GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 23, 2024

Linda Rice
535 Gilletts Lk. Rd.
Jackson, MI 49201

RE: License #: AL380007070
Investigation #: 2024A0007010
Rice Manor

Dear Ms. Rice:

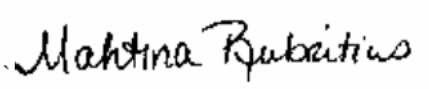
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9720.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL380007070
Investigation #:	2024A0007010
Complaint Receipt Date:	01/02/2024
Investigation Initiation Date:	01/04/2024
Report Due Date:	03/02/2024
Licensee Name:	Linda Rice
Licensee Address:	535 Gilletts Lk. Rd. Jackson, MI 49201
Licensee Telephone #:	(517) 937-2017
Administrator:	David Rice Jr.
Licensee Designee:	Linda Rice
Name of Facility:	Rice Manor
Facility Address:	356 South Union St Parma, MI 49269
Facility Telephone #:	(517) 531-3005
Original Issuance Date:	06/23/1999
License Status:	REGULAR
Effective Date:	09/12/2022
Expiration Date:	09/11/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff discovered that six of Resident A's Klonopin were missing from the bubble pack. Concern that an employee took the medication.	Yes

III. METHODOLOGY

01/02/2024	Special Investigation Intake - 2024A0007010
01/02/2024	Contact - Telephone call made to Devin Pickett, Adult Protective Services.
01/04/2024	Special Investigation Initiated - On Site - Unannounced Face to face contact with Employee #2, Resident A, other staff and residents.
02/20/2024	Contact - Telephone call made to facility. No answer.
02/20/2024	Contact - Telephone call made to Glenda Taber, Administrative Staff. Message left. I requested a returned phone call.
02/21/2024	Inspection Completed On-site - Unannounced - Face to face contact with Employee #1, other residents, and staff.
02/21/2024	Contact - Telephone call received from Glenda Taber, Administrative Staff. She will send me the contact information and documents.
02/21/2024	Contact - Telephone call made to Guardian A1. Case discussion.
02/21/2024	Contact - Document Received - Photocopies of bubble packs and memo to staff.
02/22/2024	Contact - Telephone call made Glenda Taber, Administrative Staff. Interview.
02/22/2024	Contact - Telephone call made to Employee #3. Message left. I requested a returned phone call.
02/22/2024	Contact - Telephone call made to Employee #1. Message left. I requested a returned phone call.
02/22/2024	Contact - Telephone call made to LaShanda Walker, ORR, no answer.

02/22/2024	Contact - Document Sent - Email sent to LaShanda Walker, ORR, regarding investigation.
02/22/2024	APS Referral made.
02/22/2024	Contact - Telephone call received from Employee #3. Interview.
02/22/2024	Contact - Telephone call received from Employee #1. Interview.
02/23/2024	Exit Conference – Conducted with Linda Rice, Licensee Designee.

ALLEGATION: Staff discovered that six of Resident A's Klonopin were missing from the bubble pack. Concern that an employee took the medication.

INVESTIGATION:

On January 4, 2024, I conducted an unannounced on-site investigation and made face to face contact with Employee #2. She informed me that Resident A was sleeping. I observed Resident A in her room asleep.

I interviewed Employee #2 about Resident A's medications. According to Employee #2, Employee #3 works third shift and when she (Employee #2) came to work (for 1st shift), Employee #3 asked her if she would count the medications with her, as the medication count was off. Employee #2 stated she counted the medications, and confirmed Resident A's medication count was not accurate. Employee #2 stated direct care staff had taken photocopy of the medication bubble pack and placed the copy under Glenda Taber, Administrative Staff's office door, so she would have the information when she arrived to work in the morning. Employee #2 stated Employee #3 went to retrieve the photocopy and noted it did not match the bubble pack. Employee #2 stated she told Employee #3 to take another photocopy of the bubble pack to give to the administrative staff members Glenda Taber and Teri Miskowski for review.

