GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 11, 2023

Andrew Akunne
Carnegie AFC Inc
Suite 1
3879 Packard Street
Ann Arbor, MI 48108

RE: License #: AL630279364
Investigation #: 2023A0612007
Freedom Haven

Dear Mr. Akunne:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan within 15 days.

Please contact me with any questions. In the event that I am not available and you need to speak to someone immediately, you may contact the local office at (248) 975-5053

Sincerely,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI  48202
Phone: 248-302-2409

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL630279364 |
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| **Investigation #:** | 2023A0612007 |
| | |
| **Complaint Receipt Date:** | 11/29/2022 |
| | |
| **Investigation Initiation Date:** | 11/29/2022 |
| | |
| **Report Due Date:** | 01/28/2023 |
| | |
| **Licensee Name:** | Carnegie AFC Inc |
| | |
| **Licensee Address:** | Suite 1 - 3879 Packard Street<br>Ann Arbor, MI 48108 |
| | |
| **Licensee Telephone #:** | (734) 973-7764 |
| | |
| **Administrator:** | Andrew Akunne |
| | |
| **Licensee Designee:** | Andrew Akunne |
| | |
| **Name of Facility:** | Freedom Haven |
| | |
| **Facility Address:** | 700-738 Wanda<br>Ferndale, MI 48220 |
| | |
| **Facility Telephone #:** | (248) 548-3607 |
| | |
| **Original Issuance Date:** | 03/28/2007 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 02/17/2021 |
| | |
| **Expiration Date:** | 02/16/2023 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL; AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Freedom Haven staff have been administering the incorrect medication to Resident A for roughly 27 days (July 2022 - August 2022. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 11/29/2022 | Special Investigation Intake<br>2023A0612007 |
| 11/29/2022 | Special Investigation Initiated - Letter<br>I emailed Recipient Rights Specialist Brittany Navetta regarding this allegation |
| 11/29/2022 | APS Referral<br>Recipient Rights Specialist Brittany Navetta stated she reported this allegation to Adult Protective Services (APS) on 09/03/22 |
| 12/05/2022 | Contact – Document Received<br>I received copies of Resident A's Individual Plan of Service, Easterseals (ES) Evaluation and Management Forms dated: 06/14/22, 07/06/22, 08/08/22 & 08/22/22, photos taken by Resident A's Guardian of the discontinued medications, Resident A's Medication Administration Records dated 08/01/22 - 08/31/22, and Resident A's medication records monitored by ES Registered Nurse dated 06/14/22 - 09/20/22. |
| 01/05/2023 | Inspection Completed On-site<br>I completed an unscheduled onsite investigation. I interviewed home manager, Bobie Daniels, direct care staff, Kevon Levy, direct care staff, Felicia Tyson and Resident C. |
| 01/09/2023 | Exit Conference<br>I held an exit conference via telephone with licensee designee, Andrew Akunne |

**ALLEGATION:**

**Freedom Haven staff have been administering the incorrect medication to Resident A for roughly 27 days (July 2022 - August 2022).**

**INVESTIGATION:**

On 11/29/22, I received a complaint from Recipient Rights Specialist, Brittany Navetta. The complaint alleged on 08/31/22, Easter Seals Case Manager, Jasmine Johnson received a text message from Resident A's guardian, Christina Mitchell stating that Freedom Haven staff have been administering the incorrect medication to Resident A for roughly 27 days (July 2022 – August 2022). Ms. Mitchell sent Ms. Johnson photos of the discontinued medication bubble packs that had medication missing/popped out. I initiated my investigation with an email to Recipient Rights Specialist Ms. Navetta regarding the allegation. Ms. Navetta stated she reported the allegations to Adult Protective Services (APS) on 09/03/22. Ms. Navetta substantiated her investigation.

On 12/05/22, I reviewed Resident A's Individual Plan of Service (IPOS) dated 02/14/22. The IPOS indicated that home staff will dispenses medications as prescribed and ensures that Resident A takes her medications.

