GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 13, 2023

Lorinda Anderson
Community Living Options
626 Reed Street
Kalamazoo, MI 49001

RE: License #: AS390011418
Investigation #: 2023A1024017
Lovell Street Home

Dear Ms. Anderson:

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 (616) 356-0183.

Sincerely,

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390011418
Investigation #:	2023A1024017
Complaint Receipt Date:	01/13/2023
Investigation Initiation Date:	01/13/2023
Report Due Date:	03/14/2023
Licensee Name:	Community Living Options
Licensee Address:	626 Reed Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 934-3635
Administrator:	Lorinda Anderson
Licensee Designee:	Lorinda Anderson
Name of Facility:	Lovell Street Home
Facility Address:	710 West Lovell Kalamazoo, MI 49007
Facility Telephone #:	(269) 343-6355
Original Issuance Date:	12/11/1986
License Status:	REGULAR
Effective Date:	02/05/2023
Expiration Date:	02/04/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents are not protected in the home as they have access to staff member Sharon McKenzie's personal prescription medications.	No
Staff does not supervise residents when medications are given.	Yes
Resident B was given Resident C's morning medications accidentally by staff member.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/13/2023	Special Investigation Intake 2023A1024017
01/13/2023	Special Investigation Initiated –Telephone with Recipient Rights Officer (RRO) Suzie Suchyta
01/20/2023	Contact - Document Received additional allegations from Intake #192816 regarding Resident B and Resident C.
01/20/2023	Inspection Completed On-site with administrator Lorinda Anderson, program director Tim VanDyke, home manger Danica Millard, direct care staff member Suzie Shaver, Resident A, Resident C
01/22/2023	APS Referral-allegations do not meet APS criteria.
03/05/2023	Contact - Telephone call made with direct care staff member Scott Bessy
03/05/2023	Exit Conference with license designee Lorinda Anderson
03/05/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Residents are not protected in the home as they have access to staff member Sharon Mckenzie's personal prescription medications.

INVESTIGATION:

On 1/13/2023, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged residents are not protected in the home as they have access to direct care staff member Sharon Mckenzie's personal prescription medications. This complaint further stated direct care staff member Sharon Mckenzie left her personal bag out in the living room area near Resident A and her blood thinner medications were stored in the bag. This medication was eventually found to be missing after Ms. Mckenzie left the bag unattended for a couple of hours. The complaint stated Ms. Mckenzie believes Resident A stole her medications.

On 1/13/2023, I conducted an interview with Recipient Rights Officer (RRO) Suzie Suchyta who stated she spoke with direct care staff member Sharon Mckenzie who reported her blood thinner medications came up missing after she left her bag unattended located in the living room of the facility. Ms. Suchtya stated Ms. Mckenzie believes Resident A took her bag and thew the bag away since he was in the area where her bag was placed. Ms. Suchtya stated no resident has admitted to taking the medications out of Ms. Mckenzie's bag when the bag was left unattended to by Ms. Mckenzie.

On 1/20/2023, I conducted an onsite investigation at the facility with administrator/licensee designee Lorinda Anderson, program director Tim VanDyke, direct care staff member Suzie Shaver, and Residents A and C. Ms. Anderson stated she has received complaints about Ms. Mckenzie including a recent incident where Ms. Mckenzie left her personal bag unattended in the facility that contained prescription medications. Ms. Anderson stated this is something that has been addressed with Ms. Mckenzie and believes Ms. Mckenzie has boundary issues that she needs to improve.

Mr. VanDyke stated he has also received complaints regarding Ms. Mckenzie leaving her medications unattended in the facility. Subsequently, Ms. Mckenzie was suspended for a week, participated in training courses, and received counseling regarding her misconduct.

Ms. Shaver stated she was working when Ms. Mckenzie left her personal bag containing her blood pressure medications out on the table in the facility unattended near residents. Ms. Shaver stated she believes Resident A took Ms. Mckenzie's bag that contained her prescription medications and threw the bag away because all resident bedrooms and common areas were checked after Ms. Mckenzie discovered that her bag was missing. Ms. Shaver stated the bag nor Ms. Mckenzie's medication was never found.

Residents A denied taking Ms. Mckenzie's personal bag or her prescription medications. Resident A stated he saw Ms. Mckenzie's bag left out unattended however did not touch the bag. Resident C stated she has never seen any medications left unattended however heard rumors Resident A took Ms. Mckenzie's personal bag that was left unattended in the facility and took her prescription medications out of the bag. Resident C stated she has no direct knowledge of this.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my investigation which included interviews with RRO Suzie Suchyta, administrator/licensee designee Lorinda Anderson, program director Tim VanDyke, direct care staff member Suzie Shaver, and Residents A and C there is not enough evidence to support that residents are not protected regarding accessing staff member Sharon Mckenzie's prescription medications. Ms. Shaver stated she was working when Ms. Mckenzie left her personal bag that contained her blood pressure medications out on the table in the facility unattended near residents however neither the bag nor Ms. Mckenzie's medication were never found, and Ms. Shaver does not have evidence that any residents took the bag or the medication. Resident A stated he saw Ms. Mckenzie's bag left out unattended however did not touch the bag. There is no reason to believe that any resident took Ms. Mckenzie's bag, or her medications as no resident was found with Ms. Mckenzie's belongings and no resident had any adverse reactions of taking unknown medications.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Direct care staff members do not supervise residents when medications are given.

