GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 5, 2024

Denice Wilson
Wilson Residential Care Services, Inc.
6450 Barnes Rd.
Millington, MI 48746

RE: License #: AS250268248
Investigation #: 2024A0580012
Buell Lake Center

Dear Denice Wilson:

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,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250268248
Investigation #:	2024A0580012
Complaint Receipt Date:	12/12/2023
Investigation Initiation Date:	12/15/2023
Report Due Date:	02/10/2024
Licensee Name:	Wilson Residential Care Services, Inc.
Licensee Address:	6450 Barnes Rd. Millington, MI 48746
Licensee Telephone #:	(989) 871-5090
Administrator:	Denice Wilson
Licensee Designee:	Denice Wilson
Name of Facility:	Buell Lake Center
Facility Address:	13481 Center Rd Clio, MI 48420
Facility Telephone #:	(810) 564-9569
Original Issuance Date:	11/04/2004
License Status:	REGULAR
Effective Date:	05/08/2023
Expiration Date:	05/07/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
On 10/13/23 Resident A's blood sugar was 504 and med records indicate Resident A was given more insulin than prescribed.	Yes

III. METHODOLOGY

12/12/2023	Special Investigation Intake 2024A0580012
12/12/2023	APS Referral This complaint was denied by APS for investigation.
12/15/2023	Special Investigation Initiated - Telephone Call to Kim Nguyen-Forbes, Recipient Rights, Genesee County.
12/19/2023	Inspection Completed On-site Unannounced onsite inspection.
12/19/2023	Contact - Face to Face Interview with direct staff, Raquel Bukoski.
01/03/2024	Contact - Telephone call made Call to Genesee Health Systems (GHS) Case Manager, Teevia Brown.
01/03/2024	Contact - Telephone call made Call to direct staff Mikayla Barringer.
01/04/2024	Contact - Face to Face Facetime video observation of Resident A.
01/05/2024	Contact - Telephone call made Call to Nurse Samantha Kellner.
01/05/2024	Contact - Telephone call made Call to Relative Guardian A.
01/05/2024	Exit Conference Exit conference with the licensee designee, Denice Wilson.
01/05/2024	Contact - Telephone call made Call to Kim Nguyen-Forbes, Recipient Rights, Genesee County.

ALLEGATION:

On 10/13/23 Resident A's blood sugar was 504 and med records indicate Resident A was given more insulin than prescribed.

INVESTIGATION:

On 12/12/2023, I received a complaint via BCAL Online complaints. This complaint was denied by APS for investigation.

On 12/15/2023, I spoke with Kim Nguyen-Forbes, assigned Recipient Rights Investigator in Genesee County. Kim Nguyen-Forges shared that that there is concern that staff in the home were instructed by Relative Guardian A to give Resident A more insulin than described. Documentation provided by staff indicate that Resident A was given 6 units of insulin on 10/13/2023. Resident A's blood sugar rose high that day. This is the only day within a 3-month time frame that Resident A was documented as having more insulin that required by his script.

On 12/19/2023, I conducted an onsite inspection at Buell Lake Center AFC. Contact was made with the home manager, Jillian Langworthy, who denied the allegations. Manager Langworthy stated that Resident A's guardian has expressed that Resident A be given more insulin when his blood sugar levels are high. Manager Langworthy informed Guardian A that an order from the physician would be needed to do so. Resident A has not had any incidences which required hospitalization due to his blood sugar. Resident A is currently out of the facility, attending workshop at Freedom Works. Resident a's diagnosis is Intellectually Disabled/Type 1 Diabetes.

While onsite I reviewed the October 2023 medication log for Resident A. It indicates that Resident A is prescribed Novolog Injection Flexpen. Instructions indicate to inject per sliding scale before meals. (151-230=2, 231-310=3, over 310 use 4 units). On 10/13/2023, the medication log indicates that Resident A was given 6 units of insulin during his 5pm injection, administered by direct staff, Mikayla Barringer. The Blood Sugar Reading log for Resident A has recorded that his blood sugar was 314 and rose to 504 that evening.

