GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 13, 2023

Kent Vanderloon
McBride Quality Care Services, Inc.
3070 Jen's Way
Mt. Pleasant, MI 48858

RE: License #: AS370068192
Investigation #: 2023A1033017
McBride Rosebush AFC

Dear Mr. Vanderloon:

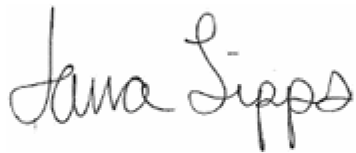
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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 #:	AS370068192
Investigation #:	2023A1033017
Complaint Receipt Date:	12/26/2022
Investigation Initiation Date:	12/26/2022
Report Due Date:	02/24/2023
LicenseeName:	McBride Quality Care Services, Inc.
LicenseeAddress:	3070 Jen's Way Mt. Pleasant, MI 48858
LicenseeTelephone #:	(989) 772-1261
Administrator:	Kent Vanderloon
Licensee Designee:	Kent Vanderloon
Name of Facility:	McBride Rosebush AFC
Facility Address:	4419 N Mission Rosebush, MI 48878
Facility Telephone #:	(989) 433-5667
Original Issuance Date:	10/01/1995
License **Status:**	REGULAR
Effective Date:	01/28/2021
Expiration Date:	01/27/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member administered Resident A's 8:00 a.m. medications at 8:00 p.m. on 12/25/22.	Yes

III. METHODOLOGY

12/26/2022	Special Investigation Intake 2023A1033017
12/26/2022	Special Investigation Initiated – Telephone calls made to Licensing Consultant, Rodney Gill, interviewed Home Manager, Amanda Bonar, via telephone.
01/05/2023	Inspection Completed On-site Interview with Home Manager, Amanda Bonar, and direct care staff, Leona Marshall. Review of medication practices and Resident A's Medication Administration Record. Review of employee file requested.
01/06/2023	Contact - Document Sent- Email request for employee file of direct care staff, Leona Marshall, sent to Jill Rivard and Lisa Torres, with human resources. Awaiting response.
01/06/2023	APS Referral made via email.
01/11/2023	Inspection Completed-BCAL Sub. Compliance
01/13/2023	Exit Conference with licensee designee Kent Vanderloon

ALLEGATION:

Direct care staff member administered Resident A's 8:00 a.m. medications at 8:00 p.m. on 12/25/22.

INVESTIGATION:

On 12/26/22 I received a complaint pertaining to the McBride Rosebush AFC (the facility). The complaint alleged that a direct care staff member had administered a second dose of Resident A’s Prednisone medication, in error, on 12/25/22. On 1/5/23 I completed an on-site investigation at the facility. I interviewed Home Manager, Amanda Bonar. Ms. Bonar reported that on 12/25/22 there was a

medication error committed by direct care staff, Leona Marshall, regarding Resident A's Prednisone. Ms. Bonar reported Resident A had a recent medical appointment on either 12/22 or 12/23 at which time Resident A was prescribed a tapering dose of Prednisone to assist with a diagnosis of Bronchitis that was not resolving. Ms. Bonar reported the Prednisone was delivered to the facility on 12/24/22 by the pharmacy. Ms. Bonar reported Ms. Marshall received the medication and began administration of the medication on 12/24/22 in the morning. The medication was ordered as follows:

- Prednisone 10MG tablet, take 4 tablets once daily for 3 days, take 3 tablets once daily for 3 days, take 2 tablets once daily for 3 days.

Ms. Bonar reported that on 12/25/22 direct care staff, Miranda Mathis, noticed that there was an error on the *Medication Administration Record* (MAR) for Resident A in reviewing the pill count for the Prednisone medication. Ms. Mathis reported to Ms. Bonar that Ms. Marshall had only administered one of the ordered four tablets on 12/24/22. Ms. Bonar reported she did not accurately hear Ms. Marshall had only administered one of the four tablets on 12/24/22 and thought she heard Ms. Mathis report that three of the ordered four tablets were administered. Ms. Bonar reported she advised for, what she thought was, one missed tablet to be administered at the next scheduled medication administration for the Prednisone medication. Ms. Bonar then reported that on 12/26/22 direct care staff, Abigail Brzoznowski, reported that the tablet count for the Prednisone medication was off again. Ms. Bonar reported she made a telephone call to Ms. Marshall, who reported she had administered the missing three tablets from the 12/24/22 administration error, in addition to four more tablets on 12/24/22 with Resident A's evening medications as she had forgotten this was a morning medication for Resident A. Ms. Bonar reported that from 12/25/22 at 8am through 12/26/22 at 8am, Resident A had been administered 15 10MG tablets of Prednisone, when his ordered dosage should have been 8 10MG tablets. Ms. Bonar reported after this error was discovered she attempted to contact the physician's office, but the office was closed. She reported that she left a voicemail message, but the facility never received a call back from the physician's office. Ms. Bonar reported that due to not being able to contact the physician she called Poison Control and received advise to wait and monitor the resident for adverse reactions. Ms. Bonar reported Guardian A1 was not informed of the incident. Ms. Bonar reported the pharmacy was not contacted regarding the medication error. Ms. Bonar reported Ms. Marshall went through medication administration training and has been working for the facility for several years. She further reported that there was a period around 2018 to 2019 where Ms. Marshall received several consultations for medication administration errors, but she has not committed a medication error since those consultations.

