GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 7, 2023

Pamela Hurley
Innovative Lifestyles, Inc.
PO Box 1258
Clarkston, MI 48347

RE: License #: AS630015466
Investigation #: 2023A0991016
Cuthbert AIS/MR

Dear Ms. Hurley:

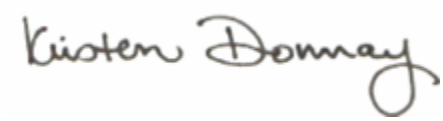
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630015466
Investigation #:	2023A0991016
Complaint Receipt Date:	03/13/2023
Investigation Initiation Date:	03/13/2023
Report Due Date:	05/12/2023
Licensee Name:	Innovative Lifestyles, Inc.
Licensee Address:	5490 Dixie Hwy Suite 1 Waterford, MI 48329
Licensee Telephone #:	(248) 623-8898
Licensee Designee:	Pamela Hurley
Name of Facility:	Cuthbert AIS/MR
Facility Address:	6720 Cuthbert White Lake, MI 48386
Facility Telephone #:	(248) 922-7119
Original Issuance Date:	10/25/1994
License Status:	REGULAR
Effective Date:	08/03/2021
Expiration Date:	08/02/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Per incident report, staff gave Resident A another resident's medications on 03/12/23.	Yes

III. METHODOLOGY

03/13/2023	Special Investigation Intake 2023A0991016
03/13/2023	Special Investigation Initiated - Telephone Call to Office of Recipient Rights (ORR) worker, Katie Garcia
03/13/2023	Referral - Recipient Rights Sent complaint to Katie Garcia
03/13/2023	APS Referral Referred to Adult Protective Services (APS) Centralized Intake
03/16/2023	Contact - Telephone call made To home manager, Shanean Butler
03/16/2023	Contact - Telephone call made To direct care worker, Chariah Matthews
03/23/2023	Inspection Completed On-site Interviewed staff and home manager, observed residents
03/23/2023	Contact - Document Received Medication administration records, hospital discharge summary, training verification, and disciplinary action
04/04/2023	Contact - Telephone call made Left message for licensee designee, Pam Hurley
04/05/2023	Exit Conference Via telephone with licensee designee, Pam Hurley

ALLEGATION:

Per incident report, staff gave Resident A another resident's medications on 03/12/23.

INVESTIGATION:

On 03/13/23, I received and reviewed an incident report from Cuthbert AIS/MR which noted that on 03/12/23 at 8:00pm, Resident A received another resident's medications by accident. Direct care worker, Chariah Matthews, accidentally gave Resident A another resident's medications, which included Metoprolol Succinate ER 25mg, Clomipramine Hydrochloride 75mg, Clonazepam 0.5mg, Nuedexta 20mg/10mg, Risperidone 1mg, and Divalproex Sodium DR (Depakote) 250mg. Resident A is allergic to Depakote. He was transported to McLaren Clarkston Emergency Department. He did not have any swelling or reactions to the medications, but was given Solumedrol 125mg, Benadryl 50mg, and Pepcid 40mg while at the hospital. I created a special investigation intake based off the information in the incident report, which was assigned to me for investigation. I initiated my investigation on 03/13/23 by making a referral to Adult Protective Services (APS) Centralized Intake. I also contacted the assigned Office of Recipient Rights (ORR) worker, Katie Garcia.

On 03/16/23, I interviewed the home manager, Shanean Butler, via telephone. Ms. Butler stated that direct care worker, Chariah Matthews, was the assigned medication passer during the evening shift on 03/12/23. Ms. Matthews accidentally gave Resident B's medications to Resident A. Resident A is allergic to Depakote, which was one of the medications he received. Ms. Matthews contacted Ms. Butler, and she came to the home and took Resident A to McLaren Clarkston Emergency Department. Resident A did not have any negative side effects. He was discharged from the hospital at 11:00pm. Ms. Butler stated that they had extra medications from February, due to it being a shorter month, so Resident B received his medications from those bubble packs and did not miss any doses.

