GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 13, 2024

James Pilot
Bay Human Services, Inc.
P O Box 741
Standish, MI 48658

RE: License #:	AS060068988
Investigation #:	2024A0123054
	Almont AFC

Dear James Pilot:

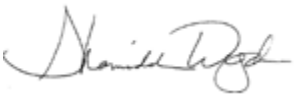
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS060068988
Investigation #:	2024A0123054
Complaint Receipt Date:	08/14/2024
Investigation Initiation Date:	08/15/2024
Report Due Date:	10/13/2024
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Tammy Unger
Licensee Designee:	James Pilot
Name of Facility:	Almont AFC
Facility Address:	140 Almont Street Standish, MI 48658
Facility Telephone #:	(989) 846-9648
Original Issuance Date:	08/01/1996
License Status:	REGULAR
Effective Date:	02/01/2023
Expiration Date:	01/31/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 08/12/2024, staff Malisa Austin failed to pass Resident A's seizure medication at 8:00 am. Later that day, Resident A had a seizure.	Yes

III. METHODOLOGY

08/14/2024	Special Investigation Intake 2024A0123054
08/15/2024	Special Investigation Initiated - Telephone I spoke with recipient rights officer Melissa Prusi.
08/20/2024	APS Referral APS referral completed.
08/23/2024	Inspection Completed On-site I conducted an unannounced on-site at the facility.
08/30/2024	Contact - Telephone call made I interviewed Guardian 1 via phone.
08/30/2024	Contact - Telephone call made I left a voicemail requesting a return call from staff Malisa Austin.
08/30/2024	Contact - Telephone call received I interviewed Staff Austin.
08/30/2024	Contact- Document Sent I sent an email to regional manager Tabatha Barnes requesting documentation.
09/03/2024	Contact- Document Received I received requested documentation.
09/13/2024	Contact- Telephone call made I made a follow-up call to the facility.
09/13/2024	Exit Conference I spoke with administrator/designated person Tammy Unger.

ALLEGATION: On 08/12/2024, staff Malisa Austin failed to pass Resident A's seizure medication at 8:00 am. Later that day, Resident A had a seizure.

INVESTIGATION: On 08/15/2024, I spoke with recipient rights officer Melissa Prusi via phone. She stated that Resident A had three prescriptions for seizures. Resident A did not receive any of their 8:00 am medications. By 7:22 pm on 08/12/2024, Resident A had a seizure. There are two incident reports. Resident A was seen by Jordyn Kippe, P.A.C. on 08/13/2024 who wrote that the breakthrough seizures were likely caused by missed medications. Staff Malisa Austin is the staff responsible for the medication error.

On 08/23/2024, I conducted an unannounced on-site at the facility. I interviewed home manager Tabitha Johnson. Staff Johnson stated that there were three missed medications that were seizure medications but all of Resident A's 8:00 am medications were missed on 08/12/2024. Staff Johnson stated that on 08/12/2024, she and assistant home manager Tiara Mervyn took had taken Resident A and Resident B on a zoo outing to Birch Run. They had left the morning of 08/12/2024 by 9:00 am. Staff Johnson stated that she received a phone call at about 1:45 pm from Staff Austin stating that Resident A's medications were missed. Staff Johnson stated that they arrived back to the facility from Birch Run around 3:00 pm or 3:30 pm. Staff Johnson stated that a call was made to Bay Arenac Behavior Health nurse Sarah VanParis, RN who stated that it was too late to pass the medications. Staff Johnson stated that Resident A had a seizure on 08/12/2024 around 7:30 pm. Staff Johnson stated that Resident A was taken to a neurologist the next day and a physician order was written. Staff Johnson stated that she does not know why the medications were not past, but they are working on being able to get notifications sent to her phone from Quick Mar.

On 08/23/2024, during this unannounced on-site visit, five residents were seen in bed, including Resident A. Resident A was asleep, and was not interviewed. The residents appeared clean and appropriately dressed. I observed Resident A's medication bubble packs during this on-site. The medications for 08/12/2024 appeared to still be in the bubble pack.

During this on-site, I also obtained requested documentation. Resident A's *Health Care Appraisal* dated 05/01/2023 was reviewed. The attached documentation, a Clinical Summary for Resident A from Charlotte Yang, MD notes that Resident A is diagnosed with "*Epilepsy, Myoclonic*".

Two A*FC Licensing Division-Incident/Accident Reports* were obtained. The first incident report dated 08/12/2024 at 1:30 pm, written by staff Malisa Austin states:

"*While checking meds staff relised they had not passed [Resident A] 8am meds. Briviact 100 mg, Divalproex 500 mg, CTNP V.T. D3 25 mcg, Topiramate 100 mg*." "*Notified Sarah Van Paris RN, advised to monitor [Resident A] for seizures, and Malisa is to take med review video through staff development.*"

The second incident report dated 08/12/2024 at 7:22 pm, written by staff Brittany Swartz states:

"*Staff was walking [Resident A] to the bathroom when [Resident A] stopped and cried out. So Brittany lowered [Resident A] onto [their] butt then onto [their] side. The seizure stopped at 7:23 pm. So lasted for 1 minute. Once [Resident A] came back to normal 2 staff members helped [them] off the floor*." "*Staff contacted [Resident A's] [Guardian 1], home manager, and on call nurse. [Resident A's] vitals were taken and reported to on call nurse. 'Made [Resident A} an appointment with [their] neurologist Jordyn Kippe. She was able to get us in right away. Jordyn Kippe reviewed [Resident A's} meds and believes that [Resident A's] seizure was due to not getting [their] morning does of seizure meds. She wrote an order to give seizure meds up to six hours late without it affecting [their] evening doses."*

