GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 13, 2023

Amber Hernandez-Bunce
Hernandez Home LLC
P.O. Box 277
Bloomingdale, MI 49026

RE: License #: AS800316739
Investigation #: 2023A1031017
Baseline Home

Dear Ms. Hernandez-Bunce:

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 (616) 356-0183.

Sincerely,
Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AS800316739
Investigation #:	2023A1031017
Complaint Receipt Date:	02/27/2023
Investigation Initiation Date:	02/28/2023
Report Due Date:	04/28/2023
Licensee Name:	Hernandez Home LLC
Licensee Address:	44409 Baseline Road Bloomingdale, MI 49026
Licensee Telephone #:	(269) 521-4130
Administrator:	Amber Hernandez-Bunce
Licensee Designee:	Amber Hernandez-Bunce
Name of Facility:	Baseline Home
Facility Address:	44409 Baseline Road Bloomingdale, MI 49026
Facility Telephone #:	(269) 521-4130
Original Issuance Date:	04/23/2012
License Status:	REGULAR
Effective Date:	10/23/2022
Expiration Date:	10/22/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive a prescribed medication for four days.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/28/2023	Special Investigation Intake 2023A1031017
02/28/2023	Special Investigation Initiated - Email sent to ORR Mark Draeger.
02/28/2023	Contact - Email exchange with Karmen Ball.
02/28/2023	Contact – Telephone Interview with Karmen Ball.
03/06/2023	Contact - Documents requested and received.
03/08/2023	Inspection Completed On-site Interview completed with home manager Anthony Kennedy.
03/20/2023	Contact - Documents requested and received.
03/21/2023	Contact - Email sent to ORR Officer Mark Draeger.
03/21/2023	Contact - Voicemail left with Northern Lakes Case Manager Christa Vasicek.
03/21/2023	Contact - Telephone Interview completed with Clorinda Starlin.
03/21/2023	Contact - Voicemail left with Lisa Prihoda at Hometown Pharmacy.
03/22/2023	Contact – Telephone Interview completed with Christa Vasicek.
03/23/2023	Contact – Telephone Interview completed with Lisa Prihoda at Hometown Pharmacy.
04/13/2023	Exit Conference held with LD Amber Hernandez-Bunce.

ALLEGATION:

Resident A did not receive a prescribed medication for four days.

INVESTIGATION:

On 2/24/23, An incident report dated 2/24/23 was received via email from the Chief Administrative Officer Karmen Ball. The incident report stated "[Resident A] was out of medication Risperidone 2mg for 4 days". The report indicated action taken by staff was that "staff called and left several messages at the CMH [Community Mental Health] for Pam the nurse requesting to refill on this medication. Staff contacted the caseworker and guardian". The report indicates the home received the medication on 2/23/23.

On 2/27/23, I followed-up by email to Ms. Ball and Recipient Rights Officer Mark Draeger requesting additional information regarding why Resident A ran out of medication. Mr. Drager reported Resident A missed a medication review on 2/13/23 and also inquired about why Resident A ran out of medications. Ms. Ball reported she was informed by the home manager that the prescribing doctor was not reachable, and therefore were not able to refill the prescriptions as needed.

On 2/28/23, I sent an email to Mr. Draeger requesting additional information regarding Resident A's missed appointment for a medication review. Mr. Draeger shared that Resident A was scheduled for a telehealth appointment on 2/13/23 for a medication review. The AFC home reported to him they did not receive the link for the telehealth appointment and Resident A subsequently missed the review. Mr. Draeger reported on 1/25/23, a note was entered in Resident A's chart that his medication was renewed for 30 days. On 2/27/23, Mr. Draeger received the incident report that read Resident A had been out of medication for four days. Mr. Draeger reported he was concerned about the missing medication due to Resident A receiving a refill on 1/25/23 for 30 days of medication and being out of medication for four days as of 2/24/23.

On 2/28/23, I interviewed Ms. Ball via telephone. Ms. Ball reported she was informed of the medication issue once it was resolved. Ms. Ball reported the home did try to contact the prescribing physician through CMH multiple times and never received a call back.

On 3/1/23, I received an email from Ms. Ball that she spoke with "Lisa" through Hometown Pharmacy and Resident A's Risperidone prescription was filled on 1/19/23. Ms. Ball was informed by the pharmacy that they had to subtract pills from the most recent prescription due to previously loaning the home pills due to a gap in medication reviews. Ms. Ball reported the home needed to borrow pills which caused

a gap where the most recent prescription was filled for 24 days and not 30. Ms. Ball reported there was a medication review scheduled on 1/13/23, but community mental health did not send the home a link to the appointment causing there to be a gap in prescriptions.

