GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 23, 2024

Marlene Burgess
Alternative Community Living, Inc.
P. O. Box 190179
Burton, MI 48519

RE: License #: AS630012726
Investigation #: 2024A0991010
Rivers Edge

Dear Marlene Burgess:

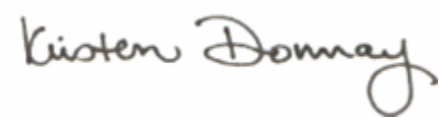
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012726
Investigation #:	2024A0991010
Complaint Receipt Date:	01/23/2024
Investigation Initiation Date:	01/24/2024
Report Due Date:	03/23/2024
Licensee Name:	Alternative Community Living, Inc.
Licensee Address:	P. O. Box 190179 Burton, MI 48519
Licensee Telephone #:	(989) 482-7039
Licensee Designee:	Marlene Burgess
Name of Facility:	Rivers Edge
Facility Address:	5345 Rivers Edge Commerce, MI 48382
Facility Telephone #:	(248) 505-1987
Original Issuance Date:	01/31/1992
License Status:	REGULAR
Effective Date:	10/01/2022
Expiration Date:	09/30/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff did not send Resident A's Clonazepam with him during a visit with his family on 01/18/24, so his mother gave him her prescribed Clonazepam.	Yes

III. METHODOLOGY

01/23/2024	Special Investigation Intake 2024A0991010
01/23/2024	APS Referral Received from Adult Protective Services (APS)- not assigned for investigation
01/24/2024	Special Investigation Initiated - Telephone Call to Office of Recipient Rights (ORR), Dawn O'Connor
01/24/2024	Referral - Recipient Rights Referred to Office of Recipient Rights
01/24/2024	Contact - Telephone call made Left message for guardian
01/24/2024	Contact - Telephone call received From Dawn O'Connor- ORR worker, not opening case for investigation
01/24/2024	Contact - Telephone call received Return phone call from guardian, interviewed Resident A's mother
02/01/2024	Inspection Completed On-site Unannounced onsite inspection, interviewed home manager
02/01/2024	Contact - Document Received Medication administration records, incident report
02/21/2024	Exit Conference Left message for licensee designee, Marlene Burgess

ALLEGATION:

Staff did not send Resident A's Clonazepam with him during a visit with his family on 01/18/24, so his mother gave him her prescribed Clonazepam.

INVESTIGATION:

On 01/23/24, I received an intake from Adult Protective Services (APS) alleging that Resident A went for a visit with his family, but staff did not include his Clonazepam medication. Resident A's mother gave Resident A her Clonazepam pills instead, as they are prescribed the same dose. APS did not assign the complaint for investigation. I initiated my investigation on 01/24/24 by making a referral to the Office of Recipient Rights (ORR).

On 01/24/24, I received a call from ORR worker, Dawn O'Connor. Ms. O'Connor stated that she spoke with the home manager from Rivers Edge, Rochelle Novak. Ms. Novak informed her that Resident A's Clonazepam is a PRN medication that is only given as needed. Their policy is that they do not send PRN medications with Resident A when he goes for visits with his parents unless they specifically ask for them. Ms. O'Connor stated that Resident A's mom asked the home manager to "reimburse her" with Resident A's Clonazepam pills because she gave Resident A her prescribed pills. The home manager did not give her any of Resident A's pills. Ms. O'Connor stated that she was not opening the complaint for investigation.

On 01/24/24, I left a message for Resident A's father who is his appointed guardian. He returned my call, but he did not wish to speak to me and passed the phone to Resident A's mother. Resident A's mother stated that last week Resident A came home for a weekend visit, but staff from the home did not send Resident A's Clonazepam. She stated that she thinks this medication is a PRN, but there was some discussion about having the psychiatrist switch it from a PRN to a regularly scheduled medication. She was not sure if this change happened. She stated that Resident A has obsessive compulsive disorder (OCD) and Asperger's and sometimes has issues when they are driving in the car. She stated that she likes him to be on his "tranquilizers" because of the issues in the car. She stated that Resident A typically comes to visit with his family for two to three days each week. This is the first time his medication was missing. Her husband went and picked up Resident A for the visit, and they did not give him Resident A's Clonazepam. All Resident A's other medications were provided for the visit. Resident A's mom stated that she is also on Clonazepam 1mg, so she gave Resident A some of her pills, because they could not get back to the home to pick up Resident A's medications right away. They went later and got more from the home. Resident A's mom stated that this was a one time thing and she does not have any other concerns about the home. She stated that Resident A would not be able to participate in an interview or answer questions about his medications.

On 02/01/24, I conducted an unannounced onsite inspection at Rivers Edge. I interviewed the home manager, Rochelle Novak. Ms. Novak stated that Resident A's Clonazepam is still prescribed as a PRN medication and is only given as needed. She stated that it is the home's policy that they only send the PRN medication with Resident A when he goes for a family visit if his parents ask for it. She did not have anything in writing that explained this policy. She stated that Resident A's father is his guardian, and he is aware of this policy. She stated that Resident A's father does not typically ask for the Clonazepam PRN. Resident A's mother, however, like to give Resident A his Clonazepam three times a day when he is with her. When Resident A went for his home visit on 01/18/24, they did not know that his mother would be there, as she had been in the hospital. Ms. Novak stated that Resident A left the home on Thursday, 01/18/24 at 12:40pm. Resident A's father called the home about the PRN medication on Friday night. Ms. Novak stated that Resident A's parents could come to the home to pick up the PRN medication if they need it. The next morning, Resident A's mother told staff that she had to give Resident A three of her own Clonazepam pills, so she asked them to "reimburse" her with three of Resident A's Clonazepam pills. Staff told her that this was not possible and Resident A's mother was not given any of Resident A's pills to make up for her own medication that she administered to him.

