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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 29, 2022

Kent VanderLoon
McBride Quality Care Services, Inc.
P.O. Box 387
Mt. Pleasant, MI 48804-0387

RE: License #: AS290404417
Investigation #: 2022A0577031
Woodhaven AFC

Dear Mr. VanderLoon:

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 (231) 922-5309.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS290404417
Investigation #:	2022A0577031
Complaint Receipt Date:	03/29/2022
Investigation Initiation Date:	03/29/2022
Report Due Date:	05/28/2022
Licensee Name:	McBride Quality Care Services, Inc.
Licensee Address:	3070 Jen's Way Mt. Pleasant, MI 48858
Licensee Telephone #:	(989) 772-1261
Administrator/Licensee Designee:	Kent VanderLoon
Name of Facility:	Woodhaven AFC
Facility Address:	1015 S. St. John Ithaca, MI 48847
Facility Telephone #:	(989) 388-4029
Original Issuance Date:	11/20/2020
License **Status:**	REGULAR
Effective Date:	05/20/2021
Expiration Date:	05/19/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was being administered the incorrect dosage of Perphenazine.	Yes

III. METHODOLOGY

03/29/2022	Special Investigation Intake 2022A0577031
03/29/2022	Special Investigation Initiated – Telephone call to Cynthia Robinson, home manager
03/29/2022	Referral - Recipient Rights to Angela Loiselle, ORR-MCN.
03/30/2022	Inspection Completed On-site Interviewed staff and reviewed/received documents.
03/31/2022	Contact - Document Received- Staff Medication Trainings.
04/18/2022	Inspection Completed-BCAL Sub. Compliance
04/18/2022	Exit Conference with licensee designee Kent VanderLoon.

ALLEGATION: Resident A was being administered the incorrect amount of Perphenazine.

INVESTIGATION:

On March 29, 2022, a complaint was received reporting that on March 24, 2022, during medication count direct care staff member Cynthia Robinson, whose role is home manager, discovered Resident A was receiving 4mg of Perphenazine instead of 8mg as prescribed. The complaint reported this has been happening since March 13, 2022, and involved the following four direct care staff Cynthia Robinson, Zachary Ridenour, Melissa Packer, and Taylor Hopkins.

On March 29, 2022, an *AFC Licensing Division Incident/Accident* Report was received reporting that on March 24, 2022, while direct care staff member Cynthia Robinson was completing a medication count, she found Resident A was prescribed Perphenazine 8mg twice daily but was only being administered 4mg twice daily. According to the *AFC Licensing Division Incident/Accident Report,* Ms. Robinson contacted the nurse for Dr. Sansait to report the incorrect dosage and seek guidance.

On March 30, 2022, Angela Loiselle, Montcalm Care Network Office of Recipient Rights, and I completed on onsite investigation and interviewed direct care staff (DCS). Upon arriving to the facility Cathy Griffis, Area Director of Services (ADOS), was having a staff meeting and conducting medication administration training to all staff which included the Five Rights of medications-person, medication, dose, route, and time. Ms. Loiselle and I observed this training and answered questions as those related to AFC licensing rules. I reviewed and received copies of direct care staff medication administration training records and all staff were trained prior to the incident occurring on March 13, 2022. During the onsite investigation I observed and received copies of Resident A's *Medication Administration Record* (MAR) and reviewed prescriptions documenting Resident A was prescribed Perphenazine 4mg, twice a day on February 07, 2022 and then the dosage was changed on February 08, 2022, to 8 mg, twice a day.

On March 30, 2022, we interviewed DCS/home manager Cynthia Robinson who reported Resident A was receiving 4mg of Perphenazine, two times a day upon discharge from the hospital and the prescription was changed to 8mg, two times a day. Ms. Robinson reported she pulled the 4mg bubble pack of medications and put it in the overflow cabinet of medications. Ms. Robinson reported on March 24, 2022, she was completing a medication reconciliation of the resident medications and in Resident A's medication basket found the bubble pack for Perphenazine, 4mg, twice daily but Resident A's MAR documented Perphenazine, 8mg, twice daily. Ms. Robinson stated, "I even passed medications on March 15, 2022, and did not catch the error."

On March 30, 2022, we interviewed DCS Taylor Hopkins who reported on March 13, 2022, she administered the last dosage of 8mg Perphenazine to Resident A at 8:00am. Ms. Hopkins reported she went to the cupboard where overflow or next cycles of medications were kept and found a bubble pack of Perphenazine for Resident A, pulled the bubble pack, and put it in Resident A's current medication basket. Ms. Hopkins reported she did not read the label on the bubble pack, she just assumed it was the correct dosage. Ms. Hopkins reported she worked on March 14, 15, 23 and 24, from 11:00am-9:00pm and passed medications on those dates. Ms. Hopkins reported she received medication training from both Montcalm Care Network and Community Mental Health Central Michigan, plus on the job training. Ms. Hopkins reported she is aware of the five rights of medication passing but did not do them.

On March 30, 2022, we interviewed DCS/ assistant home manager Zach Ridenour at a different facility. Mr. Ridenour reported he was at Woodhaven covering shifts while staff were on vacation. Mr. Ridenour reported he worked on March 14, 16, 17, 18, 19, 20, 2022 and worked from 3:00pm-11:00pm most shifts. Mr. Ridenour reported he passed medications five times during his shifts and did not notice the incorrect dosage of medication was being administered. Mr. Ridenour stated, "I was complacent, no reason or excuse for the error. I jacked up big." Mr. Ridenour reported he has been trained and understands the importance of doing the five rights when passing medications but did not do it.

DCS Melissa Packer was interviewed on March 30, 2022, by this consultant and reported she completed medication training through Montcalm Care Network and was provided hands on training at the facility. Ms. Packer reported she is aware of the five rights of passing medications. Ms. Packer reported she worked from 3:00pm-11:00pm on March 13,20,21,22,23,24, 2022 and passed medications during her shift. Ms. Packer reported she did not realize the dosage was incorrect stating, “I must not have been doing the five rights, skipped over the dosage.”

DCS Dawn Portman was interviewed on March 30, 2022, by this consultant and reported she is a new staff and is still in the process of being trained. Ms. Portman reported she has not passed medications on her own yet, she has been shadowing or being shadowed by trained staff. Ms. Portman reports she was not sure how the incorrect medications were administered during her training on March 16,17,18,19, and 22, 2022. Ms. Portman stated, “I am very diligent about doing the five rights because medication administration makes me nervous. Apparently, I did not do them, I must have computed the 4 to an 8 in my mind, I do not know how I made this mistake.”

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 the Act No. 368 of the Public Acts of 1978, as amended, being S333.l1101 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:	It has been determined through the investigation from March 13, 2022-March 24, 2022, Resident A was receiving 4mg of Perphenazine twice daily instead of 8mg of Perphenazine twice daily as prescribed. Resident A was prescribed 4mg of Perphenazine until February 08, 2022, when the dosage changed to 8mg by Resident A’s prescribing physician. Resident A was not being administered her medications as prescribed by the physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the current status of the license remains unchanged.

04/18/2022

Bridget Vermeesch — Date
Licensing Consultant

Approved By:

04/29/2022

Dawn N. Timm — Date
Area Manager