RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

August 14, 2018

Julia Jeffreys
LADD, Inc.
300 Whitney Dr.
Dowagiac, MI 49047

RE: License #: AS630012404
Investigation #: **2018A0605002**
Groveland Home

Dear Ms. Jeffreys:

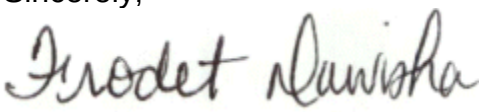
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012404
Investigation #:	2018A0605002
Complaint Receipt Date:	07/26/2018
Investigation Initiation Date:	07/26/2018
Report Due Date:	09/24/2018
Licensee Name:	LADD, Inc.
Licensee Address:	8054 Ortonville Rd Clarkston, MI 48348
Licensee Telephone #:	(517) 795-4010
Administrator:	Julia Jeffreys
Licensee Designee:	Julia Jeffreys
Name of Facility:	Groveland Home
Facility Address:	9921 Walnut Hill Drive Davisburg, MI 48350
Facility Telephone #:	(248) 634-1297
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	09/12/2016
Expiration Date:	09/11/2018
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Per incident report, on 7/19/18 resident saw a cup on the counter with a drink containing lactulose medication for another resident. It was gone when staff went to get it to give to the correct resident.	Yes
Staff did not contact appropriate health care professional when the medication error occurred.	Yes

III. METHODOLOGY

07/26/2018	Special Investigation Intake 2018A0605002
07/26/2018	Special Investigation Initiated - Telephone Telephone call made with Office of Recipient Rights (ORR) worker, Sondra Knisely.
07/31/2018	Contact - Face to Face On-site contact with Staff Member (SM) Belinda Lillard and SM, Sandra Bradley who is the home manager.
07/31/2018	Contact - Face to Face Resident B is non-verbal and was observed at New Horizons located in Davisburg.
07/31/2018	Contact - Telephone call made Telephone call made with Resident B's legal guardian, Mildred Applewhite.
07/31/2018	Contact - Telephone call made Left messages for SM Jamie Conrad and SM Emma Medlock.
08/01/2018	Contact - Telephone call received Staff members, Jamie Conrad and Emma Medlock left messages.
08/02/2018	Contact - Telephone call made Telephone call made with staff members, Jamie Conrad and Emma Medlock.
08/07/2018	Contact - Face to Face Resident A was observed at Lahser Pre-Vocational Centers, Inc., located in Clarkston. Also, interviewed was the administrative assistant, Carrie Tener.

08/07/2018	Contact - Telephone call made Telephone call made with area supervisor, Jamey Conrad.
08/13/2018	Exit Conference Exit Conference with licensee designee and administrator, Julia Jeffreys.

ALLEGATION:

- **Per incident report, on 7/19/18 Resident A saw a cup on the counter that contained a drink containing medication, Lactulose, that was for Resident B. It was gone when staff went to get it to give to the correct resident.**
- **Staff did not contact appropriate health care professional when the medication error occurred.**

INVESTIGATION:

On 07/25/18, a complaint was received from the licensing unit regarding concerns that on 07/19/18 Resident A saw a cup on the counter which contained a drink containing medication, Lactulose that was for another recipient of the home and allegedly drank it. The staff member was unaware until it was time to give Resident B the drink that it was gone. I opened a special investigation on 07/26/18. I conducted an unannounced on-site inspection on 07/31/18 and interviewed staff members, Belinda Lillard and Sandra Bradley, the home manager. I also reviewed Resident A and Resident B's medication logs and Resident A's health care chronological. In addition, I observed Ms. Lillard simulate a medication pass.

On 07/26/18, I spoke with Office of Recipient Rights (ORR), Sandra Knisely. She stated there have been ongoing issues with staff members at Groveland Home setting all the drinks out, which are already mixed with residents' medications on the counter. Ms. Knisley stated that out of the six residents, three have a form of laxative medication mixed into their drinks. Ms. Knisley stated she interviewed two staff members via telephone. She stated that Belinda Lillard was the staff member who left the drinks unattended while she was helping shower Resident C. Ms. Knisely stated she was told that Resident A and B drink their drinks out of a sippy cup and both have laxatives in their drinks. Resident A's laxative is Polyethylene GLYC 3350 NF POWD (BR) #527 and Resident B's laxative is Lactulose 10GM/15ML Syrup. Ms. Knisely stated it was alleged that while Ms. Lillard was helping Resident C in the shower, Resident A got up and took Resident B's sippy cup and drank the contents in the cup. Ms. Knisely stated no one saw Resident A drink Resident B's drink, but it's being alleged that he did because he's the only resident who has tried to drink someone else's cup in the past. Ms. Knisely stated that staff at Groveland Home did not seek medical treatment for Resident A nor did the staff contact Resident A's primary physician. Ms. Knisely stated she was told that was because "Resident A tends to have diarrhea like of bowel

movements anyway." Ms. Knisely stated, "it sounds like they have a disorganized way of handling medication."

