RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

June 27, 2017

Sherri Turner
Adult Learning Systems-Lower Michigan
Suite F
8170 Jackson Road
Ann Arbor, MI 48103

RE: License #: AS580360520
Investigation #: **2017A0116024**
Vivian Home

Dear Ms. Turner:

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,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste. 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS580360520
Investigation #:	2017A0116024
Complaint Receipt Date:	05/10/2017
Investigation Initiation Date:	05/12/2017
Report Due Date:	07/09/2017
Licensee Name:	Adult Learning Systems-Lower Michigan
Licensee Address:	Suite F 8170 Jackson Road Ann Arbor, MI 48103
Licensee Telephone #:	(734) 408-0112
Administrator:	Sherri Turner
Licensee Designee:	Sherri Turner
Name of Facility:	Vivian Home
Facility Address:	2563 Vivian Road Frenchtown, MI 48162
Facility Telephone #:	(734) 384-3506
Original Issuance Date:	01/15/2015
License Status:	REGULAR
Effective Date:	07/15/2015
Expiration Date:	07/14/2017
Capacity:	6
Program Type:	MENTALLY ILL DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Incident report documented Resident A was administered 400mg of his Lamotrigine pills instead of the prescribed 100mg.	Yes

III. METHODOLOGY

05/10/2017	Special Investigation Intake 2017A0116024
05/12/2017	Special Investigation Initiated - Telephone Interviewed home manager Sheila Beverly.
05/16/2017	Contact - Telephone call made Interviewed staff Angel Price and Joshuan Morales.
05/18/2017	Inspection Completed-BCAL Sub. Compliance Interviewed Ray Krzeminski, Regional Director at Adult Learning Systems and Resident A.
05/24/2017	Exit Conference With licensee designee Sherri Turner

ALLEGATION:

Incident report documented Resident A was administered 400mg of his Lamotrigine pills instead of the prescribed 100mg.

INVESTIGATION:

On 05/12/17, I interviewed home manager Ms. Beverly who confirmed the allegations. Ms. Beverly reported she was informed on 05/04/17 by staff Justice Shover, that Resident A was administered 400mg or more of his Lamotrigine medication on 05/02/17, 05/03/17 and 05/04/17. Ms. Beverly reported that Ms. Shover found the error when she was passing Resident A's evening medications on 05/04/17. Ms. Beverly reported on 05/04/17 after learning of the medication error, she contacted poison control who advised her to monitor Resident A and if no adverse reactions appeared, he would not need medical care. Ms. Beverly reported she went to the home and visually assessed Resident A and noticed a slight rash appearing on Resident A's back and decided to have him transported to the hospital for evaluation. Ms. Beverly reported the hospital ran several test, completed blood

work and found no health issues resulting from the additional medication ingested by Resident A. Resident A was not admitted and returned home within a few hours.

Ms. Beverly reported that the company uses a computerized medication program called ICM which stands for I Care Manager. Ms. Beverly reported after conducting a review of the prescription information in the ICM database and review of Resident A's actual medication labels she confirmed the information that was provided to her previously by Ms. Shover. Ms. Beverly reported that Resident A's prescription for Lamotrigine was still showing in ICM as give (4) 25mg pills twice per day (equaling 100mg per dose), however, a new prescription and pills came into the home on 05/01/17 that read give (1) 100mg pill twice per day. Ms. Beverly reported that the staff on shift who accepted the medication should have updated the information in ICM to reflect the change. In addition, Ms. Beverly reported that if staff Joshuan Morales and Angel Price would have followed the 5 rights of medication, reviewed the pharmacy supplied label and matched it with what was in ICM, they would have seen that the pills were no longer 25mg each, but 100mg.

Ms. Beverly reported that on 05/02/17, 05/03/17, and on 05/04/17 Resident A received the following incorrect doses of Lamotrigine;

- On 05/02/17, Mr. Morales administered Resident A 400mg of Lamotrigine at 8:00 a.m. instead of the prescribed 100mg dose. Staff Brooklyn Meddles passed the correct dose of 100mg at 8:00 p.m., resulting in Resident receiving 400mg more of the prescribed medication.

- On 05/03/17, Mr. Morales administered Resident A 400mg of Lamotrigine at 8:00 a.m. instead of the prescribed 100mg dose. Ms. Price passed another 400mg at 8:00 p.m., resulting in Resident A receiving 700mg more of the prescribed medication.

- On 05/04/17, Mr. Morales administered Resident A 400mg of Lamotrigine at 8:00 a.m. instead of the prescribed 100mg dose. Ms. Shover passed the correct dose of 100mg at 8:00 p.m., resulting in Resident A receiving 400mg more of the prescribed medication.

