GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 27th, 2021

Daniela Soave
Brighton Manor LLC
7560 River Road
Flushing, MI 48433

RE: License #:	AH470387116
Investigation #:	2021A1021044
	Brighton Manor

Dear Ms. Soave:

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 authorized representative 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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH470387116
Investigation #:	2021A1021044
Complaint Receipt Date:	08/18/2021
Investigation Initiation Date:	08/18/2021
Report Due Date:	10/17/2021
Licensee Name:	Brighton Manor LLC
Licensee Address:	7560 River Road Flushing, MI 48433
Licensee Telephone #:	(989) 971-9610
Administrator:	Sarah Molner
Authorized Representative:	Daniela Soave
Name of Facility:	Brighton Manor
Facility Address:	1320 Rickett Road Brighton, MI 48116
Facility Telephone #:	(810) 247-8442
Original Issuance Date:	03/27/2019
License Status:	REGULAR
Effective Date:	09/27/2020
Expiration Date:	09/26/2021
Capacity:	93
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A administered incorrect medication.	Yes
Additional Findings	No

III. METHODOLOGY

08/18/2021	Special Investigation Intake 2021A1021044
08/18/2021	Special Investigation Initiated - Letter referral sent to centralized intake at APS
08/23/2021	Contact - Telephone call made interviewed administrator by telephone
08/23/2021	Contact-Telephone call made Interviewed SP1
08/23/2021	Contact-Telephone call made Interviewed Natishid Clemens
08/24/2021	Contact-Telephone call made Interviewed Thomas Da-Silva
08/27/2021	Exit Conference Exit conference with authorized representative Daniela Soave

ALLEGATION:

Resident A administered incorrect medication.

INVESTIGATION:

On 8/18/21, the licensing department received a complaint with allegations Resident A was administered the incorrect medication. The complainant alleged Resident A was administered an anti-psychotic medication intended for another resident.

On 8/18/21, the allegations in this report were sent to Adult Protective Services (APS).

On 8/23/21, I interviewed administrator Sarah Molner by telephone. Ms. Molner reported the facility received a new medication shipment on third shift on 8/12. Ms. Molner reported the pharmacy delivered an injection medication for Resident B. Ms. Molner reported this medication was to be changed to an oral medication due to the facility's inability to provide injection medications. Ms. Molner reported staff person 1 (SP1) administered Resident A's medication on 8/13. Ms. Molner reported SP1 believed the medication was for a steroid injection. Ms. Molner reported Resident B's last name is the same as Resident A's first name. Ms. Molner reported SP1 administered the medication to Resident A. Ms. Molner reported Resident A had a private duty caregiver that reported it to Relative A1 that Resident A received an injection during morning medication pass. Ms. Molner reported Relative A1 called her to inform her of the medication error. Ms. Molner reported Relative A1 called around 4:30pm. Ms. Molner reported the facility immediately contacted Resident A's physician but was unable to reach anyone due to the office was closed for the day. Ms. Molner reported she reached out to the medical director of the facility. Ms. Molner reported the medical director reported there should be no adverse side effects due to the medication error. Ms. Molner reported Relative A1 picked up Resident A and took him to her house. Ms. Molner reported SP1 was immediately taken off the medication cart and has not administered medications since this incident. Ms. Molner reported if SP1 wishes to return to the role of a medication technician, SP1 will have to re-complete the medication training and shadow process.

On 8/23/21, I interviewed SP1 by telephone. SP1 reported she typically works in memory care and not assisted living. SP1 reported on 8/13 she was placed as a team lead in the assisted living. SP1 reported she was approached by Resident A's private duty caregiver about a medicated ointment for a rash. SP1 reported she quickly looked in the medication cart and saw a box that was labeled with a name like Resident A. SP1 reported she left the medication with assistant Natishid Clemens. SP1 reported she was unsure what to do with the medication and that is why she went to management for assistance. SP1 reported Mr. Clemens approached her and told her the medication was ready for administration. SP1 reported Mr. Clemens and herself administered the medication. SP1 reported herself and Mr. Clemens incorrectly read the box. SP1 reported in the medication training course, they are told the facility does not administer injections and that is why she went to management for assistance with this medication. SP1 reported Mr. Clemens reported the medication was able to be administered so she did so.

On 8/23/21, I interviewed Mr. Clemens by telephone. Mr. Clemens reported on 8/13, SP1 was administering medications in assisted living. Mr. Clemens reported SP1 came to him concerned about a medication. Mr. Clemens reported he reviewed the medication and provided the medication to SP1 to administer to Resident A. Mr. Clemens reported later that day Relative A1 contacted him to inquire about the injection. Mr. Clemens reported it was then he realized a medication error had

occurred. Mr. Clemens reported the facility is to only administer insulin injections. Mr. Clemens reported he did not think it was odd to have an injection for Resident A.

On 8/24/21, I interviewed resident care director Thomas Da-Silva by telephone. Mr. Da-Silva reported Resident B is a new admit that came with an injection medication. Mr. Da-Silva reported he was in the process of working with the physician on changing the medication to an oral medication. Mr. Da-Silva reported the pharmacy delivered the medications on second shift on 8/12. Mr. Da-Silva reported the facility usually reviews the medication delivery the following day. Mr. Da-Silva reported medication technicians are not trained on injections. Mr. Da-Silva reported he is the only staff member that can administer injections. Mr. Da-Silva reported following the medication error, SP1 was taken off the medication cart and Mr. Clemens is to complete additional medication training. Mr. Da-Silva reported all medication technicians are to now memorize and recite the seven rights of medications.

I reviewed chart notes for Resident A. The chart notes read, “On 8/13/21 this resident was administered an injection of Risperdal 12.5mg, a medication that was not prescribed for this resident. This incident was reported to our state licensing rep as well as the family and physician.”

I reviewed medication administration training for SP1. SP1 completed medication administration training on 1/21/21.

I reviewed the incident report submitted to state licensing. The narrative read,

> “*At 8:15am (SP1) administered an injection of Risperdal 12.5mg to (Resident A). This medication is not prescribed for this resident. This occurred due to the fact that the resident who is prescribed the medication last name is the same as the first name of the resident who was administered.”*

The corrective action read,

> *“Mandatory staff training scheduled for next week 8/19/21. Thomas Da-Silva, LPN will be reviewing medication administration, resident rights, and medication policies put in place by the company. (SP1) will need to retrain and be shadowed by Thomas before being allowed on the cart again.”*

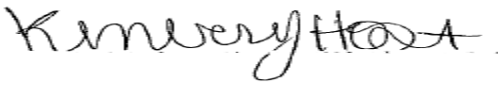
APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
ANALYSIS:	Resident A was prescribed the incorrect medication on 8/13/21. The facility did not take reasonable precautions to ensure Resident A received the correct medications.

CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/27/21, I conducted an exit conference with authored representative Daniela Soave by telephone. Ms. Soave reported Mr. Clemens has been removed from his role at the facility.

IV. RECOMMENDATION

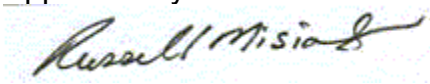
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



8/26/21

Kimberly Horst — Date
Licensing Staff

Approved By:



8/27/21

Russell B. Misiak — Date
Area Manager