GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 21, 2022

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

RE: License #: AS180010525
Investigation #: 2022A1030015
Weatherhead Home

Dear Ms. Hart:

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 (517) 284-9730.

Sincerely,

Nile Khabeiry, LMSW

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS180010525
Investigation #:	2022A1030015
Complaint Receipt Date:	12/10/2021
Investigation Initiation Date:	12/10/2021
Report Due Date:	02/08/2022
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(231) 587-8688
Administrator:	Amanda Hart
Licensee Designee:	Amanda Hart
Name of Facility:	Weatherhead Home
Facility Address:	749 Richard St Harrison, MI 48625
Facility Telephone #:	(989) 539-6661
Original Issuance Date:	02/06/1985
License Status:	REGULAR
Effective Date:	07/30/2021
Expiration Date:	07/29/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A's prescription medication was not correctly labeled.	Yes

III. METHODOLOGY

12/10/2021	Special Investigation Intake 2022A1030015
12/10/2021	Special Investigation Initiated - Telephone Interview with complainant
12/17/2021	Contact - Face to Face Interview with Lisa Wellman
12/17/2021	Contact - Face to Face Face to face with Resident A
12/17/2021	Contact - Face to Face Interview with Carmen Norris
12/17/2021	Contact - Document Received Reviewed Resident A's and Resident B's Medication Administration Records
12/20/2021	Contact - Telephone call made Interview with Christina Barns
12/21/2021	Contact - Telephone call made Interview with Billie Thomas
12/22/2021	Contact - Telephone call made Interview with Allison Davis
12/27/2021	Exit Conference by phone with licensee designee Amanda Hart

ALLEGATION:

Resident A's prescription medication was incorrectly labeled.

INVESTIGATION:

On 12/10/2021, I interviewed Complainant regarding the allegation. Complainant reported it was unclear if the medication problem of the medication being incorrectly labeled was in part created by the pharmacy or if it was an error by several direct care staff members.

On 12/17/2021, I conducted an on-site investigation at Weatherhead Home 749 Richard Road Harrison, MI. I made contact with Resident A however she was unable to be interviewed due to developmental disabilities.

On 12/17/2021, I conducted an on-site investigation at Weatherhead AFC 749 Richard Road Harrison, MI. I interviewed house manager, Lisa Wellman regarding the allegation. Ms. Wellman reported that Resident A and Resident B are both prescribed Calcium although each resident is prescribed a different milligram dose. I observed Resident A's and Resident B's medications and noted Resident A is prescribed 600 milligrams of Calcium daily and the pill is peach in color whereas Resident B is prescribed 500 milligrams of Calcium daily and the pill is green in color. Ms. Wellman reported the facility received a medication delivery from Home Town pharmacy and received the medications in bubble packs. Ms. Wellman reported direct care staff members are supposed to confirm that each resident gets the correct medication by performing a comparison between the written prescription to each resident's *Medication Administration Record* (MAR) and to the actual medication received from the pharmacy. Ms. Wellman reported the same process is supposed to be done every time medications are passed. Ms. Wellman reported the label error was discovered on 11/16/2021 and it was noted the pharmacy placed Resident B's Calcium medication label on Resident A's medication bubble package, however it was not recognized until two days after the medication was received and passed. Ms. Wellman reported Resident A received the correct medication and dosage as the label was incorrectly placed on the correct medication bubble package. Ms. Wellman reported she went through all the medications of the other residents and did not find any other label errors.

On 12/17/2021, I interviewed direct care staff member, Carmen Norris regarding the allegations. Ms. Norris reported she received the delivery from Home Town Pharmacy and checked the medications, however, did not verify the labels were accurate. Ms. Norris reported she quickly checked the bubble packs and noted the Calcium tablets were the correct color and "assumed" it was labeled for Resident A and now knows the bubble pack had Resident B's label.

On 12/20/2021, I interviewed direct care staff member Christina Barns regarding the allegation. Ms. Barns reported she has worked at Weatherhead AFC for three months. Ms. Barns reported she was one of the staff members who passes medications and

passed medication to Resident A on 11/15/2021. Ms. Barns reported she "thought" she compared the medication label to the MAR but was very busy that morning and must have not been paying attention. Ms. Barns reported she was paying attention on 11/16/2021 and discovered the label was incorrect.

On 12/21/2021, I interviewed direct care staff member Billie Thomas regarding the allegation. Ms. Thomas reported she was one of the staff members who passed medication to Resident A. Ms. Thomas reported she did not check the label like she is supposed to do and instead just looked at the pill itself. Ms. Thomas reported she will be more careful in the future.

On 12/22/2021, I interviewed direct care staff member, Allison Davis regarding the allegations. Ms. Davis reported she was aware of the mistake made regarding Resident A's medication. Ms. Davis reported Resident A's medication was mislabeled and they did not discover the error when the medication arrived from the pharmacy. Ms. Davis took responsibility for not paying attention to the label and indicated she will not make that mistake again.

On 12/27/2021, I contacted licensee designee Amanda Hart by phone for an exit conference and informed her of the violation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation which includes my personal observations of the facility, interviews with Lisa Wellman, Carmen Norris, Christina Barns, Billie Thomas, Allison Davis, and review of Resident A's and Resident B's Medication Administration Records this violation will be established as Resident A was not given her medication per the label instruction.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Based on the acceptance of an approved corrective action plan, I recommend no change in the current license status.

1/3/2021

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Nile Khabeiry Date
Licensing Consultant

Approved By:

01/21/2022

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Dawn N. Timm Date
Area Manager