On 07/31/18, I interviewed staff members, Belinda Lillard and Sandra Bradley. According to Ms. Lillard, she has been with the corporation for 4 years; however, she left for a year and then recently returned in November 2016. Ms. Lillard stated when she returned, the company had hired another staff member, Emily Medlock. Ms. Lillard stated she and Ms. Medlock were working on 07/19/18, when Resident A allegedly drank Resident B's drink mixed with Lactulose. Ms. Lillard stated that all six residents returned from workshop around 5:00 PM. She was assisting Resident C to the bathroom while Ms. Medlock was preparing dinner in the kitchen. While Resident C was on the toilet, Ms. Lillard returned to the kitchen and set out the plates and proceeded to pour all the drinks, including Resident A and B's which included Polyethylene and Lactulose. Ms. Lillard stated that Resident A and B drink their drinks out of sippy cups. Resident A has his Polyethylene mixed with cranberry juice, while Resident B's Lactulose is mixed with protein powder and milk. Ms. Lillard stated although she told Ms. Medlock she prepared the drinks with some of the medications, that Ms. Medlock was not watching as to whose cup belonged to whom. Ms. Lillard returned to Resident C to assist in giving her a shower. Shortly after, Ms. Lillard and Resident C returned to the dinner table to eat and that's when Ms. Medlock when to get Resident B's sippy cup from the counter and realized it was empty. Ms. Lillard stated that Ms. Medlock looked at Resident A and asked, "Did you drink Resident B's drink?" Resident A, "just looked to the side and didn't pay attention to what Ms. Medlock was saying." Ms. Lillard did not see Resident A drink Resident B's sippy cup. Ms. Lillard called Ms. Bradley, the home manager who advised her to write up an incident report, which she did. Ms. Lillard did not seek medical treatment for Resident A because she stated, "My home manager just told me to write the incident report." Ms. Lillard stated that when there is a medication error; someone takes someone else's medications, they must call the resident's primary doctor or the on-call nurse and document it in the health care chronological.

I reviewed the health care chronological and there was no entry made on 07/20/18 regarding a physician being contacted regarding Resident A. Ms. Lillard stated that when she returned to working for this corporation, that Ms. Medlock was the staff member who started preparing all the drinks with the medications to "make things easier," and placing them on the counter during dinner time. She stated, "prior to that, I would make the drinks with the medications in the laundry room where the medications are locked up and hand the drink to the resident." Ms. Lillard simulated a medication pass as to how she would handle the medication and administer it to the residents. Ms. Lillard stated that Resident B did not get his Lactulose administered to him on 07/19/18; even though the medication log was initialed by Ms. Lillard. Ms. Lillard stated, "this was an error I made."

On 07/31/18, I interviewed Sandra Bradley, the home manager. According to Ms. Bradley, she has been employed with the corporation for 38 years. She works the daytime shift; 6:30AM-5:00PM. Ms. Bradley stated she was not present on 07/20/18 when Resident A allegedly drank Resident B's drink mixed with his medication

Lactulose. Ms. Bradley stated that staff member, Ms. Lillard called her and said that she was getting someone out of the bathroom and when she returned, Resident A had gotten someone else's drink. Ms. Lillard told her that she prepared the drinks with the medications and thought they were safe because Ms. Medlock was in the kitchen. Ms. Bradley stated that it's not normal for Resident A to pick up someone else's sippy cup and drink it. She stated she does not believe he did but doesn't know what happened to the drink. Ms. Bradley stated she was not aware that staff have been preparing the drinks with the residents' medications and setting them on the county. She stated the process is to take the drink to the laundry room, measure the drink with the residents' medication and bring it to the resident and observe the resident drink it. Ms. Bradley stated that this medication error where a resident drank someone else's medication has never happened before, but if it did, the staff must write an incident report, contact her and follow the directions on the Standard Missed Medication Order. She stated she is not sure if Resident A's physician was contacted or not. Ms. Bradley stated this was an isolated incident and that she and the area supervisor, Jamey Conrad have taken steps to address these issues. Ms. Lillard read the medication policy and has been put on an issue review for a first offense. In addition, they will be addressing medication errors during their staff meeting this upcoming week and what the protocol is for when a medication error occurs. Ms. Bradley stated she does not know if Resident B's sister, Mildred Applewhite who is also his legal guardian was contacted regarding this incident.

On 07/31/18, I reviewed Resident A's medication log. He was given the following medications, but the log was not initialed by any staff member.

- Polyethylene Glyc 3350NF Powder, mix 17 grams in 8 ounces of liquid and drink once daily was administered at 9PM on 07/01/18, but the log was not signed.

