GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 3, 2023

Roger Covill
North-Oakland Residential Services Inc
P. O. Box 216
Oxford, MI 48371

RE: License #: AS630012587
Investigation #: 2023A0612013
Pelton House

Dear Mr Covill:

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 (248) 975-5053.

Sincerely,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012587
Investigation #:	2023A0612013
Complaint Receipt Date:	01/24/2023
Investigation Initiation Date:	01/25/2023
Report Due Date:	03/25/2023
Licensee Name:	North-Oakland Residential Services Inc
Licensee Address:	106 S. Washington Oxford, MI 48371
Licensee Telephone #:	(248) 969-2392
Administrator:	Roger Covill
Licensee Designee:	Roger Covill
Name of Facility:	Pelton House
Facility Address:	5260 Pelton Road Clarkston, MI 48346
Facility Telephone #:	(248) 623-7200
Original Issuance Date:	06/02/1989
License Status:	REGULAR
Effective Date:	05/30/2022
Expiration Date:	05/29/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 01/21/23, direct care staff failed to administer Resident A, Resident B and Resident C their 8:00 am medications.	Yes

III. METHODOLOGY

01/24/2023	Special Investigation Intake 2023A0612013
01/24/2023	APS Referral Recipient Rights Specialist, Sarah Rupkis stated she made a report to Adult Protective Services (APS) on 01/24/23
01/25/2023	Special Investigation Initiated - Telephone I spoke to reporting source, via telephone regarding the allegation
01/30/2023	Contact - Telephone call made Telephone interview with direct care staff, ReTrenia Woods
02/01/2023	Contact - Telephone call made Telephone interview with direct care staff, Yozzmine Burkett
02/02/2023	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed home manager, Chris Hodge and direct care staff, Bryan Prowant. I observed Resident C, Resident D, and Resident E during the onsite investigation.
02/03/2023	Exit Conference I called licensee designee, Roger Covill to conduct an exit conference

ALLEGATION:

On 01/21/23, direct care staff failed to administer Resident A, Resident B and Resident C their 8:00 am medications.

INVESTIGATION:

On 01/25/23, I received a complaint from the Office of Recipient Rights that alleged, on 01/21/23, staff failed to pass Resident A his medications at 8:00 am. One of those medications, Carbamazepine, was determined by an Oakland Community Health Network (OCHN) Registered Nurse (RN) to have a potential risk of harm if skipping for one day as it may have caused a seizure and elevated blood pressure. Resident A has a history of seizures. Resident A was not harmed by the missed dose of medication. I initiated my investigation with a call to Recipient Rights Specialist, Sarah Rupkus to coordinate. Ms. Rupkus stated on 01/21/23, Resident B and Resident C also did not receive their 8:00 am medications. However, per OCHN's RN there was not a potential risk of harm to Resident B and Resident C as a result of these missed medications. Ms. Rupkus made a referral to Adult Protective Services (APS) on 01/24/23.

On 01/30/23, I interviewed direct care staff, ReTrenia Woods via telephone. Ms. Woods has been employed with the company for three to four years. Ms. Woods stated she worked Friday, 01/20/23 from 11:00 pm – 7:00 am, Saturday, 01/21/23 from 7:00 am – 11:00 pm, and then, 11:00 pm – 7:00 am on Sunday, 01/22/23. On Saturday, 01/21/23, she was the assigned medication passer on the morning shift. Ms. Woods stated she was not feeling well, and she did not want to make any mistakes while passing medication so, she asked the other staff on shift, Yozzmin Burkett to pass medications for her. There are six residents in the home, Ms. Burkett forgot to pass medications to Resident A, Resident B and Resident C. Ms. Woods stated none of the residents experienced any side effects as a result of not receiving their morning medications on 01/21/23. Ms. Woods stated there is an assigned medication passer on each shift. Staff should not switch or trade this duty without approval from the home manager. Ms. Woods did not ask the home manager for approval to have Ms. Burkett pass medications for her on 01/21/23.

On 02/01/23, I interviewed direct care staff, Yozzmine Burkett via telephone. Ms. Burkett has been employed with the company for one year. Ms. Burkett stated she was scheduled to work on Friday, 01/20/23 from 11:00 am – 7:00 am. Ms. Woods and Bryan Prowant were scheduled to work 7:00 am – 3:00 pm. Mr. Prowant was late for his shift, he did not arrive until sometime between 7:20 am – 7:40 am. When Mr. Prowant came into the house he sat down and began watching TV. Ms. Woods was the assigned medication passer for 8:00 am meds however, she was not feeling well, and needed to lay down. Ms. Woods asked if anyone could pass the 8:00 am medications for her. Mr. Prowant ignored her request. Ms. Burkett stated although technically her shift had ended at 7:00 am she verbally agreed to pass the 8:00 am medications on behalf of Ms. Woods. Ms. Burkett administered 8:00 am medications to the residents. However, Ms. Woods signed the Medication Administration Record (MAR) for the 8:00 am med pass. Ms. Burkett explained that Ms. Woods signed the MAR because technically her shift ended at 7:00 am and Ms. Woods was the assigned medication passer. Ms. Burkett stated she is unsure who and/or how many residents did not receive their medications

that morning. Ms. Burkett is unable to explain how and/or why any resident was not given their medication as prescribed at 8:00 am on 01/21/23.