Ms. Novak stated that Resident A does not receive his Clonazepam often. This is the only psychiatric PRN medication that he is prescribed. She stated that Resident A sometimes gets agitated and anxious, so they give him the PRN. He is not overly aggressive. The medication was not changed to a regularly scheduled medication by the psychiatrist. It can be administered up to three times daily as needed. Ms. Novak stated that Resident A goes for family visits frequently and is usually gone for a few days each week. Resident A was not present at the facility during my onsite inspection on 02/01/24, because he was on a visit with his family. Ms. Novak stated that they gave Resident A's mom his PRN medications for this home visit.

I reviewed a copy of an incident report completed by the home manager, Rochelle Novak, dated 01/20/24. It notes that the home manager completed the form to report an incident that occurred with Resident A while he was out of the program and under his guardian's supervision at his home. At approximately 8:00pm on Friday, 01/19/24, staff received a phone call from Resident A's guardian stating that staff forgot to pack Resident A's PRN medication, Clonazepam 1mg, for his stay at his guardian's house. Staff stated that this is a PRN medication and not a routine medication, so this medication is not packed when Resident A leaves with his guardian unless requested. Around 8:30am on Saturday, 01/20/24, staff received another call from Resident A's mother, who is not his guardian, stating that she would be to the home within an hour to pick up Resident A's PRN medication for the rest of his stay, and that she needed to be reimbursed because she administered three of her own prescribed Clonazepam 1mg pills. She stated that the home owed her three of Resident A's pills. Staff told Resident A's mother that they could not reimburse her for anything. Resident A's guardian came to pick up Resident A's PRN medication for the rest of his stay and asked for the three pills that needed to go back to Resident A's mother. Staff again stated that they could

not reimburse Resident A's mother for any medication she gave Resident A. They could only provide his PRN medication for the days Resident A was scheduled to be with his guardian. The home manager reported the information to the Office of Recipient Rights, the responsible agency, Resident A's psychologist, and Adult Protective Services. The incident report notes that the manager will work with the clinical team regarding the incident and how to proceed in the future with visits outside the home.

I reviewed Resident A's medications, the December 2023 and January 2024 medication administration records (MARs), and his prescriptions. Resident A is prescribed Clonazepam 1mg tab, take one tablet by mouth three times a day as needed.

In December 2023, Resident A received his Clonazepam PRN fourteen times for agitation on 12/05, 12/06 (x2), 12/07, 12/08, 12/10, 12/11, 12/12, 12/13 (x2), 12/14, 12/19, 12/20, and 12/21. Resident A was out of the facility for fifteen days in December.

In January 2024, Resident A received his Clonazepam PRN eleven times for agitation on 01/05, 01/09, 01/10, 01/12, 01/14 (x2), 01/15, 01/16, 01/17, 01/23, and 01/30. Resident A was out of the facility for twelve days in January.

There was a note on the controlled narcotic sign out sheet on each of the three bubble packs indicating that two pills were given to Resident A's dad on 01/20/24. It also indicated that three pills were given to Resident A's mom from each bubble pack for his home visit on 02/01/24.

I reviewed a copy of Resident A's individual plan of service (IPOS) dated 12/01/2023. It notes "(Resident A) has a diagnosis of Schizophrenia, with fragmented thinking, paranoia, OCD, rituals, and fixations. He reports hearing voices, will talk to himself, with delusional thinking patterns. He has displayed aggression, verbal outbursts/oppositional behaviors. Contributing to issues is inconsistent presence at his group home (mother/parents pick him up frequently, will keep him for days). His diet is unregulated there, with significant weight gain. He is on medications but unsure whether these are taken consistently when not in the group home. Recent incident of aggression necessitated police intervention – he was jailed, and mother was hospitalized (Psychiatric); during prolonged period with no visitation/home visits per court order, (Resident A) stabilized and symptoms described above diminished. Issues have recently escalated."

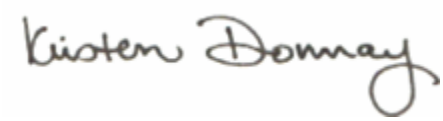
The IPOS notes that staff administer and monitor Resident A's medications. If Resident A goes home overnight, staff will provide his family with medications to cover his stay. Family will administer and monitor Resident A's medications during his visit and return any extra medications if needed. The IPOS does not stated that PRN medication will only be provided when requested.

On 02/21/24, I contacted the licensee designee, Marlene Burgess, via telephone to conduct an exit conference. Ms. Burgess was not available, so I left a detailed message regarding my findings.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A's guardian was not provided with all his medications when Resident A was out of the home from 01/18/24-01/22/24. Staff did not provide Resident A's guardian with Resident A's Clonazepam 1mg which is prescribed three times daily as needed. The home manager stated that the medication is only provided when the guardian asks for it and that Resident A does not regularly take the Clonazepam PRN. However, a review of Resident A's medication administration records showed that he was administered his Clonazepam PRN fourteen times in December 2023 and eleven times in January 2024 for agitation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

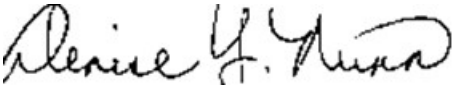


02/21/2024

_____

Kristen Donnay Date
Licensing Consultant

Approved By:



02/23/2024

_____

Denise Y. Nunn Date
Area Manager