GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 22, 2022

Shannon White-Schellenberger
Cheryl Loveday
Angels' Place Inc
Suite 2
29299 Franklin Road
Southfield, MI 48034

RE: License #: AS630015384
Investigation #: 2022A0605021
Maxwell Home

Dear Ms. White-Schellenberger:

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 (248) 975-5053.

Sincerely,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS630015384 |
| | |
| **Investigation #:** | 2022A0605021 |
| | |
| **Complaint Receipt Date:** | 01/25/2022 |
| | |
| **Investigation Initiation Date:** | 01/25/2022 |
| | |
| **Report Due Date:** | 03/26/2022 |
| | |
| **Licensee Name:** | Angels' Place Inc |
| | |
| **Licensee Address:** | Suite 2<br>29299 Franklin Road<br>Southfield, MI 48034 |
| | |
| **Licensee Telephone #:** | (248) 350-2203 |
| | |
| **Administrator:** | Shannon White-Schellenberger |
| | |
| **Licensee Designee:** | Cheryl Loveday |
| | |
| **Name of Facility:** | Maxwell Home |
| | |
| **Facility Address:** | 2809 Saddlewood<br>W Bloomfield Twp, MI 48324 |
| | |
| **Facility Telephone #:** | (248) 360-1497 |
| | |
| **Original Issuance Date:** | 11/15/1994 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 06/12/2020 |
| | |
| **Expiration Date:** | 06/11/2022 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A did not get all his medications on 01/09/2022, because direct care staff (DCS) Jessica Allen gave him the PM medications during the AM time. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 01/25/2022 | Special Investigation Intake<br>2022A0605021 |
| 01/25/2022 | Special Investigation Initiated - Telephone<br>Telephone call with Maxwell Home's home manager regarding the allegations. I scheduled the on-site investigation for 01/26/2022. |
| 01/25/2022 | Referral - Recipient Rights<br>I emailed the referral to the Office of Recipient Rights (ORR), Dawn Krull. |
| 01/26/2022 | Contact - Telephone call received<br>ORR Dawn Krull will be investigating these allegations and would like to be available via telephone while I conduct the interviews face-to-face. |
| 01/26/2022 | Inspection Completed On-site<br>I conducted an on-site investigation and interviewed direct care staff (DCS) Jessica Allen, Vernessa Brown, the home manager Keisha Calvin, and Resident A in collaboration with ORR Dawn Krull available via telephone. I reviewed Resident A's and Resident B's medications and medication logs and a simulated medication pass. |
| 01/31/2022 | Contact - Telephone call made<br>I interviewed DCS Damara Hines regarding the allegations. |
| 03/01/2022 | Contact – Telephone call made<br>I interviewed DCS Micaiah Strong and Resident E regarding the allegations. |
| 03/01/2022 | Exit Conference<br>I left a detailed message for the administrator Shannon White-Schellenberger with my findings since the licensee designee Cheryl Loveday is out of the office for one month. |

**ALLEGATION:**

**Resident A did not get all his medications on 01/09/2022, because the assistant home manager Jessica Allen gave him the PM medications during the AM time.**

**INVESTIGATION:**

On 01/25/2022, intake #184732 was referred by Oakland County Office of Recipient Rights (ORR).

On 01/25/2022, I initiated my investigation by contacting the home manager Keisha Calvin who stated that the assistant home manager Jessica Allen administered Resident A's PM medications instead of his AM medications on 01/09/2022. Ms. Calvin stated she will have Ms. Allen and DCS Vernessa Brown available tomorrow at Maxwell Home to be interviewed.

On 01/26/2022, ORR worker Dawn Krull stated that she is investigating these allegations and would be unable to conduct an on-site investigation but would like to be available via telephone during the interviews at Maxwell Home.

On 01/26/2022, I conducted an on-site investigation at Maxwell Home. The home manager Keisha Brown, DCS Jessica Allen and Vernessa Brown and Resident A were present. I began the interviews with DCS Jessica Allen with ORR Dawn Krull available via telephone. Residents B, C, D, and E were not present as they were at their workshops.

