GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 24, 2024

Earsha Riggin
14124 Merriman Road
Livonia, MI 48154

RE: License #: AS820408887
Investigation #: 2024A0122032
Successfully Living

Dear Ms. Riggin:

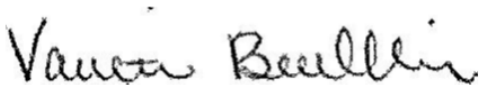
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9720.

Sincerely,



Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820408887
Investigation #:	2024A0122032
Complaint Receipt Date:	09/05/2024
Investigation Initiation Date:	09/05/2024
Report Due Date:	11/04/2024
Licensee Name:	Earsha Riggin
Licensee Address:	14124 Merriman Road Livonia, MI 48154
Licensee Telephone #:	(734) 846-1519
Administrator:	Ava Croft
Licensee Designee:	Earsha Riggin
Name of Facility:	Successfully Living
Facility Address:	821 N. Haggerty Rd Canton, MI 48187
Facility Telephone #:	(734) 392-7114
Original Issuance Date:	08/02/2022
License Status:	REGULAR
Effective Date:	02/02/2023
Expiration Date:	02/01/2025
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 09/03/2024, Resident A was given Resident B's medication.	Yes

III. METHODOLOGY

09/05/2024	Special Investigation Intake 2024A0122032
09/05/2024	Special Investigation Initiated - Letter Email sent to complainant, requesting contact so that additional information can be obtained.
09/05/2024	Contact - Telephone call made Completed interview with Complainant 1.
09/05/2024	Inspection Completed On-site Completed interview with staff, Feda Albuqatram and Nicole Lucas. Completed interview with Ava Croft, Administrator. Reviewed Resident A and B's medication administration records, medication. Reviewed Resident A's file.
09/06/2024	Contact – Telephone calls made Completed interview with staff, Davonta Davis and Briya Hick.
09/09/2024	Contact – Telephone calls made Completed APS and ORR Referrals. Left voice message for Guardian A.
09/09/2024	Contact – Telephone call made Completed interview with Resident A.
09/11/2024	Contact – document received Resident A's Discharge Summary.
09/13/2024	Exit Conference Discussed findings with licensee designee, Earsha Riggin.

ALLEGATION: On 09/03/2024, Resident A was given Resident B's medication.

INVESTIGATION: On 09/05/2024, I completed an interview with Complainant 1. Complainant 1 stated that it had been reported by assistant home manager, Nicole Lucas, on 09/03/2024 Resident A had been given Resident B's medication, specifically, Thorazine 100mg, Ativan 2mg, Trileptal 300mg, Risperdal 6mg, Ambien 10mg, Desyrel 10mg, and Clozapine 200mg at approximately 8:00 p.m.

Complainant 1 stated Ms. Lucas reported this information to the Emergency Room Physician and Nurse on 09/03/2024 when she accompanied Resident A to the hospital. Complainant 1 reported that the statement given by Ms. Lucas to the physician and nurse is part of Resident A's medical file with specific names of medications and dosages.

On 09/05/2024, I completed an interview with administrator, Ava Croft. Ms. Croft stated she had not received any reports from Ms. Lucas, staff, or medical personnel that Resident A had received Resident B's medication on 09/03/2024. On 09/05/2024, Ms. Croft reviewed Resident A's medical file through the online patient portal and confirmed that the emergency room physician and nurse received a report from Nicole Lucas stating she had given Resident A, Resident B's medication, listing specific names of medications and dosages.

Per Ms. Croft, Resident A was observed the morning of 09/03/2024 exhibiting coughing, vomiting, having diarrhea. Ms. Croft contacted Resident A's physician and he prescribed medications to address symptoms reported by Ms. Croft. Ms. Croft stated Resident A never received those medications as she was transported to the hospital based on a report received by Ms. Lucas stating her symptoms had gotten worse and Resident A needed emergency medical treatment.

On 09/05/2024, I reviewed Resident A and B's medication administration records and medications with Ms. Croft. We observed Resident A's medication administration records had an "H" written over the initials "NL" on the section of her 8:00 p.m. medications (Lipitor 40mg, Fycompa 6mg, Robinul Forte 1mg, Keppra 750mg, Lopressor 25mg, Trileptal 300mg, and Senokot-S 8.6mg/50mg) dated 09/03/2024. Ms. Croft stated she was uncertain why the "H" had been written over the initials as a way of indicating that the medication had not been administered to Resident A as she had received notification that Resident A did receive her 8:00 p.m. medication on 09/03/2024. Both, Ms. Croft and I, observed that Resident A's pharmacy bubble pack was empty of medications for 8:00 p.m. on the date of 09/03/2024.

