GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 27, 2023

Lela Shank
Country House Care, L.L.C.
1395 Seneca Street
Adrian, MI 49221

RE: License #: AL460342573
Investigation #: 2024A1032006
Country House Care

Dear Lela Shank:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL460342573
Investigation #:	2024A1032006
Complaint Receipt Date:	10/31/2023
Investigation Initiation Date:	11/01/2023
Report Due Date:	12/30/2023
Licensee Name:	Country House Care, L.L.C.
Licensee Address:	1395 Seneca Street, Adrian, MI 49221
Licensee Telephone #:	(517) 442-2164
Licensee Designee:	Lela Shank
Name of Facility:	Country House Care
Facility Address:	3339 Parr Highway, Adrian, MI 49221
Facility Telephone #:	(517) 264-9520
Original Issuance Date:	09/07/2013
License Status:	REGULAR
Effective Date:	05/06/2022
Expiration Date:	05/05/2024
Capacity:	15
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
An employee was dispensing medication incorrectly.	Yes
Resident A was not given his medication during a leave of absence from the home.	Yes
Additional Findings	No

III. METHODOLOGY

10/31/2023	Special Investigation Intake 2024A1032006
11/01/2023	Special Investigation Initiated - Letter Conformed allegations with the source
11/03/2023	Inspection Completed On-site
11/14/2023	Exit Conference

ALLEGATIONS:

An employee was dispensing medication incorrectly.

INVESTIGATION:

On 11/1/23, I confirmed the accuracy of the complaint information with the complainant.

On 11/3/23, I interviewed employee Bryan Bornson at the home. Mr. Bornson stated that he has been employed at the home for approximately one month but has worked in other Adult Foster Care homes. He denied receiving formal training in passing medications. He acknowledged that there were medication errors being made by him, because sometimes when he opened the medication packets, some of

the pills fell out. This resulted in loose pills in the medication box. He stated that this issue had been corrected.

I observed the medication box, and there were no loose pills. The medications were all in their original packages.

I observed Resident A's medication administration record. The document revealed an error, that a staff member had signed for dispensing medication during Resident A's absence from the home for the morning that he was not there.

I interviewed employee Lakisha Washington at the home. Ms. Washington advised that she is trained in dispensing medication and is the live-in employee at the home. I advised Ms. Washington that I could provide her with a training module to share with Mr. Bornson, to expand his awareness of medication management. Ms. Washington agreed to do so and provided an email address to forward the training module.

I forwarded video training modules obtained from the Licensing and Regulatory Affairs website to Ms. Washington's email address.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

ANALYSIS:	Mr. Bornson acknowledged that he was not trained to pass medications, and this lack of training may have resulted in medication errors, such as pills not in their original packaging. There was also an instance noted where someone signed that a medication was dispensed, despite the fact that the resident was not on site that morning and was not given a supply of medication when he left.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

Resident A was not given his medication during a leave of absence from the home.

INVESTIGATION:

On 11/3/23, I inquired about Resident A leaving the home for an overnight outing without a supply of medication. Mr. Bornson stated that the family left before he realized his error, but he was unable to contact the family to return to the home to retrieve the prescriptions.

I interviewed Resident A in the home. Resident A stated that he recently went to a funeral with family and left the home on the evening of October 27th and returned late in the afternoon on the 28th. He denied having a supply of medication sent with him. He reported that he is prescribed morning medications.

APPLICABLE RULE	
R 400.15312	**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:	Both Mr. Bornson and Resident A acknowledged that Resident A left the home without a supply of his morning Medication, and that arrangements were not made to provide the medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/14/23, I conducted an exit conference with licensee designee Lela Shank. I shared my findings and Ms. Shank agreed to provide an acceptable corrective action plan.

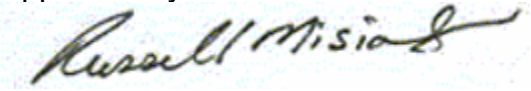
IV. RECOMMENDATION

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

11/27/23

Dwight Forde Date
Licensing Consultant

Approved By:



12/5/23

Russell B. Misiak Date
Area Manager