GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 15, 2022

Cindy Whaley
Liberty Living Inc.
P O Box 1273
Bay City, MI 48706

RE: License #:	AS090086238
Investigation #:	2023A0123007
	Liberty House

Dear Mrs. Whaley:

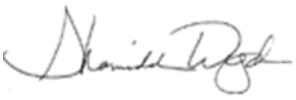
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS090086238
Investigation #:	2023A0123007
Complaint Receipt Date:	10/25/2022
Investigation Initiation Date:	10/27/2022
Report Due Date:	12/24/2022
Licensee Name:	Liberty Living Inc.
Licensee Address:	P O Box 1273 Bay City, MI 48706
Licensee Telephone #:	(989) 892-0247
Administrator:	Cindy Whaley
Licensee Designee:	Cindy Whaley
Name of Facility:	Liberty House
Facility Address:	1116 24th Street Bay City, MI 48708
Facility Telephone #:	(989) 892-4243
Original Issuance Date:	06/14/1999
License Status:	REGULAR
Effective Date:	12/18/2021
Expiration Date:	12/17/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's medications, Olanzapine and Mirtazapine were not passed on 10/19/2022, 10/20/2022, or 10/21/2022 at 8:00 pm. The medications were signed for on the medication sheets.	Yes

III. METHODOLOGY

10/25/2022	Special Investigation Intake 2023A0123007
10/27/2022	Special Investigation Initiated - Telephone I spoke with APS investigator Jackie Campbell via phone.
10/27/2022	APS Referral Information received regarding APS referral.
10/31/2022	Inspection Completed On-site I conducted an unannounced on-site at the facility.
11/02/2022	Contact - Telephone call made I spoke with Resident A's case manager via phone.
11/02/2022	Contact - Telephone call made I left a voicemail requesting a return call from staff Jared Bombly.
11/02/2022	Contact- Telephone call made I spoke with licensee designee Cindy Whaley via phone.
11/02/2022	Exit Conference I spoke with licensee designee Cindy Whaley via phone.
11/07/2022	Contact- Telephone call made I attempted to contact Staff Bombly via phone. There was no answer.
11/14/2022	Contact- Telephone call made I interviewed staff Jared Bombly via phone.

ALLEGATION: Resident A's medications, Olanzapine and Mirtazapine were not passed on 10/19/2022, 10/20/2022, or 10/21/2022 at 8:00 pm. The medications were signed for on the medication sheets.

INVESTIGATION: On 10/27/2022, I made a call to adult protective services worker Jacqueline Campbell via phone. She stated that she spoke with home manager Rachel Collins who said she filled out an incident report due to medications still being in Resident A's bubble pack, but meds on the medication administration records noted that the medication was passed. She stated that Staff Jared Bombly did not provide a reason as to why the meds were not passed. She stated that it is a newly prescribed medication and is scheduled to pass at night. Ms. Campbell stated that Resident A had no side effects from the missed three medication passes, and that he received the medication for two days, then missed the next three days. She stated that she made face to face contact with Resident A, his speech appeared jumbled, and he is his own guardian.

On 10/31/2022, I conducted an unannounced on-site visit at the facility. I interviewed home manager Rachel Collins. She stated that Staff Bombly is scheduled for a medication class on 11/10/2022. She stated that disciplinary action will take place, and that Staff Bombly has been with the company for a few years. She stated that she is not sure if this is his first medication error.

On 10/31/2022, I interviewed Resident A. Resident A stated that he does not know anything about not being given his medication, and that he does not know what medications he is on. He stated that he does take medication in the morning and at night.

On 10/31/2022, I observed Resident A's medications bubble packs. There were still pills in the pack for 10/19/2022 and 10/20/2022. The 10/20/2022 pills were noted on the bubble pack with 10/27/2022, indicating that this was the day they were actually passed. The medications are Mirtazapine Tab 15 mg and Olanzapine Tab 10 mg.

During this on-site, I received a copy of the incident report dated for 10/24/2022. The incident report states that when passing medications, home manager Rachel Collins noted that Resident A's two medications had not been passed on 10/19/2022, 10/20/2022, and 10/21/2022 for 8:00 pm. A nurse, recipient rights, and licensee designee Cindy Whaley were notified.

Also, during this on-site I obtained a copy of Resident A's medication administration records. The documentation shows that staff Jared Bombly's initials are noted for both medications at 8:00 pm on 10/19/2022, 10/20/2022, and 10/21/2022.

On 11/02/2022, I spoke with Resident A's case manager from Bay Arenac Behavioral Health Trisha Schafer. She stated that she did an on-site on 10/18/2022 and on 10/25/2022. She stated that she was not made aware of the medication error

and did not have an incident report. She stated that she had not had any concerns regarding Resident A's care, and that Resident A just moved in recently.

On 11/02/2022, I spoke with licensee designee Cindy Whaley via phone. She stated that Staff Bombly has been employed for six years. He will be receiving disciplinary action including a written write-up, re-doing the full group home medication curriculum, and will be placed on a 90-day probation.

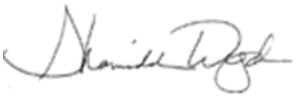
On 11/14/2022, I interviewed staff Jared Bombly via phone. Staff Bombly stated that he "got sloppy" with the five rights and "didn't do it appropriately" like he should have. He stated he tried to do his retraining the other day, but he accidentally went to the wrong location. He stated that the re-training for him has to be rescheduled.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 10/24/2022, Home manager Rachel Collins wrote an incident report stating that staff Jared Bombly did not pass two medications to Resident A on 10/19/2022, 10/20/2022, and 10/22/2022, but wrote in the medication administration record that they were passed. The medication was observed to have two pills from two of those dates still in the bubble pack. A copy of the medication administration records show that Staff Bombly did note the medications as passed. Staff Bombly was interviewed and reported that he "got sloppy" with the five rights when passing Resident A's meds, and that he has to go through re-training for medication administration. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/02/2022, I conducted an exit conference with licensee designee Cindy Whaley. I informed her of the findings and conclusion.

IV. RECOMMENDATION

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



11/15/2022

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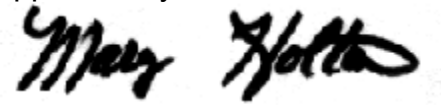
Shamidah Wyden Date
Licensing Consultant

Approved By:



11/15/2022

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Mary E. Holton Date
Area Manager