INVESTIGATION:

This complaint also alleged staff does not supervise residents when medications are given.

On 1/13/2023, I conducted an interview with Recipient Rights Officer (RRO) Suzie Suchyta who stated she has spoken to Resident A who informed her he is not supervised when he takes medications. Ms. Suchyta stated Resident A informed her that when it's time to take his medications, direct care staff members provide him with a small disposal cup that contains his medications and allow him to walk away before he swallows his medication. Resident A stated he takes the medications wherever he wishes.

On 1/20/2023, I conducted an onsite investigation at the facility with home manger Danica Millard, direct care staff member Suzie Shaver, and Residents A and C. Ms. Millard stated since the residents are "higher functioning", staff members would routinely give residents their cup of prescription medications and allow them to take their medication without staff supervision, however since there has been issues with residents not taking their medications and leaving their medications around the facility, Ms. Millard is now having residents come to the staff office door to take their medications and residents will now be supervised by staff members when they take their medications. Ms. Millard stated she has talked to all staff members about this and has signs posted throughout the facility to remind everyone that medications will be given and supervised by staff members at the staff's office door. Ms. Millard stated all residents are required supervision when taking medications and there are no special physician orders in place.

Ms. Shaver stated she has routinely administered and given residents medications without supervising them on a regular basis however direct care staff members now have a rule in place where medications can only be administered and given at the staff office and must be supervised by direct care staff. Ms. Shaver stated direct care staff implemented this new rule because resident medications were being found throughout the facility which indicated that residents were not taking their medications as instructed. Ms. Shaver stated the new system is working out much better as direct care staff members are now able to ensure residents are taking their medications. Ms. Shaver stated all residents require supervision when taking medications with no residents having physician approval to pass their own medications.

Resident A and Resident C both stated direct care staff members usually do not supervise them when they take their prescription medications however currently there is a new facility rule in place where all residents must be supervised when medications are given, and medications must be taken at the staff office. Resident A and Resident C also both stated prior to this rule, each resident was given a disposable cup with their medications and were allowed to take the cup of medications wherever they wanted within the facility without a direct care staff member being present.

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:	Based on my investigation which included interviews with RRO Suzie Suchyta, home manager Danica Millard, direct care staff member Suzie Shaver, Residents A and C there is evidence direct care staff members were not supervising residents when medications were administered. Ms. Millard, Ms. Shaver, and Residents A and C all stated direct care staff members have not been supervising residents when administering medications until recently due to a new rule put in place by facility administration requiring all residents to be supervised by direct care staff members while taking medication. This was instituted after resident medications were throughout the facility which indicated residents were not taking their medications as instructed. Both Ms. Millard and Ms. Shaver stated all residents are required supervision when taking medications and there are no special physician orders allowing residents to administer their own medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B was given Resident C's morning medications accidentally.

INVESTIGATION:

On 1/20/2023, I received an additional allegation that Resident B was given Resident C's morning medications accidentally by a direct care staff member.

On 1/20/2023, I conducted an onsite investigation at the facility with administrator Lorinda Anderson, program director Tim VanDyke, home manger Danica Millard, direct care staff member Suzie Shaver, and Resident C. Ms. Anderson, Mr. VanDyke, Ms. Millard and Ms. Shaver all stated direct care staff member Scott Bessy gave Resident B's morning medications to Resident C accidentally on 1/17/2023. Ms. Millard stated on the morning of 1/17/2023 when she arrived at work, Resident C asked her if she could have her morning medications. Ms. Millard stated when she looked on the MAR, she saw that Resident C's morning medications were already passed at 5:55am therefore she informed Resident C that she was not able to give her medications since they were already passed. Ms. Millard stated as she reviewed the MARs for each resident, she noticed that Resident B had not taken her morning medications however when she

asked Resident B about taking her morning medications, Resident B informed her that Mr. Bessy had already given her, her morning medications at 5:55am therefore Ms. Millard called Mr. Bessy to inquire. Ms. Millard stated after speaking with Mr. Bessy it was discovered that Mr. Bessy had given Resident B, Resident C's morning medication on accident. Ms. Millard stated she called poison control and Resident B's pharmacist to get further instructions. Ms. Millard stated she also apologized to Resident C for the confusion.

Mr. VanDyke and Ms. Anderson stated Mr. Bessy has worked on the overnight shift for many years and they have not had any issues with him. Mr. VanDyke and Ms. Anderson also stated due to the medication error involving Resident B and Resident C, Mr. Bessy was disciplined with a written disciplinary notice and is required to be retrained in medication administration.

Resident C stated she asked staff if she could have her morning medications on 1/17/2023 and Ms. Millard informed her that according to the MAR staff member Mr. Bessy already gave her morning medications at 5:55am. Resident C stated she informed Ms. Millard that she did not take her morning medications and she needed to check the MAR again. Resident C stated she believes Ms. Millard did not believe she was telling the truth initially however later apologized and stated that it was discovered that Mr. Bessy gave Resident B, Resident C's medications in the morning which is why the MAR stated Resident C's medications were administered.

