GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 27, 2024

Madiha Zeeshan
Grand Blanc Assisted Living, LLC
219 Church St.
Auburn, MI 48611

RE: License #: AL250390289
Investigation #: 2025A0580004
Grand Blanc Fields Assisted Living

Dear Madiha Zeeshan:

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,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250390289
Investigation #:	2025A0580004
Complaint Receipt Date:	10/23/2024
Investigation Initiation Date:	10/23/2024
Report Due Date:	12/22/2024
Licensee Name:	Grand Blanc Assisted Living, LLC
Licensee Address:	12628 Pagels Drive Grand Blanc, MI 48439
Licensee Telephone #:	(810) 606-0823
Administrator:	Madiha Zeeshan
Licensee Designee:	Madiha Zeeshan
Name of Facility:	Grand Blanc Fields Assisted Living
Facility Address:	12628 Pagels Drive Grand Blanc, MI 48439
Facility Telephone #:	(810) 606-0823
Original Issuance Date:	08/03/2018
License Status:	REGULAR
Effective Date:	02/03/2023
Expiration Date:	02/02/2025
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED AGED ALZHEIMERS

II. ALLEGATION(S)

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

III. METHODOLOGY

10/23/2024	Special Investigation Intake 2025A0580004
10/23/2024	Special Investigation Initiated - On Site Unannounced onsite inspection.
10/25/2024	APS Referral Referred to APS.
10/28/2024	Contact - Telephone call made Call to HM Jennifer Wojt.
10/28/2024	Contact - Document Received Incident Report rec'd via email.
11/14/2024	Contact - Telephone call made Call to Relative A.
11/18/2024	Contact - Telephone call made Spoke with Relative A.
11/19/2024	Exit Conference Call to LD Madiha Zeeshan.
11/20/2024	Contact - Telephone call made Call to HM Jennifer Wojt.
11/22/2024	Contact - Document Received Emailed copy of medication log received.
11/26/2024	Contact - Telephone call made Call to Robert Simms, staff at Grand Blanc Fields.

11/27/2024	Exit Conference Exit Conference with LD Zeeshan.

ALLEGATION:

Resident A was given another resident's blood pressure medication.

INVESTIGATION:

On 10/23/2024, I received a complaint via LARA-BCHS-Complaints.

On 10/23/2024, I conducted an unannounced onsite inspection at Grand Blanc Fields Assisted Living. Residents were observed in their private bedrooms throughout the facility. The residents were observed adequately clothed and groomed. No concerns were noted. The residents appeared to be receiving proper care.

While onsite, I interviewed direct staff members Joyce Wilson and Shacoya Sykes, both observed in the medication room. Both staff stated that medication is stored and locked in the medication cart, in the medication room. Both staff stated that have been trained in the 6 rights of Medication Administration for passing medication.

On 10/25/2024, I made a referral to Adult Protective Services (APS). I shared the allegations alleged in this complaint.

On 10/28/2024, I spoke with Jennifer Wojt, Home Manager (HM), who stated that it is her understanding that staff, Robert Sims, (who has since been terminated) was busy answering call lights and passing medication when he mistook one female resident for the other due to them both residing at the end of the hall. Staff Sims contacted management to inform of the mix-up. The Relative Guardian A and 911 were contacted. Resident A was transported to the hospital and the medication had no lasting impact to Resident A's health. Resident A was diagnosed with Lewy Body Dementia and has since passed away.

HM Wojt went on to state that all the staff have been trained to pass medication and she is not sure how staff Sims allowed the medication error to occur.

On 10/28/2024. I received an emailed copy of the Incident Report dated 10/05/2024. The report completed former staff, Robert Sims, states, "I gave meds to the wrong person, Resident A. Medications were Metoprolol, Levothyroxine, Omeprazole". The hospital, management, and family were called. Resident A was sent to the hospital to ensure safety. As a corrective measure, staff Robert Sims was pulled off meds. Training and protocol put in place to correct issue.

On 11/14/2024, I placed a call to Relative A. A voice mail message was left requesting a return call.

On 11/14/2024, I spoke with Relative A who shared that on 10/05/2024 she had gone to visit her mother and instantly realized something was wrong. Relative A stated that she contacted 911 and when the EMTs arrived, staff Robert Sims came to the room and admitted that he had given her the wrong blood pressure medication. Resident A went to the hospital and her blood pressure was stabilized that evening.

Relative A stated that due to other health issues, Resident A remained in the hospital for an additional week, where she passed away on 10/14/2024. Relative A stated that Resident A's passing had nothing to do with the blood pressure medication that was mistakenly issued. Relative A adds that she commended staff Sims for being honest about issuing the wrong medication. Relative A also adds that during the 3 ½ months that Resident A resided in the home, staff were attentive to Resident A's needs with no concerns.

