GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 23, 2022

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

RE: License #: AS630088206
Investigation #: 2022A0993016
Dinan Home

Dear Mrs. White-Schellenberger:

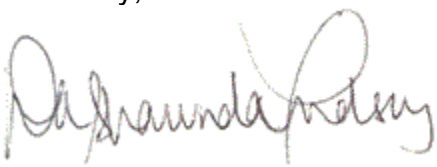
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W Grand Blvd, Suite 9-100
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630088206
Investigation #:	2022A0993016
Complaint Receipt Date:	07/20/2022
Investigation Initiation Date:	07/21/2022
Report Due Date:	09/18/2022
Licensee Name:	Angels' Place
Licensee Address:	Suite 2 29299 Franklin Road Southfield, MI 48034
Licensee Telephone #:	(248) 350-2203
Administrator:	Shannon White-Schellenberger
Licensee Designee:	Shannon White-Schellenberger
Name of Facility:	Dinan Home
Facility Address:	33130 Raphael Farmington Hills, MI 48338
Facility Telephone #:	(248) 477-2084
Original Issuance Date:	09/01/2000
License Status:	REGULAR
Effective Date:	04/21/2021
Expiration Date:	04/20/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A's medication was not administered as prescribed on 07/19/2022.	Yes

III. METHODOLOGY

07/20/2022	Special Investigation Intake 2022A0993016
07/21/2022	Referral - Recipient Rights Forwarded allegations to recipient rights advocate Alanna Honkanen
07/21/2022	Special Investigation Initiated - On Site Conducted an unannounced onsite investigation. Left a business card in front door.
07/21/2022	Contact - Telephone call made Telephone call made to licensee designee Shannon White-Schellenberger. Left a message.
07/25/2022	Inspection Completed On-site Conducted an unannounced onsite investigation. There was no answer.
07/25/2022	Contact - Telephone call made Telephone call made to home manager Yvette Stewart. Left a message.
07/26/2022	Contact - Telephone call made Telephone call made to facility. Left a message.
07/26/2022	APS Referral Forwarded allegations to adult protective services (APS).
07/27/2022	Inspection Completed On-site Conducted an announced onsite investigation
08/01/2022	Contact - Telephone call made Telephone call made to home manager Yvette Stewart. Left a message.

08/02/2022	Contact - Telephone call made Telephone call made to home manager Yvette Stewart. Left a message.
08/02/2022	Contact - Telephone call received Telephone call received from home manager Yvette Stewart
08/02/2022	Contact - Telephone call made Telephone call made to staff Augustine Nelson. Left a message.
08/02/2022	Contact - Telephone call received Telephone call received from staff Augustine Nelson
08/02/2022	Contact - Document Sent Requested verification of medication administration training for staff
08/02/2022	Contact - Document Received Received verification of medication administration training for staff
08/04/2022	Inspection Completed-BCAL Sub. Compliance Onsite completed on 07/27/2022
08/10/2022	Exit Conference Attempted to conduct an exit conference with licensee designee Shannon White-Schellenberger. Left a message.

ALLEGATION:

Resident A's medication was not administered as prescribed on 07/19/2022.

INVESTIGATION:

On 07/20/2022, I reviewed an incident report. Per the incident report, Resident A was not administered Oscal 500+D Chewable and Zyrtec 10mg on 07/19/2022. Resident A's doctor was notified of the medication error. The corrective measure was to include the home manager reviewing the medication procedure with staff to ensure staff know how to properly administer medications. In addition, a counseling notice was to be given.

On 07/21/2022, I forwarded the allegations to recipient rights advocate Alanna Honkanen.

On 07/26/2022, I forwarded the allegations to adult protective services (APS).

On 07/27/2022, I conducted an announced onsite investigation. I interviewed staff Wanda Regular and Resident A.

Ms. Regular stated she has worked in the facility for almost one year. She works the afternoon shift, either from 1pm to 9pm or 2pm to 10pm. Ms. Regular worked the afternoon shift on 07/19/2022 with staff Augustine Nelson. Ms. Regular administered all residents their medication except Resident A. Resident A was taking a shower when Ms. Regular administered the medications. This occurred between 7pm and 8pm. Ms. Regular stated it slipped her mind to administer Resident A her medications after her shower. Home manager Yvette Stewart noticed that Resident A did not receive her evening medications on 07/19/2022 the following morning. Ms. Regular stated Resident A did not experience any adverse effects or required hospitalization due to the missed medications. Ms. Regular stated she has completed medication administration training.

Resident A stated she has lived in the facility for a long time. However, she wants to live with her brother. She stated she takes all her medications. She did not know the names of her medications and/or the times she is supposed to take her medications. Resident A stated she did not have any concerns.

During the onsite investigation, I observed Resident A's medications and Resident A's medication administration record (MAR) for July. I observed staff did not initial the MAR on 07/23/2022 at 4pm to show administration of Dilantin 100mg.

On 08/02/2022, I conducted a telephone interview with home manager Yvette Stewart. She verified Resident A was not administered her evening medications on 07/19/2022. Ms. Stewart stated she observed the error the following morning when she completed a medication check. Ms. Stewart stated Resident A did not experience any adverse effects or required hospitalization due to the missed medications. Per Ms. Stewart, all staff have been trained to administer medications. She stated staff are supposed to do a buddy system. One staff administers the medications, and the other staff verifies that the medications were administered the MAR was signed. Ms. Nelson signed off that the medications were properly administered, but she did not verify that it was done.

On 08/02/2022, I conducted a telephone interview with staff Augustine Nelson. Ms. Nelson stated she has worked in the facility for approximately seven years. She works all shifts, but mostly works the midnight shift. She verified she worked with Ms. Regular on 07/19/2022. She verified Ms. Regular administered medications to the residents, but she did not administer medications to Resident A. Per Ms. Nelson, she was completing required documentation when Ms. Regular was administering medications. She stated Resident A did not experience any adverse effects or required hospitalization due to the missed medications. Ms. Nelson stated she completed medication administration training. All staff have been trained to administer medications.

On 08/02/2022, I observed training certificates verifying that Ms. Regular, Ms. Stewart, Ms. Nelson as well as staff Lateace Bobb, staff Aiyana Calvin-Oguaju, staff Ebony Collins, and staff Erin Nash completed medication administration training with Macomb Oakland Regional Center (MORC).

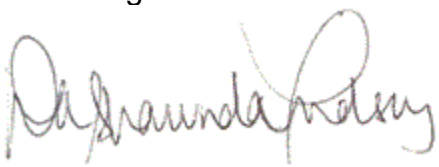
On 08/10/2022, I attempted to conduct an exit conference with licensee designee Shannon White-Schellenberger with no success. I left a message.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 07/19/2022, Resident A was not administered Oscal 500+D Chewable and Zyrtec 10mg.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of a medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	On 07/27/2022, I observed Resident A's medications and Resident A's medication administration record (MAR) for July. I observed staff did not initial the MAR on 07/23/2022 at 4pm to show administration of Dilantin 100mg.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

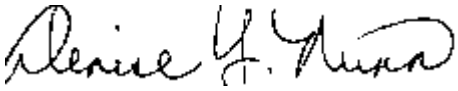
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license statue.



08/16/2022

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



08/23/2022

Denise Y. Nunn — Date
Area Manager