GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 22, 2022

Janet Patterson
Advocates for Self Determination, LLC
Suite 102
28237 Orchard Lake Rd.
Farmington Hills, MI 48334

RE: License #: AS630337268
Investigation #: 2022A0602019
Rochester Home

Dear Ms. Patterson:

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,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630337268
Investigation #:	2022A0602019
Complaint Receipt Date:	02/18/2022
Investigation Initiation Date:	02/22/2022
Report Due Date:	04/19/2022
Licensee Name:	Advocates for Self Determination, LLC
Licensee Address:	28237 Orchard Lake Rd., Suite 102 Farmington Hills, MI 48334
Licensee Telephone #:	(248) 723-7152
Administrator:	Janet Patterson
Licensee Designee:	Janet Patterson
Name of Facility:	Rochester Home
Facility Address:	4651 Rochester Road Troy, MI 48085
Facility Telephone #:	(248) 688-9032
Original Issuance Date:	12/11/2013
License Status:	REGULAR
Effective Date:	06/11/2020
Expiration Date:	06/10/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Per incident report, on 2/12/2022 staff member Tonia Allen gave Resident A the incorrect medications. Resident A was transported to Troy Beaumont for an evaluation and discharged the same day.	Yes

III. METHODOLOGY

02/18/2022	Special Investigation Intake 2022A0602019
02/22/2022	Special Investigation Initiated - Telephone Call made to the office of recipient rights – message left.
02/23/2022	APS Referral Adult Protective Services (APS) referral denied.
03/04/2022	Inspection Completed On-site Interviewed the home manager, Shawanna Walker and Resident A.
04/14/2022	Contact – Telephone call made Interviewed staff member Tonia Allen.
4/21/2022	Exit Conference Held with the licensee designee, Janet Patterson by phone.

ALLEGATION:

Per incident report, on 2/12/2022 staff member Tonia Allen gave Resident A the incorrect medications. Resident A was transported to Troy Beaumont for an evaluation and discharged the same day.

INVESTIGATION:

On 2/18/2022, a complaint was received and assigned for investigation alleging that on 2/12/2022 staff member Tonia Allen gave Resident A the incorrect medications. Ms. Allen reported that 911, the manager, and guardian were contacted. Resident A was transported to Troy Beaumont for an evaluation and discharged the same day.

On 3/04/2022, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Shawanna Walker, and Resident A. Ms. Walker stated on 2/12/2022 she received a call from Ms. Allen (exact time unknown) informing her that Resident A received Resident B's medication by accident and 911 had been called. Ms. Walker stated she arrived at the home around 8:15 am or 8:20 am and Resident A had already been transported to the hospital. Ms. Walker picked up Resident A from Troy Beaumont Hospital a few hours later. Resident A did not display any side effects from the medication she had taken.

On 3/04/2022, I interviewed Resident A at the facility. Resident A stated she recalls the day she received another resident's medication. She got up in the morning (exact date and time unknown) to take her medication. The medication was sitting on top of the medication cabinet. Resident A picked up the cup and took the medication and went back to bed. A few minutes later Ms. Allen came into her room and told her she had taken Resident B's medication and needed to go to the hospital. Resident A stated 911 was called and she was transported to the hospital. When she arrived at the hospital the doctor told her she was okay and let her go home. Ms. Walker picked her up and transported her back to the group home. Resident A said she did not experience any side effects from taking Resident B's medication.

On 3/04/2022, I received and reviewed Resident A's discharge paperwork from Troy Beaumont Hospital dated 2/12/2022. According to the discharge paperwork, Resident A was treated for a drug overdose and a diagnosis of accidental ingestion of a substance was given.

On 3/04/2022, I reviewed Resident B's 8 am medication list. The following 8 am medications were taken by Resident A:

- Atorvastatin Tab 10 mg – 1 Tab
- Centrum Silver Ultra women's – 1 Tab
- Levocarnitine 330 mg – 3 Tabs
- Perphenazine Tab 8 mg – 1 Tab
- Valacyclovir Tab 500 mg – 1 Tab
- Vitamin D3 Cap 2000 unit – 1 Cap

On 4/15/2022, I interviewed staff member Tonia Allen by telephone. Ms. Allen stated on 2/12/2022 she arrived for her shift at 12 midnight. As soon as she arrived, Resident A and Resident B asked if they could go outside to smoke. Ms. Allen told them they would have to wait until she got situated. They both went to their rooms. Around 6:15 am or 6:30 am Resident B and Resident C started arguing with one another. Resident C accused Resident B of going into her room and taking her coffee. At the same time, Resident A asked if she could go outside to smoke again. Ms. Allen told her to wait until after medications had been administered. Ms. Allen began preparing to administer medications at 7 am. As she was placing Resident B's medication in a cup, Resident C began yelling at Resident B about going into her room without permission. Ms. Allen

placed the medication on top of the medication cart and went to intervene between Resident B and Resident C. Once she returned to the medication cart, she realized Resident B's medication was gone. Ms. Allen went into Resident A's room and asked if she had taken the medication that was sitting on top of the medication cart, and she said yes. Resident A thought the medication was hers. Ms. Allen called Ms. Walker and informed her of the situation and then called 911. Resident A was transported to Troy Beaumont Hospital.

On 4/21/2022, I conducted an exit conference with the licensee designee, Janet Patterson by telephone. I informed Ms. Patterson of the investigative findings and recommendation documented in this report. Ms. Patterson stated there is no excuse for Ms. Allen's failure to lock Resident B's medication up before addressing the issue with Resident B and Resident C as it was not a life-threatening situation. Ms. Patterson agreed to submit a corrective action plan upon receipt of this report.

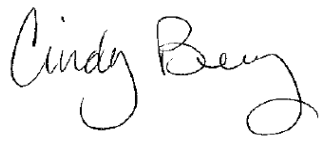
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information obtained from Ms. Allen, I determined that Ms. Allen did not administer Resident B's medication pursuant to the label instructions. Resident B's medication was left unattended on the medication cart and was consumed by Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on the information obtained from Ms. Allen, there is sufficient information to determine that she did not take reasonable precautions to ensure that Resident B's prescribed medication was not used by someone else. Ms. Allen stated she was distracted by the argument between Resident B and Resident C and left Resident B's medication unattended allowing Resident A to consume it.

CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

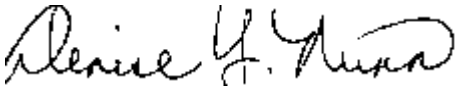
Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



04/21/2022

Cindy Berry Date
Licensing Consultant

Approved By:



04/22/2022

Denise Y. Nunn Date
Area Manager