GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 12, 2022

Monica Salingue
Spectrum Community Services
Suite 700
185 E. Main St
Benton Harbor, MI 49022

RE: License #: AS510389959
Investigation #: 2022A0230022
New Horizons

Dear Ms. Salingue:

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 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 (231) 922-5309.

Sincerely,

Rhonda Richards, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4942

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS510389959
Investigation #:	2022A0230022
Complaint Receipt Date:	03/09/2022
Investigation Initiation Date:	03/10/2022
Report Due Date:	05/08/2022
Licensee Name:	Spectrum Community Services
Licensee Address:	28303 Joy Rd., Westland, MI 48185
Licensee Telephone #:	(734) 458-8729
Administrator:	Monica Salingue
Licensee Designee:	Monica Salingue
Name of Facility:	New Horizons
Facility Address:	1053 Oak St., Manistee, MI 49660
Facility Telephone #:	(231) 887-4130
Original Issuance Date:	02/14/2018
License Status:	REGULAR
Effective Date:	08/14/2020
Expiration Date:	08/13/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's medications were left unlocked in the van overnight. When the packet was discovered, medications were missing.	Yes
Resident B's medications were left unlocked and found to be missing.	Yes

III. METHODOLOGY

03/09/2022	Special Investigation Intake 2022A0230022
03/10/2022	Special Investigation Initiated - On Site Interview with staff members Heather Bentley and Jenafae Cloutier
03/18/2022	Contact - Telephone call received Administrator Monica Salingue
04/07/2022	Contact - Telephone call made Staff member Kaira Tillotson
04/07/2022	Contact - Telephone call made Staff member Judy Altman
04/07/2022	Exit Conference with Licensee Designee Monica Salingue

ALLEGATION: Resident A's medications were left unlocked in the van overnight. When the packet was discovered, medications were missing.

INVESTIGATION: On 03/10/2022, I conducted an unannounced on-site investigation at the facility and interviewed staff members Heather Bentley and Jenafae Cloutier.

Ms. Cloutier stated that when she came to work in the morning of 03/03/2022, another staff member who had worked the overnight shift, Judy Altman notified her that Resident A's blister pack of medication from the day before was missing. She and Ms. Altman both reported the incident to their supervisor. Later in the morning Ms. Cloutier located the blister pack outdoors in the snowbank. She brought it back into the facility and it was then discovered that four tablets of Haldol were missing from Resident A's blister pack. It was noted that staff member Kaira Tillotson had taken Resident A on an outing the previous afternoon and took Resident A's blister

pack with her so she could administer his 2:00 p.m. medication. Ms. Cloutier denied taking the medication.

Ms. Bentley stated that she was made aware of Resident A's medication being left in the van by other staff members but she had not worked during that time period so she could not speak personally regarding that incident.

On 03/18/2022, I spoke with Administrator Monica Salingue regarding the complaint. She confirmed that Ms. Tillotson had taken Resident A's blister pack with her on an outing on 03/02/2022. She stated that Ms. Tillotson suddenly became very ill upon returning to the facility and needed to go home. Ms. Tillotson forgot to bring the medications in from the van. She stated that Resident A's medications were discovered missing by midnight staff member Judy Altman. Staff member Jenafae Coultier discovered the medications in a snowbank when she came into her shift in the morning of 03/03/2022, however four pills were missing out of the blister pack. She stated her office and Recipient Rights are investigating the matter. Additionally, she stated Resident A did not miss a dose of any medications as they were able to secure another Haldol from the pharmacy for the following day for his 2:00 p.m. dose.

On 04/07/2022, I spoke with staff member Kiara Tillotson regarding the above allegation. She confirmed that on 03/02/2022 she had taken Resident A on an outing for lunch and shopping. She took the blister medication pack for Resident A so she could administer his 2:00 pm medication. After lunch she administered the medication of Haldol and placed the blister pack back into the glove compartment. She then continued on the shopping outing with Resident A. Upon arrival back at the facility around 4:00 p.m. Ms. Tillotson described herself as becoming "violently ill". She stated she suspected it was from food as she has numerous food allergies. She stated she had severe nausea, headache, and dizziness. She got Resident A back into the facility quickly but then had to go home. She acknowledged she forgot and left the medication for Resident A in the glove box. She was made aware of the missing medication the following morning and explained that she had forgotten the medication in the vehicle. Ms. Tillotson denied taking the medication.

On 04/07/2022, I spoke with staff member Judy Altman who stated that while she was working during her midnight shift on 03/03/2022 she counted medications for all residents and noted Resident A was missing a blister pack of Haldol she then contacted Ms. Tillotson in the early morning hours to ask about it and Ms. Tillotson realized she left it in the van. Ms. Altman went out to the van and looked for the blister pack but found nothing. Both staff members contacted their administrator and human resources to report the situation. At around 10:00 a.m. Ms. Coultier located the blister pack in a snowbank and brought it inside where it was discovered that four Haldol tablets were missing. Both Ms. Tillotson and Ms. Altman denied taking the medication.

