GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 21, 2024

Jessica Kross
Pine Rest Christian Mental Health Services
300 68th Street SE
Grand Rapids, MI 49548

RE: License #: AL410289728
Investigation #: 2024A0340030
InterActions Residential Treatment

Dear Mrs. Kross:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On May 6, 2024, you submitted an acceptable written corrective action plan. It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved 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) 356-0183.

Sincerely,

Rebecca Piccard

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410289728
Investigation #:	2024A0340030
Complaint Receipt Date:	04/16/2024
Investigation Initiation Date:	04/16/2024
Report Due Date:	06/15/2024
Licensee Name:	Pine Rest Christian Mental Health Services
Licensee Address:	300 68th Street SE Grand Rapids, MI 49548
Licensee Telephone #:	(616) 455-5000
Administrator:	Candy McKenney
Licensee Designee:	Jessica Kross
Name of Facility:	InterActions Residential Treatment
Facility Address:	300 68th St. SE Grand Rapids, MI 49548
Facility Telephone #:	(616) 493-6013
Original Issuance Date:	09/15/2008
License Status:	REGULAR
Effective Date:	03/15/2023
Expiration Date:	03/14/2025
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was prescribed a ten-day regimen of Bactrim due to infection. During the ten days he missed seven doses.	Yes

III. METHODOLOGY

04/16/2024	Special Investigation Intake 2024A0340030
04/16/2024	APS Referral
04/16/2024	Special Investigation Initiated - Telephone Candy McKenney
04/26/2024	Inspection Completed On-site
05/06/2024	Contact - Telephone call made Candy McKenney
05/07/2024	Exit Conference Designee Jessica Kross

ALLEGATION: Resident A was prescribed a ten-day regimen of Bactrim due to infection. During the ten days he missed seven doses.

INVESTIGATION: On April 16, 2024, a complaint was filed with BCAL Online Complaints stating Resident A was receiving wound care and had been prescribed a 10-day regimen of Bactrim. Resident A did not receive seven doses during this regimen.

On April 16, 2024, the allegations were reported to Adult Protective Services (APS).

On April 16, 2024, I contacted Administrator Candy McKenney. She informed me that this issue is from December 2023. The wound Resident A sustained (self harm) at that time for which he needed the Bactrim has now completely healed. She stated Recipient Rights (ORR) had investigated the incident at that time and did substantiate a violation. Resident A is from Kalamazoo County. Ms. McKenney implemented a corrective action plan she sent to ORR when the medication errors were discovered. Staff were written-up as appropriate and all staff have been re-trained in medication passing.

On April 26, 2024, I conducted an unannounced home inspection. Due to his cognitive development, Resident A was unable to discuss his injury or remember if all medications prescribed to him were administered from last December.

On May 6, 2024, I spoke with Ms. McKenney. I requested the Medication Administration Record (MAR), Incident Reports (IR) and ORR report regarding this complaint which she sent on this day. I asked her about the Medication Administration Record for Resident A's Bactrim prescription. She stated that because the medication was to be given twice a day for the 10-day period, there was more than one packet and the other packet was put in another drawer of the medication cart for an unknown reason and staff failed to look for it or find it in the other drawer. Ms. McKenney provided education to staff at the time she found out that this error occurred. A Corrective Action Plan has previously been sent to ORR.

I reviewed the documents sent by Ms. McKenney. There is an IR dated 1/30/24, signed by Caylee Dysinger, Psych Tech which states on 12/22/23 Resident A did not receive his Bactrim because it was not available in the medication cart. There was another IR sent by Ms. McKenney signed 1/31/24 by Chase Hunter, Psych Tech. It states that on 12/27/23 Resident A did not receive his Bactrim because it was not available in the medication cart.

