GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 5, 2021

Amanda Hart
Crisis Center Inc - DBA Listening Ear
PO Box 800
Mt Pleasant, MI 48804-0800

RE: License #: AS050071211
Investigation #: 2021A0009021
North Limits

Dear Ms. Hart:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the 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 this issue, 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 (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS050071211
Investigation #:	2021A0009021
Complaint Receipt Date:	04/15/2021
Investigation Initiation Date:	04/16/2021
Report Due Date:	05/15/2021
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	Sherry Kidd
Licensee Designee:	Amanda Hart
Name of Facility:	North Limits
Facility Address:	1179 North Limits Mancelona, MI 49659
Facility Telephone #:	(231) 587-8688
Original Issuance Date:	05/16/1996
License Status:	REGULAR
Effective Date:	08/24/2019
Expiration Date:	08/23/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Medication for Resident A was left on the counter. When staff returned the medication was missing. It is believed that Resident B took Resident A's medication.	Yes

III. METHODOLOGY

04/15/2021	Special Investigation Intake 2021A0009021
04/16/2021	Special Investigation Initiated - On Site Interviews with administrator Ms. Sherry Kidd and home manager Ms. Kippin Beck. Face to face contact with Resident A.
05/04/2021	Contact – Telephone call made to direct care worker Ms. Jennifer Beckner
05/04/2021	Exit conference with licensee Ms. Amanda Hart

ALLEGATION: Medication for Resident A was left on the counter. When staff returned the medication was missing. It is believed that Resident B took Resident A's medication.

INVESTIGATION: I made an unannounced site inspection at the North Limits adult foster care home on April 16, 2021. I wore personal protective equipment to protect myself and others. I spoke with administrator Ms. Sherry Kidd who told me that the incident occurred on April 13, 2021. The medication passer who was involved, Ms. Jennifer Beckner, is not currently giving medications until this matter is investigated.

The home manager, Ms. Kippin Beck, showed me the facility's medication room. She showed me that the medication room is locked as well as the medications themselves in cabinets. Ms. Beck stated that Resident A and Resident B are both prescribed Lactulose and Mirolax which are in a liquid form. Resident B has a habit of drinking things if left out. On April 13, 2021, Ms. Beckner prepared Resident A's medication by pouring both doses into a cup. She left the cup on the counter in the medication room and went to get Resident A in the living area. When she returned with him, the medication was gone. She immediately assumed that Resident B had taken Resident A's medication because of her habit of taking things and her room being adjacent to the medication room. I asked why Ms. Beckner had not taken the medication with her and just given it to him in the living area. Ms. Beck replied that they were trained by Community Mental Health (CMH) to only dispense the medications out of the medication room. Ms. Beckner should have locked the room when she left. Ms. Beckner did immediately call the on-call supervisor when she

discovered what had happened. She also called Resident B's doctor. The doctor told her that she should obviously hold Resident B's own Mirolax and Lactulose administrations that evening. The doctor stated that the worst that would happen to Resident B would be that she could experience diarrhea since Resident A's Lactulose prescription is 30ml compared to Resident B's 18ml. Their prescription for Mirolax is the same at 17gms although Resident B had already received her daily dose of Mirolax that morning.

Ms. Kidd provided me with the agency's medication policy which included that medication is to be kept locked. This is the specific agency rule that Ms. Beckner failed to follow. She provided documentation that Ms. Beckner attended CMH "medication administration practicum" and that she "passed" on December 15, 2017 and December 19, 2021. Ms. Beckner also had medication training provided by the agency on September 14, 2020. I was provided with Resident B's medication sheet which indicated that her own Lactulose was "held" on the evening of April 13, 2021.

I spoke with direct care worker Ms. Jennifer Beckner by phone on May 4, 2021. I asked her about the medication mix-up on April 13, 2021. She replied that it was not so much a "mix-up" as it was Resident B stealing another resident's medication. Ms. Beckner stated that she had gone to give Resident A his medication in the form of pills. Resident A was lying down and can take his pills lying down. She had dispensed his Mirolax and Lactulose into a cup and left it on the medication room counter. When she returned, the cup was empty. She felt that she knew that Resident B had taken the medication since Resident B is the only person in the home who steals medication and her bedroom is adjacent to the medication room. Ms. Beckner stated that she immediately called the on-call supervisor for the agency and then Resident B's doctor. Ms. Beckner stated that she was currently not administering medication to residents until she can be retrained in on-site medication administration training. I asked her if she could have done anything differently to ensure that Resident B did not get Resident A's medication. Ms. Beckner replied that she could have locked the medication door upon leaving or waited to pour Resident A's medication into the cup when she came back.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	On April 13, 2021, Resident B apparently took Resident A's medication which was left out. Resident A and Resident B have the same prescription for Mirolax (17gms) but Resident B had already received her daily dose of Mirolax in the morning. She received 30ml of Lactulose which is nearly double her own dose of 18ml.

CONCLUSION:	VIOLATION ESTABLISHED

I conducted an exit conference with licensee Amanda Hart by phone on May 4, 2021. I told her of the findings of the investigation and gave her the opportunity to ask questions.

IV. RECOMMENDATION

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

05/05/2021

Adam Robarge Date
Licensing Consultant

Approved By:

05/05/2021

Jerry Hendrick Date
Area Manager