GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 11, 2023

Joshua Smith
DBT Institute of MI, PLLC
2950 W. Howell Road
Mason, MI 48854

RE: License #: AL330407593
Investigation #: 2023A0790058
DBT Institute of MI

Dear Joshua Smith:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 #:	AL330407593
Investigation #:	2023A0790058
Complaint Receipt Date:	08/21/2023
Investigation Initiation Date:	08/23/2023
Report Due Date:	10/20/2023
Licensee Name:	DBT Institute of MI, PLLC
Licensee Address:	2950 W. Howell Road Mason, MI 48854
Licensee Telephone #:	(517) 367-0670
Administrator:	Joshua Smith
Licensee Designee:	Joshua Smith
Name of Facility:	DBT Institute of MI
Facility Address:	2950 W. Howell Road Mason, MI 48854
Facility Telephone #:	(517) 367-0670
Original Issuance Date:	07/15/2022
License Status:	REGULAR
Effective Date:	01/15/2023
Expiration Date:	01/14/2025
Capacity:	16
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff members (DCSMs) are administering medications without proper training.	No
Unknown residents have received the wrong medications or the wrong dose of medications.	Yes
There are residents who are actively trying to kill themselves and are not receiving proper care.	No

III. METHODOLOGY

08/21/2023	Special Investigation Intake 2023A0790058
08/23/2023	Special Investigation Initiated – Telephone call to administrator Erin Smith requesting documentation relating to the allegations made in this special investigation.
08/23/2023	Contact - Telephone call made. Interviewed and requested supporting documentation from administrator Erin Smith.
08/25/2023	Contact - Document Received. Supporting documentation received from Ms. Smith.
08/30/2023	Inspection Completed On-site. Interviewed registered nurse Sheila Hoppe, direct care staff members (DCSMs) Shawna Bancroft, Samantha Mireles, Amy Brown, Resident B, and Resident C.
08/30/2023	Contact - Document Received. Email received from licensee designee Josh Smith providing information and documentation relevant to the special investigation.
09/04/2023	Contact - Document Received. Email received from Mr. Smith providing additional information regarding the special investigation.
09/26/2023	Inspection Completed-BCAL Sub. Compliance.
09/26/2023	Corrective Action Plan Requested and Due On 10/24/2023.
10/09/2023	Exit Conference with licensee designee Josh Smith.
10/11/2023	APS Referral called into Centralized Intake.

ALLEGATION: Direct care staff members (DCSMs) are administering medications without proper training.

INVESTIGATION:

I reviewed a BCAL Online Complaint dated 08/17/2023 alleging the facility is not safe. The complaint stated there are direct care staff members (DCSMs) administering resident medications who are not trained and have given unknown residents the wrong medications or the incorrect dose of medications. The complainant chose to remain completely anonymous and indicated they do not know if anything happening at the facility is a legal violation, but stated it is a scary environment for the DCSMs and the residents. The complaint stated the scary environment traumatizes the DCSMs, and the residents are leaving worse off than when they were admitted however did not provide any specific examples of events occurring causing trauma or fear.

I interviewed administrator Erin Smith via phone on 08/23/2023. I requested a roster of all direct care staff members (DCSMs) working at the facility and certificates showing all DCSMs have completed medication administration training.

Ms. Smith stated they try to limit the number of DCSMs who are involved in medication administration which is why they have a column on the roster titled Authorized to Pass. She said the DCSMs with a 'y' for yes in the designated column are trained to administer resident medication and are regularly tasked with medication administration. The DCSMs with a 'n' for no in the designated column are trained but not regularly tasked with medication administration.

Ms. Smith said they have two new hires who are still within the time frame allotted to complete the medication administration course. She stated one of their new DCSMs is a medical assistant (MA) who has been working closely with their primary nurse.

Ms. Smith stated their facility nurse provides hands-on training to the DCSMs involved in medication administration, shows them where everything is in the medication office, and how to use their electronic medication administration record (eMAR) system for recording after administering a medication pass.

I received a roster of the current DCSMs and a copy of each DCSM's certificates showing completed medication administration training from Relias, the learning management system used at the facility, on 08/25/2023.

I reviewed the roster of current DCSMs and the DCSMs' certificates showing they all completed medication administration training. I found all DCSMs who currently administer medications to residents successfully completed medication administration training through Relias, which is the learning management system used at the facility.

I completed an unannounced onsite investigation on 08/30/2023. I interviewed registered nurse Sheila Hoppe who stated she is responsible for training all DCSMs in proper medication administration. Ms. Hoppe said all new DCSMs receive medication administration training through Relias and hands-on training at the facility which she provides.

Ms. Hoppe said the DCSMs are trained to hand residents their medications in a small cup along with the cup of water and DCSMs are trained to remain with a resident and ensure all medications have been swallowed before leaving the resident. Ms. Hoppe said DCSMs are trained to follow the five rights of medication administration and shadow other experienced DCSMs before administering medications on their own.

