RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

December 6, 2018

Carl R and Patricia M Royster
2026 Oren Ave
Flint, MI 48505

RE: License #: AF250087511
Investigation #: 2019A0779001
Royster Haven

Dear Carl R and Patricia M Royster:

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 (810) 787-7031.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(517) 899-5659

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF250087511
Investigation #:	2019A0779001
Complaint Receipt Date:	10/10/2018
Investigation Initiation Date:	10/10/2018
Report Due Date:	12/09/2018
Licensee Name:	Carl R Royster and Patricia M Royster
Licensee Address:	2026 Oren Ave Flint, MI 48505
Licensee Telephone #:	(810) 233-6958
Administrator:	Carl Royster
Licensee Designee:	N/A
Name of Facility:	Royster Haven
Facility Address:	2026 Oren Ave Flint, MI 48505
Facility Telephone #:	(810) 233-6958
Original Issuance Date:	01/10/2000
License **Status:**	REGULAR
Effective Date:	12/19/2016
Expiration Date:	12/18/2018
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The home's medication log book is missing 12 initials (over a 3-day period) indicating that the prescribed medications were not passed to Resident A.	Yes

III. METHODOLOGY

10/10/2018	Special Investigation Intake 2019A0779001
10/10/2018	Special Investigation Initiated - Telephone Spoke to Complainant.
10/17/2018	APS Referral Complaint was referred to APS centralized intake.
10/17/2018	Inspection Completed On-site Interview conducted with staff person, Ivana Wilson.
10/17/2018	Contact - Telephone call made Spoke to licensee.
12/04/2018	Inspection Completed On-site Interview conducted in-person with licensee, Carl Royster.
12/05/2018	Exit Conference Conducted by phone with licensee, Carl Royster

ALLEGATION:

The home's medication log book is missing 12 initials (over a 3 day period) indicating that the prescribed medications were not passed to Resident A.

INVESTIGATION:

On 10/10/18, a phone interview was conducted with Complainant (C1). C1 stated that this facility may not be giving Resident A his medications correctly. She stated that Resident A's medication logs were missing 12 initials, over a 3-day period, indicating that Resident A's medications were not passed. C1 reported that Resident A has not had any significant behavior changes as you would think if he had missed multiple

doses of his medication, so this might simply be a documentation error. C1 stated that she is not sure if Resident A actual took the medications or not on the days in question.

On 10/17/18, a phone conversation took place with licensee, Carl Royster. Mr. Royster stated that he was aware of this issue and that he believes that all the medications were passed and that it is just a documentation issue. He stated that he has a few new staff that he will be retraining on how to properly pass medications and to properly document that. Mr. Royster reported that their medications are set up to where you cannot get to a new medication without passing the previous dose.

On 10/17/18, an on-site inspection was conducted and an interview took place with staff person, Ivana Wilson. Ms. Wilson stated that she does not always initial the medication logs at the time she passes the medication and tends to initial the logs toward the end of her shift. When asked what she is supposed to do with the medications if she sees that the previous doses were not passed, Ms. Wilson stated that the medication packets are placed in a container labeled “extra meds”. Ms. Wilson clarified that she has not seen any missed doses and is sure that the missing initials is just documentation error.

During the on-site inspection, several resident’s medication logs were reviewed. Resident A, Resident B and Resident C’s logs all had several dates in October 2018 where staff did not initial the medication logs, indicating whether the medications were passed or not. There was no staff initials for the morning medications for that date. Each resident’s medications are sealed in packets for each time of day the medications are to be passed. All packets are attached to each other on a large reel and one has to remove the previous dose packet to get to the next dose given. The “extra meds” containers were also reviewed and there were no full medication packets for the October dates in question. Resident A has a prescription which states to be given at twelve noon. Resident A has been getting his noon medication either with his morning doses of medication or when he returns from his day program in the late afternoon.

On 12/4/18, an on-site inspection was conducted and an interview took place with licensee, Carl Royster. Mr. Royster reported that he is not aware of any residents missing any doses of medication. Mr. Royster stated that he has never told any staff to put missed doses of medication in the “extra meds” container, but has told staff to give the miss doses of medication to the resident later the same day, but make sure the medications are spaced an appropriate amount of time apart from each other. Mr. Royster was told that medications must be passed pursuant to label instructions with no more than one hour each way from the time indicated. He reported that Resident A has a medication that is supposed to be passed at twelve noon, while Resident A is at his day program. He stated that he has his staff pass the noon medication either with the morning doses of medications or after Resident A returns from the day program in the late afternoon.

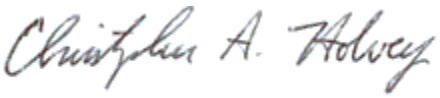
On 12/5/18, an exit conference was conducted by phone with licensee, Carl Royster.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: **(a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.**
ANALYSIS:	Licensee's Carl and Patricia Royster and several responsible persons (staff persons), failed to maintain an accurate medication log for several residents. There were several days where the medications were passed properly, but the staff forgot to initial the log.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(2) Medication shall be given pursuant to label instructions.
ANALYSIS:	Licensee's Carl and Patricia Royster and several responsible persons (staff persons), failed to administer medications to residents pursuant to label instructions. Resident A has a prescription which states to be given at twelve noon. Resident A has been getting his noon medication either with his morning doses of medication or when he returns from his day program in the late afternoon.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

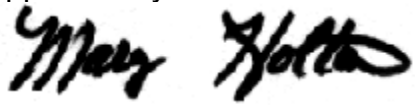
Upon receipt of an approved plan of correction, I recommend that the status of this home's license remain unchanged.



12/5/18

Christopher Holvey Date
Licensing Consultant

Approved By:



12/6/18

Mary E Holton Date
Area Manager