



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 19, 2023

Jennifer Bhaskaran
Alternative Services Inc.
Suite 10
32625 W Seven Mile Rd
Livonia, MI 48152

RE: License #: AS250010919
Investigation #: 2023A0779050
Maple Road Home

Dear Jennifer Bhaskaran:

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 (517) 643-7960.

Sincerely,

A handwritten signature in cursive script that reads "Christopher A. Holvey".

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010919
Investigation #:	2023A0779050
Complaint Receipt Date:	06/07/2023
Investigation Initiation Date:	06/09/2023
Report Due Date:	08/06/2023
Licensee Name:	Alternative Services Inc.
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Candy Hamilton
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Maple Road Home
Facility Address:	4341 W. Maple Avenue Flint, MI 48503
Facility Telephone #:	(248) 471-4880
Original Issuance Date:	11/05/1990
License Status:	REGULAR
Effective Date:	11/15/2021
Expiration Date:	11/14/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A received 20 doses of blood pressure medication when she should not have received it.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/07/2023	Special Investigation Intake 2023A0779050
06/09/2023	Special Investigation Initiated - Telephone Message left for recipient rights investigator, Michelle Salem.
06/14/2023	Contact - Telephone call made Spoke to recipient rights investigator, Michelle Salem.
06/15/2023	Inspection Completed On-site
06/28/2023	Contact - Document Received Received ORR summary report.
07/19/2023	Contact - Telephone call made Spoke to administrator, Candy Hamilton.
07/19/2023	Exit Conference Held with administrator, Candy Hamilton.
07/19/2023	APS referral Complaint was referred to APS centralized intake.

ALLEGATION:

Resident A received 20 doses of blood pressure medication when she should not have received it.

INVESTIGATION:

On 6/14/23, a phone conversation took place with recipient rights investigator, Michelle Salem, who confirmed that she was investigating the same allegations. Michelle Salem stated that several different staff at this home appear to have not properly administered Resident A's blood pressure (BP) medication over multiple weeks in May 2023. Michelle Salem stated that staff are to check Resident A's BP twice daily and then

administer the medication accordingly, but the information recorded on the medication administration report (MAR) does not match the documentation they have for the BP readings and the number of pills remaining does not match the documentation on the MAR as number of pills given.

On 6/15/23, an on-site inspection was conducted and home manager, Rachel White, was interviewed. Manager White confirmed that per the BP readings, Resident A should have only been given her BP medication three times in May but the MAR indicates that she was given it many more times than that. Manager White stated that staff have told her that they have punched the pills out of the bubble pack before checking Resident A's BP, not given her the medication and then disposed of the pills by putting them in coffee grounds and throwing them away. Manager White stated that there is no evidence of this actually taking place to confirm if the pills were given to Resident A or not. Manager White reported that they are still checking Resident A's BP twice daily, but that Resident A's physician discontinued the BP medication recently and she is no longer taking it.

On 6/15/23, Resident A stated that she was doing well and that staff at this home is taking good care of her. Resident A stated that staff are checking her BP everyday and giving her all her medications, but that she does not know what medications she takes and trusts the staff to give her the correct medications.

During the on-site inspection on 6/15/23, Resident A's BP medication and MAR for 5/1/23-5/25/23 were reviewed. Resident A's prescription for Coreg (Carvedilol) 3.12mg is written as *take 1 tab 2x daily *Hold if BP is lower than 120/90*. The BP reading documentation form shows that Resident A had 44 readings where her BP was under 120/90 and the medication should have been withheld and that there were 3 readings where her BP was higher than 120/90 and the medication should have been given. The documentation on the MAR indicates that staff had given Resident A the Coreg medication 35 times in May, but there were only 22 pills missing from the actual bubble packs of this medication.

On 6/28/23, a copy of the Office of Recipient Rights (ORR) summary report written by Michelle Salem was received via e-mail. The report confirmed and matched the information that was obtained during the review of Resident A's MAR and medications on 6/15/23. Michelle Salem stated in the report that the ORR has substantiated neglect regarding the improper administration of Resident A's Coreg medication.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A's prescription for Coreg (Carvedilol) 3.12mg is written as <i>take 1 tab 2x daily *Hold if BP is lower than 120/90</i> . A review of Resident A's BP readings, MAR, and medication bubble packs show that this medication should only have been given to Resident A 3 times between 5/1/23 and 5/25/23, but that 22 pills were missing and the MAR indicates that the medication was passed 35 times during that time period. There was sufficient evidence found to prove that Resident A's BP medication Coreg was not given properly and/or pursuant to label instructions.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 6/15/23, home manager, Rachel White, stated that per the BP readings, Resident A should have only been given her BP medication three times in May 2023 but the MAR indicates that she was given it many more times than that. Manager White stated that staff were initialing the MAR indicating that they were passing the medication, when it should not have been given, or disposing of the medication with no documentation of doing so.

On 7/19/23, a phone conversation took place with administrator, Candy Hamilton, who stated that the situation regarding the administration of Resident A's BP medication was very confusing, due to staff's improper documentation. Candy Hamilton stated that the MAR had staff initials indicating that Resident A's medication was given to her, but staff claim that there were many times when they disposed of the pills and did not give Resident A the medication. Candy Hamilton reported that staff did not complete a disposal sheet documenting that the medication was disposed of or indicate that anywhere on the MAR.

Resident A's MAR shows that staff had initialed documenting that they had given Resident A the Coreg medication 35 times in May 2023, but there were only 22 pills missing from the medication bubble packs. There was nowhere documented on the MAR or any additional documentation provided indicating that the medication was disposed of and not given to Resident A on those dates/times.

APPLICABLE RULE	
R 400.14312	Resident medications.
	<p>(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:</p> <p>(b) Complete an individual medication log that contains all of the following information:</p> <ul style="list-style-type: none"> (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:	<p>The documentation on Resident A's MAR indicates that staff had given Resident A the Coreg medication 35 times between 5/1/23-5/25/23. Staff claim that there were many times when the pills were punched from the bubble packs, but were disposed of and not given to Resident A. Nowhere on the MAR was this documented and there was no additional documentation completed to confirm of this taking place. There was sufficient evidence found to prove that staff were improperly initialing Resident A's MAR and accurately documenting when and/or if the medication was given.</p>
CONCLUSION:	VIOLATION ESTABLISHED

On 7/19/23, an exit conference was held with administrator, Candy Hamilton. She was informed of the outcome of this investigation and that a written corrective action plan is required.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

Christopher A. Holvey

7/19/2023

Christopher Holvey
Licensing Consultant

Date

Approved By:

Mary Holton

7/19/2023

Mary E. Holton
Area Manager

Date