GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 18, 2024

Holly Heath
Community Opportunity Center NPHC
14147 Farmington Rd
Livonia, MI 48154

RE: License #: AS820067419
Investigation #: 2024A0121046
Milburn II House

Dear Mrs. Heath:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On October 11, 2024, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

K. Robinson

K. Robinson, MSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820067419
Investigation #:	2024A0121046
Complaint Receipt Date:	09/06/2024
Investigation Initiation Date:	09/06/2024
Report Due Date:	11/05/2024
Licensee Name:	Community Opportunity Center NPHC
Licensee Address:	14147 Farmington Road Livonia, MI 48154
Licensee Telephone #:	(734) 838-0536
Administrator:	Holly Heath
Licensee Designee:	Holly Heath
Name of Facility:	Milburn II House
Facility Address:	19415 Milburn Livonia, MI 48152
Facility Telephone #:	(248) 615-7569
Original Issuance Date:	10/16/1995
License **Status:**	REGULAR
Effective Date:	10/10/2023
Expiration Date:	10/09/2025
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
Staff are not administering resident medication as prescribed.	Yes

III. METHODOLOGY

09/06/2024	Special Investigation Intake 2024A0121046
09/06/2024	Special Investigation Initiated - On Site Interviewed direct care staff (DCS) Kelsey Bartlett and Resident A.
09/06/2024	Referral - Recipient Rights Received
09/10/2024	Contact - Telephone call made Follow up with Home Manager, Sheanell O'Neil-Horton.
09/20/2024	Contact - Telephone call made DCS Elaine McReynolds
10/03/2024	Contact - Telephone call made Mrs. Horton-O'Neil
10/03/2024	Exit Conference Licensee designee, Holly Heath
10/11/2024	Corrective Action Plan Received/Approved
10/18/2024	Contact - Document Received Supporting documents via email from Mrs. Heath
10/31/2024	APS Referral

ALLEGATION: Staff are not administering resident medication as prescribed.

INVESTIGATION: On 9/6/24, I initiated the complaint with an unannounced onsite inspection at the facility. Direct care staff (DCS), Kelsey Bartlett was on duty caring for Resident A when I arrived. Ms. Bartlett indicated she is the assigned medication coordinator for the home; however, she was not present when the medication error occurred. According to Ms. Bartlett, former home manager, Elaine McReynolds currently works in a reduced capacity as direct care staff. Ms. Bartlett explained Ms. McReynolds failed to administer Resident A's morning medications on 9/3/24. On the day of inspection, Resident A told me that she does not receive her medication daily, but both Ms. Bartlett and current home manager, Sheanell O'Neil-Horton denied Resident A's account is accurate.

Mrs. O'Neil-Horton reported Resident A is known to say she didn't receive her medication. However, Mrs. O'Neil-Horton insists Resident A receives her medication daily. Mrs. O'Neil-Horton indicated the incident that occurred on 9/3/24 is isolated. Mrs. O'Neil-Horton stated it is not common for staff to fail to administer resident medication based on internal checks, like pill counts carried out by Ms. Bartlett. Mrs. O'Neil-Horton also stated that Resident A suffers from memory loss, so the resident may forget when she receives medication.

On 9/20/24, I interviewed Ms. McReynolds by phone. Ms. McReynolds stated the morning of 9/3/24 was very hectic due to Resident A's behavior. Ms. McReynolds explained Resident A fell during the course of her outburst, so she was immediately transported to Lakes Urgent Care for evaluation and possible treatment. It is during staff's haste to get the resident to the doctor that Ms. McReynolds forgot to administer all Resident A's 8:00 AM medication. Specifically, Ms. McReynolds acknowledged she did not give Resident A her morning dose of Buspar 10MG, Multivitamin, Klonopin 1MG, Keppra 250MG, Keppra 500MG, Synthroid 50MCG, Claritin 10MG, Proamatine 2.5MG, Ditropan XL 5MG, Lyrica 300MG, Topamax 200MG, and Trintellix 10MG. Ms. McReynolds described that entire morning as "overwhelming!"

On 10/3/24, I completed an exit conference with licensee designee, Holly Heath. Mrs. Heath acknowledged the medication error; however, Mrs. Heath concurs that the incident is isolated and not a common practice at the facility. Mrs. Heath submitted an acceptable corrective action plan on 10/11/24; she also submitted supporting documents to demonstrate compliance with the plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	DCS Elaine McReynolds is highly qualified to administer resident medication as the former home manager. However, Ms. McReynolds failed to administer Resident A's morning medication on 9/3/24 as the resident was rushed off for emergency medical treatment. There is sufficient evidence that this is an isolated incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received, therefore, I recommend the status of this license remain unchanged.

11/12/24

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Kara Robinson Date
Licensing Consultant

Approved By:

11/18/2024

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Ardra Hunter Date
Area Manager