GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 26, 2023

Scott Brown
Renaissance Community Homes Inc
P.O. Box 749
Adrian, MI 49221

RE: License #: AS470093665
Investigation #: 2023A0790041
Golf Club Road Home

Dear Mr. Brown:

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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS470093665
Investigation #:	2023A0790041
Complaint Receipt Date:	04/19/2023
Investigation Initiation Date:	04/20/2023
Report Due Date:	06/18/2023
Licensee Name:	Renaissance Community Homes Inc
Licensee Address:	Suite C 1548 W. Maume St. Adrian, MI 49221
Licensee Telephone #:	(734) 439-0464
Administrator:	Scott Brown
Licensee Designee:	Scott Brown
Name of Facility:	Golf Club Road Home
Facility Address:	2367 Golf Club Road Howell, MI 48843
Facility Telephone #:	(517) 545-9921
Original Issuance Date:	09/01/2000
License **Status:**	REGULAR
Effective Date:	06/19/2022
Expiration Date:	06/18/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A missed seven days of the psychiatric medication Clozapine because direct care staff member (DCSM) Demetrius Williams failed to take Resident A to a scheduled blood draw on 03/31/2023 as arranged. When Resident A resumed taking Clozapine, DCSMs twice administered the wrong dose of medication.	Yes

III. METHODOLOGY

04/19/2023	Special Investigation Intake 2023A0790041
04/20/2023	Special Investigation Initiated - Telephone Called recipient rights advisor Elizabeth Simon and left a voicemail message requesting a return call.
04/20/2023	APS Referral Centralized Intake was contacted via phone. APS referral was made.
04/21/2023	Contact – Telephone call made to interview recipient rights advisor Elizabeth Simon.
04/26/2023	Inspection Completed On-site Interviewed direct care staff member (DCSM) Angela Byard who functions as the house manager, DCSM Sarah Hacker, and Resident A.
04/26/2023	Contact - Telephone call received. Interviewed district supervisor Michael Blandford.

05/22/2023	Contact - Telephone call made to interview licensee designee Scott Brown. Left voicemail message requesting a return call.
05/22/2023	Inspection Completed-BCAL Sub. Compliance
05/22/2023	Corrective Action Plan Requested and Due on 06/06/2023.
05/23/2023	Contact - Telephone call received. Interviewed licensee designee Scott Brown.
05/23/2023	Exit Conference with licensee designee Scott Brown.

ALLEGATION:

Resident A missed seven days of the psychiatric medication Clozapine because direct care staff member (DCSM) Demetrius Williams did not to take Resident A to a scheduled blood draw on 03/31/2023 as arranged. When Resident A resumed taking Clozapine, DCSMs administered the wrong dose of medication twice.

INVESTIGATION:

An APS Referral was made via a call to Centralized Intake on 04/20/2023.

I interviewed recipient rights advisor Elizabeth Simon via phone on 04/21/2023. Ms. Simon confirmed the allegation that Resident A failed to receive his Clozapine (generic form of Clozaril) for seven days due to missing his blood draw on 03/31/2023. Ms. Simon explained direct care staff member (DCSM) Angela Byard who functions as the house manager went on vacation for two weeks and when she returned on 04/10/2023 she found out Resident A missed his blood draw on 03/31/2023 and had not been receiving his prescribed Clozapine. Ms. Simon said Ms. Byard immediately took Resident A to get his blood drawn. She said Resident A had to start over on the medication and began taking a much lower dose of Clozapine again on 04/11/2023.

Ms. Simon stated Clozapine is a medication with a black box warning. She said a black box warning is the most serious type of warning mandated by the U.S. Food and Drug Administration (FDA). Ms. Simon said black box warnings are prominently featured in the labeling of drugs to warn prescribers about serious adverse reactions or special

problems. Ms. Simon said Clozapine is an effective drug for individuals suffering from schizophrenia but can be extremely dangerous. She said individuals taking the drug must have their blood drawn every 28 days to check their potassium and other levels.

Ms. Simon said doctors will not refill a prescription for Clozapine until the patient has had their blood drawn and their potassium and other levels are acceptable. She said this is why Resident A's prescription was not refilled.