On 02/03/23, I completed an unscheduled onsite inspection. I interviewed home manager, Chris Hodge and direct care staff, Bryan Prowant. Resident C, Resident D, and Resident E were home at the time of the onsite investigation. Resident C, D and E were observed laying in their beds sleeping. They would not wake up to be interviewed.

On 02/03/23, I interviewed home manager Chris Hodge. Ms. Hodge stated she did not find out about the medication error until Sunday, 01/22/23, she was informed by direct care staff, Bryan Prowant. She instructed Mr. Prowant to write an incident report. On Monday, 01/23/22, Ms. Woods explained to her that the reason she asked Ms. Burkett to pass medication on her behalf was because she was not feeling well. Ms. Hodge inquired why Ms. Burkett was still at the home at 8:00 am on 01/21/23, as her scheduled shift was over at 7:00 am, she was told that Ms. Burkett was finishing her shift duties. Ms. Hodge stated staff need approval to switch the assigned medication passer. Ms. Woods was the assigned medication administrator for 01/21/23, she did not give Ms. Woods or Ms. Burkett approval to switch.

On 02/03/23, I interviewed direct care staff Bryan Prowant. Mr. Prowant stated he arrived to work at 7:00 am on 01/21/23, Ms. Woods and Ms. Burkett were both in the home. The shift went as normal, there were no issues. The next day, 01/22/23 when he went to pass medications, he observed that Resident A, Resident B and Resident C's 8:00 am medications were not passed on 01/21/23. The pills were still in the respective bubble packs. Mr. Prowant completed incident reports and informed the home manager. Mr. Prowant stated Resident A, Resident B and Resident C did not appear to experience any symptoms or side effects as a result of missing their medication.

During the onsite investigation, completed on 02/02/23, Mr. Prowant completed a simulated medication pass. He administered the medications appropriately, using the five rights of medication administration. I also observed the medication cabinet. The cabinet was locked, all medications were stored appropriately. The January 2023 medication bubble packs were not available to review at the time of my onsite investigation as they had been completed and disposed of. I reviewed the medication administration records (MAR) for Resident A, Resident B, Resident C, Resident D, and Resident E. I found no current medication errors. The MAR was thoroughly and appropriately completed for each resident. Resident A, Resident B and Resident C are prescribed the following medications at 8:00 am. On Saturday, 01/21/23, these medications were not administered to them:

- Resident A - Hydralazine 25 mg, Vitamin D3 5,000 units, Multivitamin tab, Tamsulosin 0.4 mg, Loratadine 10 mg, Sodium bicarbonate 650 mg, Levetiracetam 1,000 mg, Docusate SOD 100 mg, Carbamazepine 400 mg ER, Risperidone 0.25 mg, and Levothyroxin 50 Mcg.
- Resident B - Docusate SOD 100 mg, Lisinopril 10 mg, and Oxybutynin 5 mg.
- Resident C - Levetiracetam 500 mg, Vitamin D3 25 mcg, Levothyroxin 25 mcg, Divalproex EC 250 mg, Fluoxetine 60 mg, and Risperidone 2 mg.

Note – Although these medications were not administered to Resident A, Resident B, or Resident C on 01/21/23, at 8:00 am the MAR is signed by direct care staff ReTrenia Woods.

On 02/03/23, I called licensee designee, Roger Covill to conduct an exit conference and review my findings. Mr. Covill acknowledged that he understands a corrective action plan is required.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude Resident A, Resident B, and Resident C's medications were not given pursuant to label instructions. On Saturday, 01/21/23, direct care staff Yozzmine Burkett administered medications at 8:00 am. Ms. Burkett failed to administer Resident A, Resident B and Resident C's their medications as prescribed. These medications were observed the following day, Sunday, 01/22/23, by direct care staff. Mr. Prowant in the respective bubble packages as they were not administered. Ms. Burkett was unable to provide an explanation as to why she did not administer these medications.
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: (b) Complete an individual medication log that contains all of the following information: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude Resident A, Resident B and Resident C's Medication Administration Records (MAR) did not include the initials of the person who administered the medication, entered at the time the medication was given. On Saturday, 01/21/23, direct care staff ReTrenia Woods was the assigned medication passer. Ms. Woods asked Ms. Burkett to pass medication on her behalf. Ms. Burkett failed to administer Resident A, Resident B and Resident C's their 8:00 am medications. However, Ms. Woods signed Resident A, Resident B and Resident C's MAR indicating that the medications were administered to the residents and further indicating that she was the staff who administered the medications. Ms. Woods and Ms. Burkett consistently stated that although Ms. Woods was the assigned medication passer, she did not administer medication to Resident A, Resident B and/or Resident Cat 8:00 am on 01/21/23.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action, I recommend the status of the license remains unchanged.

02/03/2023

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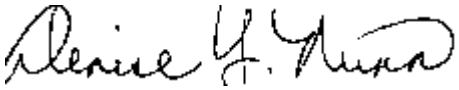
Johnna Cade Date
Licensing Consultant

Approved By:



02/03/2023

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Denise Y. Nunn Date
Area Manager