On 12/05/22, I reviewed Resident A's Easterseals (ES) Evaluation and Management Forms dated 06/14/22, 07/08/22, 08/08/22, and 08/22/22, Resident A's medication records monitored by ES Registered Nurse, Merry Mitchell dated 06/14/22 - 09/20/22 and photos taken by Resident A's Guardian of discontinued medications that were passed alongside Resident A's currently prescribed medications. Upon review of the documentation, I observed that the following medication were not given as prescribed:

- PRN packet of Melatonin Extended Release 10MG was discontinued on 06/14/22, but 1 dose was administered in error on 08/01/22.
- Morning packet of Vraylar 3MG capsule was discontinued on 08/22/22, but 6 doses were administered in error from 08/22/22 - 08/27/22.
- Bedtime packet of Fluphenazine (Prolixin) 5MG tablet was discontinued on 06/14/22, but 27 doses were administered in error from 08/01/22 - 08/26/22, and on 08/28/22.
- Morning packet with Prazosin 1MG was discontinued on 08/22/22, but 6 doses were administered in error from 08/22/22 - 08/27/22.

On 12/05/22, I reviewed Resident A's Medication Administration Record (MAR) dated 08/01/22 - 08/31/22. I observed that the following medication were not given as prescribed:

- Fluphenazine (Prolixin) 5MG tablet, 1 by mouth daily (8a) marked with "D/C" for discontinued, no initials. 27 doses were administered in error from 08/1/22 - 08/27/22 per the bubble pack but this was not documented as passed in the MAR.

- Melatonin 10MG tablet, 1 by mouth at bedtime as needed (PRN) marked with "D/C" for discontinued (on 06/14/22), no initials for 08/01/22 - 08/31/22. One dose was administered in error on 08/01/22 per the bubble pack but this was not documented as passed in the MAR.
- Quetiapine (Seroquel) 200MG tablet, 1 by mouth at bedtime as needed (PRN) marked with "D/C" for discontinued, no initials for 08/01/22 - 08/31/22. 2 doses were administered from 08/01/22 - 08/02/22 per the bubble pack but this were not documented as passed in the MAR.
- Prazosin 1MG tablet, 1 by mouth every morning (8a) and evening (8p) marked with a line through 08/01/22 - 08/09/22 to show discontinuation, then administered from 08/10/22 - 08/23/22, then medication was marked with a "D/C" for discontinued from 08/24/22 - 08/31/22. 6 doses were administered in error from 08/22/22 - 08/27/22 per the bubble pack but were not documented as passed in the MAR.
- Vraylar 3MG capsule, 1 by mouth every morning (8a) marked with a line through 08/01/22 - 08/09/22, then administered from 08/10/22 - 08/23/22. Then medication was marked with a "D/C" for discontinued from 08/24/22 - 08/31/22. 6 doses were administered in error from 08/22/22 - 08/27/22 per the bubble pack but were not documented as passed in the MAR.
- Prazosin 2MG tablet, 1 by mouth every morning (8a) marked with a line through 08/01/22 - 08/22/22 to show discontinuation, then administered from 08/23/22 - 08/31/22.
- Vraylar 6MG capsule, 1 by mouth every morning (8a) marked with a line through 08/01/22 - 08/22/22 to show discontinuation, then administered from 08/23/22 - 08/31/22.
- Olanzapine (Zyprexa) 15MG tablet, 1 by mouth at bedtime (8p) marked with a line through 08/01/22 - 08/21/22 to show discontinuation, then administered from 08/22/22 - 08/31/22.
- Quetiapine (Seroquel) 300MG tablet, 1 by mouth at bedtime (8p) as needed (PRN) marked with a line through 08/01/22 - 08/23/22, then administered from 08/24/22 - 08/31/22.

On 01/05/23, I completed an unscheduled onsite investigation. I interviewed home manager, Bobie Daniels, direct care staff, Kevon Levy, direct care staff, Felicia Tyson and Resident C.