On 07/31/18, I reviewed Resident B's medication log. He was given the following medication, but the log was not initialed by any staff member.

- Furosemide 40Mg Tab, take 1 tab by mouth once daily administered at 9PM on 07/11/18, but the log was not initialed.
- Oster Shell 500Mg Tab; take 1 tab by mouth once daily was administered at 9PM on 07/11/18, but the log was not initialed.
- Polyethyene Glyc 3350NF Powder, mix half capful in 4oz of water and drink every other day was administered at 9PM on 07/0418 and 07/18/18, but log was not initialed.
- Ranitidine 150Mg tab, take 1 tab by mouth twice daily was administered at 9PM on 07/04/18, 07/16/18, 07/18/18, and 07/28/18, but the log was not initialed.
- Triamcinolone .19% cream apply topically twice daily for 2 weeks was administered in the AM on 07/04/18, but the log was not initialed.
- Micronazole Nitrate 2% Spray or Powder apply to affected area twice daily was administered in the AM on 07/04/18, 07/22/18, and 07/28/18, but the log was not initialed.

- Aspir-low 81Mg EC Tab, take 1 tab by mouth once daily was administered at 9PM on 07/04/18, but the log was not initialed.
- Lactulose 10gram/15ML solution, take 15ML by mouth once daily was **NOT** administered on 07/19/18, but the medication log was initialed by staff member, Belinda Lillard.

On 07/31/18, I observed Resident B at New Horizons Rehabilitation located in Davisburg. The assistant care coordinator, Rebecca Schuette wheeled Resident A into the conference room. I was unable to interview him as Resident A is non-verbal and hard of hearing. He was observed to be clean. Ms. Schuette stated she has no concerns to report regarding Resident A and Groveland Home.

On 07/31/18, I spoke with Resident A's sister and legal guardian, Mildred Applewhite. Ms. Applewhite stated she was not contacted by anyone from Groveland Home regarding Resident A drinking someone else's medication. Ms. Applewhite stated, "I find it very hard to believe that Resident A got up and drank the sippy cup on the counter. He sits all day until someone tells him to get up. The only way Resident A could drink something is if they put the drink in front of him and tell him to drink it." Ms. Applewhite stated she is upset that this happened, and no one called her. She stated that Resident A cannot carry a conversation so he's unable to state what happened, but she is sure that Resident A did not drink the other Resident's drink on his own. She stated she has no concerns with the home until now.

On 08/02/18, I spoke with staff member, Emma Medlock. Ms. Medlock is the physician care technician at Groveland Home. According to Ms. Medlock, she's been employed with the corporation over a year. Ms. Medlock stated she and another staff member, Belinda Lillard were working on 07/19/18 at Groveland Home. Ms. Medlock was making dinner while Ms. Lillard was helping Resident C with her shower. Ms. Medlock stated that Ms. Lillard came out of the bathroom and began preparing the drinks. Ms. Medlock stated she prepared dinner and sat down with the residents some to eat. Ms. Lillard finished helping Resident C with her shower and came out of the bathroom. She stated that Ms. Lillard went to sit down in another room, leaving Ms. Medlock with the residents. Ms. Medlock stated she got up to get Resident B's drink when she saw the sippy cup empty. Ms. Medlock stated she did not see Resident A get up, take the sippy cup and drink it. She stated that she believes it was him because he's been helpful lately as he has been taking plates and cups from the dinner table to the kitchen sink. She stated, "Resident A is the only one capable of drinking it. It was a protein drink mixed with Resident B's medication, Lactulose." Ms. Medlock stated she then contacted, Sandy Bradley, the home manager who advised to have Ms. Lillard complete an incident report. She stated, "I did not know that I needed to call the doctor or the nurse. I monitored him, and he had no adverse effect of the Lactulose." According to Ms. Medlock, all the staff members have been premixing the medications in the drinks and setting them up on the counter. She stated, "the drinks are not always supervised, and I was conditioned to do it this way since being at this home."

On 08/02/18, I spoke with the area supervisor, Jamey Conrad. According to Ms. Conrad, she has been employed with this corporation for fourteen years. Ms. Conrad stated she was on vacation when the incident occurred with Resident A allegedly drinking Resident B's drink with his Lactulose medication. She stated she was told by the home manager, Ms. Bradley on 07/21/18 about what happened. Ms. Conrad stated she was told that Resident A possibly ingested Resident B's drink that had his medication. Ms. Conrad stated she spoke with Ms. Ballard on 07/22/18 advising her that staff member, Belinda Lillard needed to be retrained on medication set-up and administering. Ms. Conrad stated that Ms. Bradley met with Ms. Lillard and reviewed the medication policy. In addition, Ms. Conrad stated that there will be an in-service training for all staff members at the staff meeting on 08/06/18 regarding medication and the protocol and policy as to contacting the resident's physician. Furthermore, Ms. Conrad stated that Ms. Bradley left a note in staff log reminding staff not to leave medication unattended.

