GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 23, 2023

Maribeth Leonard
Jackson-Hillsdale CMH Board LifeWays
1200 N. West Avenue
Jackson, MI 49202

RE: License #: AS380407018
Investigation #: 2023A0007010
LifeWays Crisis Residential

Dear Ms. Leonard:

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
(517) 763-0211

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380407018
Investigation #:	2023A0007010
Complaint Receipt Date:	01/20/2023
Investigation Initiation Date:	01/20/2023
Report Due Date:	03/21/2023
Licensee Name:	Jackson-Hillsdale CMH Board LifeWays
Licensee Address:	1200 N. West Avenue Jackson, MI 49202
Licensee Telephone #:	(517) 789-1209
Administrator:	David Sprunger
Licensee Designee:	Maribeth Leonard
Name of Facility:	LifeWays Crisis Residential
Facility Address:	1200 N. West Avenue Jackson, MI 49202
Facility Telephone #:	(517) 789-1209
Original Issuance Date:	08/11/2021
License Status:	REGULAR
Effective Date:	02/11/2022
Expiration Date:	02/10/2024
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Allegations of multiple medication errors in the home.	Yes

III. METHODOLOGY

01/20/2023	Special Investigation Intake - 2023A0007010
01/20/2023	Special Investigation Initiated – Telephone - Call made to ORR Worker #1.
01/20/2023	Referral - Recipient Rights
01/23/2023	APS Referral made.
01/31/2023	Inspection Completed On-site - Unannounced- Face to face contact made with Ms. Tucelli, Crisis Supervisor, Mr. Stitt, Director of Access and Crisis Services, Ms. Zuzelski, Nurse, other staff, and Mr. Lowe (via Microsoft Teams).
03/15/2023	Contact - Telephone call made to Employee #1. Message left. I requested a returned phone call.
03/15/2023	Contact - Telephone call made to Employee #2. Message left. I requested a returned phone call.
03/15/2023	Contact - Telephone call received from Employee #2. Interview.
03/15/2023	Contact - Telephone call received - Voice mail message from Employee #1 (x2).
03/16/2023	Contact - Telephone call received from Employee 1. Interview.
03/16/2023	Contact - Telephone call made to Ms. Maribeth Leonard, Licensee Designee. I called the Lifeways business line and there was no answer.
03/16/2023	Contact - Document Sent- Email sent to Ms. Maribeth Leonard, Licensee Designee. I requested a phone call to conduct the exit conference.

03/16/2023	Exit Conference conducted with Ms. Maribeth Leonard, Licensee Designee.
03/16/2023	Contact - Document Sent - Email to Ms. Maribeth Leonard, Licensee Designee.

ALLEGATIONS:

Allegations of multiple medication errors in the home.

INVESTIGATION:

As a part of this investigation, I reviewed three separate incident reports for this facility, which documented medication errors for Resident A, Resident B, and Resident C.

On January 31, 2023, I conducted an unannounced on-site investigation and made face to face contact made with Ms. Tucelli, Crisis Supervisor (filling in for Mr. Sprunger), Mr. Stitt, Director of Access and Crisis Services, Ms. Zuzelski, Nurse, Mr. Lowe (via Microsoft Teams), and other staff.

We met in the conference room, and I requested to review the resident files and medication information for Resident A, Resident B, and Resident C.

Regarding Resident A:

On the first incident report, Mr. Sprunger, Program Manager, documented that on December 24, 2022, the "CRU nurse reviewed EMAR's and medication bubble cards for [Resident A] upon arrival for shift. It was found that [Resident A's] card with weekly dose of Vitamin D had two tabs missing. [Resident A] received first dose on 12/22 (day that medication was order by psychiatrist) during night med pass per [System 1]."

It was also documented that the CRU Nurse notified Dr. #1, and it was noted that the next scheduled dosage would be held.

The corrective measures included the six rights being reviewed with the direct care staff.

Ms. Zuzelski explained that they reviewed the medication logs and bubble packs and discovered that Employee #1 administered an extra dosage of the Vitamin D. Ms.

Zuzelski also provided me with a picture of the bubble pack from when the error was discovered.

A review of Employee #1's file reflected that she successfully completed the Medication Administration training on November 15, 2022.

On March 16, 2023, I interviewed Employee #1. She informed that she did not recall the details of this incident. She stated that someone had to watch her when she was administering medications. Employee #1 reported that she was trained to pass medications when she was first hired.

Regarding Resident B:

Mr. Sprunger documented on the second incident report that on January 17, 2023, the on-call RN was notified that a direct care worker administered hydroxyzine at 8:28 p.m. for anxiety. A review of the chart reflected that the last dosage was given at 4:43 p.m. It was also documented that "per medication order, it is ordered three times daily or every 8 hours as needed. The dose administered by the DCW was given 4 hours too early."

The doctor and program manager were notified. The RN spoke with Resident B and no concerns were noted.

The corrective measures included review of the Medication Rights and posting the 6 Rights information above the Medication Cart. It was also noted that supervision will go over the medication administration processes with staff.

