STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

July 11, 2017

Teresa Fowler
Meridian Senior Living
Suite 220
PO Box 120143
Grand Rapids, MI 49528-0143

RE: License #:	AL410007172
Investigation #:	2017A0356035
	Whispering Woods #3

Dear Mrs. Fowler:

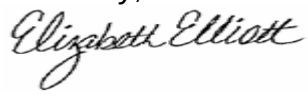
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410007172
Investigation #:	2017A0356035
Complaint Receipt Date:	05/10/2017
Investigation Initiation Date:	05/10/2017
Report Due Date:	07/09/2017
Licensee Name:	Meridian Senior Living
Licensee Address:	Meridian Senior Living Suite 220 PO Box 120143 Grand Rapids, MI 49528-0143
Licensee Telephone #:	(616) 949-9500
Administrator:	Lucijana Tomic
Licensee Designee:	Teresa Fowler
Name of Facility:	Whispering Woods #3
Facility Address:	3980 Whispering Way, SE Grand Rapids, MI 49546-5804
Facility Telephone #:	(616) 949-9500
Original Issuance Date:	01/22/1993
License Status:	REGULAR
Effective Date:	04/25/2017
Expiration Date:	04/24/2019
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
A Direct Care Worker put ear drops into Resident A's eyes mistaking the ear drops for eye drops.	Yes

III. METHODOLOGY

05/10/2017	Special Investigation Intake 2017A0356035
05/10/2017	Special Investigation Initiated - Telephone APS Kortney Post.
05/10/2017	APS Referral APS Kortney Post. Actual date: 04/03/2017
05/10/2017	Contact - Face to Face Shannon Bila, nurse and Lucijana Tomic, Administrator. Actual date: 04/03/2017 (while investigating SI2017A0356025)
05/10/2017	Contact - Document Received Docs received from Lucijana Tomic re: Resident A. Actual date: 04/03/2017 (while investigating SI2017A0356025)
05/10/2017	Contact - Face to Face Resident A, Friend 1 & 2. Actual date: 04/13/2017 (while investigating SI2017A0356025)
05/10/2017	Contact - Telephone call made Kaye Scholl, Ombudsman Actual date: 04/13/2017 (while investigating SI2017A0356025)
05/10/2017	Contact-Telephone call made Relative #1 Actual date: 04/20/2017 (while investigating SI2017A0356025)
07/10/2017	Exit Conference Terri Fowler, Licensee Designee

***Note the interviews and documents received and reviewed predate the initiation of this investigation due to the previous SI #2017A0356025.**

ALLEGATION: A Direct Care Worker put ear drops into Resident A's eyes mistaking the ear drops for eye drops.

INVESTIGATION: On 05/10/2017, I opened a Special Investigation (SI) stemming from SI #2017A0356025, a complaint from the Department of Health and Human Services (DHHS), Centralized Intake Unit that reported a Direct Care Worker (DCW) put ear drops into Resident A's eyes mistaking the ear drops for eye drops. While conducting the investigation on #2017A0356025, I discovered the allegation regarding Resident A's eye drops actually occurred in a different building on this campus than the rest of the complaint allegations. Therefore, I initiated this as a separate SI to address the particular allegation regarding Resident A's eye drops.

On 04/03/2017, I interviewed Lucijana Tomic, Administrator and Shannon Bila, facility nurse at the facility. Ms. Bila and Ms. Tomic acknowledged the allegations regarding a DCW administering ear drops into Resident A's eyes mistaking the ear drops for eye drops did occur in December 2016. Ms. Tomic stated medical evaluation and treatment for Resident A was sought and the DCW was terminated. Ms. Tomic stated the ear drops were in an unmarked, unlabeled bottle in Resident A's room and the ear drops were not on the Medication Administration Record whereas the eye drops are labeled and on the MAR. Ms. Tomic stated both medications were coincidentally in similar bottles and the DCW mistook the ear drops for the eye drops and administered them to Resident A. Ms. Tomic and Ms. Bila reported Resident A moved out of this facility on 03/02/2017.

On 04/03/2017, I received and reviewed the Incident Report dated 12/23/2016 and signed by Audra Harmon, Resident Care Manager. Ms. Tomic and Wendy Ehnis, corporate nurse signed on 03/08/2017. The report documents the medication error as occurring during the 8:00AM med pass, reported to Ms. Harmon at 9:30AM on 12/23/2016 and documents the description of the error as follows: "*Med Tech alleged to have used unlabeled bottle for eye drop administration. Resident complained of burning at administration, refresh tears to follow, resident refuses ER evaluation. Physician called and prescribes OTC (*over the counter*) drops, orders followed and daughter brings OTC meds in on 12/24/2017."* Plan of Correction to prevent future errors: "*Counseling to (DCW), off med cart until next med class. (DCW) terminated on 12/28/2017."*

On 04/03/2017, I received and reviewed Resident A's Medication Administration Records. The MARs reflect Refresh Ointment to be administered in both eyes, once daily at night and Systane Gel eye drops, to be administered in both eyes four times daily. There is no documentation of a prescription for ear drops on Resident A's MARs.