On 1/5/23, during on-site investigation I interviewed direct care staff, Leona Marshall. Ms. Marshall reported she worked on 12/24/22 when Resident A's Prednisone medication was delivered to the facility. Ms. Marshall reported she started Resident A on his first dose of this medication. Ms. Marshall reported she

had only administered one out of the four ordered tablets on 12/24/22 and spoke with the working manager on 12/25/22 regarding the error. Ms. Marshall reported she was instructed to contact Home Manager, Amanda Bonar, for direction. Ms. Marshall reported she sent a text message to Ms. Bonar reporting the shortage of the Prednisone dosage on 12/24/22 for Resident A. Ms. Marshall reported that Ms. Bonar stated to her to correct the dosage the next time the medication is administered to Resident A. Ms. Marshall reported that Ms. Bonar did not fully understand the initial medication error on 12/24/22 and thought that Ms. Marhsall had only shorted Resident A's dosage by one tablet, not three tablets. Ms. Marshall reported that on 12/25/22 she administered 7 10MG Prednisone tablets to Resident A with his evening medications. Ms. Marshall reported that she had worked from 2pm – 9pm on 12/25/22 and when she got home, after administering the incorrect dosage to Resident A she noted that she thought to herself that it was too much medication and realized she had given a morning medication in the evening. She noted she had made this realization but then fell asleep for the evening. Ms. Marshall reported she received a phone call from Ms. Bonar on 12/26/22 reporting the medication count for Resident A's Prednisone was off again and noting the medication error. Ms. Marshall reported Resident A was administered 15 10MG tablets of Prednisone between 12/25/22 at 8am and 12/26/22 at 8am. Ms. Marshall reported she was unsure whether the physician or the pharmacy were contacted regarding the errors. She reported she was aware that Poison Control was contacted for guidance.

On 1/6/23 I reviewed the employee record for direct care staff, Leona Marshall, that was emailed to me by Lisa Torres with the human resources office for the facility. The file included a completed *Michigan Workforce Background Check* eligibility letter and medication administration training that was completed on 1/15/18. Ms. Torres noted in the email the following disciplinary actions in Ms. Marshall's employee record:

- "12/30/18- Did not follow medication procedure
- 1/13/19- Did not follow medication procedure
- 5/18/19- Did not follow medication procedure
- 8/18/21- Did not follow medication procedure
- 10/27/21- Duties-Did not complete medication count
- 12/21/21- Did not follow medication procedure
- 5/23/22- Professionalism/confidentiality
- 5/31/22- Gossiping
- 12/25/22- Did not follow medication procedure"

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. Bonar and Ms. Marshall, Resident A was administered an incorrect dose of his Prednisone medication on 12/24/22 by Ms. Marshall. He was only given 10MG of the ordered 40MG dosage on this date. On, 12/25/22, Resident A was administered a second dosage of his Prednisone medication, of 70 MG, in the evening. Ms. Marshall reported that she had administered this second dosage on 12/25/22, in error. The facility accounted for two medication errors for Resident A's Prednisone medication within a two day period of time.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	Based upon interviews with Ms. Bonar and Ms. Marshall, the facility attempted to contact the physician regarding the medication error on 12/26/22, after the second medication error had been discovered. The facility did not contact the physician on 12/25/22 when the initial error had been identified. Although the facility contacted Poison Control, Resident A received an additional dosage of 70 MG of Prednisone on 12/25/22 and the facility did not continue to make efforts to contact the physician or the pharmacy, to receive instructions on how to proceed with the ordered medication. The facility did not take Resident A to the emergency department for evaluation.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	Based upon interviews with Ms. Bonar and Ms. Marshall, Ms. Bonar gave directive to Ms. Marshall to add the missed dosage of Resident A's Prednisone, from 12/24/22, to the next scheduled medication administration time, instead of calling the doctor to receive orders on how to proceed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/12/2023

Jana Lipps Date
Licensing Consultant

Approved By:

01/13/2023

Dawn N. Timm Date
Area Manager