GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 23, 2024

Jennifer Bhaskaran
Alternative Services Inc.
Suite 10
32625 W Seven Mile Rd
Livonia, MI 48152

RE: License #: AS250010669
Investigation #: 2024A0779030
Marshall Group Home

Dear Jennifer Bhaskaran:

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,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010669
Investigation #:	2024A0779030
Complaint Receipt Date:	04/17/2024
Investigation Initiation Date:	04/18/2024
Report Due Date:	06/16/2024
Licensee Name:	Alternative Services Inc.
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Amber Harris
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Marshall Group Home
Facility Address:	1531 Cedarwood Flushing, MI 48433
Facility Telephone #:	(248) 471-4880
Original Issuance Date:	10/07/1981
License **Status:**	REGULAR
Effective Date:	06/11/2023
Expiration Date:	06/10/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 2/4/24, staff NyAsia Chew administered Resident A's medications to Resident B (bedtime medication).	Yes

III. METHODOLOGY

04/17/2024	Special Investigation Intake 2024A0779030
04/18/2024	Special Investigation Initiated - Telephone Spoke to recipient rights.
04/18/2024	APS Referral Complaint was referred to APS centralized intake.
04/19/2024	Inspection Completed On-site
04/19/2024	Contact - Telephone call made Interview conducted with staff person, NyAsia Chew.
04/22/2024	Exit Conference Held with administrator, Amber Harris.

ALLEGATION:

On 2/4/24, staff NyAsia Chew administered Resident A's medications to Resident B (bedtime medication).

INVESTIGATION:

On 4/18/24, a phone conversation took place with recipient rights investigator, Kim Nguyen-Forbes, who confirmed that she was investigating the same allegations. Kim Nguyen-Forbes stated that staff person, NyAsia Chew, admitted to giving Resident B Resident A’s medication and that Resident B was not given his own PM medications on 2/4/24. Kim Nguyen-Forbes reported that a GHS nurse told her that this medication error put Resident B at risk of harm, due to the potential of significantly decreasing Resident B’s blood pressure.

On 4/19/24, an on-site inspection was conducted and home manager, Tracy McLaurin, was interviewed. Manager McLaurin stated that Staff Chew called her immediately to report the medication error and that she had Staff Chew call Resident B’s physician.

Manager McLaurin stated that the physician asked for Resident B to be taken to the hospital, which did happen. Manager McLaurin stated that Resident B was not admitted but was given fluids and sent back home. Manager McLaurin reported that Resident B is autistic and non-verbal.

Due to Resident B being non-verbal and his cognitive deficiencies, Resident B was not able to be interviewed. During the on-site inspection, Resident B was observed to be clean, well groomed and appeared to be doing fine.

On 4/19/24, a phone interview was conducted with staff person, NyAsia Chew, who admitted that on 2/4/24, she accidentally gave Resident B Resident A's bedtime medications. Staff Chew reported that she got both Resident A and Resident B's medication together at the same time and then mixed up the medication cups when giving Resident B the medication. Staff Chew stated that she realized her mistake immediately, but that Resident B had already swallowed the medications. Staff Chew stated that she took Resident B's vitals and called the physician, who recommended that Resident B not be given his own medications and be taken to the hospital. Staff Chew reported that the hospital gave Resident B fluids and sent him back home. Staff Chew stated that Resident B did fine the rest of the shift, except for being quite sleepy.

The home provided an *AFC Licensing Division Incident/Accident Report* (IR) explaining the medication incident. The information on the IR matched the information obtained during Staff Chew's interview.

Resident A and Resident B's medication administration records (MAR) were viewed and found to indicate that on 2/4/24, Resident B was not given his six bedtime medications. The home did complete a medication error information form that showed that Resident B did not receive his six bedtime medications, Clonidine, Divalproex, Ezetimibe, Quetiapine 100mg and 400mg tabs, and Tamsulosin, but was accidentally given Resident A's five bedtime medications, Olanzapine, Neurontin, Klonopin, Phenobarb, and Lisinopril.

APPLICABLE RULE	
R 400.14312	**Resident medications**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Staff person, NyAsia Chew, admitted that she had gotten Resident A and Resident B's medications mixed up on 2/4/24 and had given Resident B the wrong medications. The home provided several different documents that confirmed this

	incident/allegation to be true. There was sufficient evidence found to confirm that Resident B was given medication that was not prescribed to him, which warrants violation of this licensing rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/22/24, an exit conference was held with Administrator, Amber Harris. Admin Harris was informed of the outcome of this investigation and that a written corrective action plan is required.

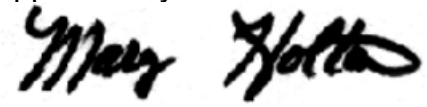
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

5/20/2024

Christopher Holvey Date
Licensing Consultant

Approved By:



5/23/2024

Mary E. Holton Date
Area Manager