STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

May 22, 2024

Carol Freeman
Family Supp Svcs For Mental Rec
G-3445 Mackin Rd.
Flint, MI 48504

RE: License #: AS250010767
Investigation #: 2024A0576028
Family Support Group Home

Dear Carol Freeman:

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.
- Be signed and dated.

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,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010767
Investigation #:	2024A0576028
Complaint Receipt Date:	04/03/2024
Investigation Initiation Date:	04/05/2024
Report Due Date:	06/02/2024
Licensee Name:	Family Supp Svcs For Mental Rec
Licensee Address:	G-3445 Mackin Rd, Flint, MI 48504
Licensee Telephone #:	(810) 732-9160
Administrator:	Carol Freeman
Licensee Designee:	Carol Freeman
Name of Facility:	Family Support Group Home
Facility Address:	G-3445 Mackin Road, Flint, MI 48504
Facility Telephone #:	(810) 732-9160
Original Issuance Date:	10/28/1986
License **Status:**	REGULAR
Effective Date:	05/08/2023
Expiration Date:	05/07/2025
Capacity:	6
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Home was supposed to take him to the hospital per doctor order and did not.	No
Resident A is not getting his insulin at the AFC home.	Yes

III. METHODOLOGY

04/03/2024	Special Investigation Intake 2024A0576028
04/05/2024	Special Investigation Initiated - Telephone Call to Complainant
05/02/2024	Inspection Completed On-site Interviewed Licensee Designee, Carol Freeman and Medical Coordinator, Tawana Gould
05/17/2024	Contact - Telephone call made Left message for Erin Rockafellow to return call
05/20/2024	Contact - Telephone call made Interviewed Erin Rockafellow
05/21/2024	Exit Conference
05/22/2024	APS Referral

ALLEGATION:

Home was supposed to take him to the hospital per doctor order and did not.

INVESTIGATION:

On May 2, 2024, I conducted an unannounced on-site inspection at Family Support Group Home and interviewed Licensee Designee, Carol Freeman regarding the allegations. Licensee Designee Freeman reported Resident A went to see his psychiatrist at Genesee Health System (GHS) on April 2, 2024, and the doctor became concerned due to Resident A slurring his words. According to Licensee Designee Freeman, Resident A has slow speech, and he responds slowly due to problems with his hearing. The doctor requested Resident A be taken to “emergency” and staff took

Resident A to urgent care because he would be seen sooner. Resident A went to urgent care at about 1pm and was home by 3pm. While at urgent care Resident A's blood sugar was tested and it was in normal range. Resident A was advised to go home and eat.

On May 2, 2024, I interviewed Medical Coordinator, Tawana Gould regarding the allegations. Coordinator Gould reported that Resident A went to see his psychiatrist, Dr. Rungta at GHS and the doctor became worried that Resident A was not receiving his insulin medication. Resident A's speech also concerned the doctor as he felt Resident A was slurring his words however Coordinator Gould reported Resident A does not have clear speech. Dr. Rungta advised staff to take Resident A to the emergency room to be evaluated and staff went back to the home to retrieve his face sheet and medication list. Licensee Designee, Carol Freeman advised staff to take Resident A to urgent care as she felt medical staff would access Resident A sooner than the hospital.

On May 17, 2024, I left a message for Resident A's Case Manager, Erin Rockafellow to return my call. On May 20, 2024, I interviewed Manager Rockafellow regarding the allegations, and she reported Resident A went to an appointment at GHS for a medication review with his psychiatrist, Dr. Rungta. Dr. Rungta was concerned with Resident A's blood sugar and Resident A was slurring his words. Dr. Rungta asked that Resident A be taken to the emergency room to have his blood sugar checked. Staff went home and to get Resident A's face sheet and while at the home, the home decided to take Resident A to urgent care as they were concerned the hospital would take a long time to see Resident A.

On May 20, 2024, I reviewed an email dated for April 4, 2024, and authored by Licensee Designee, Carol Freeman and sent to Michelle Salem, Genesee County Office of Recipient Rights (ORR) Officer. Licensee Designee Freeman explained to Officer Salem that in February 2024 when Dr. Rungta had a concern about Resident A's blood sugar, Dr. Rungta recommended that Resident A be taken to the emergency room (ER) or to an urgent care. Resident A was taken to urgent care and his blood sugar was 500 so staff then took Resident A to ER. Licensee Designee questioned why it was okay to take Resident A to urgent care first in February 2024, and not in April 2024.

On May 21, 2024, I spoke to Licensee Designee for the purposes of conducting an exit conference and she provided some clarification. Licensee Designee reported she was told on April 2, 2024, that Resident A needed to go to "emergency" to have his blood sugar taken and to her this meant he could be taken to the urgent care. Licensee Designee Freeman explained that the urgent care is in Hurley Hospital where the emergency department used to be housed. The urgent care and the hospital are in the same building and if anything had been wrong after Resident A's blood sugar was tested, he could have quickly and easily been taken to the emergency room at the hospital. Licensee Designee stated that in the past, Dr. Rungta was okay with Resident A being taken to urgent care to have his blood sugar tested. I advised Licensee

Designee Freeman that in the future to seek clarification from the doctor if he wants residents to be seen at urgent care or the hospital emergency room.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	It was alleged that Resident A was ordered to go the hospital for evaluation and staff did not take him. Upon conclusion of investigative interviews, there is not a preponderance of evidence to conclude a rule violation. On April 2, 2024, Resident A had an appointment with his psychiatrist, Dr. Rungta. The doctor became concerned due to Resident A sounding as if his speech was slurred and he had not been receiving his insulin that had been ordered in February 2024. The AFC home staff took Resident A to urgent care where his blood sugar was tested, and it was within normal range. Licensee Designee Carol Freeman stated that it was her understanding that Resident A needed to go to “emergency” and to her urgent care qualified as “emergency”. Also, in February 2024, when Resident A had an elevated blood sugar level, Dr. Rungta advised Resident A could be taken to urgent care or the hospital. There is not a preponderance of evidence to conclude that in case of sudden adverse change in Resident A’s physical condition or adjustment, the home did not obtain needed care immediately.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is not getting his insulin at the AFC home.

