GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 3, 2022

Joseph Bacall
Michigan House Senior Living
18533 Quarry Road
Riverview, MI 48193

RE: License #: AH820389597
Investigation #: 2023A0784001
Michigan House Senior Living

Dear Mr. Bacall:

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. Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820389597
Investigation #:	2023A0784001
Complaint Receipt Date:	10/06/2022
Investigation Initiation Date:	10/07/2022
Report Due Date:	12/05/2022
Licensee Name:	Michigan House Senior Living LLC
Licensee Address:	12525 Hale Street Riverview, MI 48193
Licensee Telephone #:	(248) 538-0585
Administrator:	Gabriela Birkner
Authorized Representative:	Joseph Bacall
Name of Facility:	Michigan House Senior Living
Facility Address:	18533 Quarry Road Riverview, MI 48193
Facility Telephone #:	(734) 283-6000
Original Issuance Date:	10/25/2019
License Status:	REGULAR
Effective Date:	04/25/2022
Expiration Date:	04/24/2023
Capacity:	42
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was mis-administered prescribed morphine	Yes
Inadequate training for Associate 2 and inadequate protection for Resident A	Yes
Additional Findings	No

III. METHODOLOGY

10/06/2022	Special Investigation Intake 2023A0784001
10/07/2022	Special Investigation Initiated - On Site
10/07/2022	Inspection Completed On-site
11/03/2022	Exit Conference – Telephone Conducted with authorized representative Joseph Bacall and administrator Gabriela Birkner

ALLEGATION:

Resident A was mis-administered prescribed morphine

INVESTIGATION:

The department received an incident report from the facility that on 9/28/2022, Resident A was administered too much Morphine. Under a section of the report titled *Narrative description of facts of incident – include cause, if known (observation and facts of the incident*, the report read “I [resident care director Lindsay Doolin] received a phone call from [Associate 1] regarding [Resident A’s] morphine. [Associate 1] told me that [Associate 2] had given [Resident A] to much morphine. I asked her how much he received, and [Associate 1] said, “5 ml”. [Associate 1] told me that [Resident A] was lethargic, and his blood pressure was low at that time. I got off the phone with her and tried calling his nurse [Hospice Nurse 1] from Heart to Heart three times. After multiple attempts of reaching [Hospice Nurse 1], I called Heart to Heart hospice office (around 6:35pm) and was told a nurse would call me back. While waiting for the nurse to call me back I called our on-call nurse [Associate 3] and informed him of the situation. While I was talking to our nurse a hospice nurse [Hospice Nurse 2] called me back. I explained to her that [Resident A] had

received a large amount of morphine by mistake, and she told me to call 911 and have EMS come and administer Narcan. I hung up with her and quickly called her back to let her know that the morphine had been given many hours ago (I believed at that time it was administered at 4pm) she told me not to call EMS and that a nurse was on her way out and would be there in about 15 minutes. I hung up with her and called [Resident A's Authorized Representative] to let her know of the situation and his status. I informed her of what happened the amount that was given by mistake and the amount he was supposed to receive. She asked me if she should come up and I told her that [Resident A] was okay and that his blood pressure was a little low at the time and a nurse from Heart-to-Heart hospice was on her was to see him. I called [Associate 1] back to let her know that a nurse will be there shortly and not to give him his morphine until the nurse assessed him. When the hospice nurse arrived, I called her to get an update and [Hospice Nurse 3] informed me that his blood pressure was low, and his heart rate is elevated and that she believes he is actively dying and that she would call the family. I called [Associate 2] to talk to her about the incident and she informed me that she had given him the morphine at 8am. She was extremely upset and crying. She told me that she mis read the medication and did not look down into the instructions. So, when [Associate 2] was passing the medication, it said in bold writing MORPHINE 100MG/5ML. [Associate 3] said she seen the 5ml and passed it by accident. I informed the nurse that the medication was given early that morning. The nurse [Hospice Nurse 3] called [Resident A's authorized representative], and she came up to the facility. Morphine was held for a few more hours and the staff resumed his morphine at 2 o'clock in the morning." Under a section titled *Persons notified*, the report indicated hospice and Resident A's authorized representative were contacted after staff were aware of the medication error.

On 10/07/2022, I interviewed administrator Gabriela Birkner at the facility. Ms. Birkner stated that at the time Associate 1 administered the 5ml of morphine, Resident A was prescribed .25ml. Ms. Birkner stated that Associate 1 had apparently read the information on the medication administration record (MAR), dictated from the prescription bottle label, which indicates how much medication is in the entire bottle and mistook that for the actual dosage.

I reviewed Resident A's *Physician's Order*, dated 9/27/2022. The order read, in part, "Morphine 5mg/.25ml every 2 hrs. for pain".

I reviewed Resident A's MAR specific to the afore mentioned *Physician's Order MORPHINE SULFATE (CONENTRATE) 100MG/5ML SOLN*, to be administered ".25 ML every 2 hours around the clock" starting 9/27/2022.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
For Reference: R 325.1901	**Definitions**
	(14) "Medication management" means assistance with the administration of a resident's medication as prescribed by a licensed health care professional.
ANALYSIS:	Reporting from the facility indicated that Associate 2 had administered Resident A 5ml of morphine instead of the .25ml he was prescribed which was confirmed by the administrator and review of Resident A's MAR.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Inadequate training for Associate 2 and inadequate protection for Resident A

INVESTIGATION:

Under a section titled *Corrective measures taken to prevent recurrence of this incident (Required – what was done after incident to prevent a repeat of incident*, the incident report read "[Associate 1] will no longer pass medication until she has additional training on properly administering liquid medications. She had never passed morphine and was not trained to do so, at the time of her training due to us not having a resident with scheduled morphine. All staff will be retrained on properly measuring liquid medications and our training process will include measuring liquid medications even if we do not have a resident that is currently taking and liquid medications"

When interviewed, Ms. Birkner stated Associate 2 had completed medication administration training with the facility prior to 9/28/2022, the date of the incident, however, she stated Associate 2 was not trained on how morphine administration. Ms. Birkner stated that during the time of Associate 2's training period, the facility had not had any residents receiving morphine which she stated is why the training was not provided. Ms. Birkner stated she sometimes helps with staff schedules but that staff schedules are "typically" done by resident care associate Lindsay Doolin. Ms. Birkner stated it is not normally the case that an associate would be scheduled to pass medications they are not specifically trained to pass.

