GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 1, 2023

Lisa Murrell
Community Living Centers Inc
33235 Grand River
Farmington, MI 48336

RE: License #: AS630012299
Investigation #: 2023A0605028
CLC Magnolia

Dear Ms. Murrell:

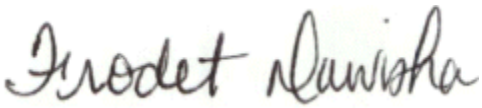
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012299
Investigation #:	2023A0605028
Complaint Receipt Date:	04/25/2023
Investigation Initiation Date:	04/25/2023
Report Due Date:	06/24/2023
Licensee Name:	Community Living Centers Inc
Licensee Address:	33235 Grand River Farmington, MI 48336
Licensee Telephone #:	(248) 229-0889
Administrator/Licensee Designee:	Lisa Murrell
Name of Facility:	CLC Magnolia
Facility Address:	17250 Cornell Southfield, MI 48075
Facility Telephone #:	(248) 569-8454
Original Issuance Date:	06/13/1978
License **Status:**	REGULAR
Effective Date:	03/13/2022
Expiration Date:	03/12/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff (DCS) Asia Bradley had two cups of medications: one with pills and the other with Nystatin Powder sitting in front of her and Resident A. She observed Resident A take the cup of pills and as she turned to initial the medication log, Resident A took the cup with Nystatin Powder and swallowed it. Ms. Bradley called poison control and Resident A was fine.	Yes

III. METHODOLOGY

04/25/2023	Special Investigation Intake 2023A0605028
04/25/2023	Special Investigation Initiated - Letter Sent the incident report to Office of Recipient Rights (ORR) worker Darlita Paulding
04/25/2023	APS Referral Adult Protective Services (APS) referral made
04/25/2023	Contact - Document Received APS denied referral
04/25/2023	Referral - Recipient Rights Referral made
04/26/2023	Contact - Document Sent Email to ORR Darlita Paulding
04/27/2023	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed direct care staff (DCS) Asia Bradley and DCS Shamanic Holt. I interviewed Residents B, C, and D.
05/16/2023	Contact - Telephone call made Interviewed the home manager (HM) Niejha McAdoo regarding the allegations
05/16/2023	Contact - Document Sent Emailed licensee designee Lisa Murrell for DCS names and contact numbers

05/16/2023	Contact - Document Received Received email from licensee designee Lisa Murrell
05/23/2023	Contact - Telephone call made Interviewed DCS Dean Parks and Christopher Moody regarding the allegations
05/23/2023	Contact - Telephone call made Left voice mail message for ORR Darlita Paulding
05/25/2023	Exit conference Left detailed message to licensee designee Lisa Murrell with my findings

ALLEGATION:

Direct care staff (DCS) Asia Bradley had two cups of medications: one with pills and the other with Nystatin Powder sitting in front of her and Resident A. She observed Resident A take the cup of pills and as she turned to initial the medication log, Resident A took the cup with Nystatin Powder and swallowed it. Ms. Bradley called poison control and Resident A was fine.

INVESTIGATION:

On 04/25/2023, intake #194804 was opened per incident report (IR) dated 04/18/2023 regarding Resident A swallowed a small amount of Nystatin powder when direct care staff (DCS) Asia Bradley put the Nystatin powder in a cup next to another cup full of Resident A's pills. Resident A took his medication cup with the pills first and then grabbed the cup with Nystatin powder and swallowed it.

On 04/25/2023, I made a referral to Adult Protective Services (APS) and Oakland County Office of Recipient Rights (ORR).

On 04/27/2023, I conducted an unannounced on-site investigation. I interviewed direct care staff (DCS) Asia Bradley and DCS Shamanic Holt. I interviewed Residents B, C, and D. Resident A was not present during this visit. Resident A works at Kroger on Mondays, Tuesdays, and Thursdays.

