GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 11, 2023

Hemant Shah
Cranberry Park Of Milford
801 Whitlow Drive
Milford, MI 48381

RE: License #: AH630392068
Investigation #: 2024A1021018
Cranberry Park Of Milford

Dear Mr. Shah:

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 authorized representative 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) 284-9730.

Sincerely,

Kimberly Horst

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630392068
Investigation #:	2024A1021018
Complaint Receipt Date:	12/06/2023
Investigation Initiation Date:	12/06/2023
Report Due Date:	02/05/2024
Licensee Name:	CRANBERRY PARK MILFORD LLC
Licensee Address:	26900 FRANKLIN RD Southfield, MI 48033
Licensee Telephone #:	(248) 210-5981
Administrator:	Kelsey Brown
Authorized Representative:	Hemant Shah
Name of Facility:	Cranberry Park Of Milford
Facility Address:	801 Whitlow Drive Milford, MI 48381
Facility Telephone #:	(248) 329-0750
Original Issuance Date:	11/29/2018
License Status:	REGULAR
Effective Date:	05/29/2023
Expiration Date:	05/28/2024
Capacity:	61
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A received incorrect medication.	No
Additional Findings	Yes

III. METHODOLOGY

12/06/2023	Special Investigation Intake 2024A1021018
12/06/2023	Special Investigation Initiated - Telephone interviewed administrator by telephone
12/07/2023	Contact - Document Received received Resident A documents
12/11/2023	Exit Conference

ALLEGATION:

Resident A received incorrect medication.

INVESTIGATION:

On 12/06/2023, the licensing department received a complaint with allegations Resident A received incorrect medications. The complainant alleged Resident A received Resident B's medications and was admitted to the hospital.

On 12/07/2023, I interviewed administrator Kelsey Brown by telephone. Ms. Brown reported on 11/24/2023, staff person 1 (SP1) administered Resident B's medications to Resident A. Ms. Brown reported SP1 immediately realized the error and contacted the facility nurse. Ms. Brown reported it was then reported to Resident A's physician and the physician recommended for Resident A to go to the emergency room. Ms. Brown reported Resident A's family was also notified. Ms. Brown reported Resident A was in observation status at the hospital and returned the following morning. Ms. Brown reported Resident A had no adverse effects of the medication error. Ms. Brown reported SP1 was immediately taken off the medication cart and was provided additional education. Ms. Brown reported SP1 is still not administering medications. Ms. Brown reported the facility nurse is also reviewing all medication technicians' competencies and is providing additional education. Ms. Brown reported

this is the second medication error with SP1. Ms. Brown reported on 11/22, a resident on hospice services was experiencing pain and SP1 administered Ativan but documented Morphine was administered. Ms. Brown reported approximately 30 minutes later, the resident was still complaining of pain, and it was then discovered that SP1 documented Morphine was administered and not Ativan.

I reviewed the incident report completed for the medication error. The narrative of the report read,

> *"Resident received medications that were intended for another resident. On call NP was contacted and instructions were to send resident to be evaluated."*

I reviewed Employee Warning Notice for SP1. The narrative read,

> *"medication error for the second time in 3 days. The first warning is for dispensing the wrong medication to a resident that result in monitoring over night in hospital. (Resident A) received his own medications as well as (Resident B). (SP1) has been removed from the med cart. She has been assigned to CG."*

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	On 11/24/2023, Resident A received incorrect medications. Upon discovery of the error, the facility immediately contacted Resident A's physician and family. In addition, the medication technician was removed from administering medications and received additional education. While this error did occur, it was an isolated incident, and it is not a systemic issue throughout the facility and the facility took appropriate action.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Brown reported medication technicians complete the Michigan Assisted Living Association (MALA) medication administration course. Once the course is completed, the medication technician does on the job training. Ms. Brown reported

the length of that training varies on the medication technician. Ms. Brown reported the facilities provide in-service education trainings. Ms. Brown reported there is no documentation of the on-the-job training.

I reviewed SP1 training records. SP1 completed the *MALA Medication Administration in HFA* training on 04/08/2023.

APPLICABLE RULE	
R 325. 1931	**Employees; general provisions.**
	(7) The home's administrator or its designees are responsible for evaluating employee competencies.
ANALYSIS:	Interviews conducted and review of employee training documentation revealed the facility does not have a program in place to ensure the competencies of facility medication technicians after completion of the MALA medication administration course and the on-the-job training completed at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kimberly Horst 12/8/2023

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 12/11/2023

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section