On 04/13/2017, I interviewed Resident A at her current residence. Resident A reported a DCW "put peroxide in my right eye" and she could feel it burning. Resident A stated she was taken to see Dr. Verdier and that's when they figured out the ear drops were actually put in Resident A's eye. Resident A stated the ear drops did not have any type of label on it stating what it was and she had the homemade ear drops in her room and not locked in the medication cart along with her other medications. Resident A stated she received treatment and is able to see out of both

eyes. Resident A's friends, Friend 1 & Friend 2 showed up to visit with Resident A while I was interviewing her and both friend's confirmed the mix up in medications between Resident A's ear drops and eye drops.

On 04/13/2017, I interviewed Kay Scholl, representative from the Office of the Ombudsman. Ms. Scholl stated she received a telephone complaint from Resident A's relative and followed up on concerns including the administration of the wrong medication to Resident A by a DCW at this facility. Ms. Scholl suggested I talk to Relative #1 for more detailed information and stated this incident occurred some months ago but she addressed the concern with Ms. Tomic in a meeting with her on 02/17/2017. Ms. Scholl stated a DCW administered ear drops that were not marked or labeled and not in the locked medication cart but rather kept in Resident A's room into Resident A's eyes mistaking them for her prescription eye drops. Ms. Scholl stated she was told by Relative #1 the ear drops have "a peroxide like substance" in it that would give a burning sensation if put into the eye. Ms. Scholl stated Resident A has moved from this facility.

On 04/20/2017, I interviewed Relative #1 via telephone. Relative #1 confirmed the incident regarding the mix up in medications occurred in this facility shortly after Resident A moved into this facility in December 2016. Relative #1 stated Resident A's doctor told her (Relative #1) to mix hydrogen peroxide with some water to treat Resident A's ear issues. Relative #1 stated the ear drops are not a prescribed medication and she unwittingly put the home made ear drops in a bottle that was very similar to the bottle Resident A's prescription eye drops came in. However, Relative #1 stated she placed the unmarked, unlabeled, non-prescription ear drops tucked into a corner of a bedside table in Resident A's room so she could administer them to Resident A when she came to visit. Relative #1 stated she then gave all of the prescribed medications including the eye drops to the med tech never telling the med tech about the ear drops in the bedside table. Relative #1 stated she has no idea how the ear drops were discovered or how they ended up being administered to Resident A but Resident A called her (Relative #1) and said her eyes were burning. Relative #1 stated she called Dr. Verdier to receive directions on what to do and Resident A has recovered from this incident. Relative #1 stated she has no idea why a trained med tech would administer a medication without a label on it without finding out what it was and why it was without a label but stated it happened and it could have had worse results than it did.

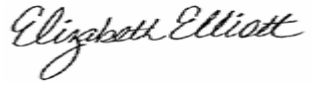
On 07/10/2017, I conducted an Exit Conference with Licensee Designee, Terri Fowler via telephone. Ms. Fowler acknowledged that Resident A's unmarked, nonprescription ear drops were administered into her eyes by a DCW at the facility. Ms. Fowler stated this incident was reported to Ms. Harmon on the date it occurred, 12/23/2016 however; Ms. Tomic, Ms. Ehnis and Ms. Fowler were not made aware of this incident until a medication review was completed on 03/08/2017. Ms. Fowler stated the DCW was terminated at the time of the incident and a different nurse is in charge of this facility. Ms. Fowler agrees that the information, analysis and conclusion of the applicable rule is reasonable.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	The complainant reported that a DCW put ear drops into Resident A's eyes and mistook the ear drops for eye drops. Ms. Bila and Ms. Tomic acknowledged a DCW administered ear drops into Resident A's eyes mistaking the ear drops for eye drops. Ms. Tomic stated the ear drops were in an unmarked, unlabeled bottle in Resident A's room and the ear drops were not on the Medication Administration Record whereas the eye drops are labeled and on the MAR. Ms. Tomic stated both the eye medication and the ear remedy were coincidentally in similar bottles and the DCW mistook the ear drops for the eye drops and administered them to Resident A. The IR documented the medication error reporting a med tech used an unlabeled bottle for eye drop administration. Resident complained of burning at administration and medical treatment sought. The MARs reflect Refresh Ointment to be administered in both eyes, once daily at night and Systane Gel eye drops, to be administered in both eyes four times daily. There is no documentation of a prescription for ear drops on Resident A's MARs. Resident A reported a DCW "put peroxide in my right eye" and she could feel it burning.

	Relative #1 confirmed that a homemade ear drop remedy mixed up by her (Relative #1) upon the direction of Resident A's doctor was administered into Resident A's eyes by a DCW at the facility who assumed the drops were for Resident A's eyes. The bottle was in an unmarked, unlabeled bottle in the bedside table, not in a locked medication cart but in Resident A's room at the facility placed there by Relative #1. A homemade remedy for ear drops was placed by Relative #1 into Resident A's room at the facility. The remedy was not in a locked medication cart nor was it was it marked or labeled but the ear drop remedy of peroxide and water was administered into Resident A's eyes by a DCW at the facility as though it were one of her prescribed medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

RECOMMENDATION

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



07/10/2017

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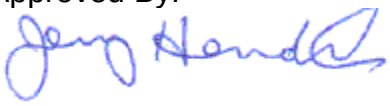
Elizabeth Elliott — Date
Licensing Consultant

Approved By:



07/11/2017

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Jerry Hendrick — Date
Area Manager