Ms. Allen has been with Angel's Place, Inc. since 2015. She was made the assistant home manager in 2016. Ms. Allen works Fridays (9AM-6PM), Saturdays and Sundays (7AM-3PM). There are five residents and one staff member per shift. Ms. Allen completed medication administration training with Macomb-Oakland Regional Center (MORC) and medication refresher training via online on 01/11/2022. Ms. Allen emailed me and Ms. Krull a copy of her medication administration certificate. The allegations were discussed. On 01/09/2022 around 7AM when she arrived, Resident A was in his bedroom because Resident A was quarantined after being on vacation for two weeks out of the state. Ms. Allen stated she usually has Resident A sit at the dining room table when she passes medications, but this time because Resident A was being quarantined, she took Resident A's medications directly to him in his bedroom. Ms. Allen stated she grabbed Resident A's medication basket from the locked cabinet and stated, "then without paying attention to AM or PM, I grabbed the PM blister packs instead of the AM blister packs. I passed Resident A his medications and did not know I had grabbed the wrong blister packs until the next day when I read the incident report (IR) written by DCS Vernessa Brown." Ms. Allen stated she did not follow the five rights of medication administration when she passed Resident A's medications because, "If I did follow the five rights, I would have noticed that I grabbed the PM blister packs

instead of the AM blister packs." Ms. Allen stated she popped all the medications out of the blister packs, put them in a cup and took them directly to Resident A who likes to take all his pills at once. She took Resident A his breakfast first, he ate breakfast and then took all his medications. She watched him take his medications and then returned to the medication log and initialed the medication book. She stated that she did not follow the five rights again because if she did, she would have realized that she had given Resident A his PM medications and not his AM medications. Ms. Allen stated she must have been distracted by Resident C who was present that day and having a behavioral issue. Ms. Allen stated Resident C's behaviors are cussing at residents and staff, banging on the walls, and stealing from residents. Ms. Allen stated an IR is usually written if Resident C was acting up, but she could not recall if an IR was completed on 01/09/2022 or not to explain the medication error. Ms. Allen stated she then passed all the other residents' medications correctly without any errors. On 01/10/2022, after Ms. Allen read the IR written on 01/09/2022, she immediately contacted her supervisor Shannon White-Schellenberger and informed Ms. White-Schellenberger that it was her (Ms. Allen) who passed the PM medications in the AM to Resident A. Ms. Allen stated she and Ms. White-Schellenberger discussed what happened and that was the end of the conversation.

On 01/26/2022, I interviewed DCS Vernessa Brown regarding the allegations. Ms. Brown has been with Angel's Place, Inc. for 18 years. She works the afternoon shifts from 3PM-11PM Sundays-Fridays and then on Saturdays from 10AM-6PM. Ms. Brown completed medication administration training through MORC and the refresher training online in 2021. On 01/09/2022, Ms. Brown arrived at her shift at 3PM and all the residents were present. She stated that Resident A was in his bedroom because he was being quarantined after being on vacation for two weeks out of state. Around 9PM, Ms. Brown went to pass Resident A's PM medications and found that all the pills were missing from the blister pack for 01/09/2022. Ms. Brown then pulled the AM blister packs and found that all the pills from the AM blister pack were still in the blister pack and not passed. Ms. Brown pulled the standing missed medical order (SMMO) sheet and found only two of the AM medications she was able to administer to Resident A, so she administered the medications. She then called the home manager Keisha Calvin and informed her of what happened. Ms. Calvin advised Ms. Brown to complete an IR regarding Ms. Allen passing the PM medications instead of the AM medications to Resident A. Ms. Brown completed the IR and stated that this was an isolated incident as Ms. Brown verified the other residents' medications and they were correct. Ms. Brown stated policy for passing medications is to pull the medication book, call the resident to the dining room table, follow the five rights of medication pass, punch out the medication and watch the resident take the medication and then initial the medication log. Ms. Brown stated after she passed the two medications from the AM blister pack to Resident A in the PM on 01/09/2022, she forgot to initial the medication log. Ms. Brown stated she initialed the medication log on 01/24/2022 after she learned she had not signed the log by the home manager Ms. Calvin.