On 03/16/23, I interviewed direct care worker, Chariah Matthews, via telephone. Ms. Matthews stated that she has worked at Cuthbert for more than six months and is fully medication trained. She was working the midnight shift on 03/12/23 from 4:00pm-8:30am. While passing 8:00pm medications, she accidentally administered Resident B's medications to Resident A. She stated that this was her first time having a medication error. She was going through some personal things and got sidetracked while passing medications. Ms. Matthews stated that when she was passing medications on 03/12/23, she set up the medications in advance by popping out each resident's medications into a medication cup and set them all out on the counter. She stated that she usually labels each medication cup with the resident's name or initials, but she did not label them that day. She accidentally grabbed Resident B's medications and gave them to Resident A. She did not check to make sure she was giving the medications to the correct resident until it was too late. Ms. Matthews called 911 and contacted the home manager. She

stated that the home manager took Resident A to the hospital, as Resident A is allergic to Depakote, which is one of the medications that he received in error. Resident A did not have any negative side effects as a result of receiving the incorrect medications. Resident B received his medications as prescribed. Ms. Matthews stated that following the medication error, she completed a refresher medication training. She stated that she was originally trained to pass each resident's medications one at a time instead of setting them up in advance. She observed a more experienced staff person in the home setting up all the medications in advance. She recognized that setting the medications up in advance is quick and easy, but that is how errors get made. Ms. Matthews stated that from now on, she will not set up medications in advance. She will pass medications to one resident at a time and will make sure she is following the eight rights of medication passing.

On 03/23/23, I conducted an unannounced onsite inspection at Cuthbert with the assigned ORR worker, Katie Garcia. I interviewed direct care worker, Chariah Matthews. Ms. Matthews provided the same information that she gave during our phone interview. Ms. Matthews stated that there are currently five residents in the home. All five residents receive 8:00pm medications. She demonstrated how she passed medications on 03/12/23, showing that she popped each resident's medications into a clear medication cup and had them all sitting out on the counter. She stated that Resident A and Resident B's medications were next to each other, and she grabbed the wrong medications and passed them to Resident A. She noticed her error almost immediately. She called the home manager and Resident A was transported to the emergency department. Staff monitored Resident A closely when he returned to the home and he did not have any negative side effects.

On 03/23/23, I interviewed the home manager, Shanean Butler. Ms. Butler stated that Ms. Matthews received a refresher training on medication passing on 03/14/23, which included a review of the eight rights of medication administration. She also received a written disciplinary action for the medication error, which was placed in her file. Ms. Butler provided copies of the training verification and disciplinary action.
During the onsite inspection, I reviewed the medication administration records (MARs) and medications for the residents in the home. No other discrepancies were noted. I reviewed a copy of Resident B's medication administration record. Resident B's 8:00pm medications that Resident A received in error were Metoprolol Succinate ER 25mg, Clomipramine Hydrochloride 75mg, Clonazepam 0.5mg, Nuedexta 20mg/10mg, Risperidone 1mg, and Divalproex Sodium DR (Depakote) 250mg.

I reviewed a copy of the McLaren Clarkston Emergency Department discharge summary. It indicates that Resident A was admitted on 03/12/23 at 8:48pm due to inadvertent/accidental ingestion of drugs. The summary notes that Resident A received his medications at 8:00pm as prescribed, as well as another resident's medications. Resident A has a recorded allergy to Depakote, but no one knows what the reaction is. He exhibited no nausea, vomiting, difficulty breathing, chest pain/abdominal pain, rashes, or itching. Resident A was awake, and his behavior was at baseline. Resident A was given Solumedrol 125mg, Benadryl 50mg, and Pepcid 40mg. Caregivers were

advised to continue monitoring Resident A and to continue Benadryl every six hours for the next 24 hours.

On 04/05/23, I conducted an exit conference via telephone with the licensee designee, Pam Hurley. Ms. Hurley agreed to submit a corrective action plan to address the findings in the report. She stated that she would conduct medication training with all staff to ensure that they are passing medications to one resident at a time and are not setting up medications in advance.

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 gathered through my investigation, there is sufficient information to conclude that staff did not keep resident's medications in the original pharmacy-supplied container. Direct care worker, Chariah Matthews stated that she set up medications for all of the residents in medication cups before passing medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that reasonable precautions were not taken to ensure that prescription medication was not used by a person other than the resident for whom the medication was prescribed. On 03/12/23, Resident A received Resident B's medications in error after direct care worker, Chariah Matthews, popped each of the resident's 8:00pm medications into medication cups and set them all on the counter prior to passing medications. She did not follow her medication training by passing medications to one resident at a time and did not follow the eight rights of medication passing prior to passing the wrong medications to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

04/05/2023

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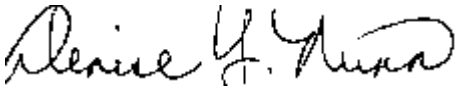
Kristen Donnay Date
Licensing Consultant

Approved By:



04/07/2023

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Denise Y. Nunn Date
Area Manager