On 01/05/23, home manager Bobie Daniels stated when medications are discontinued, they are sent back to the pharmacy. However, the pharmacy will not pick up the medication until they have a full box to send back. So, when a medication is

discontinued it is taken out of the resident's medication basket and stored in a locked room in the back of the house until they have collected enough medications for the pharmacy to pick up. This room is locked; the keys are kept with the staff who is on shift. Ms. Daniels stated in July 2022 – August 2022, Resident A had several medications that were discontinued (she could not recall the names of these medications). The medication bubble packs were removed from Resident A's medication basket and put into the back room to be sent back to the pharmacy. However, an unknown staff went into the back room, got the discontinued pills, and put them back into Resident A's medication basket. The discontinued medications were then administered to Resident A by multiple staff along with Resident A's prescribed medications. Ms. Daniels admitted that Resident A received discontinued medication from July 2022 – August 2022.

On 01/05/23, I interviewed direct care staff, Kevon Levy and direct care staff, Felicia Tyson. Mr. Levy and Ms. Tyson were both working the morning shift on 01/05/23. Ms. Tyson and Mr. Levy were unable to confidently confirm if both of them or one of them administered morning medications today. They were further unable to name which residents that they gave medications to. Mr. Levy completed a simulated medication pass. During the demonstration he stated that he administers medication to one resident at a time. He pops all the medications out of the bubble packs and puts them into a medication cup. Then, he signs the medications administered record (MAR) indicating that all the medications were passed for that date and time. After signing the MAR, he gives the medication to the resident.

On 01/05/23, I completed an unscheduled onsite investigation. I reviewed Resident A's January 2023 medication administration record (MAR), current medication bubble packs, and medication discontinue (D/C) orders. I observed that the following medication were not given as prescribed:

- Quetiapine Fumarate ER 50 mg ER tablet was discontinued on 01/04/23. Resident A received 2 doses in error: 01/05/23 at 8 am and 01/05/23 at noon.
- Quetiapine Fumarate ER 400 mg tablet - take 1 tablet by mouth 2 hours before bedtime (6PM) was discontinued on 01/04/23. Resident A received 1 dosage in error on 01/04/23 at 6 pm.
- Quetiapine Fumarate 400 mg tablet - take 1 tablet by mouth at bedtime (8PM). The medication was not signed for on any date in the MAR. The medication was popped out of the bubble pack on 01/04/23. Resident A received 1 dosage in error on 01/04/22 at 6 pm. She was given this medication in addition to 1 tablet of Quetiapine Fumarate 400 mg at 8 pm.

On 01/05/23, I attempted to interview Resident A. Resident A verbally declined to be interviewed.

During an unscheduled on-site investigation completed on 01/05/23, I reviewed Resident B's January 2023 medication administration record (MAR) and observed medications. There were no medications signed as administered on 01/05/23. However, all Resident B's prescribed medications were popped out of the bubble packs on 01/05/23. Direct care staff, Felicia Tyson stated she administered Resident B her medication on 01/05/23. During the onsite inspection, Ms. Tyson admitted that she did not sign the MAR after administering the medication on 01/05/23.

I observed that Resident B has a bubble pack of Oxcarbazepine 300 mg tab that reads take one and half tablet by mouth twice daily for 31 days. Resident B's MAR is transcribed incorrectly. The MAR stated: Oxcarbazepine 300 mg tab – take one tablet at bedtime (8PM). This medication is not being administered as prescribed.

I observed that Resident B has a bubble pack of Amlodipine Besylate 5 mg that reads take 1 tablet by mouth once daily. The pharmacy labeled the bubble pack "Morning." Resident B's MAR is transcribed incorrectly. Resident B's MAR stated: Amlodipine Besylate 5 mg take 1 table at bedtime (8PM). This medication is not being administered as prescribed.

I observed that Resident B has a bubble pack of Clozapine 100 mg tab that reads take 1 tablet by mouth every morning for 28 days and take 3 tablets by mouth at bedtime for 28 days. Resident B's MAR is transcribed incorrectly. Resident B's MAR stated: "Clozapine 100 mg p.o tab (1) tab once daily" (8AM). This medication is not being administered as prescribed. The MAR does not indicate that a dose is being administered at bedtime.

I observed that Resident B has a bubble pack of Hydroxyzine Pamoate 25 mg that reads take 1 table by mouth twice daily for 31 days. Resident B's MAR is transcribed incorrectly. Resident B's MAR stated: Hydroxyzine Pamoate 25 mg take 1 tablet daily (8 AM). This medication is not being administered as prescribed. The MAR does not indicate that this medication is being administered twice daily.