I interviewed DCS Asia Bradley regarding the allegations. Ms. Bradley has worked for Community Living Centers Inc., (CLC) for one year. She works midnight shifts but was still present this morning because she was waiting for the HM to arrive at the home. Ms. Bradley stated on 04/18/2023, she was administering medications. She placed Resident A's pills in a cup and then put a small amount of Nystatin powder in another cup. She took both cups to the dining room table where Resident A was sitting. She placed the cup with the pills in front of Resident A and the cup with the Nystatin powder in front of

her. She watched Resident A take the cup with the pills and as she turned to initial the medication log, she looked up and Resident A picked up the cup with the Nystatin powder and swallowed it. Ms. Bradley asked Resident A, “Why did you swallow it?” He stated, “I don’t know.” Ms. Bradley stated, “It happened so fast.” She immediately called poison control who advised her to flush out the Nystatin powder by giving Resident A water and to keep him hydrated. Poison Control advised Ms. Bradley that Resident A would be ok and did not have to seek medical attention because it was a very small amount of Nystatin powder he ingested. Ms. Bradley stated this was an isolated incident. She reported that the pharmacy does not refill the Nystatin powder frequently; therefore, the HM Niejha McAdoo advised staff to put a small amount of the Nystatin powder in the cup “to stretch it out.” Ms. Bradley showed me a post it notes that stated, “please shake Resident A little powder in a med cup, don’t give to Resident A.” Ms. Bradley stated she normally hands the cup with Nystatin powder to Resident A and then Resident A goes into the bathroom by himself and puts the Nystatin powder on his groin area. She stated, “I’m giving him some privacy.” Ms. Bradley stated she does not supervise Resident A putting the Nystatin powder on his groin and there is no script and/or documentation from Resident A’s prescribing physician stating that Resident A can apply the Nystatin powder without staff supervision.

Note: I observed Ms. Bradley correctly simulate a medication pass. She was advised that she must supervise all medication given and/or applied to the residents unless the prescribing physician states otherwise.

On 04/27/2023, I interviewed DCS Shamanic Holt regarding the allegations. Ms. Holt has worked for CLC since 12/2022. She too works mornings and sometimes afternoons. Ms. Holt was not present on 04/18/2023 when Resident A swallowed the Nystatin powder. Ms. Holt does not pass medications as she is still in training for medication administration. She reported that medication is already passed prior to her arriving to her shifts. She stated she does not have any information regarding Resident A swallowing the Nystatin powder.

On 04/27/2023, I interviewed Resident B regarding the allegations. Resident B likes living here and stated, “staff are ok.” He was unable to provide any concerns regarding staff and reported he did not witness Resident A swallowing the Nystatin powder. Resident B stated he takes all his medications and has no concerns about his medications.

On 04/27/2023, I interviewed Resident C regarding the allegations. Resident C stated, “it’s fine living here.” He has no concerns about staff and takes his medications as prescribed. He stated that “Resident A goofed. Him took the cup with the powder that was sitting in front of him and swallowed it.” Resident C was unable to provide any further information.

On 04/27/2023, I interviewed Resident D regarding the allegations. Resident D stated he does not like when the “guys wake up in the morning and make noise.” He gets all

his medications on time and reported no concerns. He does not know anything about Resident A swallowing any type of powder.

On 05/16/2023, I interviewed via telephone the home manager (HM) Niejha McAdoo regarding the allegations. The HM has been with CLC for seven years. She was not present on 04/18/2023 when Resident A swallowed the Nystatin powder. The midnight shift DCS Asia Bradley passed medications around 6AM. Ms. Bradley put both the Nystatin powder and Resident A's pills in separate cups and placed them on the table. Ms. Bradley gave the cup of pills to Resident A and as Ms. Bradley was initialing the medication log, Resident A grabbed the cup with the Nystatin powder and swallowed the powder. Ms. Bradley followed protocol calling Poison Control first and then called the HM advising her what happened. Ms. Bradley stated after Ms. Bradley had Resident A drink plenty of water, Resident A was ok and did not require any medical treatment. The HM stated that staff must supervise Resident A putting the Nystatin powder on his groin area as Resident A cannot apply the powder himself. The HM stated after this incident, she completed an in-service training with all staff regarding Resident A's Nystatin powder. Currently, staff will no longer put Nystatin powder in the cup. Staff must accompany Resident A to a private area and shake some Nystatin powder on his groin area. The HM will email a copy of the in-service training.