A copy of Resident A's QuickMar medication administrator record for August 2024 were obtained. There are no staff initials on 08/12/2024 at 8:00 am for the following medications: Briviact Tab 100 mg, Divalproex Tab 500 mg DR, GNP Vit D3 Tab 1000UNIT, and Topiramate Tab 100 MG. Resident A's *Assessment Plan For AFC Residents* dated 01/23/2024 states that for *Taking medications*, they are "*Dispensed by staff*." A Bay Human Services *Medical Appointment's Progress Note* dated 08/13/2024 and signed by Jordyn Kippe PA-C states that Resident A was seen on 08/13/2024 because of a "*breakthrough seizure likely caused is missed medication*." It goes on to state "*Continue Briviact 100 mg BID, Depakote 500 mg- BID, and Topamax 100 MG 2 tabs (200) BID. Please do not miss doses, can give dose up to 6 hours late. Nayzilarn is available for breakthrough seizures. Please take on all trips away from facility*."

On 08/30/2024, I spoke with Resident A's Guardian 1 via phone. Guardian 1 stated that the medication pass error was a mistake. Overall, Resident A loves living at the home, and Guardian 1 is happy with the current placement. Guardian 1 stated that they have no concerns. Resident A always presents neat, clean, and Resident A is bathed daily. Guardian 1 stated that they have been no other issues with medications. Guardian 1 stated that on the morning of 08/12/2024, the facility took a trip to a zoo in Birch Run. It may have been hectic that morning, although this isn't an excuse. Guardian 1 stated that they were shown by home manager Tabatha Johnson that there is a new system in place where if there is no medication pass within an hour, Staff Johnson receives a text message notification on her phone. Guardian 1 stated that staff are on top of things when they happen.

On 08/30/2024, I interviewed staff Malisa Austin via phone. Staff Austin stated that on 08/12/2024, she was assigned to medications. Staff Austin was getting another resident's medication and thought that she had already passed Resident A's medication. Staff Austin stated that she noticed a couple hours or so later that the medications were missed, but by then it was too late to pass them. Staff Austin stated that Resident A was on an outing at a zoo, about an hour from the facility. Staff

Austin stated that she called Staff Johnson and notified her of the missed medications. Staff Austin stated that when Resident A had the seizure, her co-worker, staff Brittany Swartz had yelled out to her for assistance with lying Resident A on the floor. Staff Austin stated that by the time she responded, Staff Swartz had already lowered Resident A to the floor. Staff Austin stated that this is her second medication error for Resident A. Staff Ausitn stated that some time previously, she forgot to pass Resident A's Briviact. Staff Ausitn stated that Resident A did not have a seizure from this missed med pass. Staff Ausitn stated that she had to write a written explanation as to what occurred, she received written disciplinary action, and she has to watch a training video.

On 08/30/2024, I received a copy of a Bay Human Services *Medication Error Review* Sheet dated 08/12/2024, authored and signed by home manager Tabatha Johnson. It details that medication error Staff Austin committed on 08/12/2024. It notes for the action that was or will be taken as a result of the error to be "*Med error corrective action and med video to be completed through staff development*." A copy of Bay Human Services *Employee Corrective Action* for Staff Austin was received as well. Staff Austin received a written warning due to the medication error. It notes that Staff Austin will have to complete a med video through staff development per Bay Arenac Behavioral Health nurse Sarah VanParis, RN.

On 09/13/2024, I made a follow-up call to the facility. I spoke with assistant manager Tiara Mervyn via phone. Staff Mervyn stated that she was on the outing with Resident A on 08/12/2024 but left work at 4:00 pm and did not witness the seizure.

On 9/13/2024, I interviewed Resident A. Resident A stated that they like living in the home. Resident A stated that they get medications in the morning and at night. Resident A did not recall missing any medications. Resident A stated they take medications for seizures. When asked if they had any seizures lately, Resident A stated they had a couple seizures lately.

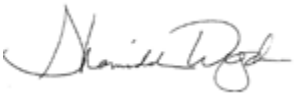
On 09/13/2024, I conducted an exit conference with Tammy Unger via phone. I informed Tammy Unger of the findings and conclusions. Tammy Unger stated that Staff Mervyn did receive disciplinary action and has to complete a medication training.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 08/23/2024, I conducted an unannounced on-site at the facility. Home manager Tabatha Johnson was interviewed and confirmed that Resident A's 8:00 am medications were not passed to Resident A prior to Resident A leaving on an outing on 08/12/2024. Resident A had a seizure later that evening.

	During the on-site on 08/23/2024, I observed the medication for 08/12/2024 to still be in Resident A's medication bubble packs. *AFC Licensing Division- Incident/Accident* reports dated 08/12/2024 detail the missed med doses, as well as Resident A having a seizure. QuickMar documentation for August 2024 also reflect that staff did not initial for the 08/12/2024 8 am medications. On 08/30/2024, I spoke with Guardian 1 via phone. Guardian 1 reported being aware of the issue but did not report any other care concerns. On 08/30/2024, I interviewed staff Malisa Austin via phone. She confirmed during her interview that she did not pass Resident A's 8:00 am medications. On 09/13/2024, I interviewed Resident A who reported having a couple seizures lately but did not recall missing any doses of medication. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

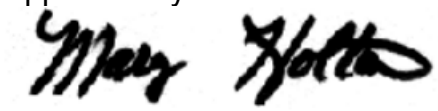
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6).



09/13/2024

Shamidah Wyden — Date
Licensing Consultant

Approved By:



09/13/2024

Mary E. Holton — Date
Area Manager