I observed that Resident B's MAR stated Vitamin D 125 mg – take 1 tablet every Thursday. The MAR indicated that the medication is administered in the morning. During my onsite investigation completed on Thursday 01/05/23, this medication had not been administered to Resident B. The pill was in the bottle and the MAR was not signed. The staff on shift, Mr. Levy and Ms. Tyson stated morning medications had already been administered. They provided no explanation as to why this medication was not administered to Resident B.

On 01/05/23, I reviewed Resident B's prescribed PRN medications. Resident B is prescribed the following:

> Naproxen 500 mg – take 1 tablet by mouth twice daily as needed for pain
> Albuterol Sulfate 108 mcg – inhale 2 puffs every 4 – 6 hours as needed
> Resident B has an inhaler of albuterol, 2 bubble packs of Naproxen and a bottle of Naproxen in her medication basket. Neither of Resident B's prescribed PRN medications are written on her January 2023 MAR.

I observed that Resident B's MAR stated: Cholecalciferol/ oyster shell 200 unit/ 500 mg – take one tab daily (8AM). This medication was not onsite and available for review. However, the medication was signed for on Resident B's MAR from 01/01/23 – 01/04/23. During the onsite inspection, home manager, Bobie Daniels contacted the pharmacy. The pharmacy stated this medication was only prescribed to Resident B for one month, October 2022. The medication has not been delivered to the home since.

During my onsite investigation completed on 01/05/23, I observed an unlabeled medication cup on the desk in the staff office. The cup had two round pills, one orange and one yellow. Direct care staff Felicia Tyson stated the medication is prescribed to Resident C. Ms. Tyson stated Resident C refused his morning medications on 01/05/23. I reviewed Resident C's January 2023 MAR with Ms. Tyson. Resident C's morning medications were signed for, indicating they had been administered on 01/05/23. Ms. Tyson admitted she signed the MAR without administering the medications to Resident C. Ms. Tyson stated when a resident refuses a medication staff should indicate on the MAR that the medication was refused, and a note should be written in the log. Ms. Tyson did not follow this procedure.

During an unscheduled on-site investigation completed on 01/05/23, I observed that Resident C's MAR stated: Clopidogrel 75 mg – take 1 tablet by mouth once daily. The medication is not signed for on 01/02/23. However, the medication was popped out of the bubble pack.

I observed that Resident C's MAR stated: Atorvastatin Calcium 20 mg – take 1 tablet by mouth at bedtime. The medication was not signed for on 01/01/23 or 01/04/23. However, the medication was popped out of the bubble pack.

On 01/05/23, I observed that Resident C's MAR stated: Humalog Kwikpen 100 unit – inject 2 -12 units into the skin with meals and at bedtime (4 times daily). Give based on blood sugar before the meal. I reviewed Resident C's blood sugar chart. Resident C's blood sugar was not documented on the following dates: 12/24/22 – 12/27/22, 12/30/22, 12/31/22, and 01/04/23. Per Resident C's December 2022 MAR Humalog Kwikpen was administered to him at varying times on dates that his blood sugar was not documented. The MAR nor the blood sugar chart documents how many units of medication Resident C received on any date. During the onsite inspection, direct care staff Ms. Tyson stated

she signed Resident C's MAR on 01/05/23, indicating that his medication was administered to him at 8 AM and noon. However, Resident C refused his medication. The medication was not passed.

On 01/05/23, I interviewed Resident C. Resident C stated he wants off all of his medications they are killing him.

