GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 9, 2023

Linda Rice
535 Gilletts Lk. Rd.
Jackson, MI 49201

RE: License #: AL380007070
Investigation #: 2023A0007004
Rice Manor

Dear Ms. Rice:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL380007070
Investigation #:	2023A0007004
Complaint Receipt Date:	11/22/2022
Investigation Initiation Date:	11/23/2022
Report Due Date:	01/21/2023
Licensee Name:	Linda Rice
Licensee Address:	535 Gilletts Lk. Rd. Jackson, MI 49201
Licensee Telephone #:	(517) 937-2017
Administrator:	N/A
Licensee Designee:	Linda Rice
Name of Facility:	Rice Manor
Facility Address:	356 South Union St Parma, MI 49269
Facility Telephone #:	(517) 531-3005
Original Issuance Date:	06/23/1999
License Status:	REGULAR
Effective Date:	09/12/2022
Expiration Date:	09/11/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Allegations of a medication error.	Yes

III. METHODOLOGY

11/22/2022	Special Investigation Intake - 2023A0007004
11/23/2022	Special Investigation Initiated – Letter to APS
11/23/2022	APS Referral Made.
12/06/2022	Contact - Document Received - Denial Letter from APS.
12/07/2022	Inspection Completed On-site - Unannounced - Face to face contact with Ms. Keller, Direct Care Staff, Resident A, and other residents and staff.
01/04/2023	Contact - Telephone call made to Ms. Taber, Administrative Staff. She will resend a copy of the medication logs.
01/05/2023	Contact - Document Received - Medication Logs.
01/06/2023	Contact - Telephone call made to Ms. Taber, Administrative Staff. Case discussion.
01/06/2023	Exit Conference conducted with Ms. Linda Rice, Licensee Designee.

ALLEGATIONS:

Allegations of a medication error.

INVESTIGATION:

As a part of this investigation, I reviewed the incident report that documented the following:

On November 10, 2022, Employee #1 came to Ms. Taber, Administrative Staff, and stated that she noticed that Resident A received both her 8:00 p.m. and 8:00 a.m. medications on November 9, 2022. Resident A also received her 8:00 a.m. medications on November 10, 2022. Resident A's physician was immediately contacted and informed about the medication errors. Staff were instructed to monitor Resident A and that it was not necessary to hold the scheduled medications for the remainder of the day. Staff documented that Resident A ate fine throughout the day and evening, and her vitals were normal.

It was also noted on the incident report that Resident A's guardian, case management, and ORR were also contacted.

Ms. Keller was removed from passing medications until she was retrained. Ms. Taber also spoke with her about the occurrence and the impact that it could have had on Resident A.

On December 7, 2022, I conducted an unannounced on-site investigation and made face to face contact with Ms. Keller, Direct Care Staff, Resident A, and other residents and staff.

I interviewed Ms. Keller, Direct Care Staff. She informed me that she has been employed for 15-years and she felt terrible when they told her about the medication error that occurred. Ms. Keller stated that there was a lot going on that day, as a resident was in behaviors. She brought Resident A out of the medication room to deal with the issues. Then she brought Resident A back into the medication room and readministered the medications. Ms. Keller again stated that she felt terrible about this incident occurring. She stated that she was retrained and talked to about the error. I requested that they send me a copy of the medication logs for November.

While at the facility, I observed Resident A sitting in her recliner in the living area of the home. She appeared to be doing well and smiled while I was talking to her.

On January 6, 2023, I spoke with Ms. Taber, Administrative Staff. She confirmed that Ms. Keller was retrained to administer medications. I informed her that I would be requesting a written corrective action plan.

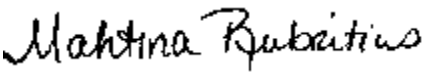
On January 6, 2023, I conducted the exit conference with Ms. Linda Rice, Licensee Designee. I informed her of the findings, my recommendations, and I requested a written corrective action plan to address the established violation.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	It was documented on the incident report that Resident A received both her 8:00 p.m. and 8:00 a.m. medications on November 9, 2022. Resident A also received her 8:00 a.m. medications on November 10, 2022. Ms. Keller stated she felt terrible about the medication error that occurred. She stated that she was retrained and talked to about the error. According to Ms. Taber, Ms. Keller was removed from passing medications until she was retrained. Ms. Taber also spoke with her about the occurrence and the impact that it could have had on Resident A. The physician was contacted, and staff were instructed to monitor Resident A. Resident A did not have any adverse effects. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A was not given her medications as prescribed. **THIS IS A REPEAT VIOLATION:** See SIR# 2021A0007004 - 11/13/2020 for additional information.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



01/06/2023

Mahtina Rubritius — Date
Licensing Consultant

Approved By:

01/09/2023

Ardra Hunter — Date
Area Manager