GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 27, 2022

James Pilot
Bay Human Services, Inc.
P O Box 741
Standish, MI 48658

RE: License #:	AS090395688
Investigation #:	2022A0123050
	Rose Home

Dear Mr. Pilot:

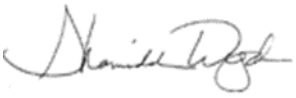
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090395688
Investigation #:	2022A0123050
Complaint Receipt Date:	08/09/2022
Investigation Initiation Date:	08/09/2022
Report Due Date:	10/08/2022
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Tammy Unger
Licensee Designee:	James Pilot
Name of Facility:	Rose Home
Facility Address:	308 Ireland Auburn, MI 48611
Facility Telephone #:	(989) 662-4595
Original Issuance Date:	10/01/2018
License Status:	REGULAR
Effective Date:	04/01/2021
Expiration Date:	03/31/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 08/07/2022, staff failed to provide Resident A her pain medications and antibiotics. Resident A reported to be in pain. Resident A went 15 hours without pain medication while she had broken toes and a laceration.	Yes

III. METHODOLOGY

08/09/2022	Special Investigation Intake 2022A0123050
08/09/2022	APS Referral- Information received regarding APS referral.
08/09/2022	Special Investigation Initiated - Telephone I spoke with recipient rights officer Kevin Motyka via phone.
08/09/2022	Contact - Document Received Documentation received via email from Mr. Motyka.
08/11/2022	Inspection Completed On-site I conducted an unannounced visit at the facility.
09/14/2022	Contact - Telephone call made I spoke with nurse Tabbitha Heckman via phone.
09/21/2022	Contact - Telephone call made I left a voicemail requesting a return call from staff Chelsey Willey via phone.
09/21/2022	Contact - Telephone call received I spoke with Staff Willey via phone.
09/21/2022	Contact- Telephone call made I left a message requesting a return call from staff Christine Socia.
09/21/2022	Contact- Telephone call made Requested documentation received via email from regional manager Shelly Gault.
09/22/2022	Contact- Document Received

	I received requested documentation via email.
9/26/2022	Contact- Telephone call made I made a second attempt to contact Staff Socia. There was no answer.
09/26/2022	Exit Conference I spoke with licensee designee Joe Pilot via phone.

ALLEGATION: On 08/07/2022, staff failed to provide Resident A her pain medications and antibiotics. Resident A reported to be in pain. Resident A went 15 hours without pain medication while she had broken toes and a laceration.

INVESTIGATION: On 08/09/2022, I spoke with Kevin Motyka of Bay Arenac Behavioral Health recipient rights via phone. He stated that he received an incident report regarding the incident and will send a copy of the incident report.

On 08/09/2022, I received a copy of two incident reports from Mr. Motyka. The first incident report dated 08/05/2022, states that Resident A was getting into the van with assistance by staff. Resident A went forward in her powerchair and caught her foot in a piece of metal from the back seat of the van causing her foot to split open by her big toe. Staff called 911.

A second incident report dated 08/07/2022 authored by staff Christine Socia states the following:

"As staff was passing a.m. medications on 08/07/2022 they noticed that [Resident A's] new antibiotic and her pain reliever her 2 newest meds, had not been passed at the listed med times of 12:00 am and 6:00 am, the previous night. There was no new P.O. written in the med book, only a note so staff was unaware. Nurse Tabbitha called for instructions. She came up with new med passing times for the 2 new medications. It is to be followed until 3:00 pm on 08/08/2022. After Norco & antibiotic given, then nurse Tabbitha is to be called for further instructions. The mars med page with the 2 new medications listed on it, moved to be the very 1st page of [Resident A's] MARS pages. This will make it more visible to med passers, thereby making it easier to follow. Staff will write PO's when nurse instructs anything, med person will also go through book."

On 08/11/2022, I conducted an unannounced on-site visit at the facility. I interviewed Resident A, who is her own guardian. Resident A stated that she hurt her foot, the EMTs came and picked her up. She received pain meds and stitches. She stated that she has used her pain medications, and they are on a regular schedule, but it was not like that before. She stated that the first night she came home from the hospital, it was quite a while before she received her meds. She stated that she asked for them, but staff said she did not have any. She stated that she came home

from the emergency room with medications. She stated that the script was sent to the pharmacy, they picked up the meds and came home about midnight. She stated that she got her meds around 3:00 am, and that she was told to wait for nighttime to get pain medications. She stated that hurting her foot was an accident, and it happened as she was getting in the van. She stated that her foot was hanging, and it should not have been. She stated that the staff person keeps blaming herself, but it was not staff's fault.