INVESTIGATION:

On May 2, 2024, I conducted an unannounced on-site inspection at Family Support Group Home and interviewed Licensee Designee, Carol Freeman regarding the allegations. Licensee Designee Freeman confirmed Resident A was not receiving his

insulin medication as ordered due to his primary care physician, Dr. Pfung not writing a prescription for needles required to take the medication. Resident A was first ordered insulin on February 8, 2024, however the doctor did not order needles on this date. Facility staff called to Dr. Pfung regarding the need for the doctor to write an order for needles however the home did not get an order. Resident A's Case Manager, Erin Rockafellow went to Resident A's doctor on April 2, 2024, and the doctor finally wrote the order for the needles.

Licensee Designee Freeman explained that Resident A gets blood work done weekly due to a psychotropic medication he is prescribed. On February 5, 2024, Resident A had lab work done at Quest and the results revealed his blood sugar was elevated at 519. Quest called Dr. Rungta, Resident A's psychiatrist to report their findings. Dr. Rungta called the home and advised staff to take Resident A to urgent care or the hospital to be evaluated. Resident A was taken to urgent care, and they advised AFC staff to take Resident A to the hospital, which they did.

I reviewed Hurley Hospital discharge paperwork dated for February 6, 2024. The paperwork indicated Resident A was seen and treated at the hospital on February 6, 2024. Resident A had a glucose test completed.

Licensee Designee Freeman explained that AFC Staff, Mia Fox took Resident A to his medication review on April 2, 2024, with Dr. Rungta. Staff Fox requested that Resident A's team (Dr. Rungta, Case Manager, Erin Rockafellow) call the home to speak with Licensee Designee Freeman about Resident A and him not receiving his medication however they declined.

On May 2, 2024, I interviewed Medical Coordinator, Tawana Gould regarding the allegations. Coordinator Gould reported that she and Resident A attended a training on February 13, 2024, to learn how to administer Resident A's insulin. The training was at Genesee Health System (GHS) and conducted by a nurse. Coordinator Gould reported she advised the nurse that the home does not have the needles to administer Resident A his medication and the nurse advised she would "get on it". The nurse stated Resident A's primary care physician, Dr. Pfung "orders stuff but doesn't put it through". Coordinator Gould reported that she called numerous times to Dr. Phung's office to get the order for the needles however was unsuccessful.

On May 17, 2024, I left a message for Resident A's Case Manager, Erin Rockafellow to return my call. On May 20, 2024, I interviewed Manager Rockafellow regarding the allegations, and she reported Resident A was prescribed insulin by Dr. Phung his primary care doctor from Genesee Community Health Center (GCHC). A nurse from the Dr. Phung's office told Manager Rockafellow the AFC staff called "several times" to get the needles they needed to administer Resident A's insulin medication however Dr. Phung "needed to sign off" on the script. The doctor never signed the script for the needles until April 2, 2024, when Manager Rockafellow went to his office during her lunch and waited 45 minutes for the doctor to sign the order.

On May 20, 2024, I reviewed a *GHS Contact Note* dated for April 2, 2024, and authored by Erin Rockafellow Resident A's Case Manager. The contact note documented that On April 2, 2024 Case Manager Rockafellow called the Genessee County Health Center (GCHC) and spoke with Dr. Phung's nurse regarding Resident A's lack of needles for his insulin. The nurse reported that staff from Resident A's AFC home have been in contact with GCHC many times about this issue. The nurse stated that the order has been given to Dr. Phung several times and he has not signed the order. The nurse stated the order has now been signed and will be filed at the pharmacy on record.

On May 21, 2024, I interviewed Resident A who reported he has been living at his home for 5 years. Resident A likes his home however sometimes other residents have behaviors. Resident A confirmed he takes his insulin, and he receives his medication once per day. Resident A was taking a pill but not he receives an injection. Resident A denied any concerns regarding his home and believes the home is meeting all his needs. Resident A reported he feels well at this time and denied any concerns.

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:	It was alleged that Resident A was not receiving his insulin medication as ordered by his doctor. Upon conclusion of investigative interviews, there is a preponderance of evidence to conclude a rule violation. Resident A was ordered insulin in February 2024. Resident A required needles in order administer the medication and this required a doctor order. The doctor did not order the needles at the same time as the medication and staff called the doctor several times to obtain the needles however was unsuccessful Resident A's case manager went to Resident A's doctor office in April 2024 and waited in the office for the doctor to write the script and Resident A has started receiving his medication as ordered.

	There is a preponderance of evidence to conclude Resident A's medication, insulin, was not given as prescribed. .
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 21, 2024, I conducted an Exit Conference with Licensee Designee, Carol Freeman. I advised Licensee Designee Freeman I would be requesting a corrective action plan for the cited rule violation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in the license status is recommended.

5/22/2024

Christina Garza Date
Licensing Consultant

Approved By:

5/22/2024

Mary E. Holton Date
Area Manager