GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Karen LaFave
Adult Learning Systems - UP, Inc
Suite-4
228 West Washington
Marquette, MI 49855

March 25, 2024

RE: License #: AS520302805
Investigation #: 2024A0873011
Woodridge

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,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
234 W. Baraga Ave.
Marquette, MI 49855
(906) 250-9318

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS520302805
Investigation #:	2024A0873011
Complaint Receipt Date:	02/05/2024
Investigation Initiation Date:	02/05/2024
Report Due Date:	04/05/2024
Licensee Name:	Adult Learning Systems - UP, Inc
Licensee Address:	Suite-4 228 West Washington Marquette, MI 49855
Licensee Telephone #:	(906) 228-7370
Administrator/ Licensee Designee:	Karen LaFave
Name of Facility:	Woodridge
Facility Address:	169 Fairbank Street Marquette, MI 49855
Facility Telephone #:	(906) 273-1100
Original Issuance Date:	10/01/2009
License Status:	REGULAR
Effective Date:	03/21/2022
Expiration Date:	03/20/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A's medications are missing	Yes
Additional Findings	No

III. METHODOLOGY

02/05/2024	Special Investigation Intake 2024A0873011
02/05/2024	Special Investigation Initiated - Telephone Interview with Lydia Fenton
02/05/2024	APS Referral referred to APS
02/08/2024	Contact - Face to Face Staff interviews at Adult Learning Systems
02/15/2024	Inspection Completed On-site
03/18/2024	Contact - Telephone call made Interview with pharmacy manager at LT Pharmacare
03/25/2024	Inspection Completed-BCAL Sub. Compliance
03/25/2024	Exit Conference with Karen LaFave

ALLEGATION:

Resident A's medications are missing.

INVESTIGATION:

On 2/2/24, I received a phone call from Lydia Seibert, area manager for Adult Learning Systems (ALS), to report that Woodridge had about 150 doses of lorazepam missing. L.T. Pharmacare, the pharmaceutical distributor who delivered the shipment of medications to the home, believes the lorazepam were delivered. Staff at the home disputed this. According to the home, the package of medication

was delivered to the home in a closed box, taken to the med room, and opened by the home manager and assistant manager.

On 2/8/24, I interviewed home manager Cherry Mashue at the home. Ms. Mashue reported that she came into work on 1/29/24, at 7pm and noticed the delivered package of medications in a common area. She brought the package to the staff office but did not lock the door. Ms. Mashue remembers staff Senia Pohlman and assistant manager Daisy Mae Beauchamp were at the home when the medications were delivered. On 1/31/24 Ms. Mashue came into work at 9:30pm and gave the box of medications to staff Michelle Metternich and staff Leah Fortino to put them away.

On 2/8/24, I interviewed staff member Senia Pohlman at the home. Ms. Pohlman reported that she has been employed at the home for a little over 9 months. During that time she has never signed off on medications delivered and is unsure of if there is an official process to follow when medications are delivered. Ms. Pohlman reported that assistant manager Beauchamp was the one that received and signed off on the medications being delivered but then put the box down in the common area because she had to run to the bathroom.

On 2/8/24, I interviewed assistant manager Daisy Mae Beauchamp at the home. Ms. Beauchamp reported she was the one that accepted the medication delivery from L.T. Pharmacare. Ms. Beauchamp reported that she took the box of medication and brought it into the med room. Ms. Beauchamp reported that the box of medication was moved from the med room to the staff office, but she was not sure why or when this occurred.

On 2/8/24, I interviewed staff member Michelle Metternich at the home. Ms. Metternich reported that L.T. Pharmacare delivers medications once per month in an unsealed box with the controlled medications in a bag separated from the rest. Ms. Metternich reported that Ms. Beauchamp accepted the medication delivery that day and placed the box in the staff office without checking them. Ms. Metternich reported that when she later saw inside the box, she noticed the bag of controlled medications was not there but assumed it had been placed in the office so was not concerned about it.

On 2/8/24, I interviewed staff Leah Fortino at the home. Ms. Fortino reported that she has been employed by ALS for about a year and in that time, she has never had any problems with medications being delivered or going missing. In her experience Ms. Beauchamp or Ms. Mashue will check the medications when delivered and then Ms. Metternich will put them in the med room. Ms. Fortino also reported that she observed the box of medications in both the staff office and the med room at different times of the day.

During the course of the interviews, several staff reported that although Resident A’s medications went missing, staff were able to obtain more lorazepam to ensure she did not miss a dose.

On 2/15/24, I completed an on-site inspection of the home. While there I observed where the meds were delivered and where they should have gone. If, according to some staff, the meds were left in the “common area,” this would allow staff as well as residents to have access to the medications. I was told the staff did a thorough search of the home and have not found the medications anywhere. Staff did not believe that any resident would have taken the medications.

On 3/18/24, I interviewed L.T. Pharmacare pharmacy manager Natalie Smith by phone. Ms. Smith reported she has been in that position for about a year and has never had medications go missing. She is responsible for ensuring her staff get the medications ready in bubble packs and she is the last person to look over the medications before they are given to the delivery driver. The driver who took the delivery that day reported to her that staff did not look in the medication box when it was delivered. Ms. Smith reported to me that, since this incident occurred, they have instituted policy changes which include having the delivery driver call L.T. Pharmacare if staff at a home do not check the medications to ensure all of them are there. If this occurs L.T. Pharmacare will not deliver the meds and will instead attempt to contact the home’s management.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	After conducting interviews with several staff, it seems that there is no protocol for staff at the home to follow when medications are delivered. Many of the staff members interviewed had conflicting narratives about what occurred the day the medications were delivered and remembered seeing the box of medications in several places throughout the home over the course of several days. When delivered, the box is not sealed, leaving them accessible to anyone in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/25/24, I shared the results of this report with license designee Karen LaFave. Ms. LaFave agreed with the findings and explained that ALS is working on a better system to have medications delivered to the home and are now having staff count the medications with the driver as they are delivered.

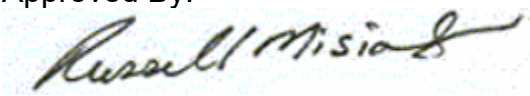
IV. RECOMMENDATION

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

3/25/24

Garrett Peters — Date
Licensing Consultant

Approved By:



3/27/24

Russell B. Misiak — Date
Area Manager