On 01/26/2022, I interviewed the home manager Keisha Calvin regarding the allegations. Ms. Calvin has been working for Angel's Place, Inc. for eight years. She works Mondays-Fridays from 7AM-3PM and some weekends. Ms. Calvin completed medication administration training through MORC. The allegations were discussed. On the evening of 01/09/2022, Ms. Calvin received a telephone call around 9PM from DCS Ms. Brown. Ms. Brown informed Ms. Calvin that Resident A's PM pills were not in the blister pack and that the AM pills were still in the blister pack. Ms. Brown told Ms. Calvin that it seemed that the assistant home manager Jessica Allen passed Resident A's PM pills instead of his AM pills. Ms. Calvin asked Ms. Brown if Ms. Brown checked the SMMO to see if any of the AM medications can be passed to Resident A in the PM. Ms. Brown told Ms. Calvin, "Yes, I was only able to pass two of the medications, which I did." Ms. Calvin stated on 01/10/2022, Ms. Calvin arrived at Maxwell Home and reviewed Resident A's 7AM medication log and saw that some of the AM pills were still in the blister pack. Ms. Calvin discussed the incident with Ms. Allen who stated, "Yes, I saw the IR and it was me who gave Resident A the PM medications instead of his AM medications." Ms. Calvin stated Ms. Allen did not follow the five rights of medication administration because if Ms. Allen did, then Ms. Allen would have realized she (Ms. Allen) pulled the PM blister packs instead of the AM blister packs. Ms. Calvin stated she reviewed all the IR's for 01/09/2022 and there were no other IR's written, therefore, Resident C did not have a behavior on 01/09/2022 even though Ms. Allen reported that Resident C "may have had a behavior," which would have attributed to Ms. Allen's distraction and not following the five rights.

Ms. Calvin stated this was not Ms. Allen's first medication error. Ms. Allen had another medication error about one year ago when Ms. Allen passed a resident's medication, but Ms. Allen did not supervise that resident taking their pill as the pill was found in the residents' possession. Ms. Calvin stated Resident A missed the following AM medications on 01/09/2022: Allopurinol 100MG, Folic Acid 1MG, Multi-Vitamin and Namenda XR 28MG. Ms. Calvin stated Angel's Place, Inc. has a medication buddy system check that occurs daily for medications. The process is that the person passing medications signs the medication buddy system check stating they passed the medication, then the next shift that comes in must check the blister packs and the medication logs to confirm the first person passed the medications and then the person checking must sign the medication buddy system check sheet too.

On 01/26/2022, I attempted to interview Resident A but due to his cognitive disability, I was unable to obtain information regarding the allegations. Resident A did state that staff give his medications to him at the dining room table.

I reviewed the medication buddy system check from 01/08/2022-01/21/2022 and there were many missing signatures from the medication administrator signature and the person checking the medications signature. It appears staff are not following Angel's Place, Inc. protocol regarding the buddy system check.

I observed the assistant home manager conduct a simulated medication pass which was completed correctly and then reviewed Resident A's and medications and medication logs. I found the following medication errors:

- Resident A's Folic Acid 1MG Tab: take one tablet by mouth every day was not given at 8AM on 01/09/2022 as the pill was still in the blister pack.
- Resident A's Allopurinol 100MG Tab: take one tablet by mouth every day was not given at 8AM on 01/09/2022 as the pill was still in the blister pack.
- Resident A's Metoprolol Er 25MG Tab: take one tablet by mouth every day was given at 9PM on 01/10/2022, but staff did not initial the medication log.
- Resident A's Midodrine HCL 5MG Tab: take one tablet by mouth three times daily was given at 4PM on 01/09/2022-01/12/2022 and on 01/17/2022 and at 9PM on 01/17/2022, but staff did not initial the medication log.
- Resident A's Risperidone 1MG Tab: take one tablet by mouth at bedtime was passed at 9PM on 01/09/2022 but staff did not initial the medication log, instead staff put a line through the box.
- Resident A Senna 8.6 MG Tab: take two tablets by mouth in the evening at bedtime was passed at 9PM on 01/09/2022 but staff did not initial the medication log, instead staff put a line through the box.

I reviewed Resident B's medications and medication logs and there were no medication errors found.

On 01/31/2022, I interviewed DCS Damara Hines regarding the allegations via telephone. Ms. Hines has worked for Angel's Place, Inc. for four years. She works Mondays-Wednesdays 9AM-6PM and sometimes Saturday nights-Sunday. On 01/09/2022, Ms. Hines worked from 10AM-6PM and she did not have to pass any of Resident A's medications; therefore, she did not learn of the medication error until she arrived at work on 01/10/2022. Ms. Hines did not complete the medication buddy system check when she arrived at the home on 01/09/2022 because she only conducts the buddy check if she passes medications on that day. The home manager Keisha Calvin advised Ms. Hines that the assistant home manager Jessica Allen passed Resident A's PM medications instead of his AM medications the morning of 01/09/2022. Ms. Hines stated when she passes medications, she pulls the medication log out, then the residents' medication basket, calls the resident to the dining room table and then follows the five rights of medication passing. Ms. Hines stated she then hands the pills in the cup to the resident and supervises the resident taking their medications and then initials the medication log after completing the five rights again. Ms. Hines stated she completed MORC training in addition to the online refresher training in 2021. Ms. Hines stated this was not Ms. Allen's first medication error as there was an incident last year when Ms. Allen did not supervise a resident taking his medication and that resident's medication was found in the resident's possession later.

