GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 6, 2023

Stephanie Riley
Valley Residential Serv Inc.
P O Box 186
St Charles, MI 486550186

RE: License #: AS230068521
Investigation #: 2023A1033007
Mulliken Afc Home

Dear Ms. Riley:

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. 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) 284-9730.

Sincerely,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS230068521
Investigation #:	2023A1033007
Complaint Receipt Date:	11/15/2022
Investigation Initiation Date:	11/15/2022
Report Due Date:	01/14/2023
Licensee Name:	Valley Residential Serv Inc.
Licensee Address:	300 S Saginaw St. Charles, MI 48655
Licensee Telephone #:	(231) 580-5204
Administrator:	Denise Foren
Licensee Designee:	Stephanie Riley
Name of Facility:	Mulliken Afc Home
Facility Address:	9120 E Eaton Hwy Mulliken, MI 48861
Facility Telephone #:	(517) 649-2377
Original Issuance Date:	11/01/1995
License **Status:**	REGULAR
Effective Date:	07/26/2021
Expiration Date:	07/25/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Direct care staff could not locate Resident A's Pantoprazole medication and instead administered Fenofribrate medication instead, on 11/7/22, 11/8/22, and 11/9/22.	Yes

III. METHODOLOGY

11/15/2022	Special Investigation Intake 2023A1033007
11/15/2022	Special Investigation Initiated - Telephone Interview with Licensing Consultant, Julie Elkins.
11/17/2022	Inspection Completed On-site Interview with Administrator, Denise Foren and Assistant Manager, Keith Rohrbacher. Review of employee files for Victoria Clark & Zerrick Daniels. Review of Medication Administration Records (MAR) and medication reconciliation for Resident A & Resident B.
11/30/2022	Contact - Telephone call made Attempt to interview direct care worker, Zerrick Daniels. No answer.
12/01/2022	Contact - Telephone call made Attempt to interview Mr. Daniels, sent text message requesting a call back. No response.
12/01/2022	Contact - Telephone call made Interview with direct care worker, Victoria Clark, via telephone.
12/06/2022	Inspection Completed-BCAL Sub. Compliance
01/09/2023	Exit Conference Exit conference conducted, via telephone, with Licensee Designee, Stephanie Riley.

ALLEGATION:

Direct care staff could not locate Resident A's Pantoprazole medication and instead administered Fenofibrate medication instead, on 11/7/22, 11/8/22, and 11/9/22.

INVESTIGATION:

On 11/14/22 an *AFC Licensing Division Incident/Accident Report* (IR) form was received from the Mulliken AFC Home (the facility). The IR was completed for Resident A with an incident date of 11/7/22. The form was completed by facility Administrator, Denise Foren. Under section, *Explain What Happened/Describe Injury (if any)*, the IR noted, "Pantoprazole 40mg (6:30AM) was put with [Resident A] PRN medication. Medication passer pulled the wrong medication (Fenofibrate 48mg a PM medication) to replace it when they couldn't find it. This error continued for 11/7, 11/8, 11/9." Under section, *Action taken by Staff/Treatment Given*, the IR noted, "Assistant Manager replaced Pantoprazole to its proper location and removed the Fenofibrate that was being passed in the AM. Assistant Manager called Pharmacy to determine how to follow up. Pharmacist direct that [Resident A] should return to his proper regiment and that there should be no ill side effects." Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, the IR noted, "Written counseling, watch medication passes x 5, go to medication refresher." The IR noted that the two staff involved in the medication error for Resident A were direct care staff, Victoria Clark and Zerrick Daniels.

On 11/17/22 I completed an on-site investigation at the facility. I interviewed Ms. Foren regarding the incident. Ms. Foren reported that the direct care staff, Ms. Clark and Mr. Daniels were working together at the facility, on 11/7/22, 11/8/22, and 11/9/22. Ms. Foren reported Ms. Clark was working in the capacity of a medication passer and Mr. Daniels was working as a medication checker. Ms. Foren reported the medication passer is responsible to pass all resident medications and sign off that they have been administered correctly. She reported the role of medication checker is responsible to ensure the medication passer has passed all medications correctly by verifying their work. Ms. Foren reported the Assistant Manager, Keith Rohrbacher, is responsible to check all the resident medications against the resident *Medication Administration Record* (MAR) at least one time per week. Ms. Foren reported that on 11/9/22 Mr. Rohrbacher was checking resident medications and noted that Resident A's medications were not administered correctly on the dates 11/7/22, 11/8/22, and 11/9/22. She reported he brought this to her attention and she made a phone call to the pharmacy to see what they should do regarding this error. Ms. Foren reported the pharmacy advised them that there should not be any ill consequences from this error for Resident A and that he should be returned to his regular medication regiment and monitored. Ms. Foren reported Resident A did not exhibit any ill side effects from this medication error that were visible to direct care staff members observations.

