GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 14, 2022

Holly Heath
Community Opportunity Center NPHC
14147 Farmington Rd
Livonia, MI 48154

RE: License #: AS820078503
Investigation #: 2022A0119009
Curtis House

Dear Mrs. Heath:

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,

Shatonla Daniel, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-3003

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820078503
Investigation #:	2022A0119009
Complaint Receipt Date:	12/16/2021
Investigation Initiation Date:	12/16/2021
Report Due Date:	02/14/2022
Licensee Name:	Community Opportunity Center NPHC
Licensee Address:	14147 Farmington Road Livonia, MI 48154
Licensee Telephone #:	(734) 422-1020
Administrator:	Holly Heath
Licensee Designee:	Holly Heath
Name of Facility:	Curtis House
Facility Address:	33730 Curtis Livonia, MI 48152
Facility Telephone #:	(734) 422-1020
Original Issuance Date:	12/23/1997
License **Status:**	REGULAR
Effective Date:	11/14/2021
Expiration Date:	11/13/2023
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Per incident report 12/17/2021, Resident A's Geodon medication was not administered by staff on 12/08/2021 and 12/11/2021 at 8:00 p.m. dosage.	Yes

III. METHODOLOGY

12/16/2021	Special Investigation Intake 2022A0119009
12/16/2021	Special Investigation Initiated - Telephone Licensee Designee/ Administrator- Holly Heath, left a message
12/16/2021	Inspection Completed On-site Resident A and Staff- Charlotte Blair
12/16/2021	Inspection Completed-BCAL Sub. Compliance
12/21/2021	Contact - Telephone call made Home Manager- Jonathan Smith and Staff- Gretchen Adamczyk
01/03/2022	Contact- Telephone call received Administrator- Holly Heath
01/26/2022	Contact - Document Sent Office of Recipient Rights
01/26/2022	APS Referral Made
02/09/2022	Contact- Telephone call made Victoria Nwisu
02/09/2022	Exit Conference Licensee Designee/ Administrator- Holly Heath

ALLEGATIONS:

Per incident report 12/17/2021, Resident A's Geodon medication was not administered by staff on 12/08/2021 and 12/11/2021 at 8:00 p.m. dosage.

INVESTIGATION:

On 12/16/2021, I completed an onsite inspection and interviewed Staff Charlotte Blair and observed Resident A due to her disability. Ms. Blair stated she was made aware that Resident A missed her medications. She stated that Jonathan Smith is a new home manager and missed administering the medication.

I observed Resident A's Geodon medication still in the bubble pack for 12/08/2021 and 12/11/2021. I observed Resident A's medication administration sheet to be initialed on 12/08/2021 by Victoria Nwosu at the 8:00p.m. dosage and initialed on 12/11/2021 by Jonathan Smith at the 8:00p.m. dosage.

On 12/21/2021, I telephoned and interviewed Staff- Gretchen Adamczyk and Home Manager- Jonathan Smith regarding the above allegations. Ms. Adamczyk stated she discovered the medication error the next day. She stated there is no internal process for staff medication errors other than the resident missed a medication. She stated she saw the pills left in the package on 12/11/2021 and again on 12/08/2021.

Mr. Smith stated he is new manager to the home and it was an oversight on his part. He stated that he was not rushing while administering medication but did not give Resident A all of her medications on 12/11/2021. Mr. Smith stated he was not too sure of the procedure for missed medications so his assistant, Ms. Adamczyk contacted Resident A's doctor for medical guidance. Mr. Smith stated Resident A's doctor did not request any additional medical follow-up at that time.

On 01/03/2022, I received a telephone call from Administrator- Holly Heath regarding the above allegations. Mrs. Heath stated she has been made aware that a medication error did occur where Resident A did not receive her 8:00 p.m. Geodon medications. Mr. Smith is a new home manager and was only a few days on the job at the time of a medication error. She stated Mr. Smith is fully medication trained but a medication error did occur during the process of becoming fully accumulated to his job duties.

On 02/09/2022, I telephoned and interviewed Staff- Victoria Nwisu regarding the above allegations. Ms. Nwisu denied she was working on 12/08/2021. I spoke with her and informed her that her initials were on Resident A's medication administration record. However, Ms. Nwisu denied she had any knowledge of not administering Resident A's medication.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Staff- Gretchen Adamczyk stated she discovered the medication error the next day. She stated she saw the pills left in the package on 12/11/2021 and again on 12/08/2021. I observed Resident A's Geodon medication still in the bubble pack for 12/08/2021 and 12/11/2021. I observed Resident A's medication administration sheet to be initialed on 12/08/2021 by Victoria Nwosu at the 8:00p.m. dosage and initialed on 12/11/2021 by Jonathan Smith at the 8:00p.m. dosage. Home Manager- Jonathan Smith stated he is new manager to the home, and it was an oversight on his part. He stated that he was not rushing while administering medication but did not give Resident A all of her medications on 12/11/2021. Licensee Designee/ Administrator- Holly Heath stated has been made aware that a medication error did occur where Resident A did not receive her 8:00pm Geodon medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/14/2022

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Shatonla Daniel Date
Licensing Consultant

Approved By:

02/14/2022

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Ardra Hunter Date
Area Manager