On 08/07/18, I spoke with Ms. Conrad. She stated she is aware that there were many areas in the medication log where medication was administered to Resident A and B but that the medication log was not initialed by staff. She stated that the home has implemented a two-person check. In addition, the medication log was also part of the in-service staff training that was held on 08/06/18; and all individuals who did no initial the log when they should have, are getting a write-up.

On 08/07/18, I observed Resident A at Lahser Pre-Vocational Centers, Inc., located in Clarkston. The administrative assistant, Carrie Tener brought Resident A to the conference room; however, as soon as he entered the room, he quickly turned around and left. Ms. Tener attempted several times to have Resident A return, but he declined, and continued to walk back to his room. Ms. Tener escorted Resident A back to his room and returned. She stated that Resident A is waiting for his sister to pick him up and he thought this consultant was her. Ms. Tener stated that Resident A is non-verbal. He always wears his sunglasses and hat and is always "dressed sharp." Ms. Tener stated that Resident A can be "very stubborn when he wants to be." She stated he will refuse to get up from his seat any given day and other days, he's extremely helpful. Ms. Tener stated he will help pack others' lunchboxes but that she has never seen him take another person's lunch or their drinks. Ms. Tener has no concerns with Resident A or Groveland Home.

On 08/13/18, I conducted the exit conference with the licensee designee and administrator, Julia Jeffreys. Ms. Jeffreys stated she is aware of the incident that occurred where Resident A allegedly drank Resident B's sippy cup that had his medication in it. Ms. Jeffreys stated she was not aware that staff members were preparing the drinks with the medications during mealtime and placing them on the counters. She has addressed appropriate medication administering with the staff.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my investigation, Resident A was not always protected by staff members. On 07/19/18, he got up and took Resident B's sippy cup with the prescription medication Lactulose and drank it.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**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:	Precautions were not taken by staff members to ensure that the appropriate prescription medication Lactulose was taken by the resident the medication was prescribed for.
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: **(a) Be trained in the proper handling and administration of medication.**

ANALYSIS:	Staff members, Belinda Lillard and Emma Medlock did not appropriately administer the residents' prescription medication. Ms. Lillard and Ms. Medlock had prepared the drinks with the prescription medication during mealtime and left the drinks unsupervised on the kitchen counter. Resident A took Resident B's sippy cup and drank it, which had Resident B's medication Lactulose. According to Sandra Bradley, the home manager and Jamey Conrad, the area supervisor, this was not the proper handling and administration of medications.
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 the following provisions: **(b) Complete an individual medication log that contains all the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

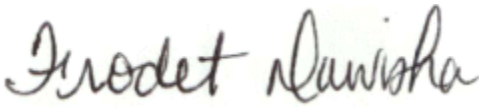
ANALYSIS:	During the on-site inspection, I reviewed Resident A and Resident B's medication logs. • Staff Members **did not** initial the medication log for Resident A when Polyethylene Glyc 3350NF Powder, mix 17 grams in 8 ounces of liquid and drink once daily was administered at 9PM on 07/01/18. • Staff member, Belinda Lillard initialed the medication log on 07/19/18, when Resident B did not get his Lactulose. • Ranitidine 150Mg tab, take 1 tab by mouth twice daily was administered to Resident B at 9PM on 07/04/18, 07/16/18, 07/18/18, and 07/28/18, but the log was not initialed. • Triamcinolone .19% cream apply topically twice daily for 2 weeks was administered to Resident B in the AM on 07/04/18, but the log was not initialed. • Micronazole Nitrate 2% Spray or Powder apply to affected area twice daily was administered to Resident B in the AM on 07/04/18, 07/22/18, and 07/28/18, but the log was not initialed. • Aspir-low 81Mg EC Tab, take 1 tab by mouth once daily was administered to Resident B at 9PM on 07/04/18, but the log was not initialed.
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 the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuse prescribed medication or procedures and follow and record the instructions given.**

ANALYSIS:	Staff members, Belinda Lillard and Emma Medlock did not contact appropriate health care professional after Resident A drank Resident B's drink with his prescription medication Lactulose.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

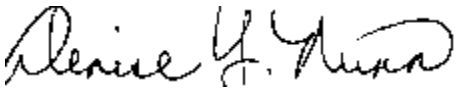
Contingent upon the licensee submitting an acceptable corrective action plan, I recommend that the special investigation be closed with no change to the license.



08/13/18

Frodet Dawisha Date
Licensing Consultant

Approved By:



08/14/2018

Denise Y. Nunn Date
Area Manager