On 10/07/2022, I interviewed resident care director Lindsay Doolin at the facility. Ms. Doolin provided statements consistent with those provided by Ms. Birkner regarding

Associate 2's training. Ms. Doolin stated that, more specifically, Associate 2 had not yet received training on how to pass "liquid morphine". Ms. Doolin stated Resident A had only been at the facility for a few days and that Associate 2 had been trained prior to the date Resident A moved in. Ms. Doolin stated that prior to the incident, the facility did not have a simulated liquid medication pass incorporated into their med training. Ms. Doolin stated that both she and Ms. Birkner review staff schedules prior to posting them. Ms. Doolin stated it was not until after the incident that it was discovered Associate 2 had not been specifically trained on administration of liquid morphine. Ms. Doolin stated that the misadministration was discovered when Associate 1 was attempting to administer Resident A's 4pm dose of morphine. Ms. Doolin stated the morphine is administered with a syringe and that apparently, when Associate 1 opened the medication cart to get Resident A's morphine ready for administration, she could not locate a syringe. Ms. Doolin stated it was later discovered that the previous doses, given at 10am, 12pm and 2pm, were administered by Associate 4 who had apparently not put the syringe, used for the medication, back in the cart. Ms. Doolin stated that Associate 1 then used a walkie talkie, which all staff carry, to ask if someone could locate one of the extra syringes, kept on hand by the facility, for her to use. Ms. Doolin stated that this is when Associate 2 reportedly notified Associate 1 of the medication error earlier in the day. Ms. Doolin stated Associate 1 has had disciplinary action issued against her and has since been taken off the med passing duties for additional training.

On 10/07/2022, I interviewed Hospice Nurse 1 [HN1] at the facility. HN1 stated she was Resident A's primary hospice nurse. HN1 stated she had not been available during the incident which is why the on-call nurse, Hospice nurse 3, had responded to the call. HN1 stated she had seen Resident A the day before the incident, 9/27/2022 and determined he was actively passing. HN1 stated his blood pressure and heart rate had stabilized later in the evening, but that when she came to see him on 9/29/2022, he was having periods of apnea (episodes in which he stopped breathing) and had not been eating or drinking. HN1 stated Resident A has since passed away.

On 10/07/2022, I interviewed Associate 2 at the facility. Associate 2 provided statements consistent with those of Ms. Doolin regarding the events of 9/28/2022. Associate 2 stated that when Associate 2 requested a syringe over the walkie talkie to administer morphine, it occurred to her she must have administered the medication incorrectly as no syringe had been in the cart when she administered Resident A's morning morphine, so she used a medicine cup. Associate 2 stated she knows she should have asked for assistance with the medication since she was not trained on administration of liquid morphine but is unsure why she did not do so. Associate 2 stated that prior to working with the facility, she worked as a caregiver in a group home for approximately seven years. Associate 2 stated she did pass medications in her previous position but had not passed liquid morphine in that position either. Associate 2 stated she has been taken off med passing duties and is going through medication training again with the inclusion of training on how to correctly administer liquid morphine.

I reviewed Associate 2's *Aide Training Check List*, provided by Ms. Birkner. According to the checklist, Associate 2 had completed medication administration training on 9/18/2022.

Review of Resident A's MAR for 9/28/2022 revealed that Associate 4 initialed the MAR, as having administered Resident A's morphine, for the 10am and 2pm doses, however no initials were entered for the 12pm does with no exception reason entered on the MAR.

I reviewed a document titled *EMPLOYEE DISCIPLINARY ACTION*, provided by Ms. Birkner and attributed to Associate 2. Review of the document revealed Associate 2 was given a final written warning on 10/05/2022 for administering "the incorrect amount of morphine to [Resident A]" on 9/28/2022.

I reviewed Resident A's *MEDICAL CERTIFICATE of DEATH*, provided by Ms. Birkner, which noted Resident A's *MANNER OF DEATH* as "Natural". According to the certificate, Resident A passed away on 9/29/2022.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.**
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R 325.1901	**Definitions**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm,

	humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Review of facility incident reporting regarding the misadministration of medication to Resident A revealed Associate 2 had not been properly trained on how to administer liquid medications. Interviews with the administrator, resident care director and Associate 2, as well as documentation relative to Associate 2's disciplinary action, confirmed the reporting. While the resident care director, Lindsay Doolin, reported that Associate 4 had indicated to her that Resident A was administered his 10am, 12pm and 2pm doses, review of the MAR revealed no initials were entered for the 12pm does. Additionally, facility administration did not take adequate actions to ensure the protection of Resident A in that, while having documented that Associate 2 had fully completed her training, she had not completed all necessary training to administer liquid morphine but was still scheduled to pass medications to a resident who required such administration.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Aaron L Clum 10/26/2022

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Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 11/03/2022

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section