ALLEGATION: Resident B's medications were left unlocked and discovered to be missing.

While at the facility on 03/10/2011, I spoke with Ms. Cloutier and Ms. Bentley regarding the above allegations. Both staff members reported that Ms. Altman picked up medications for all residents for the month of March on 02/24/2022 and that the medications were placed on top of a cabinet in the medication room. The medications remained there until 02/27/2022 when they were finally checked in and logged into a locked medication cabinet. Ms. Cloutier stated she began logging in medications for the month of March on February 27th. The medications, she took from a paper bag on top of a cabinet in the medication/Laundry room. She could not log all medication in on her shift therefore Ms. Altman began to finish logging them in on her midnight shift when she noted one of two blister packs of gabapentin was missing for Resident B.

Ms. Bentley stated she learned of the missing medications and looked in the medication cart and lock boxes to see if medications were misplaced but she could not locate them. Ms. Cloutier stated on 02/28/2022 she checked the medication cart, cupboards, lock boxes, medication cooler and behind the washer and dryer with Ms. Tillotson but could not locate the medications. Both staff state they had observed the bag of medications on top of the cabinet unlocked in the medication/laundry room for several days. I observed the cabinet, and it is in a room that is always open and unlocked.

On 04/07/2022, I spoke with Ms. Tillotson who stated that on 02/24/2022 Ms. Altman picked up the medications for March for all residents after her midnight shift. Ms. Tillotson stated she assisted Ms. Altman in unloading the medications and put them on top of the cabinet in the medication/laundry room where they remained until 02/27/2022 when Ms. Cloutier and Ms. Altman checked them in. Both Ms. Bentley and Ms. Cloutier denied that they took the missing medication. Ms. Tillotson checked with the pharmacist who reviewed the video tape of the medications being placed in the bag on 02/24/2022 and the pharmacist stated the tape revealed that both blister packs were indeed put into the bag that Ms. Altman picked up.

On 04/07/2022, I spoke with Ms. Altman who confirmed that she had picked up medications for all residents on 02/24/2022 after her midnight shift. She stated she offered to do this for the facility on her own time as she was going to the store anyway. When she came back to the facility, she and Ms. Tillotson unloaded the medications and Ms. Altman said she left to go home and told the other staff members "I am not going to check these in because I am not on the clock." Ms. Altman stated when she was working on 02/27/2022 on the midnight shift she was tasked with finishing the logging of March medication as Ms. Cloutier had started the logging but did not have time to finish the task. As Ms. Altman was logging in the medications for March, she noted that Resident B was missing a blister pack of 30 pills of gabapentin. She proceeded to check the medication cart, lock boxes, and all through the other medications waiting to be checked in and could not find the

missing 30 pill blister pack. She then notified her medication technician, Ms. Bentley and told her to check with the pharmacy when they opened to see if they had forgotten it. Ms. Altman stated she learned later that the pharmacy stated they did not forget to put the medications in the bag. Ms. Altman denied that she took the medications.

On 04/07/2022, I conducted an exit conference with Licensee Designee, Monica Salingue and reviewed the findings of the investigation. She stated she had already started to work on a corrective action plan as it was clear that staff had left medications unlocked and unaccounted for during the three-day period from 02/24/2022 through 02/27/2022. Although the pharmacy stated they put the medications in the bag she stated they have made mistakes in the past. Regarding the missing medications found in the snowbank, the van was not locked so she stated it is hard to know who may have taken the four missing pills. She added that although Ms. Tillotson suddenly fell ill and did not bring in the medications, there needed to be a protocol set in place for leaving the facility with medications. She also noted that the facility obtained additional medications for both residents so that neither went without any doses at any time. She has already set a new policy in place that medications will be locked in a closet until they are ready to be logged into the medication cart.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on statements from four staff members and the facility administrator there is evidence to substantiate the allegation that prescription medication for Resident A was not kept in a locked cabinet or drawer when it was left in the unlocked van overnight. Additionally, all staff members confirmed that an entire bag of medications for all residents at the facility was kept in an unlocked room on top of a cabinet for three days.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Reasonable precautions were not taken to ensure that prescription medication was not used by a person other than the resident for whom the medication was prescribed. According to four staff members and the facility administrator the medication for Resident A was left in an unlocked van and later found outside in a snowbank with four pills missing from the blister pack. Additionally, all staff members confirmed that an entire bag of medications for all residents at the facility was kept in an unlocked room on top of a cabinet for three days.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Rhonda Richards 04/12/2022

Rhonda Richards Date
Licensing Consultant

Approved By:

Jerry Hendrick 04/12/2022

Jerry Hendrick Date
Area Manager