GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 18, 2023

Carol Freeman
Family Supp Svcs For Mental Rec
G-3445 Mackin Rd.
Flint, MI 48504

RE: License #: AS250010767
Investigation #: 2023A0576031
Family Support Group Home

Dear Ms. Freeman:

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.
- 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 (517) 643-7960.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010767
Investigation #:	2023A0576031
Complaint Receipt Date:	03/25/2023
Investigation Initiation Date:	03/30/2023
Report Due Date:	05/24/2023
Licensee Name:	Family Supp Svcs For Mental Rec
Licensee Address:	G-3445 Mackin Road, Flint, MI 48504
Licensee Telephone #:	(810) 732-9160
Administrator:	Carol Freeman
Licensee Designee:	Carol Freeman
Name of Facility:	Family Support Group Home
Facility Address:	G-3445 Mackin Road, Flint, MI 48504
Facility Telephone #:	(810) 732-9160
Original Issuance Date:	10/28/1986
License Status:	REGULAR
Effective Date:	05/08/2021
Expiration Date:	05/07/2023
Capacity:	6
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 03/25/2023, Resident A was brought to Hurley Medical Center for an ingestion. At the AFC home he was given the wrong medications which belonged to another resident.	Yes

III. METHODOLOGY

03/25/2023	Special Investigation Intake 2023A0576031
03/27/2023	Contact - Document received Reviewed Incident Report (IR)
03/30/2023	Special Investigation Initiated - Telephone Interviewed Home Manager, Tawana Gould
04/10/2023	Inspection Completed On-site Interviewed Licensee Designee, Carol Freeman, and Resident A
04/17/2023	Contact - Telephone call made Message left for Staff, Deshawn Manuel to return call
04/17/2023	Exit Conference Exit Conference conducted with Licensee Designee, Carol Freeman
04/17/2023	APS Referral
04/18/2023	Contact - Telephone call made Interviewed Staff, Deshawn Manuel

ALLEGATION:

On 03/25/2023 Resident A was brought to Hurley Medical Center for an ingestion. At the AFC home he was given the wrong medications which belonged to another resident.

INVESTIGATION:

On March 27, 2023, I reviewed an AFC Licensing Division - Incident / Accident Report (IR) dated for March 27, 2023, and authored by Carol Freeman. The IR documented

that on March 25, 2023, Resident A was given medication prescribed for another resident. Employee stated he did not carefully look at the last name and both residents have the same last name initial. Staff immediately recognized the mistake and Resident A was directed to spit out the medication, which he did. Ambulance was called and Resident A was transported to the hospital. Resident A was given sodium chloride and observed at the hospital then discharged. Corrective measures include having a staff meeting to go over medication training in a group and also retrain all staff individually.

On March 30, 2023, Tawana Gould was interviewed regarding the allegations. Ms. Gould reported she was contacted by staff and advised Resident A was administered the wrong medication. Resident A spit the medication out however the ambulance transported Resident A to the hospital. Resident A was not admitted to the hospital and has since returned home.

On April 10, 2023, I conducted an unannounced on-site inspection at Family Support Group Home and interviewed Licensee Designee, Carol Freeman, and Resident A. Ms. Freeman advised that Staff, Deshawn Manuel made the medication error involving Resident A. According to Ms. Freeman, Resident A was administered Resident B's medication. Mr. Manuel knew right away that he gave Resident A the incorrect medication and the confusion may have been due to both residents having similar initials. It is not certain if Resident A swallowed any of the medication as he was immediately directed to spit the pills out. 911 was contacted and Resident A was transported to the hospital where Resident A was given something to drink, observed, and sent home after 4 hours.

Mr. Manuel was hired in November 2022, and completed medication training in December 2022. At this time, Mr. Manuel is not administering resident medication and will be retrained according to Ms. Freeman.

During the on-site inspection, resident medications and medication administration sheets were reviewed. No concerns were noted.

On April 10, 2023, I interviewed Resident A who reported he has lived at his home for a few months, and he likes his home. Regarding the allegations, Resident A stated Staff, Deshawn Manuel gave him someone else's medications by accident. Resident A swallowed some of the pills and went to the hospital. Resident A did not get sick, and he did not have to stay at the hospital. Resident A does not know what medications he takes. Resident A gets along with Mr. Manuel and denied any concerns regarding his home.

On April 17, 2023, I called Staff, Deshawn Manuel. There was no answer, and a message was left requesting Mr. Manuel return my call. On April 18, 2023, I interviewed Mr. Manuel regarding the allegations. Mr. Manuel reported that he set up resident medications and "got them mixed up". Resident A got the wrong medication, and he swallowed some and spit some out. As soon as this happened Mr. Manuel called 911 and his manager.

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:	It was alleged that Resident A was administered the wrong medications and sent to the hospital as a result. Upon completion of investigative interviews and review of documentation, there is a preponderance of evidence to conclude a rule violation. I reviewed an IR dated for March 27, 2023, that documented Resident A was provided medications prescribed to another resident. Licensee Designee, Carol Freeman reported there was a medication error and Resident A was provided medication of another resident. Resident A went to the hospital to ensure his health and safety after the medication error. Resident A reported he was accidentally given another resident's medications. Staff, Deshawn Manuel confirmed he made a medication error, and that Resident A was given the wrong medication. There is a preponderance of evidence to conclude prescription medication was not given as prescribed by a licensed physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

On April 10, 2023, I conducted an Exit Conference with Licensee Designee, Carol Freeman. I advised Ms. Freeman I would be requesting a corrective action plan for the cited rule violation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in the license status is recommended.

4/18/2023

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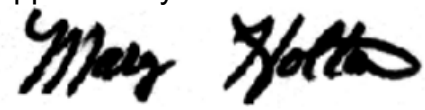
Christina Garza Date
Licensing Consultant

Approved By:



4/18/2023

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Mary E. Holton Date
Area Manager