On 03/01/2022, I contacted Maxwell Home to interview Residents B, C, D and E regarding the allegations. I spoke with DCS Micaiah Strong who is Resident C's 1:1 staff. Ms. Strong stated Resident B was at a doctor's appointment and that Resident C and Resident D were non-verbal and would be unable to carry a conversation due to their developmental disability. Ms. Strong stated she has worked for Angel's Place, Inc. since October 2021 as Resident C's staff; therefore, Ms. Strong does not pass medication nor is she trained on medication administration. Ms. Strong stated she has no information regarding the medication error on 01/09/2022; however, she can state that there were no IR's written to her knowledge regarding Resident C on 01/09/2022. In addition, Ms. Strong stated, "in my experience and when I work with Resident C, he rarely has behaviors. If he did, he would have one behavior within a week because I can redirect him and help him through his behaviors. Also, staff would tell me if he had any behaviors in the weekend as I do not work weekends and I cannot recall the assistant home manager Jessica Allen or any other staff reporting any behaviors on 01/09/2022 from Resident C."

On 03/01/2022, I attempted to interview Resident E via telephone, but was unable to gather any information regarding the allegations. Resident E stated he was "good," and had "no problems," at Maxwell Home.

On 03/01/2022, I contacted the licensee designee Cheryl Loveday via telephone but was advised that Ms. Loveday is out of the office for a month; therefore, I was transferred to the administrator, Shannon White-Schellenberger. I left a detailed message for Ms. White-Schellenberger with my findings.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | (2) Medication shall be given, taken, or applied pursuant to label instructions. |
| **ANALYSIS:** | Based on my investigation and review of Resident A's medications and medication logs, Resident A did not get his medications as prescribed on 01/09/2022. The assistant home manager Jessica Allen administered Resident A's PM medications instead of Resident A's AM medications the morning of 01/09/2022. Therefore, Resident A missed the following AM medications; Allopurinol 100MG, Folic Acid 1MG, Multi-Vitamin and Namenda XR 28MG. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| APPLICABLE RULE | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | (4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:<br>(b) Complete an individual medication log that contains all of the following information:<br>(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. |
| **ANALYSIS:** | Based on my investigation and review of Resident A's medications and medications logs, I found the following medication errors:<br>• Resident A's Metoprolol Er 25MG Tab: take one tablet by mouth every day was given at 9PM on 01/10/2022, but staff did not initial the medication log.<br>• Resident A's Midodrine HCL 5MG Tab: take one tablet by mouth three times daily was given at 4PM on 01/09/2022-01/12/2022 and on 01/17/2022 and at 9PM on 01/17/2022, but staff did not initial the medication log.<br>• Resident A's Risperidone 1MG Tab: take one tablet by mouth at bedtime was passed at 9PM on 01/09/2022 but staff did not initial the medication log, instead staff put a line through the box.<br>• Resident A Senna 8.6 MG Tab: take two tablets by mouth in the evening at bedtime was passed at 9PM on 01/09/2022 but staff did not initial the medication log, instead staff put a line through the box.<br><br>In addition, DCS Vernessa Brown reported during her interview that she did not initial Resident A's medication log on 01/09/2022 at 9PM at the time she administered Resident A's medications Metoprolol and Midodrine. Ms. Brown stated she initialed the medication log for medications she passed on 01/09/2022 not until she was advised by the home manager Keisha Calvin on 01/24/2022. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

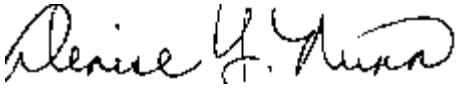
## IV. RECOMMENDATION

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

03/01/2022

Frodet Dawisha — Date
Licensing Consultant

Approved By:



03/22/2022

Denise Y. Nunn — Date
Area Manager