GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 16, 2023

Iryl Felicidario
Ultra Care, Inc
2033 Harned Dr.
Troy, MI 48085

RE: License #: AS630079486
Investigation #: 2023A0465017
Norton Home

Dear Mr. Felicidario:

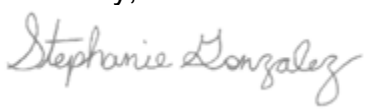
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630079486
Investigation #:	2023A0465017
Complaint Receipt Date:	03/07/2023
Investigation Initiation Date:	03/10/2023
Report Due Date:	05/06/2023
Licensee Name:	Ultra Care, Inc
Licensee Address:	2033 Harned Dr. Troy, MI 48085
Licensee Telephone #:	(248) 689-2056
Administrator:	Iryl Felicidario
Licensee Designee:	Iryl Felicidario
Name of Facility:	Norton Home
Facility Address:	6887 Norton Troy, MI 48098
Facility Telephone #:	(248) 828-8527
Original Issuance Date:	08/31/1998
License Status:	REGULAR
Effective Date:	02/27/2022
Expiration Date:	02/26/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 3/6/2023, direct care staff, Cheryl Estrada, placed Resident A's Lorazepam 1mg medication in the kitchen cabinet unsecured, and forgot to administer this medication to Resident A as prescribed.	Yes

III. METHODOLOGY

03/07/2023	Special Investigation Intake 2023A0465017
03/10/2023	Special Investigation Initiated - Telephone I spoke to licensee designee/administrator, Jude Felicidario, via telephone
03/21/2023	Inspection Completed On-site I conducted an onsite investigation. I conducted a walkthrough of the facility, reviewed resident files, observed residents, reviewed medication records, and interviewed direct care staff, Jocelyn Tagalag
03/28/2023	Contact - Telephone call made I spoke to Guardian A1 via telephone
04/04/2023	Contact - Telephone call made I spoke to Guardian B1 via telephone
04/04/2023	Contact - Telephone call made I spoke to direct care staff, Cheryl Estrada, via telephone
04/14/2023	Contact - Telephone call made I spoke to direct care staff, Jocelyn Felicidario, via telephone
04/24/2023	Exit Conference I conducted an Exit Conference with Jude Felicidario via telephone

ALLEGATION:

On 3/6/2023, direct care staff, Cheryl Estrada, placed Resident A's Lorazepam 1mg medication in the kitchen cabinet unsecured, and forgot to administer this medication to Resident A as prescribed.

INVESTIGATION:

On 3/7/2023, an *Incident/Accident Report* was received from licensee designee/ administrator, Jude Felicidario. The incident report indicated the following: on 3/6/2023, direct care staff, Cheryl Estrada, placed Resident A's Lorazepam 1mg tablet in the kitchen cabinet unsecured, and forgot to administer this medication to Resident A. Direct care staff, Jocelyn Felicidario, came into work at 8:00pm, and while putting dishes away, found Resident A's Lorazepam tablet preset in a cup inside the cabinet next to the dishes. Ms. Felicidario observed that the medication cup had Resident A's name on it and is a medication that was supposed to be administered to Resident A earlier that day, at 7:00am. Ms. Felicidario notified Resident A's neurologist and primary care physician of this medication error. The incident report indicated that Ms. Estrada was interviewed regarding this incident, and Ms. Estrada acknowledged that she had forgotten to administer Resident A's medication and agreed to complete additional medication training.

On 3/10/2023, I spoke to licensee designee/administrator, Jude Felicidario, via telephone. Mr. Felicidario acknowledged that all of the information contained in the *Incident/Accident Report* is accurate.

On 3/21/2023, I conducted an onsite investigation at the facility. At the time of my onsite investigation, there were five residents residing in the home. All five residents have medical diagnosis of Dementia and/or Intellectual/Cognitive limitations and were unable to be interviewed for this investigation. I completed a walkthrough of the facility, reviewed Resident A's file, observed all residents, reviewed medication records, and interviewed direct care staff, Jocelyn Tagalag. I observed all five residents to be properly dressed and with adequate hygiene. I observed all prescribed medications in a locked cabinet area, and I did not observe any unsecured medications inside the home.

The *Face Sheet* stated that Resident A was admitted to the facility on 10/24/2018 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Cerebral Palsy and Severe Intellectual Disability. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, is non-verbal, requires assistance with all personal care tasks and uses a wheelchair for mobility assistance. The *Medication Administration Record* for the month of March 2023, stated that Resident A is prescribed Lorazepam 1mg Tablet, to be administered by mouth in the morning at 7:00am, and reflected the missed medication on 3/6/2023.