- On 05/04/17 Ms. Shover found the error and on 05/05/17 Resident A began receiving the correct 100mg dose of his Lamotrigine medication.

Ms. Beverly reported that since the incident Mr. Morales has been scheduled for medication refresher training for 05/12/17 and Ms. Price will complete her medication refresher course on 06/09/17. Both Mr. Morales and Ms. Price received a written reprimand.

On 05/16/17, I interviewed Ms. Price who reported she has been employed with the company and working in the home since 02/17/17 and is fully trained. Ms. Price reported that she does not know how she made the medication error on 05/03/17

and reported that she followed the six rights of medication. Ms. Price reported when she looked at the information in ICM it stated to give Resident A (4) 25mg Lamotrigine pills and, “That’s what I did”. I asked Ms. Price did she review the pharmacy printed label on the medication bottle and she reported that she did not. I provided consultation and informed Ms. Price that a part of following the 5 rights of medication administration includes reviewing the label on the medication bottle to ensure it matches the medication administration record (MAR) or in her case, the information contained in their ICM database. Ms. Price reported an understanding and admitted that if she had reviewed the label she would have caught the error. Ms. Price reported that she is glad that Resident A did not suffer any ill effects from the medication error and reported she is double and triple checking medication prior to administering. Ms. Price reported she will be taking a medication refresher course due to her error.

I interviewed Mr. Morales on 05/16/17 and he reported that he has been employed with the company for about a year and is fully trained. Mr. Morales admitted that he is responsible for the medication errors that occurred on the morning of 05/02/17, 05/03/17, and 05/04/17. Mr. Morales reported that he is not making excuses, but reported that this specific medication has been changed three or four times for Resident A. Mr. Morales reported that the dosage started at 25mg, then went to 50mg, 75mg and 100mg within a relatively short time frame. Mr. Morales reported with each change in the dose things became a little more confusing because of how the pharmacist dispensed the medication. However, Mr. Morales admitted that he did not check the medication label before administering Resident A’s Lamotrigine medication and therefore was not aware that the new prescription with the 100mg pills had been delivered to the home. Mr. Morales also reported that the new prescription information was not entered into the ICM database and when he reviewed it prior to administering the medication, it still documented to give Resident A (4) 25mg Lamotrigine pills. Mr. Morales gave the 4 pills but reported being unaware that each pill was 100mg. Mr. Morales was remorseful and thankful that Resident A was not harmed as a result of his error. Mr. Morales reported that this is his first time ever having a medication error. He reported that he completed a medication refresher course on 05/12/17 and received a written reprimand.

On 05/18/17, I conducted an onsite inspection and interviewed Resident A. Resident A reported he is really happy living in the home and reported getting along with his roommate. Resident A did not appear to be aware of how or why he was given more medication than was prescribed, but knew that he had been. Resident A reported he had to go to the hospital to be checked out because of the rash on his back. Resident A was very friendly and was comfortable in his surroundings.

I interviewed Mr. Krzeminski and he reported being aware of the medication error once it was discovered on 05/04/17. Mr. Krzeminski reported that the home accepts full responsibility for the error and he is just glad that Resident A did not suffer any ill effects. Mr. Krzeminski reported that both staff have been verbally reprimanded and will also have to complete a medication refresher. Mr. Krzeminski reported that the

staff person who accepted the medication and did not update it in the ICM database will be spoken to about her responsibility in the matter.

I conducted the exit conference on 05/24/17 with Mrs. Turner. Mrs. Turner reported she was made aware of the medication error and reported that if staff had followed the 5 rights of medication and checked the medication label this would have been prevented. I informed Mrs. Turner of the specific rule violations cited and she reported an understanding. Mrs. Turner reported she would submit an acceptable corrective action plan upon receipt of the report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Mr. Morales administered Resident A the incorrect dose of his prescription Lamotrigine medication on the mornings of 05/02/17 05/03/17, and 05/04/17. Ms. Price administered the incorrect dose of the same medication on 05/03/17. Both Mr. Morales and Ms. Price failed to give the medication pursuant to the label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**

ANALYSIS:	Mr. Morales and Ms. Price, without regard to intent, modified Resident A's Lamotrigine medication, by administering between 400mg-700mg more than was prescribed on 05/02/17, 05/03/17, and 05/04/17. Further, when the new prescription and medication was delivered to the home, staff failed to document the new prescription instructions. This failure contributed to Resident A being administered the incorrect dose of Lamotrigine on the aforementioned dates.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/15/17

Pandrea Robinson
Licensing Consultant

Date

Approved By:

06/27/17

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Ardra Hunter
Area Manager

Date