



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 16, 2024

Vadie Terry
Terry Adult Foster Care Inc.
1754 Vandyke
Detroit, MI 48214

RE: License #: AM820383027
Investigation #: 2024A0901035
Terry AFC

Dear Vadie Terry:

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 (313) 456-0380.

Sincerely,

A handwritten signature in black ink that reads "Regina Buchanan". The script is cursive and fluid, with the first name "Regina" and last name "Buchanan" clearly legible.

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM820383027
Investigation #:	2024A0901035
Complaint Receipt Date:	05/22/2024
Investigation Initiation Date:	05/23/2024
Report Due Date:	07/21/2024
Licensee Name:	Terry Adult Foster Care Inc.
Licensee Address:	12747 Indiana Street Detroit, MI 48238
Licensee Telephone #:	(313) 921-3957
Administrator:	Vadie Williams
Licensee Designee:	Vadie Terry
Name of Facility:	Terry AFC
Facility Address:	1754 VanDyke Detroit, MI 48214
Facility Telephone #:	(313) 921-3957
Original Issuance Date:	06/06/2017
License Status:	REGULAR
Effective Date:	06/06/2024
Expiration Date:	06/05/2026
Capacity:	8

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED
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II. ALLEGATION(S)

	Violation Established?
Resident A was given another resident's medication.	Yes

III. METHODOLOGY

05/22/2024	Special Investigation Intake 2024A0901035
05/22/2024	Referral - Recipient Rights
05/22/2024	APS Referral
05/23/2024	Special Investigation Initiated - Telephone Administrator, Vadie Williams
05/29/2024	Contact - Document Received Email from Vadie Williams
06/06/2024	Contact - Telephone call made Resident A's Case Manager
06/07/2024	Contact - Telephone call made Guardian A1
06/11/2024	Contact - Telephone call made DCW, LeAngel Collins
06/11/2024	Inspection Completed-BCAL Sub. Compliance
07/12/2024	Exit Conference Licensee Designee, Vadie Terry

ALLEGATION:

Resident A was given another resident's medication.

INVESTIGATION:

On 05/23/2024, I made a telephone call to the administrator, Vadie Williams. Vadie confirmed the allegations. She stated direct care worker, LeAngel Collins, made the mistake and gave Resident A Resident B's medications. She was taken to the hospital and kept overnight for observation.

On 05/29/2024, I received an email from Vadie that consisted of the incident report, medication logs, verification of LeAngel's medication training, and an employee warning form, in which LeAngel was placed on probation and retrained on medication administration. The incident report was dated for 08/16/2024 at 8:00 p.m. It indicated LeAngel went in the medication cabinet to start passing medications. She had already handed Resident A her medications, when she realized the medications were on the wrong side of the cabinet and she had given her Resident B's medications. She tried to stop Resident A, but she had already taken them. LeAngel called poison control for instructions. Resident A was given Resident B's Benzotropine Mesylate, Klonopine, Clozaril, Depakote, Inderal, and Seroquel.

On 06/06/2024, I made a telephone call to Justina, Resident A's case manager from All Wellbeing Services. She stated she was aware of the incident and that she had not had any other issues with the home prior to this. Justina stated she recommended that LeAngel be retrained on the five rights of medication training, before being allowed to pass medications again.

On 06/07/2024, I made a telephone call to Guardian A1, Tonya Harper from Michigan Guardian Services. She stated she was made aware of the incident and was satisfied with the way the home handled it. She also stated LeAngel was reprimanded and retrained.

On 06/11/2024, I made a telephone call to LeAngel. She was very apologetic. She explained that the medications are normally arranged in a certain order. Therefore, she passed the medications in the order she was accustomed to them being in. She did not realize that someone had changed the order. She had just handed Resident A what she thought was her medications, when she noticed the error. LeAngel tried to stop Resident A, but she had already taken them. She said everything happened so quickly.

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:	Based on the information obtained during this investigation, reasonable precautions were not made to insure that prescription medications were not given to anyone other than the person they were prescribed to. Resident A was mistakenly given Resident B's 8:00 p.m. medications.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.



Regina Buchanan
Licensing Consultant

07/16/2024

Date

Approved By:



07/16/2024

Ardra Hunter
Area Manager

Date