On 01/09/23, I held an exit conference via telephone with licensee designee, Andrew Akunne to review my findings. Mr. Akunee stated the issue with Resident A receiving discontinued medications was also investigated by the Office of Recipient Rights. The case was substantiated. For the corrective action plan the staff were in-serviced on medication administration. The in-service was completed three weeks ago. I informed Mr. Akunee that there were medication errors made from 01/01/23 – 01/05/23, which is after the staff had been in-serviced. I informed Mr. Akunee of my recommendation for a 6-month, 1st provisional license. He acknowledged. Mr. Akunee further acknowledged his understanding that upon recipient of this report he would need to provide a corrective action plan.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15312** | **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 S333.1101 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:** | Based on my observation during the onsite investigation completed on 01/05/23, Resident C's medication was not kept in the original pharmacy supplied container or in a locked cabinet or drawer. Direct care staff Felicia Tyson stated Resident C refused his morning medications on 01/05/23. I observed the medication in an unlabeled medication cup sitting on the desk in the staff office. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| APPLICABLE RULE | |
|---|---|
| **R 400.15312** | **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 A's medications were not given pursuant to the label instructions. During the onsite investigation completed on 01/05/23, I observed multiple discrepancies amongst Resident A's January 2023 MAR, medication bubble packs, and medication discontinue orders. Resident A received two doses of Quetiapine Fumarate ER 50 mg ER in error. One dose of Quetiapine Fumarate ER 400 mg in error, and on 01/04/23, Resident A was given Quetiapine Fumarate 400 mg tablet at 6 pm in addition to Quetiapine Fumarate 400 mg at 8 pm. These medications were not given to Resident A pursuant of the label instructions. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br>**Reference Renewal Licensing Study Report dated 03/04/2021; CAP dated 04/09/2021.** |

| APPLICABLE RULE | |
|---|---|
| **R 400.15312** | **Resident medications.** |
| | (4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:<br>(b) Complete an individual medication log that contains all of the following information:<br>(i) The medication.<br>(ii) The dosage.<br>(iii) Label instructions for use.<br>(iv) Time to be administered.<br>(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.<br>(vi) A resident's refusal to accept prescribed medication or procedures. |

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| **ANALYSIS:** | In August 2022 there were multiple discrepancies observed amongst Resident A's Medication Administration Record (MAR), discontinue orders, and the medication bubble packs. On 08/01/22, Resident A received one dose of Melatonin 10MG tablet (1 by mouth at bedtime as needed) in error. The administration of this medication was not signed for on the MAR. From 08/1/22 - 08/27/22, Resident A received 27 doses of Fluphenazine (Prolixin) 5MG tablet (1 by mouth daily, 8am) in error. The administration of this medication was not signed for on the MAR. Six does of Prazosin 1MG tablet (1 by mouth every morning, 8am and evening, 8pm) were administered to Resident A in error from 08/22/22 - 08/27/22. The administration of this Medication was not documented in the MAR. Resident A received six doses of Vraylar 3MG capsule (1 by mouth every morning, 8 am) in error from 08/22/22 - 08/27/22. The administration of this medication was not documented on the MAR.<br><br>Based on the information gathered through my investigation there is sufficient information to conclude that Resident B and Resident C's medication logs were not adequately maintained. Resident B's January 2023 medication log does not consistently include the correct dosage of medication, label instructions for use and/or time to be administered.<br><br>On Resident B and Resident C's January 2023 medication logs, the initials of the person who administered the medication was not consistently written at the time the medication was given. Resident C's January 2023 medication log did not document his refusal to accept his prescribed medications on 01/05/23. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br>**Reference Renewal Licensing Study Report dated 03/04/2021; CAP dated 04/09/2021**. |

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15312** | **Resident medications.** |
| | (7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist. |
| **ANALYSIS:** | Based on the information gathered through my investigation there is sufficient information to conclude that Resident A's medications were not properly disposed of after they were |

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|---|---|
| | discontinued. From July 2022 – August 2022 Resident A had several medications that were discontinued. These medications were not properly disposed of. They remained easily accessible to direct care staff locked in a back room that all staff can access with a key that is provided to them while they are on shift. As such, the medications continued to be administered to Resident A in error. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

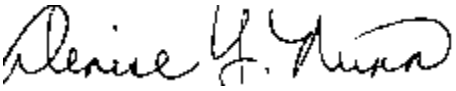
## III. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, issuance of a 1st provisional license is recommended.

01/11/2023

Johnna Cade Date
Licensing Consultant

Approved By:



01/11/2023

Denise Y. Nunn Date
Area Manager