GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 6, 2025

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

RE: License #: AS820067419
Investigation #: 2025A0121012
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 February 21, 2025, 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 #:	2025A0121012
Complaint Receipt Date:	01/15/2025
Investigation Initiation Date:	01/15/2025
Report Due Date:	03/16/2025
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?
Resident received another resident's medication on 12/18/24.	Yes

III. METHODOLOGY

01/15/2025	Special Investigation Intake 2025A0121012
01/15/2025	Special Investigation Initiated - Telephone Jessica Allison-Lamb, Recipient Rights Investigator (RRI)
01/15/2025	Contact - Telephone call made Left message for Home Manager, Kyle Gibson
01/15/2025	Contact - Telephone call received Message from Kyle Gibson
01/15/2025	APS Referral
01/15/2025	Referral - Recipient Rights
01/16/2025	Contact - Telephone call made Call to Kyle Gibson
01/16/2025	Contact - Telephone call received Felicia Wilkerson, Manager
01/16/2025	Contact - Telephone call received Holly Heath, licensee designee.
01/22/2025	Inspection Completed-BCAL Sub. Compliance Interviewed Mrs. Heath, Ms. Gibson, Resident A and C.
01/28/2025	Contact - Document Received Follow up email from Mrs. Heath.
01/31/2025	Contact - Telephone call made Sheanell O'Neil-Horton, former home manager.
02/03/2025	Exit Conference Holly Heath

02/21/2025	Corrective Action Plan Received/Approved.

ALLEGATION: Resident received another resident's medication on 2/18/24.

INVESTIGATION: On 1/15/25, I initiated the complaint with a phone call to Recipient Rights Investigator, Jessica Allison-Lamb. Mrs. Allison-Lamb reported former home manager, Sheanell O'Neil-Horton accidentally gave Resident A, Resident B's morning medication. According to Mrs. Allison-Lamb, new home manager Kyle Gibson discovered the medication error. Poison control was notified. On 1/15/25, I interviewed Ms. Gibson by phone. Ms. Gibson confirmed a medication error occurred at the home on 12/18/24.

On 1/16/25, I received a call from licensee designee, Holly Heath. Mrs. Heath acknowledged the error did occur. To help mitigate the problem, Mrs. Heath reported all direct care staff were required to complete extensive medication administration refresher training. Also, Mrs. Heath reported Mrs. O'Neil-Horton was suspended for 2 days and placed on a Performance Improvement Plan to monitor how she handles resident medication. Mrs. Heath described Mrs. O'Neil-Horton as a competent employee who's been dealing with recent family issues. Mrs. Heath suspects the distractions with her home life may have led to Mrs. O'Neil-Horton's inability to focus.

On 1/22/25, I completed an onsite inspection at the facility. There are currently 3 residents in care. I interviewed Resident A and C; Resident B was out of state on vacation with family. Both Resident A and C reported staff administer their medications daily without incident. Home manager, Kyle Gibson reported Resident B didn't show any adverse reactions after consuming Resident A's medication. According to Ms. Gibson, Resident B "she went on about her day as normal" and even attended her day program. Because Resident A's medication was administered to Resident B, Ms. Gibson contacted the pharmacy to reconcile the pill count. The request was granted, so Resident A did not run out of medication. Mrs. Heath was present on the day of inspection. Mrs. Heath explained the home is without a Medication Coordinator since the previous staff, Kelsey was terminated in December. Mrs. Heath said they are actively looking to refill the position. I expressed concern that the home was recently found in violation for the same rule (See SIR # 2024A0121046). Mrs. Heath assured me that she's making changes company wide to address the problem. While at the facility, I reviewed the medication records. On 12/18/24, Mrs. O'Neil-Horton administered Resident B's Cordarone 100MG, Norvasc 5MG, Caltrate+D 600MG, Eliquis 2.5MG, Feosol 325MG, Lasix 20MG, Prilosec 20MG, and Zoloft 100MG to Resident A by mistake. Resident B's morning medications are also signed out as having been administered by Mrs. O'Neil-Horton.

On 1/31/25, I interviewed Mrs. O'Neil-Horton by phone. Mrs. O'Neil-Horton acknowledged she made a mistake and gave Resident A, Resident B's morning medication because their names are so similar. Mrs. O'Neil-Horton admitted, "I was tired." Mrs. O'Neil-Horton seemed very remorseful for her actions. She stated, "I'm still upset with myself over this!"

On 2/3/25, I completed an exit conference with Mrs. Heath. A corrective action plan was requested. I cautioned Mrs. Heath that continued noncompliance would result in modification of the license considering the seriousness of the violation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 12/18/24, Mrs. O'Neil-Horton administered the wrong medication to Resident A. Resident A was given Resident B's morning medications.
CONCLUSION:	**VIOLATION ESTABLISHED** This is a **REPEAT VIOLATION;** See SIR# 2024A0121046. On 10/11/24, Mrs. Heath submitted an approved corrective action plan, but to date, the plan hasn't been successfully implemented. Therefore, Mrs. Heath is being afforded additional time to achieve compliance.

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain the same to afford the licensee an opportunity to implement said plan.

03/05/25

Kara Robinson — Date
Licensing Consultant

Approved By:

03/06/25

Ardra Hunter — Date
Area Manager