I interviewed direct care staff members (DCSMs) Shawna Bancroft, Samantha Mireles, and Amy Brown. Ms. Bancroft and Ms. Mireles both stated they administer medications to residents. Ms. Bancroft stated she was trained to administer medications. Ms. Bancroft said she successfully completed a two-hour medication administration training through Relias, received hands-on training from Ms. Hoppe, and shadowed other experienced DCSMs before administering medications to residents on her own. Ms. Mireles said she is a certified medical assistant, has previous experience administering medications, was trained by Ms. Hoppe, and completed the two-hour mediation administration training through Relias.

Ms. Brown said she does not administer medications and has not completed medication administration training through Relias.

APPLICABLE RULE	
R 400.15312	**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: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Based on information gathered during this special investigation through review of documentation and interviews with administrator Ms. Smith, registered nurse Ms. Hoppe, DCSMs Ms. Bancroft, Ms. Mireles, and Ms. Brown there is no evidence indicating DCSMs are administering medications without proper training.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Unknown residents have received the wrong medications or not the correct dose of medications.

INVESTIGATION:

The complaint stated DCSMs have given unknown residents the wrong medications or the wrong dose of medications.

On 08/23/2023, I interviewed Ms. Smith who admitted there have been a few medication errors since the facility opened. Registered nurse Sheila Hoppe admitted there have been three medication administration errors since the facility opened. Ms. Hoppe stated she wrote up Medication Error Reports (MRRs) and *AFC Licensing Division – Incident / Accident Reports* when the errors occurred. She said one of the errors occurred because the administration of the medication was scheduled incorrectly in the *eMAR,* which was her responsibility. Ms. Hoppe said she was the person responsible for the three medication administration errors.

I reviewed the reports and found Ms. Hoppe to be the person responsible for all three medication administration errors made. The first medication administration error occurred on 05/24/2023, medication was scheduled incorrectly in *eMAR*, and the resident received a double dose of Venlafaxine (225 mg 5/24 at 0800 and 200 mg 05/24 at 1800 hours). The resident who is no longer at the facility, was not harmed. The facility has an attending physician on staff, and they were made aware of all medication administration errors. The outcome to resident was their next dose of Venlafaxine (200 mg on 05/25 at 0800) was held per doctor's order and the medication restarted on 05/26/2023. The resident was monitored for side effects, and none were noted.

The next medication administration error occurred on 06/05/2023 when a different resident, who is also no longer at the facility, received an extra dose of Klonopin in the AM (one dose as scheduled before breakfast and one dose in error after breakfast). The outcome was the resident's next dose of Klonopin (06/05/2023 at 1200) was held per doctor's order. The resident was monitored for side effects, complained of some dizziness, no falls, or any additional side effects.

The third and final medication administration error occurred on 07/16/2023 when a third different resident who also no longer resides at the facility received Buspirone 15 mg instead of Midodrine 5 mg as prescribed. The outcome was the resident was given scheduled Midodrine 5 mg per doctor's order and monitored for side effects of Buspirone. There were no side effects reported.

DCSMs Ms. Mireles and Ms. Bancroft both denied ever making a medication administration error. Ms. Mireles and Ms. Brown both indicated they were unaware of any medication administration errors occurring at the facility. Ms. Bancroft stated she was not a witness but heard on one occasion of a previous resident who received the wrong medication. She was unaware if the resident experienced any side effects from

receiving the wrong medication and had no additional information regarding the alleged incident.

I was unable to interview Resident A because of significant mental health issues. Resident A suffers from depression, unspecified; post traumatic stress disorder (PTSD); dissociative identity disorder; and borderline personality disorder. I was informed Resident A dissociates, has multiple personalities, and has a history of suicidal ideation. Resident A has a fear of men and is not communicative. I interviewed Resident B and Resident C and they both indicated they have never been given the wrong medication, wrong dose of a medication, medication given at the wrong time, or been the recipient of a medication administrative error while at the facility. Resident B and Resident C both stated they are unaware of any medication administrative errors occurring at the facility.

APPLICABLE RULE	
R 400.15312	**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 administrator Ms. Smith, registered nurse Ms. Hoppe, DCSMs Ms. Bancroft, Ms. Mireles, Ms. Brown, Resident B, and Resident C there is evidence indicating three medication administration errors have occurred since the facility opened. Those three former residents were given medications not in accordance with the label instructions (given more than prescribed) or were given the wrong medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: There are residents who are actively trying to kill themselves and are not receiving proper care.

INVESTIGATION:

The complaint said there are residents who are actively trying to kill themselves and are not getting proper care. The lack of proper direct care staff training and proper response creates an unsafe and traumatizing environment for direct care staff members and other residents according to Complainant.