On 08/11/2022, during my on-site visit, I obtained copies of Resident A's August 2022 medication administration records. The MARS sheet shows that Staff Willey passed Resident A Tylenol 500 MG PRN at 12:37 am for foot pain on 08/06/2022, and another staff passed the same medication again for the same reason at 7:45 am. Resident A's NORCO 5/325 MG/Tab GEQ (Take 1 tab by mouth every 6 hours if needed for severe pain for up to 3 days) is written in on her MARS. The Norco is documented as being passed on 08/07/2022 at 9:00 am, 3:00 pm, 9:00 pm, and 3:00 am. And on 08/08/2022 at 9:00 am, and 3:00 pm, then discontinued. It is also documented as passed on 08/06/2022 at 12:00 am, 12pm, and 6:00 pm. There appeared to be a missed dose on 08/06/22 at 6:00 am, and again at 12:00 am and 6:00 am on 08/07/2022. Resident A's Cleocin 150 MG CAP/GEQ (Take 3 capsules by mouth every six hours for seven days) was documented to be passed on 08/06/2022 at 12:pm, and 6:00 pm. Missed doses appear to be 12:00 am and 6:00 am on 08/06/2022. The MARS shows that the Cleocin was rescheduled for 9:00 am, 3:00 pm, 9:00 pm, and 3:00 am on 08/07/2022 onward, with the medication documented as being passed each time except again on 08/10/2022 at 9:00 pm.

On 09/14/2022, I made a call to Bay Arenac Behavioral Health nurse Tabbitha Heckman via phone. Ms. Heckman stated that she scheduled out Resident A's medications for 12, 6, and 12 due to Resident A fracturing her bones in her ankle and having a laceration. She stated that Resident A had a PRN Norco script. She stated that staff did not pass the antibiotic or pain meds and Resident A went about nine to twelve hours without a dose. She stated that she got a call from the next shift staff who stated that the meds had not been passed for 12:00 am and 6:00 am. She stated that she instructed the staff to pass them, and she re-timed the medication. She stated that Resident A got a 6:00 pm dose, and then again around 9:15 am the following morning, so Resident A went about 15 hours without medications.

On 09/21/2022, I spoke with staff Chelsey Willey via phone. Staff Willey stated that Resident A was supposed to get her medication at 3:00 am, and her last dose was around 9:00 pm. Staff Willey stated that she started her shift at 11:00 pm. She stated that there were no notes left that she needed to pass medication to Resident A, as second shift did not relay the information, and there was no physician order in the file. She stated that when she started doing med counts, she found a sticky note detailing information that should have been documented on a physician order. She stated that when she left at the end of her shift, she told a first shift staff about it, and the staff replied "oh, so you didn't pass the meds?" She stated that she believes the window that Resident A did not get her medications was 9:00 pm to 8:00 am. She

states that she had never passed medication on third shift and felt bad about it. She stated that if she knew a med was coming, she would have double checked for it. She stated that at a bed check during her shift, Resident A did not mention needing her medication, but did start complaining of pain around 6:00 am, and this is when she went to get Resident A a Tylenol for pain, and then found the sticky note about the new scripts.

On 09/21/2022, and 09/26/2022, I made two unsuccessful attempts to contact staff Christine Socia via phone.

On 09/22/2022, I received a copy of Resident A's *Health Care Appraisal* dated 06/28/2022. Resident A's documentation checks that she uses a wheelchair and notes that she uses an amigo. Resident A's *Assessment Plan for AFC Residents* dated for 11/08/2021 also notes that she uses a powerchair/wheelchair. A copy of Resident A's script for her power wheelchair dated 08/11/2022 was received as well.

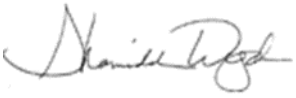
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	An incident report dated 08/07/2022 states that Resident A was not passed her pain and antibiotic medications on 08/07/2022 at 12:00 am and 6:00 am. Resident A stated that she had to wait a long time to get her nighttime pain medication. Resident A's medication administration records indicate that Resident A had multiple missed doses of her pain medication and antibiotic. Nurse Tabbitha Heckman confirmed that Resident A missed doses of her medications, and she had to re-time the medication due to the error.

	Staff Willey was interviewed and confirmed that she did not pass Resident A's medication at the designated time. She stated that there was no physician order on file at the time for the medication. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/26/2022, I spoke with licensee designee Joe Pilot via phone. I informed him of the findings and conclusion.

IV. RECOMMENDATION

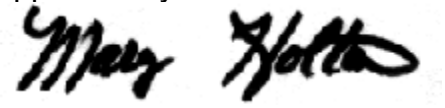
Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 6).



09/27/2022

Shamidah Wyden Date
Licensing Consultant

Approved By:



09/27/2022

Mary E. Holton Date
Area Manager