GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

March 4, 2024

Marla Garchow
Heart and Soul Living, LLC
1855 Carlisle Road
Traverse City, MI 49696

RE: License #: AS280417032
Investigation #: 2024A0009015
Heart And Soul Living, LLC

Dear Ms. Garchow:

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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (616) 356-0100.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
701 S. Elmwood, Suite 11
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS280417032
Investigation #:	2024A0009015
Complaint Receipt Date:	02/22/2024
Investigation Initiation Date:	02/23/2024
Report Due Date:	03/23/2024
Licensee Name:	Heart and Soul Living, LLC
Licensee Address:	1855 Carlisle Road Traverse City, MI 49696
Licensee Telephone #:	(231) 342-4878
Administrator:	Marla Garchow
Licensee Designee:	Marla Garchow
Name of Facility:	Heart And Soul Living, LLC
Facility Address:	1855 Carlisle Road Traverse City, MI 49696
Facility Telephone #:	(231) 342-4878
Original Issuance Date:	10/04/2023
License Status:	TEMPORARY
Effective Date:	10/04/2023
Expiration Date:	04/03/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was given another resident's medication by mistake.	Yes

III. METHODOLOGY

02/22/2024	Special Investigation Intake 2024A0009015
02/23/2024	Special Investigation Initiated - On Site Interview with licensee designee Marla Garchow and direct care worker Diane Garchow
02/26/2024	Contact - Document received from licensee designee Marla Garchow
02/26/2024	Contact - Telephone call received from licensee designee Marla Garchow
02/26/2024	APS Referral
02/27/2024	Contact – Telephone call received from adult protective services worker Adam Bragg
02/28/2024	Inspection Completed On-site Interview with licensee designee Marla Garchow and direct care worker Tiffany Showalter Face to face contact with Resident A
02/29/2024	Contact – Telephone call made to Resident A's Guardian, voicemail full – sent text message
03/01/2024	Contact – Telephone call made to Resident A's Guardian
03/04/2024	Exit conference with licensee designee Marla Garchow

ALLEGATION: Resident A was given another resident's medication by mistake.

INVESTIGATION: I received an AFC Licensing Division – Incident/Accident Report (BCAL-4607) on February 22, 2024. It read, *'Getting meds ready to pass. Went to area where residents were sitting and spooned some of the meds to (Resident A)*

which were meant for another resident. Meds given accidently – Guanfacine 2 mg., Risperadone 4mg., Glypyrrolate, Vitamin D and Vitamin E.' The report indicated that the resident's physician, guardian and Community Mental Health (CMH) nurse were all contacted immediately about the medication error.

I made an unannounced site visit at the Heart And Soul Living, LLC adult foster care home on February 23, 2024. I spoke with licensee designee Marla Garchow at the time of my visit. She reported that the date of the medication error was February 19, 2024. The direct care worker involved, Tiffany Showalter, had recently changed from the night shift to the day shift. She had administered medication during the night shift, but these administrations were slightly different from what was given during the day and the change must have confused her. The two residents were sitting right next to each other at the time of the medication error. They both receive their pills in apple sauce. It was Ms. Marchow's understanding that Ms. Showalter simply erred when giving it to Resident A instead of the other resident. Ms. Showalter realized her mistake immediately and reported what had happened to the other direct care staff on duty, Diane Garchow. Ms. Diane Garchow reported it immediately to her and then called Resident A's physician, the CMH nurse and Resident A's guardian. They were told by Resident A's physician to monitor Resident A's blood pressure and respiration. They did this as well as kept a close eye on Resident A following the error. The CMH nurse and a nurse from the physician's office came to check on Resident A that day. Ms. Garchow stated that Resident A had not seemed her normal self for the next couple of days, so they kept her home from school. Ms. Showalter was removed from medication administration duties at that time. Ms. Garchow said that she spoke to Ms. Showalter about the need for her to stay focused during all medication administrations. Ms. Showalter is now scheduled to take a refresher course in medication administration.

I then spoke with direct care worker Diane Garchow who was present at the time of the medication error. I asked her about the medication error that had occurred on February 19, 2024. Ms. Diane Garchow reported that it was "totally accidental" on the part of Ms. Showalter. She said that Ms. Showalter was new to the day shift and that the medications are a bit different. It occurred at around 7:00 a.m. on February 19, 2024. Ms. Showalter had already given Resident A her medication but then gave her the other resident's medication as well. The two residents were sitting right next to each other. Ms. Diane Garchow stated that she did observe her putting the spoonful of applesauce with pills into Resident A's mouth but it was too late by then. Ms. Showalter also realized her mistake immediately. She said that she immediately called Ms. Marla Garchow who was out of town at the time and told her what had happened. Ms. Garchow told her to call the physician, CMH nurse and guardian. They did that and monitored Resident A's vitals as well as keeping a close eye on her after that. Ms. Diane Garchow confirmed that Ms. Showalter was immediately taken off medication administration duties following the incident. I asked her how Resident A was after taking some of the other resident's medication. Ms. Diane Garchow said that she was "acting very drugged". She couldn't hold her head up and her muscles were very limp. Resident A was not herself for the next two days.

