out. Resident A saw her own medication lying out and took it. Other medications were accessible at the time.	Yes

III. METHODOLOGY

10/07/2022	Special Investigation Intake 2023A0009001
10/07/2022	Special Investigation Initiated – Telephone call received from home manager Ms. Kippon Beck
10/12/2022	Inspection Completed On-site Interview with home manager Ms. Kippon Beck
10/26/2022	Contact – Telephone call made to direct care worker Ms. Taylor Henriet
10/26/2022	Contact – Telephone call made to administrator Ms. Sherry Kidd
10/26/2022	Exit conference with administrator Ms. Sherry Kidd

ALLEGATION: The medication room door was left open and unlocked. Resident A's medication was left out. Resident A saw her own medication lying out and took it. Other medications were accessible at the time.

INVESTIGATION: I received a telephone call from home manager Ms. Kippon Beck on October 7, 2022. She said that there had been a “medication error” at the facility the night before. Ms. Beck explained that the staff who was administering medication had gone to get a second staff to witness the passing of the medication, which is currently their policy at the facility. The person administering the medication left the medication room door open and the medications unlocked. He left Resident A’s medication in her applesauce on the counter. When both staff returned, Resident A was drinking her applesauce which contained her medication. Ms. Beck said that Resident A only took the medication which was scheduled for her to take at that time. There was no evidence that she took any other medication.

I conducted an on-site inspection at the North Limits adult foster care (AFC) home on October 12, 2022. Ms. Beck was present at the time of the home inspection. She took me to the medication room to show me what had happened. The two staff involved in the incident were Brandon Derenzy and Taylor Henriet. Mr. Derenzy is

the one who prepared the medication for Resident A and then went to get Ms. Henriet to witness his administering the medication to Resident A. Resident A and another resident were sitting nearby when Mr. Derenzy left the medication room to get the second staff. He had to go all the way to the kitchen to get Ms. Henriet. It is their policy that he lock the medication room door whenever he has to leave the vicinity. He did not do that. When the staff returned, they found Resident A drinking the applesauce that contained her medication which is how she takes her medication. Ms. Beck showed me the doctor's order which allows for Resident A to have her medication crushed into applesauce. The medication involved was 3 mg. of Risperdol and 10 mg. of Busipirone. Other medication was unlocked but there was no indication that Resident A took any other medication. Ms. Beck stated that Mr. Derenzy's employment was terminated after the incident due to this and other reasons.

I spoke with direct care worker Taylor Henriet by telephone on October 26, 2022. She was present when Resident A took her medication unsupervised. Ms. Henriet stated that Mr. Derenzy had prepared Resident A's medication along with another resident's medication. Both were left on the counter of the unlocked medication room when he went to get her to witness the administration. By the time Ms. Henriet got back to the medication room, she observed Resident A holding her empty apple sauce cup. Mr. Derenzy said that he had already crushed up her medication in the apple sauce. The second resident's medication was still sitting on the counter. It did not look as if Resident A had touched the other resident's medication. Ms. Henriet said that she called the home manager immediately to report what had happened. Ms. Beck told her to complete an incident report on what happened and record it in the progress notes. They also took vital readings on Resident A just to make sure she was okay although there had been no indication that she had gotten anything other than her own scheduled medication.

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:	It was discovered through this investigation that on October 6, 2022, medication was not kept locked while a staff person left the vicinity of the medication room.

CONCLUSION:	**VIOLATION ESTABLISHED**

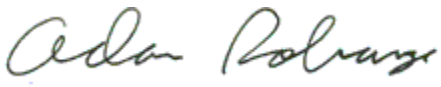
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	On October 6, 2022, Resident A took her own medication without being supervised by the licensee, administrator or direct care staff.
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:	It was discovered through this investigation that direct care staff did not take precautions to ensure that medication was not used by someone other than for whom the medication was prescribed. Resident A was able to take her own medication which was left out and may have just as easily taken another resident's medication which was also on the medication room counter.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with administrator Ms. Sherry Kidd by telephone on October 26, 2022. We discussed the findings of my investigation and the corrective action plan she would put in place to prevent future medication errors.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend to change in the license status.



10/26/2022

Adam Robarge Date
Licensing Consultant

Approved By:

10/26/2022

Jerry Hendrick Date
Area Manager