I reviewed the MAR from December 2023 for Resident A. The prescription for the Bactrim was 2 tablets every 12 hours to begin 12/21/2023 and end on 12/31/2023. It was ordered by Kara Noseda, PA. The following medication passes were recorded to have been missed:

- 12/22/23 - AM
- 12/23/24 – AM
- 12/24/23 – AM & PM
- 12/25/23 – AM
- 12/27/23 – AM
- 12/28/23 – AM

I received the ORR report dated March 20, 2024, which included interviews of home manager Diane Salsbury. Ms. Salsbury stated the Bactrim was packaged differently from the pharmacy due to it being prescribed for 10 days. Ms. Salsbury acknowledged that the Bactrim was missed on more than one occasion, but the medication was in the cart. She stated that she believed staff did not look for it and should have contacted management or call the pharmacy to resolve the issue.

Staff Briana Stone was interviewed but she no longer works at Interactions. Ms. Stone was a trained medication technician. She stated that there were times when the Bactrim was not administered because the medication was not available. She stated that normally in these situations she would ask a coworker for assistance or call for assistance but she does not remember what she did back in December of last year.

Supervisor Greg Williams was interviewed and stated that the Bactrim was not out of stock but was in a different location due to being only a 10-day prescription and dispensed from a different container, so it was not hanging with the daily medications. Mr. Williams stated that if staff would have contacted him for assistance, he would have shown them where the medication was located.

Staff Chase Hunter was interviewed. He stated he is a trained medication passer and does administer medications. Mr. Hunter stated he worked on Christmas Day, 12/25/23. He stated he could not find the Bactrim for Resident A because it was not in the medication cart. He knew the medication had been ordered but thought it had not yet been delivered to the home. It was on the MAR but could not be found. Mr. Hunter was unable to confirm this because it was Christmas Day and the pharmacy was closed.

Staff Dennis Moore was interviewed. Mr. Moore is a medication administrator and worked on 12/28/2023. Mr. Moore did not remember the incident of the Bactrim medication missing. He stated that if the medication was not administered then it must not have been available at the time. Normally, if he cannot find a medication, he would call nursing and the pharmacy but he does not remember if he called on this occasion.

Staff Samuel Osusa-Oteto was interviewed. He is trained to administer medication. He stated that on 12/24/23 during the evening medication administration he did not provide Resident A with the Bactrim because it was not available. Mr. Osusa-Oteto remembered asking someone about this but did not remember who it was. He stated the medication was not in the medication cart.

I reviewed the MAR for Resident A. He was prescribed sulfamethoxaxole-trimethorprim (Bactrim DS; Septra DS) 800-160 MG tablet; 2 tablet dose to be given every 12 hours for infection beginning 12/21/23. The following med passes were recorded to have been missed:

- 12/22/23 - AM
- 12/23/24 – AM
- 12/24/23 – AM & PM
- 12/25/23 – AM
- 12/27/23 – AM
- 12/28/23 – AM

Ms. McKenney provided me with a copy of the Corrective Action Plan (CAP) she submitted to ORR. The CAP has already been implemented and education and staff discipline has already occurred.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The allegation was made that Resident A was not given medication as prescribed. Ms. McKenney provided documentation for the incident as well as the Corrective Action Plan she has already implemented. She confirmed that Resident A did not receive all his prescribed Bactrim as ordered due to staff not following protocol when they could not find the medication because the medication was in the cart, but not in the normal packaging or location. Resident A's MAR does document missed med passes on 7 occasions. Staff Sone, Moore, Osusa-Oteto, and Hunter admitted to not passing Resident A his Bactrim due to it not being available. There is a preponderance of evidence that Resident A did not receive all of his prescribed Bactrim. A rule violation is being cited.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On May 7, 2024, I conducted an exit conference with Designee Jessica Kross. We discussed the allegation and I informed her of the above-cited rule violation but also that Ms. McKenney had sent an approved CAP. She agreed and had no further questions.

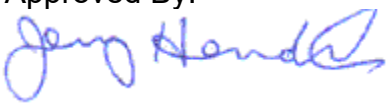
IV. RECOMMENDATION

An approved Corrective Action Plan has been received and implemented. I recommend no change to the current license status is recommended.

Rebecca Piccard May 21, 2024

Rebecca Piccard Date
Licensing Consultant

Approved By:



May 21, 2024

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Jerry Hendrick Date
Area Manager