GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 3, 2022

Jennifer Bhaskaran
Alternative Services Inc.
Suite 10
32625 W Seven Mile Rd
Livonia, MI 48152

RE: License #: AS150247007
Investigation #: 2022A0009019
Bay Springs

Dear Ms. Bhaskaran:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time-frame for the 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,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS150247007
Investigation #:	2022A0009019
Complaint Receipt Date:	04/12/2022
Investigation Initiation Date:	04/13/2022
Report Due Date:	05/12/2022
Licensee Name:	Alternative Services Inc.
Licensee Address:	32625 W Seven Mile Rd, Suite 10 Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Tamie Stevens
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Bay Springs
Facility Address:	232 Court Street Boyne City, MI 49712
Facility Telephone #:	(231) 582-0631
Original Issuance Date:	04/11/2002
License Status:	REGULAR
Effective Date:	10/11/2020
Expiration Date:	10/10/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was given his prescribed narcotic twice by mistake.	Yes

III. METHODOLOGY

04/12/2022	Special Investigation Intake 2022A0009019
04/13/2022	Special Investigation Initiated – Telephone call made to North Country Community Mental Health (CMH) recipient rights officer Ms. Brandy Marvin
04/15/2022	Inspection Completed On-site
04/20/2022	Inspection Completed On-site Interview with direct care worker Ms. Tiffany Churches Face to face with Resident A
04/22/2022	Contact – Telephone call made to home manager Ms. Carrie Lundy
04/25/2022	Exit conference with licensee designee Ms. Jennifer Bhaskaran

ALLEGATION: Resident A was given his prescribed narcotic twice by mistake.

INVESTIGATION: On April 12, 2022, I received an Incident/Accident Report (BCAL-4607) from Bay Springs home manager Ms. Carrie Lundy. The incident report indicated that Resident A received two doses of his prescribed narcotic (Klonopin) on April 11, 2022. The error had reportedly happened during the afternoon of that day. They had contacted medical personnel at that time and reported the situation.

I spoke with North Country Community Mental Health (CMH) recipient rights officer Brandy Marvin by phone on April 13, 2022. I asked her about the incident that had occurred at the Bay Springs adult foster care (AFC) home regarding Resident A. Ms. Marvin stated that she did see documentation that the medication error had been reported to the on-call CMH nurse. Ms. Marvin stated that she would follow-up with the nurse to see what recommendations she had made regarding the incident. Ms. Marvin also stated that they might provide additional medication training to the staff at Bay Springs.

I made an unannounced site inspection at the Bay Springs AFC home on April 15, 2022. A pest control company was fumigating the home at the time of my visit. The

pest control employee stated that the staff and residents would not be returning until after business hours due to the fumigation.

I made another unannounced site inspection at the Bay Springs AFC home on April 20, 2022. I wore personal protection equipment to protect myself and others. I spoke with direct care worker Tiffany Churches. Ms. Churches showed me Resident A's medication log for April 11, 2022. The medication log was initialed by staff on April 11, 2022, indicating that Resident A did receive his afternoon dose of Klonopin. There was no indication on the medication log of the medication error. I asked Ms. Churches where they record medication errors. She showed me the "medication count sheet" where she believed the medication error was discovered. On the bottom of the medication count sheet was written, "4/11 – 2 Klonopin given accidentally to (Resident A). Nurse called and I.R. filled out." It was signed by home manager Carrie Lundy. Ms. Churches showed me how they count the residents' narcotic pills during shift changes and that Ms. Lundy must have caught the error at that time. Ms. Churches said that she was not sure how the medication error occurred since she felt there are many safeguards in place to prevent errors.

I also observed and interacted with Resident A during my inspection. Resident A is not verbal in regard to language but seemed happy to see me. He was interactive and seemed in good spirits at that time.

I spoke with home manager Carrie Lundy by phone on April 22, 2022. She said that she had discovered the mistake on April 11, 2022, shortly after the medication error had been made. A new employee had erroneously given Resident A two of his Klonopin on that date in the afternoon. She said that the employee is relatively new, having started in February of 2022, but has been trained to pass medication. Resident A's Klonopin comes from the pharmacy in blister-packs. The new employee had "popped" the last Klonopin pill in one blister-pack and put it into the medication cup. She then went through the procedure of "logging in" a new blister-pack. When she did this she mistakenly "popped" another Klonopin pill out of the new blister-pack and put it in the cup. She should have realized that she had two Klonopin pills in the cup at that time but did not. Ms. Lundy stated that she did a medication count shortly after and found the error. They contacted the on-call CMH nurse and other medical personnel at that time who stated they should monitor Resident A. There was no sign he was in any distress. Ms. Lundy stated that she will be providing an in-service training to the staff on passing medication.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	It was confirmed through this investigation that on April 11, 2022, Resident A was given two of his Klonopin pills when he was only supposed to get one pursuant to the label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee designee Ms. Jennifer Bhaskaran by phone on April 25, 2022. I told her of the findings of investigation and gave her the opportunity to ask questions.

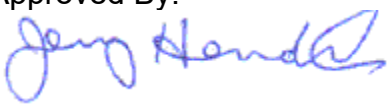
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

05/02/2022

Adam Robarge — Date
Licensing Consultant

Approved By:



05/03/2022

Jerry Hendrick — Date
Area Manager