GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 28, 2023

Timothy Carmichael
Crisis Center Inc - DBA Listening Ear
PO Box 800
Mt Pleasant, MI 48804-0800

RE: License #: AS050337198
Investigation #: 2023A0009020
Kresnak

Dear Mr. Carmichael:

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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the 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 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 (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

Enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS050337198 |
| | |
| **Investigation #:** | 2023A0009020 |
| | |
| **Complaint Receipt Date:** | 04/11/2023 |
| | |
| **Investigation Initiation Date:** | 04/12/2023 |
| | |
| **Report Due Date:** | 05/11/2023 |
| | |
| **Licensee Name:** | Crisis Center Inc - DBA Listening Ear |
| | |
| **Licensee Address:** | 107 East Illinois<br>Mt Pleasant, MI 48858 |
| | |
| **Licensee Telephone #:** | (989) 773-6904 |
| | |
| **Administrator:** | Sherry Kidd |
| | |
| **Licensee Designee:** | Timothy Carmichael |
| | |
| **Name of Facility:** | Kresnak |
| | |
| **Facility Address:** | 644 Kresnak Road<br>Mancelona, MI 49659 |
| | |
| **Facility Telephone #:** | (231) 587-8055 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 12/25/2021 |
| | |
| **Expiration Date:** | 12/24/2023 |
| | |
| **Capacity:** | 4 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was given another resident's medication in error. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 04/11/2023 | Special Investigation Intake<br>2023A0009020 |
| 04/12/2023 | Special Investigation Initiated – Telephone call made to direct care worker Mary Pines |
| 04/13/2023 | Contact - Telephone call received from administrator Sherry Kidd |
| 04/18/2023 | Inspection Completed On-site<br>Interview with home manager Bobbi Cinader |
| 04/27/2023 | Contact – Telephone call made to direct care worker Seth Adams |
| 04/27/2023 | Contact – Telephone call made to administrator Sherry Kidd |
| 04/27/2023 | Exit conference with administrator Sherry Kidd |
| 05/02/2023 | APS Referral |

**ALLEGATION: Resident A was given another resident's medication in error.**

**INVESTIGATION:** I received an AFC Licensing Division – Incident/Accident Report (BCAL-4607) by email on April 11, 2023. The report indicated that Resident A had been given another resident's medication in error the night before. The direct care worker who made the error, Seth Adams, immediately notified Poison Control, administration and attempted to contact the resident's physician.

I spoke with direct care worker Mary Pines by phone on April 12, 2023. She said that she was not present when the medication error occurred two nights before but had heard about it. She said that she had worked at the facility for 10 years and is always very careful to give the correct medication to each resident. She said that she was not aware of any other medication errors occurring in the home. Ms. Pines said that the staff person who had made this error was a relatively new staff person.

I spoke with administrator Sherry Kidd by phone on April 13, 2023. She told me that direct care worker Seth Adams had given Resident A another resident's medication.

He had discovered his mistake almost immediately and reported it to the proper authorities. She said that she would be going over proper medication protocol with him as well as other staff in the home. She stated that Mr. Adams had admitted that he had been in a hurry and that he wasn't paying close enough attention to what he was doing. He promised that it would not happen again. They plan on adding pictures to the medication administration books as well as having a second staff on-hand to observe the administration.

I made a site visit at the Kresnak adult foster home on April 18, 2023. I spoke with home manager Bobbi Cinader during the time of my visit. She said that Mr. Adams had been fully trained in medication administration and showed competence before he made the medication error on April 10, 2023. He thought that he could save time by doing the medication administration of several residents all at the same time. This is not how they train staff on how to properly administer medication. Being in a hurry and doing more than one resident at a time led to the error. He ended up just grabbing the wrong cup and giving it to Resident A. Mr. Adams realized his mistake almost immediately and did report it right after it happened. Ms. Cinader said that he was very apologetic and remorseful for what had happened. He realized the gravity of what could have happened although Resident A turned out to be fine. He was adamant that he would closely follow the medication administration protocol from that point forward. Mr. Adams and the rest of the staff are all receiving new training on medication administration to ensure something like this does not happen again. Ms. Cinader provided me with the facility's Medication Passing Protocol and showed me the multiple steps that ensure that the proper medication is given to each resident.

I spoke with direct care worker Seth Adams by phone on April 27, 2023. I asked him about the circumstances on April 10, 2023, which led to Resident A receiving another resident's medication. Mr. Adams said that he and a coworker were busy putting groceries away and that he went to give the residents their evening medications. He said that he skipped the usual medication administration protocol and instead set up all the medications at the same time. He put each resident's medication into a separate cup. He did lock up the medication when he went to get the first resident. That resident was in the bathroom so he instead got Resident A and brought him to the medication room. He wasn't thinking so instead gave him the first resident's medication in error. Mr. Adams admitted that he wasn't paying close enough attention to what he was doing and that he was in a hurry. He realized almost immediately what he had done and told his coworker. Mr. Adams said that he then called Poison Control and told them all of what he had given Resident A. They told him that Resident A should be fine but that they should monitor him closely. Mr. Adams said that he then called his administration to report what happened and then tried to contact Resident A's physician. It occurred in the evening so he spoke with the physician's after-hours answering service. They recorded the information and told him that the physician would call him back. The physician did not call back. He and his coworker did monitor Resident A closely that night and took his vitals hourly. Resident A seemed okay and verbally replied that

he was okay and felt fine. They also told the next shift what was going on who agreed to continue to monitor Resident A. Mr. Adams said that he felt bad about his mistake and said that it would not happen again.

I conducted an exit conference with administrator Sherry Kidd by phone on April 27, 2023. She said that they had added photographs of each resident to the resident medication books and have retrained the staff that they must do each resident's medication administration separately. A second staff will be observing the medication administration of each resident for the time-being to ensure that there are no further medication errors. I told Ms. Kidd about the findings of my investigation and gave her the opportunity to ask questions.

| **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:** | It was confirmed through this investigation that Resident A received another resident's medication in error on April 10, 2023. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

04/28/2023

Adam Robarge Date
Licensing Consultant

Approved By:

04/28/2023

Jerry Hendrick Date
Area Manager