Ms. Croft and I observed Resident B's medication administration records and medications dated 09/03/2024. Resident B's medication administration records displayed the initials "NL" 09/03/2024 for the 8:00 p.m. medications (Thorazine 100mg, Ativan 2mg, Trileptal 300mg, Risperdal 2mg, Desyrel 100mg, and Ambien 10mg) documenting the medication had been administered. Resident B's

medication bubble packet was observed to be empty of medications for 8:00 p.m. on 09/03/2024. These are the same medications listed as being given to Resident A on 09/03/2024.

On 09/05/2024, I completed an interview with assistant home manager, Nicole Lucas. Ms. Lucas stated she administered both Resident A's and B's evening medication on 09/03/2024. She then observed Resident A coughing and throwing up as she was assisting Resident A in the bathroom. Ms. Lucas stated her first thought was, "I hope I didn't pass the wrong medication," as she had not observed Resident A respond in this manner prior.

I asked Ms. Lucas how Resident A could have been given the wrong medication, to which she responded that Resident A did not receive the wrong medication. Ms. Lucas initially stated she gave Resident A's medication to her individually, i.e. one medication at a time, however, she changed and stated she took Resident A's medication into the bathroom and administered it to her there.

Ms. Lucas denied reporting to the emergency room physician and nurse that she had given Resident A the wrong medication. Ms. Lucas stated she reported to them, "I hope I didn't give Resident A the wrong medication." Ms. Lucas stated she doubled checked, saw that Resident A's medication was the last medication she had taken out of the cabinet, and that was how she verified that Resident A was given the correct medication. Ms. Lucas did not contact the emergency room physician or nurse to update them on her alleged findings, i.e. that she had given Resident A the correct medications.

Per Ms. Lucas, she observed Resident A vomiting "yellowish mucus and choking" on 09/03/2024 and that was why Resident A was transported to the hospital. Ms. Lucas denied giving Resident A, Resident B's medication.

On 09/06/2024, I completed an interview with staff, Davonta Davis. Mr. Davis confirmed that he worked the evening of 09/03/2024, however he stated he was assigned as Resident B's 1:1 staff. Mr. Davis reported that Resident B is diagnosed with seizures and must be monitored at all times, therefore, he did not observe Resident A the evening of 09/03/2024 nor did he observe interaction between Resident A and Ms. Lucas. Mr. Davis stated he did not receive any reports regarding Resident A receiving Resident B's medication.

On 09/06/2024, I completed an interview with staff, Briya Hick. Ms. Hicks confirmed that she worked the evening of 09/03/2024 and provided some assistance to Resident A. I asked Ms. Hicks to describe what assistance she gave to Resident A in addition to anything that she observed with Resident A on the evening of 09/03/2024. Ms. Hicks' description of the evening changed several times; however, this is what she reported: Per Ms. Hicks she assisted Resident A with dinner and took Resident A to the living room after dinner to watch television. Ms. Hicks excused herself to go to the bathroom and when she returned to the living room, Ms.

Lucas told Ms. Hicks that Resident A needed to be taken to the emergency room because she wasn't feeling well. Ms. Hicks stated she did not notice anything out of the ordinary with Resident A prior to Ms. Lucas stating Resident A needed to go to the emergency room and stated she appeared "perfectly normal" during and after dinner.

On 09/09/2024, I completed an interview with Resident A. I asked Resident A why she was in the hospital, to which she replied, "I took the wrong medications, that's why they put me in the hospital." Resident A stated, "the doctor," told her why she was in the hospital. Due to Resident A's cognitive limitations, she could not answer specific questions regarding what happened the evening of 09/03/2024.

On 09/11/2024, I reviewed Resident A's After Visit Summary dated 09/10/2024 which documents she received medical treatment at Trinity Health Livonia Hospital from 09/03/2024 through 09/10/2024. The Summary documents Resident A received information for Polypharmacy, which is defined as, "taking many medications," and COVID-19. The information stated what problems can be related with these issues and ways to address the problems.

On 09/09/2024, I contacted Guardian A via telephone to complete an interview. Guardian A was unavailable, and I left a voice message requesting a return telephone call. As of 09/13/2024, I have received no contact from Guardian A.

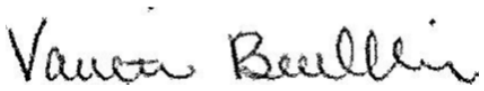
On 09/13/2024, I completed an exit conference with licensee designee, Earsha Riggin where my findings were discussed with her. Ms. Riggin stated she understood my findings and would submit a corrective action plan to address the rule violation found.

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:	Based upon my investigation, which consisted of multiple interviews with Complainant 1, staff, Resident A, and a review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that on 09/03/2024, Resident A was given Resident B's medication. Therefore, on 09/03/2024, Resident A did not receive her prescription medication as prescribed by her licensed physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of an acceptable corrective action plan, I recommend no change to the license status.



Vanita C. Bouldin
Licensing Consultant
Date: 09/13/2024

Approved By:

Ardra Hunter
Area Manager
Date: 09/24/2024