On 11/20/2024, I spoke with HM Wojt who stated that no other resident was affected, clarifying that Resident A was the only person who was given incorrect medication on 10/05/2024.

On 11/22/2024, I reviewed the October 2024 medication log for Resident A. The log indicates that on 10/01/2024-10/05/2024 (date of hospitalization), Resident A did not receive her prescribed medication of Nitrofurantoin CAP 100MG, Pantoprazole Tab, 20MG, Multivitamin Tablet, Culturelle CAP, Docusate Sodium Tab 100MG, Mag Oxide Tab, 400mg due to the medication being unavailable.

On 11/25/2024, I sent an email to HM Wojt inquiring what the code "medication unavailable" means per the medication log. HM Wojt responded that it means that the medication either not yet been delivered by the pharmacy or the resident's family. When I inquired if that means the residents do without their medication as prescribed, Manager Wojt did not respond.

On 11/26/2024, I spoke with former staff, Robert Sims, who stated that he worked for the facility an estimated 2 months, however, he'd never worked on that side and was not familiar with the residents. Robert Sims is not sure of how he ended up giving Resident A the wrong medication. Resident A is the only resident who received the wrong medication as he caught the error prior to administering medication to the other resident. Staff Sims stated that he received medication training prior to passing medication to residents.

On 11/19/2024, I conducted an exit conference with Madiha Zeeshan, Licensee Designee (LD). LD Zeeshan stated that as an added measure, management staff are observing direct staff during random intervals to ensure that staff are passing medication one resident at a time.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	It was alleged that Resident A was given another resident's blood pressure medication. Staff members Joyce Wilson and Shacoya Sykes, both stated that have been trained in the 6 rights of Medication Administration for passing medication and medication is stored and locked in the medication cart, in the medication room. Home Manager, Jennifer Wojt, stated that it is her understanding that staff, Robert Sims, (who has since been terminated) was busy answering call lights and passing medication when he mistook 1 resident for the other, administering the wrong medication. The Incident Report dated 10/05/2024, completed former staff, Robert Sims, states, "I gave meds to the wrong person, Resident A. Medications were Metoprolol, Levothyroxine, Omeprazole". The hospital, management, and family were called. Resident A was sent to the hospital to ensure safety. Relative A stated that staff Robert Sims admitted that he'd give Resident A the wrong blood pressure medication. Licensee Madiha Zeeshan stated that as an added measure, management staff are observing direct staff during random intervals to ensure that staff are passing medication one resident at a time. Former staff, Robert Sims, stated that he is not sure of how he ended up giving Resident A the wrong medication. Staff Sims never worked on that side and was not familiar with the residents. Based on the interviews conducted and documents reviewed, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/22/2024, the October 2024 medication log for Resident A indicates that on 10/01/2024-10/05/2024 Resident A did not receive her prescribed medication of Nitrofurantoin CAP 100MG, Pantoprazole Tab, 20MG, Multivitamin Tablet, Culturelle CAP, Docusate Sodium Tab 100MG, Mag Oxide Tab, 400mg due to the medication being unavailable.

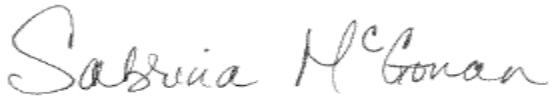
On 11/25/2024, I sent an email to HM Wojt inquiring what the code “medication unavailable” means per the medication log. HM Wojt responded that it means that the medication either has not yet been delivered by the pharmacy or the resident’s family. When I inquired if that means the residents do without their medication as prescribed, Manager Wojt did not respond.

On 11/27/2024, I conducted an exit conference with Madiha Zeeshan, Licensee Designee (LD) where I addressed the rule violation. Suggestions were given to order medications earlier or using a different pharmacy to ensure that a resident does not go without their medication.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The October 2024 medication log for Resident A indicates that on 10/01/2024-10/05/2024 Resident A did not receive her prescribed medication of Nitrofurantoin CAP 100mg, Pantoprazole Tab, 20mg, Multivitamin Tablet, Culturelle CAP, Docusate Sodium Tab 100mg, Mag Oxide Tab, 400mg due to the medication being unavailable. HM Wojt responded that it means that the medication either not yet been delivered by the pharmacy or the resident’s family. Based on the documents reviewed and the response received from Home Manager, Jennifer Wojt, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

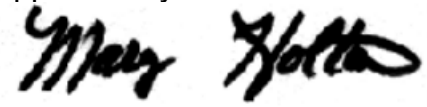
Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.



November 27, 2024

Sabrina McGowan — Date
Licensing Consultant

Approved By:



November 27, 2024

Mary E. Holton — Date
Area Manager