Her vitals were fine during that time, though, and she did not seem to be in any major distress.

I received a telephone call from licensee Marla Garchow on February 26, 2024. She reported that there had been another medication error at the facility that day. Ms. Garchow stated that it involved the same staff member, same resident and same exact medication error. The only difference was that Resident A was not given as many of the other resident's medication in this instance. I asked Ms. Garchow about her report to me only days before that Ms. Showalter had been taken off medication administration duties for the time-being. She said that Ms. Showalter had been put back on medication administration duties "with supervision". Ms. Garchow said that she did a "med check" but admitted that she had turned her back for a moment when Ms. Showalter made the second error. I asked her if Ms. Showalter had undergone the refresher medication administration training. Ms. Garchow replied that Ms. Showalter had started it but had not yet completely finished it. I told Ms. Garchow that she absolutely needed to get a handle on this issue immediately. She said that Ms. Showalter was again removed from medication administration duties. I spoke with her about ways to ensure that the medication was given correctly such as residents coming up to the window one at a time and pictures being used to help identify the correct resident. Ms. Garchow said that she was going through their process to ensure that they are giving the "right medication to the right resident at the right time". She said that the CMH nurse had agreed to do a medication administration in-service at the facility for all the staff that week.

I received another AFC Licensing Division – Incident/Accident Report (BCAL-4607) from licensee Marla Garchow on February 26, 2024. This detailed the incident earlier that day in which direct care worker Tiffany Showalter had again erroneously given Resident A another resident's medication. This time, after looking at which pills remained, they determined that Resident A was only given the other resident's Risperadone, vitamin D and vitamin E.

I spoke with adult protective services worker Adam Bragg by telephone on February 27, 2024. He said that he had been assigned the matter of the successive medication errors that occurred at the Heart And Soul Living adult foster care home. He said that he planned on visiting the facility that day.

I made another unannounced site visit at the Heart And Soul Living, LLC adult foster care home on February 28, 2024. I spoke with licensee Marla Garchow at that time. She reported that the adult protective services worker had been to the facility as well as someone from the CMH Office of Recipient Rights. Ms. Garchow said that she has already instituted having residents come up to the door to the medication room or be brought up to the door by another staff person. She said that each staff will need to ensure that they have the right medication for the right resident at the right time. She said that the CMH nurse still planned on conducting the medication administration in-service later that afternoon.

I spoke with direct care worker Tiffany Showalter at the time of my site visit. I asked her about the medication errors she was involved in. Ms. Showalter said that she had always worked the night shift but had changed to the day shift on the day of the initial medication error. She said that she had administered medication during the night shift and never made any mistakes. Ms. Showalter said that she would give Resident A her Fiber Therapy powder which is orange in color at night and she was the only one who received the powder. During the day shift, another resident gets the Fiber Therapy powder as well which is what confused her. She mixed in the other resident's orange powder and just thought in her mind that she was giving it to Resident A. Ms. Showalter confirmed that she gave Resident A the other resident's medication in error on February 19, 2024. This included the other resident's Guanfacine, Risperadone, Glycopyrrolate and two vitamins. Ms. Showalter confirmed that they then called licensee designee Marla Garchow, the physician, CMH nurse and Resident A's guardian. I asked her what they observed with Resident A after she received the other resident's medication. Ms. Showalter stated that Resident A was really drowsy for the rest of the day. They kept checking her vitals and made sure she ate food and drank a lot of liquid. I asked her about the second medication error, two days before. Ms. Showalter said that she felt that the powder issue just confused her again. She said that she has not administered medication since the second error. She said that she might be better at providing resident care than medication administration. Ms. Showalter said that basically they contacted everyone again and had to observe Resident A. She was drowsy again but it was not as pronounced. This was likely due to the fact that she did not get all of the other resident's medication the second time.

I had face-to-face contact with Resident A at the time of my site visit. She was in good spirits at the time of my visit and appeared generally well-cared for at that time.

I spoke with Resident A's guardian by telephone on March 1, 2024. She said that she had been informed of both medication errors regarding her daughter. She had been told both times on the same days that they occurred. Nothing like that had happened before. She had previously been really happy with her daughter's care at the facility. She did still trust them to care for her daughter and did not think it would happen again.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Resident A was given another resident's medication on two separate occasions. These medication errors occurred on February 19, 2024 and then again on February 26, 2024. Resident A was "acting very drugged" and could not hold her

	head up after being given the wrong medication the first time. She missed two days of school because of the medication error. Her reaction was reportedly not as pronounced the second time since she had only gotten some of the other resident's medication. In consideration of the above information, it is determined that the licensee did not take reasonable precautions to insure that prescription medication was not used by a person other than the resident for whom the medication was prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee Marla Garchow by telephone on March 04, 2024. I told her of the findings of my investigation and gave her the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend a six-month provisional license for the above summarized quality of care violation.

03/04/2024

Adam Robarge Date
Licensing Consultant

Approved By:

03/04/2024

Jerry Hendrick Date
Area Manager