GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 18, 2020

Sonia McKeown
JARC
Suite 100
30301 Northwestern
Farmington Hills, MI 48334

RE: License #: AS630281660
Investigation #: 2020A0611031
Charach

Dear Ms. McKeown:

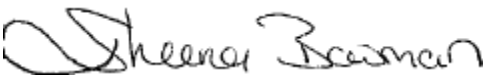
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630281660
Investigation #:	2020A0611031
Complaint Receipt Date:	06/12/2020
Investigation Initiation Date:	06/16/2020
Report Due Date:	08/11/2020
Licensee Name:	JARC
Licensee Address:	Suite 100 30301 Northwestern Farmington Hills, MI 48334
Licensee Telephone #:	(248) 940-2617
Administrator:	Charkyra Brooks
Licensee Designee:	Charkyra Brooks
Name of Facility:	Charach
Facility Address:	6701 Country Club Lane West Bloomfield, MI 48322
Facility Telephone #:	(248) 538-0972
Original Issuance Date:	06/14/2006
License Status:	REGULAR
Effective Date:	04/19/2019
Expiration Date:	04/18/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident J did not receive his Xanax 1mg on 06/01/20 or 06/02/20.	Yes

III. METHODOLOGY

06/12/2020	Special Investigation Intake 2020A0611031
06/16/2020	Special Investigation Initiated - Telephone I made a telephone call to the licensee designee, Sonia McKeown on 06/10/20 regarding the incident report that was received on 06/04/20. The allegations were discussed. Ms. McKeown was informed that a special investigation will be opened.
06/16/2020	Contact - Document Received On 06/11/20, I received a copy of a performance improvement/corrective action form, and a record of training session form via fax from Ms. McKeown.
06/17/2020	Contact - Telephone call made I made a telephone call to staff member, Alicia Williams. The allegations were discussed.
06/17/2020	Exit Conference I completed an exit conference with the licensee designee, Sonia McKeown via email.
06/18/2020	Contact-Document Received I received a copy of Resident J's medication administration record (MAR) for the month of May 2020 and June 2020.

ALLEGATION:

Resident J did not receive his Xanax 1mg on 06/01/20 or 06/02/20.

INVESTIGATION:

An incident report dated 06/02/20, was received by the licensing consultant on 06/04/20. As a result, a special investigation was opened.

On 06/10/20, I made a telephone call to the licensee designee, Sonia McKeown. Regarding the allegations, Ms. McKeown stated staff member, Alicia Williams waited too long to request a refill of Resident J's Xanax; which lead to Resident J missing three doses of his medication. Ms. McKeown stated Ms. Williams received a corrective action and was re-trained on how to reorder medications. Ms. McKeown stated she will send me copies of the corrective action form and the training verification form.

On 06/11/20, I received a copy of a performance improvement/corrective action form, a record of training session, and a sign in sheet for a medication training. According to the performance improvement/corrective action form, Ms. Williams is required to provide daily oversight of medications, which includes reviewing the medication book and reaching out to the nurse for support if needed. The performance improvement/ corrective action form is signed by Ms. Williams and dated for 06/03/20.

According to the record of training session, Ms. Williams was trained on medication review, signature of bubble packs, reordering medications, five medication rights, and medication documentation. The record of training session is signed by Ms. Williams and dated for 06/03/20. The sign in sheet dated 06/03/20, has signatures of five employees including Ms. McKeown. The sign in sheet was for a medication training.

On 06/17/20, I made a telephone call to the home manager, Alicia Williams. Regarding the allegations, Ms. Williams stated Resident J did not have any refills for his Xanax. Resident J initially had a doctor's appointment scheduled in March however, the appointment was canceled due to COVID-19. Ms. Williams stated she did not follow up with the doctor during the month of April or May regarding scheduling an appointment or inquiring about Telemedicine. Resident J ran out of Xanax on 05/31/20. Ms. Williams contacted the doctor to refill Resident J's medication, however; she was informed the medication cannot be refilled until Resident J is seen by the doctor. Ms. Williams scheduled a doctor's appointment for 06/09/20. Ms. Williams stated the company nurse contacted the doctor and requested an emergency order for Resident J's Xanax. Resident J's Xanax was refilled on 06/02/20. Ms. Williams stated Resident J was not administered Xanax for one day.

On 06/18/20, I received a copy of Resident J's medication administration record (MAR) for the month of May 2020 and June 2020. Resident J is prescribed Xanax twice a day. According to the MAR for the month of May 2020, Resident J was administered his Xanax twice a day as prescribed. According to the MAR for the month of June 2020, Resident J was not administered Xanax at 8:00 am on 06/01/20 or 06/02/20. Resident J started to receive his Xanax as prescribed at 4:00 pm on 06/02/20.

On 06/17/20, I conducted an exit conference with the licensee designee, Sonia McKeown via email. The findings and recommendations were provided. Ms. McKeown was informed that a corrective action plan will be required.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident J ran out of his Xanax on 05/31/20. His medication was not refilled until 06/02/20. According to the MAR for the month of June 2020, Resident J was not administered Xanax at 8:00 am on 06/01/20 or 06/02/20. Resident J started to receive his Xanax as prescribed at 4:00 pm on 06/02/20.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

Sheena Bowman 06/18/20
Licensing Consultant Date

Approved By:

Denise Y. Nunn 06/18/2020
Area Manager Date