GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 23, 2023

Sonia McKeown
JARC
Suite 100
6735 Telegraph Rd
Bloomfield Hills, MI 48301

RE: License #: AS630300830
Investigation #: 2023A0602010
Nusbaum Home

Dear Ms. McKeown:

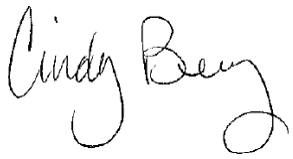
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630300830
Investigation #:	2023A0602010
Complaint Receipt Date:	12/16/2022
Investigation Initiation Date:	12/16/2022
Report Due Date:	02/14/2023
Licensee Name:	JARC
Licensee Address:	Suite 100 - 6735 Telegraph Rd Bloomfield Hills, MI 48301
Licensee Telephone #:	(248) 403-6013
Administrator:	Sonia McKeown
Licensee Designee:	Sonia McKeown
Name of Facility:	Nusbaum Home
Facility Address:	29420 Minglewood Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-4616
Original Issuance Date:	08/10/2009
License Status:	REGULAR
Effective Date:	05/12/2022
Expiration Date:	05/11/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive three of her prescribed medications from 12/01/2022 through 12/13/2022.	Yes

III. METHODOLOGY

12/16/2022	Special Investigation Intake 2023A0602010
12/16/2022	Special Investigation Initiated - Telephone Call made to the home.
12/21/2022	Inspection Completed On-site Interviewed the home manager, observed Resident A and reviewed Resident A's medication administration record.
01/12/2023	Contact – Telephone call made Message left for staff member, Myeshia Zambrama.
02/14/2023	Contact – Telephone call made Call made to staff member Tadiba Kourouma – no answer.
02/14/2023	Contact – Telephone call made Message left for staff member Shawntan Madison.
02/14/2023	Contact – Telephone call made Spoke with the assistant home manager, Shilinda Carter.
02/15/2023	Contact – Telephone call received Interviewed staff member Shawntan Madison.
02/15/2023	Contact – Telephone call made Spoke with the nurse, Chris McClue.
02/15/2023	Exit Conference Held with the licensee designee, Sonia McKeown by telephone.

ALLEGATION:

Resident A did not receive three of her prescribed medications from 12/01/2022 through 12/13/2022.

INVESTIGATION:

On 12/16/2022, a complaint was received and assigned for investigation alleging that Resident A did not receive three of her prescribed medications from 12/01/2022 through 12/13/2022.

On 12/21/2022, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Melissa Lukas, observed Resident A and reviewed Resident A's medication administration record for the month of December 2022. Ms. Lukas stated Chris McClue is a registered nurse who works for JARC and conducts monthly medication audits at the facility. On 12/13/2022, Ms. McClue was conducting a medication audit and observed that Resident A had not received the following medications from 12/01/2022 through 12/13/2022, Escitalopram 20 mg 7 am, Imipram HCL 10 mg 7 am and Myrbetriq 50 mg 7 am. The medications were not in the home but there were staff initials observed on the medication administration record (MAR). According to Ms. Lukas, Resident A was out of refills on the above listed medications and did not notify the home. However, staff signed the MAR as if the medication was being administered. Ms. Lukas said all staff members were written up. On 12/15/2022, Ms. McClue conducted an in-service on proper medication administering. She and the assistant manager, Shilinda Carter will be in-serviced on the proper procedures of handling medications when they are delivered to the home. Ms. Lukas stated on 12/13/2022 Resident A's physician was contacted, and she was instructed to continue to administer all medication as prescribed once received. The pharmacy was also notified and delivered Resident A's medication the same day (12/13/2022). Resident A began taking all medication as prescribed on 12/14/2022.

On 12/21/2022, I reviewed Resident A's MAR for the month of December 2022. According to the MAR, there were staff initials documented on 12/1/2022 through 12/21/2022 for Escitalopram 20 mg 7 am, Imipram HCL 10 mg 7 am and Myrbetriq 50 mg 7 am. I did not observe anything documented on the MAR indicating that Resident A did not receive any of the medication listed above.