According to Employee #2, Employee #1 worked the previous night when something changed with Resident A's medication. Employee #2 did not provide any details on what changed with Resident A's medications. Employee #2 stated direct care staff are supposed to keep the medication keys on their person during shift. In addition, direct care staff are supposed to count medications together, but they have been "slacking" completing this process according to Employee #2.

According to Employee #2, Resident A did not go without her medications and this information was not mentioned to Resident A. Employee #2 reported that she did not know if Guardian A1 had been notified about the situation.

On February 21, 2024, I conducted an unannounced on-site investigation and made face to face contact with Employee #2, residents, and staff. Employee #2 stated that Resident A was asleep. I reinterviewed Employee #2, as I had follow-up questions and needed clarification. Employee #2 stated that Employee #3 had taken a photocopy (Photocopy #1) of the bubble pack, and she had already placed it under Glenda Taber's door. Photocopy #1 was retrieved. Employee #2 stated she completed a medication count but it did not match with Employee #3's count, as documented on Photocopy #1. According to Employee #2, Employee #3 "freaked out." A photocopy of the bubble pack was taken again (Photocopy #2), to document the additional missing medications. Employee #2 informed me that there were two different photocopies of the same bubble pack. Employee #2 and Employee #3 compared the two photocopies and noted the missing medications and medication count discrepancies.

On February 21, 2024, I spoke with Glenda Taber, Administrative Staff. She informed me that she would send me the staff contact information, copies of the bubble packs, and a memo that was provided to staff.

On February 21, 2024, I spoke with Guardian A1. She stated that ORR had notified her regarding the compliant. Guardian A1 stated that they typically have two direct care staff administering the medications, as well as other safeguards in place. Guardian A1 stated that Terry Miskowski, Administrative Staff, was upset about the missing medications and was reviewing the medications and patterns, to determine if additional information could be gathered. Guardian A1 stated that there was also a new staff in the facility; however, it was unclear who took the medications. Guardian A1 reported that she had not heard a final decision from ORR regarding the conclusion of their investigation.

As a part of this investigation, I reviewed documents gathered during the facility's internal investigation and authored by administrative staff members Glenda Taber and Terry Miskowski.

- It that noted that on December 20, 2023, Resident A's medications were given as prescribed. It was also documented that on December 20, 2023, at 5:28 p.m., Employee #3 notified management that the controlled medication count was off. Employee #3 was advised to make a copy of the bubble packs and document the actual count she completed on the controlled count sheet, and the matter would be investigated in the morning. The following morning, the medication count was off again. The medication count was also completed on 3rd shift.

- The administrative staff spoke to Employee #3, who reported seeing Employee #1, who was a new employee in the medication room that night. Employee #1 was not trained to pass medications, so she had no reason to be in the medication room. When administrative staff asked Employee #3 where her medication keys were located, she informed administrative

staff that she left them laying on the desk. It was also documented that Employee #3 had been employed with the home since April of 2022, and there had never been an issue like this when she has worked.

- Administrative staff also met with Employee #1 who denied taking the medication or being in the med room. Employee #1 was removed from the schedule and sent for a drug test.

I also reviewed the photocopies of the bubble packs with the missing medications. While the photocopies were poor quality and difficult to read, I was able to see where staff circled the missing medications on the bubble packs. I was not able to see any dates on the bubble packs.

On February 22, 2024, I spoke with Glenda Taber, Administrative Staff. We reviewed and discussed the photocopies. She informed me that Resident A is prescribed Clonazepam (generic for Klonopin) 1mg (PRN) and Clonazepam 2mg (I tablet, by mouth, once daily), and these were the missing medications.

According to Glenda Taber, Employee #3 contacted her inquiring what to do because the controlled medication count was not accurate. Glenda Taber stated she instructed her to make a copy of the bubble pack and document the information. Glenda Taber stated the next morning, when the medications were counted again, two additional pills were missing from when Employee #3 first discovered the missing medications. Glenda Taber stated there was a total of five missing pills. Employee #1 and Employee #3 were the staff on duty when the additional two pills went missing. Glenda Taber asked Employee #3 where her keys were, and she informed that she removed them to clean, placing them on the staff desk. According to Glenda Taber, Employee #3 also reported to see Employee #1 in the medication room. Glenda Taber stated that Clonazepam is a controlled substance and it's locked in the medication room, inside a lock box.

