GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 15, 2022

Anh Huynh
Twin Oaks Extended Care Corp.
27024 Norfolk
Inkster, MI 48141

RE: License #: AS820293252
Investigation #: 2022A0121043
Twin Oak III

Dear Ms. Huynh:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On October 24, 2022, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (313) 456-0380.

Sincerely,

K. Robinson

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820293252
Investigation #:	2022A0121043
Complaint Receipt Date:	09/23/2022
Investigation Initiation Date:	09/23/2022
Report Due Date:	11/22/2022
Licensee Name:	Twin Oaks Extended Care Corp.
Licensee Address:	27024 Norfolk Inkster, MI 48141
Licensee Telephone #:	(734) 620-8067
Administrator:	Anh Huynh, Designee
Name of Facility:	Twin Oak III
Facility Address:	36880 Mario Ann Ct. Romulus, MI 48174
Facility Telephone #:	(734) 941-5033
Original Issuance Date:	04/07/2008
License **Status:**	REGULAR
Effective Date:	01/19/2022
Expiration Date:	01/18/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Medication error involving two residents.	Yes

III. METHODOLOGY

09/23/2022	Special Investigation Intake 2022A0121043
09/23/2022	Referral – Recipient Rights (to LARA)
09/23/2022	APS Referral (Rights referred to APS; APS denied the intake)
09/23/2022	Special Investigation Initiated - Telephone Call to Ann Huynh
09/30/2022	Contact - Telephone call made Follow up call to Ms. Huynh
10/05/2022	Inspection Completed-BCAL Sub. Compliance Interviewed Home Manager, Bria Mickles, DCW Charles Keys, Resident A and B
10/12/2022	Contact - Telephone call made Phone interview with DCW, Derrick McVee
10/12/2022	Exit Conference Ms. Huynh
10/24/2022	Corrective Action Plan Received
10/24/2022	Corrective Action Plan Approved

ALLEGATION: Medication error involving two residents.

INVESTIGATION: On 9/23/22, I initiated the complaint with a call to licensee designee, Ann Huynh. Ms. Huynh acknowledged direct care worker, Derek McVee gave Resident A and B the wrong medications on 9/12/22 at 8:00 p.m. Ms. Huynh reported Resident A and B were taken to Beaumont Annapolis hospital on 9/13/22, the morning after the medication error occurred. Per Ms. Huynh no unusual findings were reported by the hospital. Both residents were released to go home within hours.

On 9/30/22, I made a follow-up call to Ms. Huynh. Ms. Huynh reported Resident A is no longer certain she received the wrong medication. On 10/4/22, I phoned Recipient Rights Investigator, Avery Barnett. Mr. Barnett had no knowledge of Resident A recanting her statement.

On 10/5/22, I conducted an unannounced onsite inspection at the facility. I interviewed Resident A and B. Resident A said she knows she was given the wrong medication because Derek gave her a red pill when she normally doesn't take a red pill. Although it was difficult to understand Resident B, she stated, "Derek didn't do his job." Resident B reported Derek gave her a pink pill when she normally doesn't take any pink pills. According to the Home Manager, Bria Mickles, she is confident all residents know what medication they take, so she believes Derek administered the wrong medication to Resident A and B. Specifically, Bria reported Resident A told her, Derek gave her red and green pills which are the colors of Resident B's pills. Bria believes Derek accidentally gave Resident A, Resident B's medication and he gave Resident B, Resident A's medication. Bria explained Staff are required to administer resident medication in the Staff office. However, Derek did not follow protocol. Bria reported Derek administers resident medication while they are seated at the dining room table. Bria said when she came to work on 9/13/22 to relieve Derek off the midnight shift, she noticed "{Resident A} was not herself." Bria explained Resident A "kept falling" as she tried to get out of bed, and she defecated on herself which is unlike Resident A. When asked what's wrong, Bria said Resident A self-reported she took the wrong medication. Bria said Resident C and D also reported Resident A was given the wrong medication. Then, Resident B asked if her medication had been changed since she recently received new pills, meaning pills she did not recognize.

On 10/12/22, I interviewed Derek by phone. Derek reported he's been employed at Twin Oaks for 15 years. He said he's been providing direct care to residents for a total of 27 years without incident. Derek had a difficult time accepting the facts that increasingly suggest he made a medication error. Derek emphasized that "if" he did make an error, it was not deliberate.

On 10/12/22, I completed an exit conference with Ms. Huynh. Ms. Huynh indicated Derek received a written reprimand following a 2-week suspension and he was required to complete a medication administration refresher course before he can

resume administering resident medication. Ms. Huynh does not dispute the department's finding and recommendation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	• Derek McVee did not follow company protocol when administering resident medication. • Rather than administer medication one-by-one, Derek opted to have all residents sit together as he administered their evening medication on 9/12/22. • As a result, the facts suggest, Derek mixed Resident A and B's medications. He gave Resident A, Resident B's red pill (colace 100mg) and green pill (loxapine 50mg); and he gave Resident B, Resident A's pink pill (Depakote 500mg). • Therefore, the department finds Resident A and B were not given medication pursuant to the label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.

12/15/22

Kara Robinson Date
Licensing Consultant

Approved By:

12/15/22

Ardra Hunter Date
Area Manager