On 12/21/2022, I observed Resident A resting in a recliner chair in the living room. She said she was not feeling well and did not want to answer any questions.

On 2/14/2023, I interviewed the assistant home manager, Shilinda Carter by telephone. Ms. Carter stated Resident A did not receive some of her medications (exact names unknown) as prescribed from 12/01/2022 through 12/13/2022. The facility uses an electronic medication system (Quick Mar). Residents' medications are delivered to the home in bubble packs and must be scanned each time they are administered. Ms. Carter said some of the bubble packs do not scan into the system and must be manually inputted. It is unknow if the medications Resident A did not receive required a manual entry into the system or if they were required to be scanned. Either way, staff documented as if Resident A's medications were administered when in fact three of them were not. All staff members were in-serviced on medication administration and the home manager and assistant home manager were in-serviced on proper procedures when medications are delivered to the home. Ms. Carter informed me that staff member Myeshia Zambrama no longer works for the company and Shawtan Madison works in another JARC home.

On 2/15/2023, I interviewed staff member Shawtan Madison by telephone. Ms. Madison stated she currently works at another JARC home but was working at the Nusbaum home at the time Resident A did not receive her medication. She said at the time the incident occurred she was relatively new, not fully trained in medication administration and was shadowing another staff member (name unknown). The staff member who she was shadowing told her to scan the medication into Quick Mar after she popped them out of the bubble pack and administered them to the resident. Ms. Madison said she had never passed medication before and was following the lead of another staff member. She was later informed that some of Resident A's medications were not contained in the bubble pack and was in-serviced on the proper way to administer medication.

On 2/15/2023, I interviewed Chris McClue who is a nurse with JARC and does monthly medication audits at the facility. Ms. McClue stated during her monthly medication audit, she compared Resident A's medication that was contained in each bubble pack to what was listed in Quick Mar. All morning medication is contained in one bubble pack, all afternoon medication is contained in one bubble pack, all evening medication is contained in one bubble pack, and all bedtime medication is contained in one bubble pack. She observed that the names of the medication were listed on the bubble packs, but the following morning medications were not in the bubble packs, Escitalopram TAB 20 mg, Imipram HCL TAB 10 mg and Myrbetriq TAB 50 mg. Staff were documenting in the Quick Mar as if the medication was administered. Ms. McClue stated it is the pharmacy's responsibility to notify the home when a new prescription is needed for any medication prior to running out. The pharmacy failed to do this. It is also the home manager's responsibility to inspect all medication when it is delivered to the home and make sure each bubble pack contains all prescribed medication. The medication passer

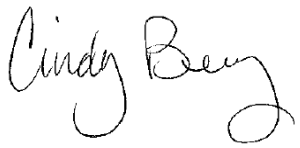
also has a responsibility to check the medication contained in the bubble pack and make sure it coincides with what is listed in Quick Mar. Ms. McClue in-serviced all staff on how to compare medication packaging labels with what is listed in Quick Mar before administering them to the residents. She also contacted the pharmacy and informed them that the home was not make aware that Resident A needed new prescriptions for some of her medication.

On 2/15/2023, I conducted an exit conference with the licensee designee, Sonia McKeown by telephone. I informed Ms. McKeown of the investigative findings and recommendation documented in this report. She agreed to submit a corrective action plan upon receipt of this report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the information obtained from Ms. Lukas, Ms. Carter, Ms. Madison and Ms. McClue, there is sufficient information to determine that Resident A's morning medication, Escitalopram TAB 20 mg, Imipram HCL TAB 10 mg and Myrbetriq TAB 50 mg were not administered as prescribed on 12/01/2022 through 12/13/2022. Ms. McClue observed the error during her monthly medication audit and in-serviced all staff involved on how to compare medication packaging labels with what is listed in Quick Mar before administering them to the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

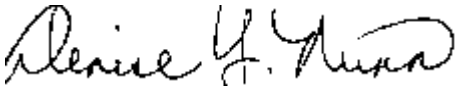
Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



02/15/2023

Cindy Berry — Date
Licensing Consultant

Approved By:



02/23/2023

Denise Y. Nunn — Date
Area Manager