Ms. Simon stated before Ms. Byard went on vacation, she made sure all the residents' doctors and other medical appointments such as blood draws were covered and assigned specific DCSMs to take the residents to these appointments. Ms. Simon said during a phone interview, Ms. Byard indicated she wrote down all the residents' appointments on the facility calendar with the DCSM who would be driving them to the appointment and informed the residents of their scheduled doctors and other medical appointments during the two weeks she would be on vacation.

Ms. Simon said DCSM Demetrius Williams was assigned to take Resident A for his blood draw on 03/31/2023. Ms. Simon said during a phone interview, Mr. Williams informed her he cannot recall why he did not take Resident A to get his blood drawn on 03/31/2023. Ms. Simon stated Mr. Williams said he is drawing a complete blank and does not recall why he failed to do so.

I reviewed an *AFC Licensing Division – Incident / Accident Report* dated 04/10/2023. The report was written by Ms. Byard and stated when she returned to work, she reviewed documentation to ensure residents were taken to all their medical appointments. The report indicated prior to Ms. Byard leaving for vacation she ensured there was a DCSM scheduled to transport all the residents to their medical appointments. The report said Ms. Byard discovered Resident A had not been transported to his blood draw which should have been completed on 03/31/2023. The report indicated Mr. Byard further discovered Resident A had not received his Clozapine for seven days because of missing his blood draw. The report stated Resident A called 911 twice to be transported to the hospital because he was not felling well while not receiving Clozapine.

I reviewed a second *AFC Licensing Division – Incident / Accident Report* dated 04/25/2023. The report was written by Ms. Byard and stated she discovered Resident A was not receiving the correct dose of his Clozapine.

I conducted an unannounced onsite investigation on 04/26/2023. I interviewed Ms. Byard. Ms. Byard disclosed Resident A was to be transported to a scheduled blood draw by DCSM Demetrius Williams on 03/31/2023. She said Mr. Williams failed to transport Resident A to his scheduled blood draw and because of not getting his blood drawn, Resident A's refill of Clozapine was never ordered by his primary care physician (PCP), and he subsequently went seven days without the medication. Ms. Byard said when she spoke with Mr. Williams about not transporting Resident A to his appointment to get his blood drawn on 03/31/2023, he said the van was not available to transport

Resident A. Ms. Byard stated Mr. Williams has been written up for not transporting Resident A.

I reviewed a Disciplinary Action form dated 04/19/2023 naming Demetrius Williams as the employee involved disciplinary action. The description of complaint read: “On 03/31/2023, Demetrius was the driver on shift and should have taken Resident A to get his Clozapine draw completed and failed to do so resulting in Resident A not receiving his medication.” Mr. Williams did not sign the Disciplinary Action form and wrote the following under employee’s plans for problem solution: “Refusal, van was not here for transport recall the day in question.” “Refer to employee who had vehicle in use.”

I interviewed district supervisor Michael Blandford via phone on 04/26/2023. Mr. Blandford stated he was at the facility on 03/31/2023 when Resident A was to be taken for his blood draw. Mr. Blandford said the van was sitting in the driveway when he arrived at the facility. Mr. Blandford stated the van was available when Resident A was to be transported to get his blood drawn. Mr. Blandford also stated there were other DCSMs working at the time and there was no reason Resident A should not have been taken to get his blood drawn.

I reviewed Disciplinary Action forms dated 04/19/2023 and naming DCSMs Demetrius Williams, Judy Quarderer, Ashley Byars, and Sarah Hacker as the employees involved disciplinary action. The description of complaint indicated: Mr. Williams, Ms. Quarderer, and Ms. Byars continued to initial they passed a medication, but the medication was not at the facility. As a result, Resident A did not receive the medication Clozapine for seven days.

According to the Disciplinary Action forms, Mr. Williams initialed he gave Resident A his Clozapine on 04/07/2023 and 04/12/2023 even though the medication was not at the facility, Ms. Quarderer initialed she gave Resident A his Clozapine on 04/08/2023, 04/09/2023, 04/09/2023, and 04/10/2023 even though the medication was not at the facility, and Ms. Byars initialed she gave Resident A his Clozapine on 04/06/2023 even though the medication was not at the facility. Ms. Hacker initialed she gave Resident A his Clozapine on 04/05/2023 even though there was no Clozapine left for Resident A at the facility.

