GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 4, 2024

Thomas Quakenbush
Community Homes Inc
3925 Rochester Rd.
Royal Oak, MI 48073

RE: License #: AS630390444
Investigation #: 2024A0993005
Greer Home

Dear Mr. Quakenbush:

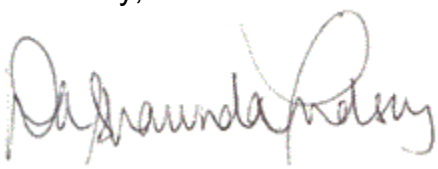
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630390444
Investigation #:	2024A0993005
Complaint Receipt Date:	11/30/2023
Investigation Initiation Date:	12/01/2023
Report Due Date:	01/29/2024
Licensee Name:	Community Homes Inc
Licensee Address:	3925 Rochester Rd. Royal Oak, MI 48073
Licensee Telephone #:	(248) 336-0007
Administrator:	Thomas Quakenbush
Licensee Designee:	Thomas Quakenbush
Name of Facility:	Greer Home
Facility Address:	2035 Lochaven Rd. West Bloomfield, MI 48324
Facility Telephone #:	(248) 336-0007
Original Issuance Date:	12/11/2018
License Status:	REGULAR
Effective Date:	06/11/2023
Expiration Date:	06/10/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was given the wrong medications by staff Raynesha Hawkins. Resident A was taken to the hospital.	Yes

III. METHODOLOGY

11/30/2023	Special Investigation Intake 2024A0993005
11/30/2023	Referral - Recipient Rights Allegations received from recipient rights advocate Kathleen Garcia
12/01/2023	Special Investigation Initiated - On Site Conducted an unannounced onsite investigation
12/05/2023	Contact - Telephone call made Telephone call made to staff Raynesha Hawkins
12/06/2023	Contact - Telephone call made Telephone call made to recipient rights advocate Kathleen Garcia
12/06/2023	APS Referral Forwarded allegations to adult protective services (APS)
01/02/2024	Contact - Telephone call made Telephone call made to Resident A at New Horizons Rehabilitation
01/03/2024	Exit Conference I attempted to hold exit conference with licensee designee Thomas Quakenbush. I left a message.

ALLEGATION:

Resident A was given the wrong medications by staff Raynesha Hawkins. Resident A was taken to the hospital.

INVESTIGATION:

On 11/30/2023, I received the allegations from recipient rights advocate Kathleen Garcia.

On 12/01/2023, I conducted an unannounced onsite investigation. I interviewed home manager Nicole Loafman. Ms. Loafman confirmed Resident A was given the wrong medications by staff Raynesha Hawkins, and Resident A was taken to the hospital. While preparing the medications at 7pm on 11/19/2023, Ms. Hawkins was distracted by Resident B. Ms. Hawkins accidentally administered Resident B's medications to Resident A. Ms. Loafman did not state which medications were administered to Resident A in error. Resident A was evaluated at the hospital and discharged back to the facility. Ms. Loafman stated Ms. Hawkins completed medication administration training.

While at the facility, I observed Resident A's medication administration record (MAR) for November 2023. The medications mistakenly administered to Resident A in November 2023 were Zocor 20mg, Melatonin 5mg, Luvox 100mg, and Sanctura 20mg. I observed Resident A's medication administration record (MAR) for December 2023 as well as Resident A's medications for that month. I did not observe any medication administration errors. I also observed a certificate verifying Ms. Hawkins completed medication administration training.

On 12/05/2023, I conducted a telephone interview with staff Raynesha Hawkins. Ms. Hawkins confirmed she administered Resident A the wrong medications, and Resident A was taken to the hospital. Ms. Hawkins stated she was distracted by Resident B while preparing the 7pm medications on 11/19/2023. Ms. Hawkins accidentally administered Resident B's medications to Resident A. Resident A was evaluated at the hospital and discharged back to the facility. Ms. Hawkins confirmed she completed medication administration training. Ms. Hawkins stated this was her first medication administration error.

On 12/06/2023, I conducted a telephone interview with recipient rights advocate Katie Garcia. She stated her investigation was pending.

On 12/06/2023, I forwarded the allegations to adult protective services (APS).

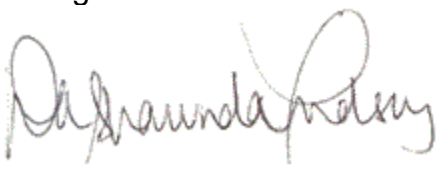
On 01/02/2024, I conducted a telephone interview with Resident A at New Horizons Rehabilitation. Resident A confirmed he was given the wrong medications and taken to the hospital. He stayed at the hospital for one day and was discharged back to the facility.

On 01/03/2023, I attempted to hold exit conference with licensee designee Thomas Quakenbush with no success. I left a message.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Ms. Hawkins administered Resident B's medications to Resident A on 11/19/2023. The medications mistakenly administered to Resident A in November 2023 were Zocor 20mg, Melatonin 5mg, Luvox 100mg, and Sanctura 20mg. Resident A was taken to the hospital, evaluated, and discharged back to the facility. While at the facility on 12/01/2023, I observed Resident A's medication administration record (MAR) for November and December. I also observed Resident A's December medications. I did not observe any other medication administration errors. I also observed a certificate verifying Ms. Hawkins completed medication administration training.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

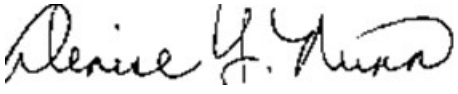
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



01/03/2024

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



01/04/2024

Denise Y. Nunn — Date
Area Manager