GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 22, 2023

Hope Lovell
LoveJoy Special Needs Center Corporation
17101 Dolores St
Livonia, MI 48152

RE: License #: AS780413488
Investigation #: 2023A0584037
State Road Home

Dear Ms. Lovell:

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 (517) 284-9727.

Sincerely,

Candace Coburn, 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 #:	AS780413488
Investigation #:	2023A0584037
Complaint Receipt Date:	06/23/2023
Investigation Initiation Date:	06/23/2023
Report Due Date:	08/22/2023
Licensee Name:	LoveJoy Special Needs Center Corporation
Licensee Address:	17101 Dolores St Livonia, MI 48152
Licensee Telephone #:	(517) 574-4693
Administrator:	Hope Lovell
Licensee Designee:	Hope Lovell
Name of Facility:	State Road Home
Facility Address:	10860 State Road Morrice, MI 48857
Facility Telephone #:	(517) 574-4693
Original Issuance Date:	10/01/2022
License Status:	REGULAR
Effective Date:	03/31/2023
Expiration Date:	03/30/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 6/17/2023, facility staff member Melissa Nisse passed Resident B's medication to Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/23/2023	Special Investigation Intake -2023A0584037.
06/23/2023	Special Investigation Initiated - via email.
06/23/2023	APS Referral sent.
07/18/2023	Inspection completed on-site. Interviews with Resident A, B, C, D, E, F, direct care staff Kendra Larkin, Selena Croyle, and program manager Shelby Morse.
08/15/2023	Contact – Second telephone call attempted to contact Melissa Nisse, direct care worker and left a voice message to call back.
08/15/2023	Contact - Telephone call made to Shelby Morse, home manager.
08/17/2023	Contact - Document Received from Ardis Bates, Shiawassee Health and Wellness Recipient Rights officer.
08/17/2023	Exit Conference via telephone with licensee designee Hope Lovell.

ALLEGATION:

On 6/17/2023, facility staff member Melissa Nisse passed Resident A's medication to Resident B

INVESTIGATION:

On 6/23/2023 the Bureau of Community and Health Systems received the above allegation via the online complaint system.

On 7/18/2023, I conducted an unannounced investigation at the facility and observed the facility to be clean and in good condition.

I attempted to interview Residents A, B, D, E, and F; however, none were able or willing to answer my questions. Residents A, B, D, E, and F all appeared to be clean and well groomed.

I interviewed Resident C, who stated that he is treated well in the facility and his care needs are meet. Resident C appeared clean, happy and well groomed.

At the time of my inspection, direct care staff members Kendra Larkin and Selena Croyle, as well as the home manager Shelby Morse were on duty.

I interviewed Ms. Larkin and Ms. Croyle, who both stated they did not personally observe the medication error that occurred on 6/17/2023. Both Ms. Larkin and Ms. Croyle stated they understand the importance of carefully checking medication and ensuring it is given to the correct resident. It was observed that both Ms. Larkin and Ms. Croyle worked well and efficiently with the residents.

I interviewed Ms. Morse who stated that Melissa Nisse was no longer working at the facility and had transferred to a company home in the Lansing area. Ms. Morse confirmed the allegation occurred and stated Ms. Nisse followed the facility's protocol once the error was discovered. According to Ms. Morse, Ms. Nisse notified her of the error and then contacted poison control for further instructions. Ms. Morse provided Ms. Nisse's telephone phone number and her employee record for review.

I reviewed Ms. Nisse's employee record and confirmed that on 6/15/2023, she completed training on the administration of medications to residents.

On 7/18/2023 and 8/15/2023, I attempted to contact Ms. Nisse for a telephone interview. However, she did not return my telephone call.

On 8/15/2023 I contacted Shiawassee Health and Wellness Recipient Rights Officer Ardis Bates via email. Ms. Bates provided me notes from her interview with Ms. Nisse, which read:

> *"On 6/19/23, Melissa was interviewed and provided the following relevant information:*
>
> - *On 6/17/23, she worked with Georgina during the 1st shift and she was the staff person responsible for preparing, administering, and ensuring that Resident A took only the medications prescribed to her.*
> - *While passing medications that morning, she accidentally gave Resident A the wrong medications. She gave Resident B's medications, Allergy Relief 10 mg tablet, Aspirin Low 81 mg tablet, Hydroco 325 mg tablet, Morphine Sulfate 15 mg ER tablet, Movantik 12.5 mg tablet, Omeprazole 40 mg Capsule, Carafate 1mg tablet to Resident A.*
> - *After giving Resident A the medication, she realized her error and told Georgina that she had accidentally given Resident A the wrong medications.*

- *She immediately called Shelby (her immediate supervisor) and Poison Control.*

She monitored Resident A for the remainder of her shift and did not observe any adverse effects as a result of the medication error.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medications shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon my investigation, which consisted of interviews with facility staff members and residents, as well as a review of relevant facility documents pertinent to the allegation, there is enough evidence to substantiate the allegation that on 6/17/2023, facility staff member Melissa Nisse gave Resident A Resident B's medication in error.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my onsite investigation on 07/18/2023, I requested and reviewed the medication administration records (MAR) for Resident A, B, C, D, E, and F for the month of June 2023.

Resident B's MAR was missing facility staff members' initials for the administration of Sucralfate 1GM tab at 11:00 am on 6/10/2023.

Resident D had no facility staff members' initials entered for the administration of Lisinopril 20MG at 8pm on 6/7/2023, Depakote 250MG one tablet at 3:30 pm on 6/28/2023 and 6/30/2023, and Lamictal 200 MG, Align CAP 4MG, Amlodipine 5MG tab, Colace Clear cap 50mg and Thera M TAB at 7:30 am on 6/30/2023.

Resident E's MAR was missing facility staff members' initials for the administration of Polyeth Clyc Powder at 3pm on 6/28/2023, and Quetiapine 200 MG tab at 10pm on 6/14/2023 and 6/17/2023.

Resident F's MAR was missing facility staff members' initials for the administration of Hydroco/APAP 5-325mg tab at 7pm and Morphine Sul 15MG tab at 8pm on 6/30/2023.

I observed on all six resident MARs there were no facility staff members' initials indicating the passing of all their medications for the afternoon time on 6/1/2023 and the morning and afternoon times on 6/2/2023 and 6/3/2023.

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:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	During my investigation, it was discovered there was missing facility staff member's initials on Resident A, B, C, D, E, and F MARs several times in the month of June 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/17/2023, I conducted an exit conference with licensee designee Hope Lovell and shared with her the findings of this investigation.

IV. RECOMMENDATION

After receiving an acceptable corrective action plan, I recommend no changes in the status of this license.

8/18/2023

Candace Coburn — Date
Licensing Consultant

Approved By:

8/22/2023

Michele Streeter — Date
Area Manager