I interviewed direct care staff, Jocelyn Tagalag, who stated, "I have not made any medication errors and I have never preset medications for a resident. I know that we are not supposed to do that. I was not working on the day that Ms. Estrada forgot to administer Resident A's medication, but I am aware of the incident. I spoke to Ms. Estrada about this incident, and she told me that she was in the process of administering medication to Resident A when another resident asked for assistance with using the bathroom. Ms. Estrada told me that she placed Resident A's medication cup

in the kitchen cabinet temporarily so that she could tend to the other resident. But afterwards, Ms. Estrada forgot that she had not administered the medication and forgot that the medication was unsecured in the kitchen cabinet. Ms. Estrada apologized for this error and has recently attended additional medication trainings to make sure this does not happen again. This is the only time something like this has happened."

On 3/28/2023, I spoke to Guardian A1 via telephone. Guardian A1 stated, "Resident A has been being cared for by the facility for many years. I have no concerns regarding the medication management by staff in the home. I believe they are doing a good job. The staff communicate all issues and concerns that arise and keep me informed of things pertaining to Resident A."

On 4/4/2023, I spoke to Guardian B1 via telephone. Guardian B1 stated, "I do not have any concerns or issues with the staff. I have been highly satisfied with the care the staff have provided to Resident B. I am notified quite often by staff of any issues that happen."

On 4/4/2023, I spoke to direct care staff, Cheryl Estrada, via telephone. Ms. Estrada stated, "I have been working at the facility for four months. On 3/6/2023, I was working, and I made a medication mistake. At 7:00am, I prepared Resident A's Lorazepam 1mg medication to administer it. But as I was preparing to give it to Resident A, another resident asked for help with toileting. I decided to help the other resident first, and without thinking it through, I placed Resident A's medication cup in the kitchen cabinet. The cabinet does not have a lock on it, but I thought as long as it was hidden away, it was okay to do that for just a few minutes. But then, afterwards, I got busy doing other things and forgot that I never administered that medication. It was an error on my part and I am very sorry for this mistake. I know that I should not have done that. And I know that all medication has to be locked up and administered after it is taken out of the container. I have completed additional medication training, and this won't happen again."

On 4/14/2023, I spoke to direct care staff, Jocelyn Felicidario, via telephone. Ms. Felicidario stated that she has worked at the facility since 2016 and is the home manager. Ms. Felicidario stated, "On 3/6/2023, I came into work at 8pm and Ms. Estrada left work because her shift ended. While I was putting away dishes, I saw a medication cup in the cabinet. The cup had Resident A's name on it and contained his Lorazepam 1mg tablet inside. I have administered Resident A's medication many times and I knew this was a medication he was supposed to receive at 7am. I immediately called Ms. Estrada and she confirmed that she put the pill in the cabinet and forgot that it was there and never administered the medication. The medication was in the kitchen cabinet, which is not a locked or secured area. I called management and I also wrote an incident report. We notified Resident A's neurologist and primary care physician. Since it was past the four-hour window, we had to wait to administer that medication until the next morning. Since this incident, I have provided additional medication training to Ms. Estrada and we also have implemented an additional medication check, that is required to be done by each staff prior to the end of their shift to ensure that we catch any

medication errors as soon as possible. Since this incident, no further medication errors have occurred."

On 4/24/2023, I conducted an exit conference with licensee designee/administrator, Jude Felicidario. Mr. Felicidario is in agreement with the findings of this report.

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 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:	According to Ms. Estrada, on 3/6/2023, she placed Resident A's Lorazepam 1mg tablet in a medication cup and placed it into an unsecured cabinet at approximately 7:00am. Ms. Estrada stated that she subsequently forgot the medication was in the cabinet for the remainder of her shift. Ms. Estrada is aware that all prescribed medications must remain in the original container and secured in a locked cabinet or drawer. Ms. Estrada acknowledged that this allegation is true. According to Ms. Felicidario, upon arriving at work, she discovered the Lorazpam 1mg tablet inside the cabinet at approximately 9:00pm. Ms. Felicidario completed an incident report and required Ms. Estrada to take additional medication training courses. Based on the information above, there is sufficient information to confirm that on 3/6/2023, Ms. Estrada did not ensure that Resident A's Lorazepam 1mg was kept in the original pharmacy-supplied container and in a locked cabinet or drawer.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	According to Ms. Estrada, on 3/6/2023, she forgot to administer Resident A's Lorazepam 1mg tablet at 7:00am, as prescribed and pursuant to label instructions. Ms. Estrada acknowledged that this allegation is true. According to Ms. Felicidario, upon arriving at work, she discovered Resident A's Lorazpam 1mg tablet inside the cabinet at approximately 9:00pm and realized that this medication had not been administered as required. Ms. Felicidario stated that she notified management, Resident A's neurologist and primary care physician and Guardian A1. Ms. Felicidario stated that she also completed an incident report and required Ms. Estrada to take additional medication training courses. Based on the information above, there is sufficient information to confirm that on 3/6/2023, Ms. Estrada did not administer Resident A's Lorazepam 1mg pursuant to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that the special investigation be closed upon receipt of an acceptable corrective action plan.

Stephanie Gonzalez

4/26/2023

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Stephanie Gonzalez — Date
Licensing Consultant

Approved By:

Denise Y. Nunn

05/16/2023

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Denise Y. Nunn — Date
Area Manager