On 11/17/22, during on-site investigation, I interviewed Mr. Rohrbacher. Mr. Rohrbacher reported he is the Assistant Manager at the facility and part of his responsibilities include a weekly check of all resident medications to ensure medications are administered correctly. Mr. Rohrbacher reported that on 11/9/22 he was reviewing resident medications and found there was a discrepancy with Resident A's medications. Mr. Rohrbacher reported that he found Resident A was receiving his Fenofibrate 48mg medication twice a day for three days (11/7/22, 11/8/22, 11/9/22), when this medication is ordered as one tablet by mouth once daily. Mr. Rohrbacher reported Resident A's Pantoprazole 40 mg medication was not administered for the dates 11/7/22, 11/8/22, and 11/9/22. Mr. Rohrbacher reported the two medications are a similar size and color and this is perhaps why the mistake was made, but he was unsure why the medication checker, Mr. Daniels, did not identify this error. Mr. Rohrbacher reported the pharmacy was called and consulted regarding the medication error. Mr. Rohrbacher reported that the facility administrator was told, by the pharmacy staff, that there should be no ill side effects for Resident A and to monitor him at this time and return to regular medication regiment. Mr. Rohrbacher reported that both, Mr. Daniels and Ms. Clark, have been disciplined and required to take a medication refresher course. He further reported that Mr. Daniels and Ms. Clark are on a probationary period where they are being observed passing medications by facility management.

On 12/1/22 I interviewed Ms. Clark, via telephone. Ms. Clark reported that she is aware of the medication error pertaining to Resident A's Fenofibrate and Pantoprazole medications. Ms. Clark reported she was having medical issues during this period related to her Diabetes. She further reported she feels her blood sugars were dropping and she was not thinking clearly. She reported, "I was feeling kind of foggy," and attributed this for the possibility of why she made the medication error. Ms. Clark reported she has since seen her primary care physician and has been placed on insulin due to her Diabetes. Ms. Clark reported she has been disciplined for this medication error and did take a medication refresher course.

On 11/30/22 and 12/1/22 I made attempts to interview Mr. Daniels. I did not receive any response to my inquiries to interview Mr. Daniels.

During on-site investigation, on 11/17/22, I reviewed the medications and MAR for Resident A. Resident A's Fenofibrate medication, and his Pantoprazole medication are both oval shaped, yellow pills, that come in similar pharmacy packaging. I completed a medication reconciliation for Residents A and B, during this on-site investigation. All the medications prescribed to these residents were available on-site and marked as administered on the MARs.

During on-site investigation, on 11/17/22, I reviewed the employee files for Mr. Daniels and Ms. Clark. Both, Mr. Daniels and Ms. Clark had evidence of medication administration training in their employee files as well as evidence of a refresher medication administration course that was conducted on 11/14/22. Mr. Daniels completed medication passer training on 6/19/18 and medication checker training on

7/15/18. Ms. Clark completed medication passer training on 8/19/21 and medication checker training on 7/14/21.

On 10/25/22, Special Investigation #2022A0466057 cited a rule violation of Rule R 400.14312, Resident medications, (2) Medication shall be given, taken, or applied pursuant to label instructions. The analysis of this special investigation noted the resident in the report was not administered his prescribed Omeprazole medication from 6/1/2022 through 8/10/2022 as prescribed. The resident was prescribed "Omeprazole DR 20mg capsule, take 1 capsule by mouth twice daily" but was being administered Omeprazole once daily from 6/01/2022 through 08/10/2022. The *Corrective Action Plan* (CAP), dated 10/17/22, and completed by Licensee Designee, Stephanie Riley, noted, "The error was corrected immediately, and medication was administered twice daily. All staff were in-serviced on the error and medication administration on 8/12/22. Counselings were completed on staff involved in missing the continual error, including management. The Assistant Manager is responsible for checking the MARs at the beginning of the month and comparing the MAR to the physician order to ensure accuracy. This will be completed with the manager and/or designated staff. The Assistant Home Manager will check this weekly for all shifts. The Area Manager will monitor at least quarterly during work site examinations to ensure plan of correction is being followed. All counselings and inservices are complete and documentation is attached." Included with the CAP was documentation from Ms. Riley of *Written Counseling Form*s for all employees counseled related to this violation. There were written counseling forms for Mr. Daniels and Ms. Clark dated for 8/11/22, regarding this medication administration error. Additionally, a training record was provided of a *Staff Meeting/In-service,* where staff were trained on medication administration practices, dated for 8/12/22, which notes the attendance of Mr. Daniels and Ms. Clark.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based upon interviews with Ms. Foren, Mr. Rohrbacher, and Ms. Clark, as well as observations from on-site investigation and review of employee files for Ms. Clark and Mr. Daniels, Ms. Clark and Mr. Daniels did not administer Resident A's Fenofibrate and Pantoprazole medications as prescribed by Resident A's medical providers. Ms. Clark acknowledged that she had administered the incorrect medication (Fenofibrate) on the dates 11/7/22, 11/8/22, and 11/9/22, resulting in Resident A receiving a duplicate dosage of this medication for a three-day period. Ms. Clark reported that during these three days Resident A's Pantoprazole medication was not administered as prescribed due to this error. Mr. Daniels was working in the capacity of a medication checker and failed to identify the error in medication administration by Ms. Clark on the dates 11/7/22, 11/8/22, 11/9/22. Per my review of the corrective action plan for a previous special investigation, this is the second medication error for both direct care staff members Ms. Clark and Mr. Daniels within a six-month period despite retraining.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2022A0466057 AND CAP DATED 10/17/2022].**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

12/21/22

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Jana Lipps Date
Licensing Consultant

Approved By:

01/06/2023

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Dawn N. Timm Date
Area Manager