Ms. Smith said they do not have any residents actively suicidal. She said they have a protocol that is followed regarding suicidal ideation. Ms. Smith said their process is as follows:

- Residents are admitted on a Q30 which is their lowest form of DCSM intervention (DCSMs will have eyes on everyone every 30 mins and will note if there is any need for intervention)
- Q15s are utilized for residents requiring a greater amount of observation due to current level of risk. When a resident is on Q15s, DCSMs will have to have eyes on the resident every 15 minutes and this observation will have to be documented.
- 1:1's are utilized for residents believed to be at the greatest risk of harm and is the highest level of care they are able to take on within the residential program's facility and structure. When a resident is on a 1:1, the resident always remains in eyesight of a DCSM. Every 15 minutes, the DCSM will document what the resident was doing during those 15 minutes. Only a licensed clinician can determine if/when a resident can be moved off this status.

Ms. Smith said if a resident is at imminent risk for suicide (either directly or indirectly), their licensed clinicians will do an imminent risk assessment to help determine whether the resident should be sent to the emergency room for further evaluation and possible admission into a psychiatric hospital. Ms. Smith stated if a resident is at risk for suicide, they call 911 or take the resident to an emergency room. She said they currently use two different types of imminent risk assessments (both are Evidence-Based risk assessments); the Linehan Risk Assessment Management Protocol (LRAMP) and the Columbia Suicide Scale (CSS).

I interviewed Registered Nurse Ms. Hoppe said they have no residents currently suicidal. Ms. Hoppe stated they have had a few residents who have attempted to harm themselves since the facility opened. She said they have had residents try to smother themselves, run down the driveway, choke themselves with their sweatshirt, and cut themselves. Ms. Hoppe stated DCSMs intervened on each occasion, and the residents were unable to harm themselves. Ms. Hoppe said the residents who have been actively suicidal were treated appropriately and proper protocol was followed to ensure the residents safety. She stated both residents she was aware of suffering from suicidal ideation while at the facility were placed on 1:1 supervision, meaning they had a DCSM with eyes on them continuously.

Ms. Hoppe said none of these residents have caused or received any serious injuries while experiencing suicidal ideation. She stated a couple residents have scratched, cut superficially, and/or burned themselves. Ms. Hoppe said no major medical treatment was required and no residents were sent to the emergency room.

Ms. Hoppe said they have a DCSMs group messaging system and information is consistently and immediately shared with all DCSMs when residents are acting peculiar and/or concerns arise regarding potential suicidal ideation. Ms. Hoppe stated she has never witnessed a resident experiencing suicidal ideation or harming themselves.

Ms. Mireles stated she has not witnessed any incidents of suicidal ideation while working at the facility.

Ms. Bancroft and Ms. Brown both stated there have been residents who have experienced suicidal ideation and have attempted to harm themselves in the past. They both stated there are no current residents experiencing suicidal ideation. Ms. Brown stated she is aware of the following two incidents. She said on one occasion a resident name unknown attempted to cut themselves with plastic pen. Ms. Brown stated on another occasion Resident A attempted to strangle herself with her sweatshirt and later a pillowcase. Ms. Brown said Resident A is not currently suicidal and has not been for quite some time.

Ms. Brown stated when these incidents happened, all items were immediately removed from the resident's rooms and rest of the facility which posed a threat to their safety and wellbeing. Ms. Brown stated the residents were also immediately placed on a heightened level of supervision. Ms. Brown said 1:1 supervision was utilized in these circumstances until the residents returned to baseline and there was no further evidence of suicidal ideation, nor threat of harm.

Resident B and Resident C both stated they were aware of Resident A previously experiencing suicidal ideation. Resident B and Resident C said Resident A is not currently experiencing suicidal ideation as far as they are aware. Resident B and Resident C stated they did not personally witness Resident A attempt to harm herself but heard DCSMs found her with something around her neck. Resident B and Resident C stated they are not sure but Resident A may have used a sweatshirt, pillowcase, ankle brace, or leg brace to attempt to strangle herself. Resident B stated she did not personally witness Resident A attempt to harm herself on another occasion but did observe cuts on her arm that were red in color. Resident B said she heard Resident A had cut herself with a plastic pen. Resident B and Resident C stated DCSMs removed everything from Resident A's room they felt Resident A could use to harm herself and placed Resident A on 1:1's when these incidents occurred. Resident B stated Resident A is no longer suicidal but believes she is still on 1:1 supervision. Resident C stated DCSMs provide good supervision. She said DCSMs caught Resident A attempting to harm herself and kept her safe. Resident C stated DCSMs conduct weekly room checks to ensure all residents are safe and there are no items in their rooms posing a safety threat.

I completed an exit conference with licensee designee Josh Smith and informed him a rule violation was established. Mr. Smith was requested to provide a corrective action plan (CAP) addressing the medication administration errors.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a

	resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	Based on information gathered during this special investigation through review of documentation and interviews with administrator Ms. Smith, registered nurse Ms. Hoppe, DCSMs Ms. Bancroft, Ms. Mireles, Ms. Brown, Resident B, and Resident C there was no evidence indicating there are residents who are actively trying to kill themselves and are not receiving proper care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

10/09/2023

Rodney Gill Date
Licensing Consultant

Approved By:

10/11/2023

Dawn N. Timm Date
Area Manager