Regarding Employee #1 completing a drug screen, Glenda Taber stated Employee #1 completed a 10-panel test, which was negative, except for marijuana.

Glenda Taber informed me that a memo was sent to staff regarding the expectations related to medication practices and consequences for not following the protocols.

On February 22, 2024, I interviewed Employee #3. She informed me that it is routine for her to have other staff recheck her medication count, to ensure consistency and accuracy. According to Employee #3, at the end of shift (on the day in question), Employee #4 checked the meds, and he had the same count as she did. Employee #3 stated that she contacted Glenda Taber and Teri Miskowski, about the med count being off, made a copy of the bubble pack and put it in an envelope in the administrative office. Once completed, they closed the med room and Employee #4 left, and Employee #1 arrived for shift.

According to Employee #3, when Employee #2 arrived for her shift at 6:00 a.m., she counted the pills, and the count was “way off.” Employee #3 stated “I was tripping out!” She then went and retrieved the copy of the bubble pack from the office to show Employee #2 the previous counts. They made another copy of the bubble pack. Employee #3 stated that she told Employee #2, that she did not understand what happened and why there were more missing medications. Employee #3 stated she did not recall exactly how many pills were missing but believed there were six to eight pills gone. Employee #3 stated it was only she and Employee #1 on duty and she (Employee #3) did not take the medications.

I inquired about her keys, and Employee #3 informed me that she had placed them on the staff desk, while she was cleaning, as she was afraid that they would fall out of her pocket into the toilet. Employee #3 stated that she went outside for a smoke break, around 3:00 a.m. and she could see Employee #1 in the med room. She stated the only the light over the desk was on, but it was enough light to illuminate the room. Employee #3 stated that she asked Employee #1 why she was in the med room and Employee #1 said she wasn’t.

On February 22, 2024, I interviewed Employee #1. She stated that she is not trained to administer resident medications, so she had no reason to be in the medication room. She denied taking Resident A’s medications. She confirmed that the administrative staff also interviewed her regarding this matter and that she was suspended, and drug tested. According to Employee #1, her drug test came back clean, and she returned to work. Since this incident, they reinstated facility policies, including staff must count meds after each shift, instead of just passing off the keys.

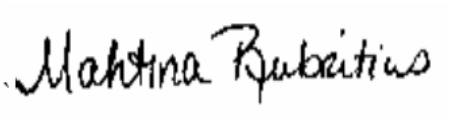
On February 23, 2024, I conducted the exit conference with Linda Rice, Licensee Designee. She informed me that she was aware of the situation and the memo had been sent to staff regarding the expectations. I informed her of my findings and recommendations. Linda Rice agreed to submit a written corrective action plan to address the established violation.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

ANALYSIS:	Resident A is prescribed Clonazepam (generic for Klonopin) 1mg (PRN) and Clonazepam 2mg (I tablet, by mouth, once daily). Employee #3 completed a controlled substance medication count for Resident A's Clonazepam and discovered that the count was off. She contacted the administrative staff once the discovery was made. Employee #2 also reviewed the medications and found that the med count was inaccurate. Photocopies of the bubble pack were taken on two occasions to document the discrepancies. I reviewed the photocopies of the bubble packs and observed where staff circled the missing medications on the bubble packs verifying five pills were missing. Administrative staff member Glenda Taber stated there was a total of five missing pills as well. Employee #1 and Employee #2 denied taking Resident A's medications. While it is unknown who took the medication, there is a preponderance of the evidence to support the allegations that at least five of Resident A's prescribed medication (Clonazepam) were missing and taken by someone for whom the medication was not prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains the same.



02/23/2024

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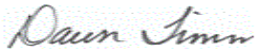
Mahtina Rubritius Date
Licensing Consultant

Approved By:



02/23/2024

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Dawn N. Timm Date
Area Manager