On 05/16/2023, I received an email from licensee designee Lisa Murrell with staff's contact information. Ms. Murrell also advised that Resident A was positive for Covid along with the other residents at the home; therefore, I was unable to return to the home to interview Resident A.

On 05/23/2023, I interviewed DCS Dean Parks via telephone regarding the allegations. Mr. Parks has been with CLC for three years. He works the afternoon shifts. Mr. Parks was not present on 04/18/2023 when Resident A ingested the Nystatin powder. Mr. Parks was informed that Resident A swallowed the Nystatin powder when it was put in a cup. Mr. Parks stated he used to put the powder in the cup, hand the cup to Resident A in his bedroom and supervise Resident A shake the powder on his groin area. Mr. Parks stated he always supervises Resident A apply the powder. He stated he has no other information to offer regarding the allegations.

On 05/23/2023, I interviewed DCS Christopher Moody regarding the allegations. Mr. Moody has been with CLC for five years. He is fill-in staff. He too was not present on 04/18/2023 when Resident A ingested the Nystatin powder. Mr. Moody heard that the staff that was on duty put Nystatin powder in the medication cup and placed it on the table to be applied later. Resident A decided to take the cup and swallow the powder. Mr. Moody stated he has completed medication training and when he administers Resident A's Nystatin, he used to put it in a cup, take the cup with him upstairs in Resident A's bedroom and applied the Nystatin powder on Resident A's groin area. Mr. Moody stated he has never put the Nystatin powder in front of Resident A in a cup and has always applied the powder himself on Resident A's groin area.

On 05/25/2023, I left a detailed voice mail message for licensee designee Lisa Murrell with my findings.

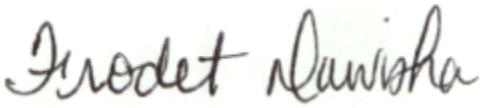
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation and information gathered, Resident A's Nystatin was not applied pursuant to label instructions. Per the label instructions, Nystatin should be applied to affected area topically twice daily. On 04/18/2023, DCS Asia Bradley put some of the Nystatin powder in a medication cup along with another cup with Resident A's pills. She put the cup with the pills in front of Resident A at the dining table where she was administering medication and then put the cup with Nystatin powder in front of her. She supervised Resident A take the cup with the pills and as she turned to initial the medication log, she looked up and saw that Resident A grabbed the cup with the Nystatin powder and swallow it. Ms. Bradley stated, "it happened so fast." She immediately called Poison Control, followed their instructions and Resident A was fine. This was an isolated incident. Since this incident, the home manager Niejha McAdoo completed an in-service with all DCS and moving forward, staff will not put the Nystatin powder in the medication cup. Instead, DCS will accompany Resident A to a private area and shake the powder on Resident A's groin area.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 and information gathered, DCS Asia Bradley reported that when she puts the Nystatin powder in the medication cup, she usually hands the cup to Resident A who then goes into the bathroom and applies the Nystatin powder himself without staff supervision on his groin area. Ms. Bradley stated, “I want to give him privacy.” Ms. Bradley stated Resident A does not have in writing from his prescribing physician that Resident A can apply Nystatin powder unsupervised to his groin area.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



05/25/2023

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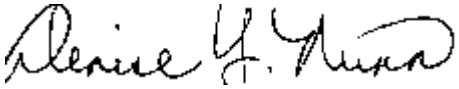
Frodet Dawisha Date
Licensing Consultant

Approved By:



06/01/2023

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Denise Y. Nunn Date
Area Manager