I reviewed a Disciplinary Action form dated 04/19/2023 and naming DCSM Andraya Wright as the employee involved disciplinary action. The description of complaint indicated, Ms. Wright had passed Resident A’s Clozapine three days prior to it running out and she should have notified the pharmacy but failed to do so resulting in Resident A not receiving the medication for 11 days.

I reviewed a Disciplinary Action form dated 04/19/2023 and naming DCSM Sarah Hacker as the employee involved in the disciplinary action. The description of complaint indicated, Ms. Hacker would have been the medication passer to pass Resident A’s last Clozapine pill and did not notify the pharmacy resulting in Resident A not receiving the medication for 11 days.

I reviewed Resident A's *medication administration record (MAR)* and confirmed Mr. Williams, Ms. Quarderer, Ms. Byars, and Ms. Hacker continued to initial the *MAR* on the dates mentioned on the Disciplinary Action forms indicating they had administered Resident A's Clozapine even though Resident A had run out of the medication.

Ms. Byard said she spoke to Resident A when she returned from vacation. She stated Resident A reported he called 911 twice while she was gone because he was not feeling well. Ms. Byard said she asked Resident A how he was feeling when he called 911 and Resident A stated he was feeling unusual, upset, and sad.

Ms. Byard stated she subsequently found DCSMs had skipped ahead on Resident A's Bubble Packet and were giving Resident A five Clozapine tablets by mouth at bedtime instead of three tablets he was supposed to initially receive. Ms. Byard explained the level of Clozapine Resident A had been taking had to be gradually increased because of unexpectedly and abruptly not receiving the medication and for eleven days. She stated Resident A was to receive three tablets at bedtime for three days, four tablets for three days, and then five tablets for five days. She said Resident A received three tablets at bedtime the first night and then received five tablets the second and third night.

I observed the Bubble Packet and confirmed the medication error indicated above.

I interviewed DCSM Sarah Hacker, and she disclosed there were still Clozapine tablets for Resident A on 04/05/2023. She said on 04/05/2023 she administered the Clozapine to Resident A and then initialed the electronic *MAR* as she was trained to do.

I informed Ms. Byard about Ms. Hacker indicating there was still Clozapine tablets to administer to Resident A on 04/05/2023. Ms. Byard stated there should not have been any Clozapine tablets left on 04/05/2023 because Resident A failed to get his scheduled blood draw on 03/31/2023 and his PCP did not write a prescription to refill the medication.

I interviewed Resident A. Resident A stated he is feeling better. He said he almost feels normal again. Resident A said he was feeling psychotic and delusional when he was not getting his Clozapine. He stated his stomach was not feeling right either. Resident A said he had an awful stomachache while not taking his Clozapine.

I conducted an exit conference with licensee designee Scott Brown informing him rule violations were established because of this special investigation. Mr. Brown was asked to provide a corrective action plan (CAP) outlining steps taken to ensure no additional medication errors occur at the facility.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on information gathered during this special investigation through review of documentation and interviews with DCSMs Ms. Byard, Ms. Hacker, Resident A, and district supervisor Michael Blandford there was evidence indicating Resident A missed seven days of the psychiatric medication Clozapine because DCSM Mr. Williams did not take Resident A for a scheduled blood draw on 03/31/2023 as arranged. There was also evidence found indicating when Resident A resumed taking Clozapine, DCSMs twice administered the wrong dose of medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**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: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**

ANALYSIS:	Based on information gathered during this special investigation through review of documentation and interviews with DCSMs Ms. Byard, Ms. Hacker, Resident A, and district supervisor Michael Blandford there was evidence indicating DCSMs Mr. Williams, Ms. Quarderer, Ms. Byars, and Ms. Hacker continued to initial they passed a medication, but the medication was not at the facility. As a result, Resident A did not receive the medication Clozapine for seven days.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

05/22/2023

Rodney Gill Date
Licensing Consultant

Approved By:

05/26/2023

Dawn N. Timm Date
Area Manager