On 3/6/23, I received the medication administration record (MAR) from the home's Care Coordinator Mequesha Merritt. The February 2023 MAR was reviewed and indicates Resident A did not receive his prescribed Risperidone 2mg in the morning and at bedtime from 2/18/23-2/21/23 for a total of eight missed doses.

On 3/8/23, I went to the home to interview Resident A. Resident A was not able to engage in the interview process due to being nonverbal.

On 3/8/23, I interviewed the home manager Anthony Kennedy in the home. Mr. Kennedy reported he noticed Resident A had a couple pills left and he contacted the doctor multiple times requesting a prescription refill. Mr. Kennedy reported he contacted the corporate office for assistance to get the medication refilled due to the doctor's office through CMH not contacting him back. Mr. Kennedy confirmed that Resident A did not receive his prescribed Risperidone 2mg for four days due to CMH not refilling the prescription. Mr. Kennedy reported he could only recall a missed medication review in January 2023 due to the home not receiving a link for the telehealth appointment.

On 3/20/23, Ms. Merritt provided documentation verifying attempts made by the home to contact the doctors office to refill the prescription and obtain a link for the telehealth appointment. On 2/13/23, the home contacted CMH at 2:33pm requesting a link to the appointment. The home was sent to the nurse's phone line and left a voicemail. The home attempted to contact CMH again at 3:22pm and left another message. The home did not receive a call back from CMH. On 2/14/23, the home contacted CMH regarding Resident A and left another message with the doctor's office. On 2/20/23, the home left another voicemail with the nurse requesting a medication refill. On 2/22/23, the home had a virtual meeting with Resident A's case manager Christa Vasicek, a nurse, and behavior specialist. CMH was informed during the meeting that the home made multiple attempts to contact the prescribing physician regarding Resident A's medications and never received a telephone call back. During the meeting, Ms. Vasicek contacted CMH and informed them the home was trying to get ahold of the doctor to have a prescription filled.

On 3/21/23, I interviewed Resident A's guardian Clorinda Starlin via telephone. Ms. Starlin reported she was not initially contacted by the home. Ms. Starlin reported she did receive an incident report regarding the medications. Ms. Starlin reported she did not have any additional information aside from what was noted in the incident report.

On 3/22/23, I interviewed Resident A's case manager Christa Vasicek via telephone. Ms. Vasicek reported she was first notified on 2/22/23 that Resident A was out of

medication. Ms. Vasicek reported the home informed her they made multiple attempts to contact the doctor's office to have the prescription refilled. Ms. Vasicek reported at the telehealth appointment on 2/22/23 there was a nurse present and they were able to refill the prescription and it was delivered to the home on 2/23/23.

On 3/23/23, I interviewed the pharmacist Lisa Priholda through Hometown Pharmacy. Ms. Priholda reported the pharmacy attempted to refill the prescription by faxing a request directly to the doctor's office at the beginning of February. Ms. Priholda reported it is the home's responsibility to follow up with the prescription after their initial attempt. Ms. Priholda reported the pharmacy was contacted by the home stating Resident A was out of medication. Ms. Priholda reported the home was provided with 6 tablets of Risperidone 2mg on 2/22/23 to provide to Resident A until the prescription was refilled. Ms. Priholda reported the full prescription was refilled and delivered to the home on 2/23/23.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	As a result of interviews held with staff, case manager, guardian, pharmacy, and the review of documentation, it has been determined that Resident A did not receive his prescribed medication pursuant to label instructions. However, the home did make multiple attempts to contact the prescribing physician through CMH in efforts to have his prescription refilled and CMH did not contact the home back. The home began making attempts to refill the prescription five days prior to Resident A running out of medication. The home also made attempts to attend the initial telehealth appointment in February for Resident A's medication review and did not receive information back to attend. Due to the circumstances, Resident A was not able to take his prescribed medications at no fault of the home but due to lack of communication from the prescribing physician.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The MAR for February 2023 was reviewed and indicates Resident A did not receive his prescribed Risperidone 2mg in the morning and at bedtime from 2/18/23-2/21/23. The missed medications were labeled as "refused by resident" for each day.

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 the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	The home did not properly complete Resident A's medication log. The home improperly documented Resident A's reason for not taking his prescribed medications. The MAR indicates the resident refused the medication which is not accurate given the circumstances. Resident A was not provided with his medication due to the prescription not being refilled and available in the home. Resident A could not have refused a medication that was not available and offered to him.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that there be no change to the status of the license.

KDuda 4/11/23

Kristy Duda Date
Licensing Consultant

Approved By:

Russell Misiak 4/11/23

Russell B. Misiak Date

Area Manager