Residents were observed in their rooms, in the living room watching television and in both the kitchen and dining room areas if the home. They were adequately groomed and appeared to be receiving adequate care.

On 12/19/2023, while onsite, I interviewed direct staff, Raquel Bukoski. She denied the allegations that Resident A was overmedicated. Staff Bukoski stated that recently the nurse from GHS came out and asked what staff does when Resident A's blood sugar gets too high. Staff Bukoski stated that she informed the nurse that they do things such as give him water, vegetables and walk him around the facility. Staff Bukoski then asked the nurse if he can be given more insulin if needed.

On 01/03/2024, I spoke with Genesee Health Systems (GHS) Case Manager, Teevia Brown, assigned to Resident A. Teevia Brown shared that when she spoke with the home manager, Jillian Mari, she denied that Resident A has ever been given 6 units of insulin and staff must've made a documentation error. Case manager Brown has not had any prior concerns regarding Resident A's care in the home. Case manager Brown added that Resident A's high sugar levels have been a concern for some time. Guardian A had been resistant to dietician services; however, she has recently agreed.

On 01/03/2024, I spoke with direct staff Mikayla Barringer. She denied overmedicating Resident A stating that she has never given him 6 vials of mediation and must have written the number in error. Staff Barringer shared that the blood sugar levels on Resident A's log reflect his before dinner level of 314 and his after-dinner levels at 504.

On 01/04/2024, I conducted a Facetime video observation of Resident A. Resident A was observed fully clothed while in his bedroom, sitting on his bed. Resident A responded hello. Resident A acknowledged that he receives his insulin. Resident A could not say whether he had been given more than prescribed. While on camara, other residents in the home were observed walking about in the kitchen area of the home. They were groomed and appeared to be receiving adequate care.

On 01/05/2024, I spoke with GHS Nurse Samantha Kellner. Nurse Kellner stated that while vising the facility on 12/06/2023 and reviewing Resident A's medication logs for the months of September, October, and November 2023, she noticed that on 10/13/2023, Resident A's blood sugar levels peaked at 504. The medication log reflects that he was given 6 units of insulin. When asked how the facility addresses the resident's high blood sugar, staff Raquel Bukoski was present and responded that they contact Relative Guardian A who instructs them to give him additional insulin. Nurse Kellner stated that she informed Staff Bukoski that they would need a prescription to do so, due to the instructions stating that 4 injections is the maximum prescribed.

On 01/05/2024, I spoke with Relative Guardian A. She denied instructing the facility to give Resident A additional insulin when his blood sugar gets high. Relative Guardian A stated that she has however, given additional insulin when Resident A visits home. Relative Guardian A shared that Resident A visits with the Endocrinologist every 3 months to have his blood sugar levels assessed to determine the sliding scale. Resident A has not had his sliding sale changes in years and has always had issues with his blood sugar. Resident A has been in the home for the past 3 years. Staff have done an excellent job providing his care. Relative Guardian A stated that she does not have one bad thing to say about the home.

On 01/05/2024, I spoke with Kim Nguyen-Forbes, Recipient Rights, who stated that she has yet to complete her investigation. The licensing rule violation information was provided.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	It was alleged that Resident A's blood sugar was 504 and med records indicate the resident was given more insulin than prescribed. Based on a review of Resident A's October 2023 Medication Log which indicated that he was given 6 units of insulin, interviews conducted with the Home Manager Jillian Langworthy, direct staff members, Raquel Bukoski and Mikayla Barringer, RN at GHS, Samantha Kellner, Recipient Rights Investigator, Kim Nguyen-Forbes, GHS assigned case manager for Resident A, Teevia Brown, and Relative Guardian A, there is enough evidence to support this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/05/2024, I conducted an exit conference with the licensee designee, Denice Wilson. She was informed of the findings of this investigation.

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.

Sabrina McGowan January 5, 2024

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Sabrina McGowan Date
Licensing Consultant

Approved By:

Mary Holton January 5, 2024

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Mary E. Holton Date
Area Manager