GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 1, 2021

Nicole Deneweth
Homes of Opportunity Inc
Suite C
23420 Greater Mack Ave.
St. Claire Shores, MI 48080

RE: License #: AS820014663
Investigation #: 2021A0116029
Jackson AFC Home

Dear Ms. Deneweth:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820014663
Investigation #:	2021A0116029
Complaint Receipt Date:	08/09/2021
Investigation Initiation Date:	08/10/2021
Report Due Date:	10/08/2021
Licensee Name:	Homes of Opportunity Inc
Licensee Address:	Suite C 23420 Greater Mack Ave. St. Claire Shores, MI 48080
Licensee Telephone #:	(248) 338-7458
Administrator:	LaShawn Jackson
Licensee Designee:	Nicole Deneweth
Name of Facility:	Jackson AFC Home
Facility Address:	14434 Jackson Taylor, MI 48180
Facility Telephone #:	(734) 281-6452
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	06/17/2021
Expiration Date:	06/16/2023
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Incident report dated 7/31/2021 documented that staff Brittany Colosimo witnessed unusual lethargy in Resident A. Ms. Colosimo checked the 8am medications that the midnight shift had passed and discovered staff passed a double dose of Citalopram 20mg to Resident A.	Yes

III. METHODOLOGY

08/09/2021	Special Investigation Intake 2021A0116029
08/10/2021	Special Investigation Initiated - On Site Interviewed staff Jeanette Jenkins, Resident D and home manager Lashawn Jackson (via telephone). Visually assessed Resident's A-C.
08/10/2021	Inspection Completed-BCAL Sub. Compliance
08/11/2021	Contact - Telephone call received Interviewed licensee designee Nicole Deneweth.
08/11/2021	Contact - Document Received Received staff training for Sonya Whitaker.
08/25/2021	Contact - Telephone call made Interviewed staff Sonya Whitaker.
08/27/2021	Contact - Telephone call made Left message for Ms. Deneweth requesting a call back.
08/30/2021	Exit Conference With licensee designee Nicole Deneweth

09/01/2021	Contact-Telephone call made Interviewed former staff Britany Colosimo.

ALLEGATION:

Incident report dated 7/31/2021 documented that staff Brittany Colosimo witnessed unusual lethargy in Resident A. Ms. Colosimo checked the 8am medications that the midnight shift had passed and discovered staff passed a double dose of Citalopram 20mg to Resident A.

INVESTIGATION:

On 08/10/21, I conducted an unscheduled onsite inspection. I interviewed staff Jeanette Jenkins and she reported that she was not working when the medication error occurred but had heard about it. Ms. Jenkins reported that Resident A is well and to her knowledge did not have any serious adverse reactions from the medication error. I asked Ms. Jenkins for Ms. Whitaker's employee file so that I could review and confirm her medication training. Ms. Jenkins reported that the files are not maintained onsite.

On 08/10/21, while onsite Ms. Jenkins contacted home manager Lashawn Jackson via telephone. I interviewed Ms. Jackson and she reported that on the morning of 07/31/21 she received a telephone call from staff Brittany Colosimo informing her that Resident A was lethargic and very sleepy. Ms. Jackson reported that Ms. Colosimo checked the a.m. medications and observed that Resident A's p.m. and a.m. dose of 20 mg Citalopram had both been administered at 8:00 a.m. by midnight staff Sonya Whitaker. Ms. Jackson reported that Ms. Colosimo contacted poison control who informed her that due to the low dose of the medication Resident A should not have any negative effects and advised that staff should monitor and ensure she eats regularly throughout the day. Ms. Jackson reported that Resident A was her normal self later that same evening and continues to do well. Ms. Jackson further added that Ms. Whitaker was disciplined and in serviced on the five rights of medication.

On 08/10/21, I visually observed Residents A-C as they are non-verbal and unable to be interviewed. They all were neatly dressed and groomed and appeared well.

On 08/10/21, I interviewed Resident D and he reported that he likes living in the home, reported that the staff treats him nice, and the food is good. Resident D reported that staff administers his medication everyday and to his knowledge he gets his medication as prescribed.

On 08/10/21, I reviewed Resident A's medication and medication administration record (MAR) and confirmed that the 20mg Citalopram is to be administered to Resident A twice per day once in the morning and once in the evening according to

the label instructions. I also compared all of Resident A's medications to the MAR and did not observe any additional discrepancies.

On 08/11/21, I interviewed licensee designee Nicole Deneweth. Ms. Deneweth reported that she was aware of the medication error and reported that Ms. Whitaker was in-serviced on medication administration and given a verbal reprimand. I requested Ms. Deneweth to email me Ms. Whitaker's direct care training since it was not available onsite. Ms. Deneweth reported that she would send it over before the close of business today.

On 08/11/21, I received and reviewed Ms. Whitaker's direct care training. Ms. Whitaker was trained in medication in 2005 and completed an online medication refresher course on 08/11/21.

On 08/25/21, I interviewed staff Sonya Whitaker. Ms. Whitaker reported that she is not going to make any excuses for her error. Ms. Whitaker reported that she was distracted and talking to a co-worker instead of focusing on properly preparing and passing medication. Ms. Whitaker reported that her negligence caused the error, and she takes full responsibility for it. Ms. Whitaker added that she is thankful that Resident A did not suffer any adverse reaction from the medication error and that it was a wake up call for her to always remain focused at the task before her.

On 08/30/21, I conducted the exit conference with Ms. Deneweth and informed her of the findings of the investigation. Ms. Deneweth reported an understanding of the rule violation and reported she would submit an acceptable corrective action plan to address the violation.

On 09/01/21, I interviewed former staff Brittany Colosimo. Ms. Colosimo reported that she no longer works in the home due to concerns she had with management and staffing. Ms. Colosimo reported that on the morning of 07/31/21 she began her shift at 8:00 a.m. and reported that around 10:00 a.m. she observed Resident A to be lethargic and sleepy. Ms. Colosimo reported that she checked Resident A's medication and MAR and observed that Resident A's 8:00 a.m. and 8:00 p.m. 20mg Citalopram bubble packs were rubber banded together, which was not the norm and then observed that both the 8:00 a.m. and 8:00 p.m. doses were gone. Ms. Colosimo reported that is when she realized that Ms. Whitaker had administered both doses. Ms. Colosimo reported that she contacted poison control and they informed her that Resident A would be fine because the dosage was low. Ms. Colosimo further reported that poison control advised her to monitor Resident A throughout the day, make sure she eats regularly and not to administer the evening dose of the medication. Ms. Colosimo reported that Resident A ate throughout the day but remained sleepy. She reported at around 10:00pm Resident A woke up and was back to her normal self.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A was administered a double dose of her 20mg Citalopram pills by staff Sonya Whitaker. Ms. Witaker admitted that she was distracted while preparing Resident A's medication, causing her to administer both the a.m. and p.m. doses of the Citalopram at the same time. Consultant review of Resident A's medication and MAR confirmed that the medication is to be given once in the a.m. and once in the p.m. This violation is established because Ms. Whitaker failed to give the medication pursuant to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

09/01/21

Pandrea Robinson
Licensing Consultant

Date

Approved By:

09/01/21

Mary Holton
Area Manager

Date