While at the facility, I reviewed Resident B's and C's Medication Administration Record (MAR) for the month of January 2022. Resident C's MAR showed Resident C morning medication administered on 1/17/2023 and the following medications listed are Hydrochlorothiazide 25mg, Meloxicam 15mg, Aspirin EC 81mg, Vitamin B-12 500mg, and Glipizide ER 10mg.

I also reviewed the facility's *AFC Licensing Division-Accident/Incident Report* (report) dated 1/1/7/2023. According to this report, direct care staff member Ms. Millard asked Resident B why she had not taken her morning medications and Resident B replied that she was given her morning medications by Mr. Bessy earlier in the morning. This report stated also earlier in the day Resident C reported that she did not receive her medications however the MAR recorded that she did receive them. The report stated Ms. Millard then realized that Resident B was given Resident C's medications at 6am. Staff then called poison control and Gull Pointe Pharmacy and followed their instructions for both Residents B and Resident C.

On 3/5/2023, I conducted an interview with direct care staff member Scott Bessy. Mr. Bessy stated that on 1/17/2023 he accidentally gave Resident B, Resident C's morning medications. Ms. Bessy stated he was not very familiar with the residents and thought Resident B was Resident C. Mr. Bessy stated there is a picture of each resident on their medication box however Mr. Bessy did not look at the picture to ensure the correct resident was receiving medication and was simply "not paying attention." Mr. Bessy stated he usually works overnight shift which does not require much interaction with the

residents therefore he was not used to passing medications to the residents despite being trained in medication administration. Mr. Bessy stated after this medication error he had to be retrained in medication administration and was disciplined with a written disciplinary notice.

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:	Based on my investigation which included interviews home manager Danica Millard, program director Tim VanDyke, administrator/licensee designee Lorinda Anderson, direct care staff member Scott Bessy, Suzie Shaver, Resident C and review of the facility's MAR and *AFC Licensing Division-Accident/Incident Report* there is evidence to support Resident B was given Resident C's morning medications. Ms. Anderson, Mr. VanDyke, Ms. Millard and Ms. Shaver all stated direct care staff member Scott Bessy gave Resident B's morning medications to Resident C accidentally on 1/17/2023. Mr. Bessy stated he was not very familiar with the residents and thought Resident B was Resident C therefore he accidentally passed the wrong medication to Resident B. Mr. Bessy further stated there is a picture of each resident on their medication box however Mr. Bessy did not look at the picture to ensure he was administering medication to the correct resident and was not paying attention. Mr. Bessy did not take precautions to ensure the prescription medication was not used by a person other than the resident for whom the medication was prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

While at the facility on 1/20/2023, Mr. VanDyke, Ms. Anderson, and Ms. Millard stated direct care staff member Robert Britingan gave Resident C the incorrect dosage amount for her medication Carbamazepine 200mg on 12/14/2022. Resident C was given 3 tablets at noon however the correct dose is 2 tablets at noon. In addition, direct care staff did not administer the medication Hydrochlorothiazide 25mg.

While at the facility's I reviewed the Resident C's MAR for December 2022 which documented Resident C was given three tablets of Carbamazepine 200mg and was not given Hydrochlorothiazide 25mg on 12/14/2022. Per the label instructions, Resident C is

prescribed 200 mg Carbamazepine to take 2 tablets once daily and 25 mg Hydrochlorothiazide to take 1 tablet by mouth every morning after meals with water.

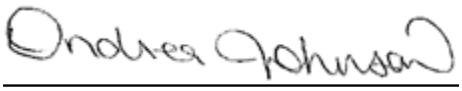
I also reviewed the facility's *AFC Licensing Division-Accident/Incident* Report dated 12/15/2022. According to this report direct care staff member Mr. Britingan passed Resident C the wrong dosage amount of Carbamazepine 200mg and was given 3 tablets at noon instead of the prescribed 2 tablets at noon. Mr. Britingan also did not pass the medication Hydrochlorothiazide 25mg. The report stated staff called the pharmacist and disciplinary action will be given to Mr. Britingan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken or applied pursuant to label instructions.
ANALYSIS:	While at the facility, Mr. VanDyke, Ms. Anderson, and Ms. Millard stated direct care staff member Robert Britingan gave Resident C the incorrect dosage amount of her medication Carbamazepine 200mg on 12/14/2022. Resident C was given three tablets at noon however the correct dose is two tablets at noon. In addition, direct care staff also did not administer the medication Hydrochlorothiazide 25mg to Resident C. The report stated staff called the pharmacist and disciplinary action was given to Mr. Britingan. Medications for Resident C was not given pursuant to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/5/2023, I informed Ms. Anderson of my findings. I allowed Ms. Anderson an opportunity to ask questions and make comments.

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend the current license status remain unchanged.



Ondrea Johnson — 3/5/2023
Licensing Consultant — Date

Approved By:

03/13/2023

Dawn N. Timm — Date
Area Manager