GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 29, 2022

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

RE: License #:	AS090086238
Investigation #:	2023A0123013
	Liberty House

Dear Mrs. Whaley:

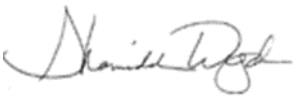
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2023A0123013
Complaint Receipt Date:	11/29/2022
Investigation Initiation Date:	12/01/2022
Report Due Date:	01/28/2023
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 AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 11/18/2022, staff Jared Bombly transported Resident A to the hospital. Resident A was discharged with two prescription medications that Staff Bombly failed to fax to the pharmacy. The prescriptions were found three days later. Resident A has not been receiving his medications, putting him at risk of harm.	Yes

III. METHODOLOGY

11/29/2022	Special Investigation Intake 2023A0123013
11/30/2022	APS Referral Information received regarding APS referral.
12/01/2022	Special Investigation Initiated - Telephone I spoke with recipient rights investigator Kevin Motyka via phone.
12/01/2022	Contact - Document Received Requested documentation received from Mr. Motyka.
12/01/2022	Contact - Telephone call made I spoke with BABHA nurse Sarah Van Paris via phone.
12/06/2022	Inspection Completed On-site I conducted an unannounced on-site visit at the facility.
12/16/2022	Contact - Telephone call made I left a voicemail requesting a return call from staff Jared Bombly.
12/16/2022	Contact - Document Sent I sent an email to Resident A's public guardian.
12/16/2022	Contact - Document Received I received an email response from Resident A's public guardian.
12/28/2022	Contact - Telephone call made I interviewed staff Jared Bombly via phone.
12/28/2022	Exit Conference I conducted an exit conference with licensee designee Cindy Whaley via phone.

ALLEGATION: On 11/18/2022, staff Jared Bombly transported Resident A to the hospital. Resident A was discharged with two prescription medications that Staff Bombly failed to fax to the pharmacy. The prescriptions were found three days later. Resident A has not been receiving his medications, putting him at risk of harm.

INVESTIGATION: On 12/01/2022, I spoke with recipient rights investigator Kevin Motyka via phone. He stated that staff Jared Bombly is responsible for the medication error because nothing was done with the script for about two to three days.

On 12/01/2022, I interviewed Bay Arenac Behavioral Health nurse Sarah Van Paris via phone. She stated that she was told that staff was not provided the script at the appointment, but the script was found at the home. Resident A has a history of COPD and frequent lung infections. She stated that nursing notes dated 11/18/2022, stated that Resident A was short of breath, had difficult talking, and was wheezing. He was sent to Redi-Med and received a steroid which mitigated the risk of harm. She stated that had she'd known that she would not have said that it was a risk of harm for him to not have had his scripts filled. She stated that Resident A would have probably been hospitalized if he did not receive the steroid shot. She stated that she thinks the steroid shot prevented hospitalization.

On 12/06/2022, I conducted an unannounced on-site visit at the facility. I interviewed home manager Shauna Sweet, Resident A, and I observed Resident A's current medication bubble packs. No issues were noted with the bubble packs.

Staff Shauna Sweet was interviewed. She stated that Staff Bombly was moved to another facility to work third shift. She stated that she is the individual who found the scripts when going through the discharge paperwork. She stated that one script was for seven days and the other lasted five days, and the medications have been completed. She stated that Resident A's O2 levels are good, and he receives breathing treatments.

Resident A was interviewed. He stated that he remembers going to get medical treatment. He stated that he does not remember getting a new script, but he went to get medical treatment because of his lungs. He stated that he does not remember specifics but remembers taking an antibiotic.

During this on-site I received copies of requested documentation. There were two physician authorizations dated 11/18/2022 for doxycycline 100 mg tablet (*take one tablet by mouth 2 times a day for 7 days*), and prednisone 10 mg tablet (*take two tablets for 5 days*). A copy of Resident A's medication administration record for November 2022 documents that the doxycycline 100 mg tablet were passed to Resident A by staff on 11/21/2022 thru 11/28/2022. The records show that the prednisone 10 mg tablets were passed on 11/22/2022 thru11/26/2022.

A copy of Resident A's *After Visit Summary* from the MyMichigan Health Park Bay notes that he was to start taking doxycycline and prednisone. The document is dated 11/18/2022.

On 12/16/2022, I emailed Resident A's public guardian, Guardian 1, due to her office being closed for the day. On 12/16/2022, Guardian 1 responded back via email stating that she was not aware of the alleged incident and did not have any concerns regarding Resident A's care.

An *AFC Licensing Division- Incident/Accident Report* dated 11/18/2022 states that the home nurse was called due to Resident A having difficulty breathing and was taken to the emergency room for shortness of breath. He was taken to MyMichigan Health, received a steroid shot and was sent home.

An *AFC Licensing Division- Incident/Accident Report* dated 11/21/2022 states that Resident A went to the emergency room on 11/18/2022 and was given two scripts that staff did not fax to the pharmacy. The home manager found the scripts on 11/21/2022. The scripts were faxed to the pharmacy and the meds were started on 11/21/2022. The home nurse was contacted. Staff was spoken to about the importance of going through the discharge papers.

On 12/28/2022, I interviewed staff Jared Bombly via phone. He stated that he took Resident A to the emergency room, received the scripts that needed to be filled, but he forgot about the scripts. He stated that it was a "brain fart" on his part that was an honest mistake. He stated that on that day when he returned back to the home, he had other job responsibilities he had to get done by the end of his shift, and he forgot to notify the manager about the scripts.

On 11/15/2022, I concluded Special Investigation Report #2023A0123007. R400.14312(2) was substantiated due to staff Jared Bombly not passing a resident two medications on 10/19/22, 10/20/2022, and 10/22/2022. The corrective action plan dated for 11/16/2022, stated that Staff Bombly would be enrolled in a full in-person basic medication training, and be on a 90-day probation.

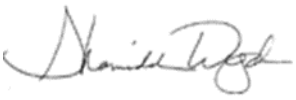
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Staff Jared Bombly was interviewed and reported that after Resident A's hospital visit on 11/18/2022, he forgot to get Resident A's scripts filled with the pharmacy. Due to Staff Bombly not getting Resident A's scripts filled timely, Resident A was not able to begin taking his prescribed medication until three days later.

	There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2023A0123007 dated 11/15/2022**

On 12/29/2022, I conducted an exit conference with licensee designee Cindy Whaley via phone. I informed her of the findings and conclusion.

IV. RECOMMENDATION

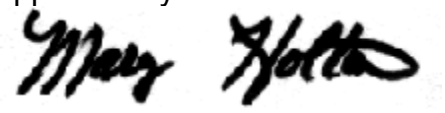
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of this AFC small group home license (capacity 6).



12/29/2022

Shamidah Wyden Date
Licensing Consultant

Approved By:



12/29/2022

Mary E. Holton Date
Area Manager