During the meeting, Ms. Zuzelski informed me that the mediation error occurred on January 17, 2023. Resident B was prescribed hydroxyzine, and she (Ms. Zuzelski) administered the prescribed medication at 4:43 p.m. At 8:28 p.m., Employee #1 administered the anxiety medication again. Ms. Zuzelski spoke to both staff (Employee #1 and Employee #2), as they had called about Resident B having a rash. The medication was prescribed three times daily or every 8 hours, as needed. It was discovered that the medication had been given too early. Ms. Zuzelski also provided me with the program notes regarding this incident.

During the interview with Employee #1, I inquired about the incident regarding Resident B, and she informed that she did not remember the situation. She recalled that she did call Ms. Zuzelski but could not recall any additional information. I inquired about what happened after the medication errors were discovered and she informed me that Mr. Sprunger talked to her. She stated that he spoke to all the staff individually and discussed things that were occurring, including medication errors.

Regarding Resident C:

On the third incident report, Mr. Sprunger documented on January 18, 2023, that "upon daily review of medication administration record, it was found that [Resident C] did not receive nighttime dose of Zoloft. EMAR shows missed dose. Pill count was verified and incorrect." It was also documented that Resident C was questioned regarding how many meds he took the night before and he stated, "I can't remember."

The doctor and program manager were notified.

The corrective measures included supervision with staff.

Ms. Zuzelski informed me that the medication error occurred on January 18, 2023, and it was discovered on January 19, 2023. According to Ms. Zuzelski, Resident C was prescribed Zoloft (50 mg - ½ tablets) for four days. After four days, the medication was to be increased to a full tablet. After observing and counting the medications left in the bubble pack, and reviewing the EMAR, it was determined that the medication error occurred. Instead of getting four days of the ½ tablet of Zoloft, he received 3 days of the medication, as a ½ tablet was left in the bubble pack. Ms. Zuzelski also provided the pictures of the medication bubble packs.

A review of Employee #2's file reflected that she was hired on October 31, 2022. Employee #2 successfully completed the Overview of Medication Administration training on November 11, 2022. She also completed the Lifeways Medication Administration training on January 17, 2023.

Mr. Lowe and the Lifeways staff expressed a willingness to address the problems with the medication administration.

According to Mr. Stitt, after the medication errors occurred, they implemented an internal corrective action plan. It was also reported that Mr. Sprunger met with the staff individually regarding the medication errors and retrained them. Mr. Sprunger also sent an email to the team and will be sending the nurses to a Train-The-Trainer Training.

On March 15, 2023, I interviewed Employee #2. She was cooperative with the investigation. Employee #2 recalled the situation involving the medication error and stated that she had also spoken to ORR about the matter. Employee #2 stated that when passing medications, she will let the residents know what she is about to do, and she will close the door to the medication room. Resident C went into a panic attack, he was knocking and banging on the door, and he kept calling her name. She reported that she gave him his PRN medication, but the dosage of Zoloft got missed, as he was having a panic attack. I inquired about what happened after the

medication error was discovered and Employee #2 stated that Mr. Sprunger talked with her about the issue.

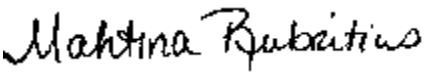
On March 16, 2023, I conducted the exit conference with Ms. Maribeth Leonard, Licensee Designee. I informed her of my findings. Ms. Leonard reported that they put additional measures in place to address the medication errors, including a process for documentation, and additional staff training. Ms. Leonard agreed to submit a written corrective action plan to address the established violation.

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

ANALYSIS:	According to the incident report, “CRU nurse reviewed EMAR’s and medication bubble cards for [Resident A] upon arrival for shift. It was found that [Resident A’s] card with weekly dose of Vitamin D had two tabs missing. [Resident A] received first dose on 12/22 (day that medication was ordered by psychiatrist) during night med pass per [System 1].” Ms. Zuzelski explained that they reviewed the medication logs and bubble packs and discovered that Employee #1 administered an extra dosage of the Vitamin D. Resident B was prescribed hydroxyzine, and Ms. Zuzelski administered the prescribed medication at 4:43 p.m. At 8:28 p.m., Employee #1 administered the anxiety medication again. The medication was prescribed three times daily or every 8 hours, as needed. Employee #1 administered the hydroxyzine too early. It was documented on the incident report that Resident C did not receive the nighttime dosage of Zoloft. According to Ms. Zuzelski, Resident C was prescribed Zoloft (50 mg - ½ tablets) for four days. After four days, the medication was to be increased to a full tablet. After observing and counting the medication left in the bubble pack, and reviewing the EMAR, it was determined that the medication error occurred. Instead of getting four days of the ½ tablet of Zoloft, he received 3 days of the medication, as a ½ tablet was left in the bubble pack. According to Employee #2, Resident C went into a panic attack, he was knocking and banging on the door, and he kept calling her name. She reported that she gave him his PRN medication, but the dosage of Zoloft got missed. 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, Resident B, and Resident C did not receive their medications as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, I recommend that the status of the license remains unchanged.



3/20/2023

Mahtina Rubritius — Date
Licensing Consultant

Approved By:

3/23/2023

Ardra Hunter — Date
Area Manager